NCD Clinic Guideline

1. Objectives

- ✓ Prevent and control common NCDs through behavior and life style modifications
- ✓ Facilitate early diagnosis and management of common NCDs
- ✓ Build capacity at various levels of health care for prevention, diagnosis and treatment of common NCDs
- ✓ Train human resource within the public health setup (doctors, paramedics, community health workers, and nursing staff) to cope with the increasing burden of NCDs
- ✓ Establish and develop capacity for palliative & rehabilitative care
- ✓ Streamline and standardize NCD clinical services across the country

2. Reception: First contact point.

- Provide information about NCD clinic to interested clients and new clients
- Explain procedure for registration and services offered at the clinic.
- Registration form for new clients: to be filled by nurse/health worker (annex 1)
- Enter registration form details into computer.
- Generate clinic registration number and memo for NCD clinic for appointments/walk-ins.
- Give appointment/guide client according to the purpose of visit (refer to registration form)
    - Purpose of visit 1,2: direct towards designated nurse
    - Personal request to meet doctor/counselor/health educator: talk to the concerned and facilitate the procedure.
    - Purpose of visit 3: Explain about the NCD clinic services
    - Purpose of visit 4: Direct towards Health Educator

- If for appointment: direct patient.
- For follow-up patients, trace patient file, or inform NCD nurse to trace file and send patient with file for measurements.
- At the end of each NCD clinic day: list the appointments/follow-ups for the next clinic day.
- One day prior to NCD clinic day: give appointment reminder messages to the clients.

3. NCD nurse (in the absence of nurse, Community Health worker can also perform this role):

- Prepare set-up for NCD clinic on clinic day, including patient files, scales, equipment, protocols, etc.
- Take Medical History (update once every 6 months or if any new condition occurs).
- NCD risk factor history [dietary habit, tobacco use, physical activity levels, mental wellbeing] (update one every 3months, or as per PEN protocol)
- Check the following: (adjust according to doctor's advice/patient's particulars)
    - RBS
    - FBS and or PPBS (For suspected cases of Diabetes & Diabetic Patients)
    - Weight, height
    - Calculate BMI
    - Waist Circumference
    - Blood pressure
    - Pulse
    - Cholesterol [if needed] (see report)
    - Calculate Cardiovascular Disease Risk (CVD risk) from WHO chart.

- If first-time screening or cholesterol level not checked, refer to doctor for initial assessment and to get investigation slip.
- Follow-ups:
    - If NO current NCD risk factor or illness found AND CVD risk <30%: Refer directly to Health Educator and follow-up as above.
    - If ANY NCD risk factor or illness found, OR CVD risk ≥ 30%, direct to Doctor, and follow-up as per protocol.

- Direct the person to doctor/ health educator/counselor: Give appointment or walk-in. Coordinate with concerned for this.
- If blood investigations advised: follow blood sample collecting procedure.
- Collect laboratory reports and handover to the patients or family members. Explain blood reports to patient (if needed: discuss with doctor prior to this).
- Give appointment to doctor accordingly and note review date in patient file.
- If using any form of tobacco product or quit<6 months: Give brief advice and quit leaflet as per PEN protocol, and refer to tobacco cessation clinic.
- If never used any form of tobacco product/quit>6 months: Enter role model file (file will be kept in cessation clinic)

4. Health Educator (HE):

- Fill NCD Risk Factor History (update 1/3months, or as per PEN protocol)

- If following information are not available, HE should check on the following measurements to target health education:
    - RBS
    - FBS and or PPBS (For suspected cases of Diabetes & Diabetic Patients)
    - Weight, height
    - Calculate BMI
    - Waist Circumference
    - Blood pressure
    - Pulse
    - Cholesterol [if needed] (see report)
    - Calculate Cardiovascular Disease Risk (CVD risk) from WHO chart.

- Give personalized Health Education according to WHO PEN protocols. (adjust according to doctor's advice and patient's particulars)
- Refer to doctor if any CVD risk >30% or
- Refer to counselor/psychologist for counseling if needed.
- If using any form of tobacco product or quit<6 months: Give brief advice and quit leaflet as per PEN protocol, and refer to tobacco cessation clinic.
- If never used any form of tobacco product/quit>6 months: Enter role model file (file will be kept in cessation clinic)
- Give follow-up every 3 months. Write in appointment book.
- Re-do all at every visit.
- Provide group health education sessions during waiting time or as separate classes.

5. Doctor:

- Do consultation.
- Do additional history taking, review the NCD risk factors, CVD risk and previous reports and prescriptions.
- Calculate CVD risk, if not done by nurse/ Health educator.
- Assess and manage according to WHO PEN protocol.
- Give personalized advice, prescription.
- Enter notes into the NCD patient file AND patient's book. If e-prescription issued, copy may be added into file and book.
- Refer to Health Educator/Psychologist as needed.
- Send patient to NCD nurse: if blood investigations needed. Indicate clearly the required investigations.
- Refer for physician consultation if CVD risk≥ 30% every 6 months, or as required according to PEN protocol.
- Give follow-up according to the status of the patient: Write in patient notes and

patient's book.

- Next visit: NCD nurse prior to consultation.

6. Counselor:

- Person-oriented counseling for lifestyle modification (including tobacco cessation), stress management, any other problems requiring counseling
- Write counselor's notes
- Give follow-up accordingly: Write in appointment book.
- Give referral to doctor/health educator/NCD nurse as needed.

As a team:

- Staff briefing: among all technical staff (At the beginning of every day at NCD Clinic)
  - Elect a coordinator for technical staff meetings.
  - Discuss all cases of each week: Follow ethics in this matter.
  - Coordinate on follow-ups and treatment.
  - Plan for improvement and give feedback to administration.
  - Discuss an important NCD topic each day.
  - ** Debriefing

- Once monthly meeting: among technical and administrative staff.
  - Discuss issues, plan on further improvements.
  - Inform about inventory, equipment, and other relevancies: by technical staff
  - Give feedback to staff.

7. NCD Surveillance
   - Facility quarterly NCD summary report (Annex 2) need to be sent to ncds.maldives@gmail.com.
   - Every NCD clinic have to maintain daily NCD registry. Please use the format attached in annex 3.

Annex 1 - Patient clinical record

Health Facility:…… Atoll:……

NCD Registration No: _____ Date: __ /__ /___

Patient Name:			**DOB:** (DD/MM/YY)	**Sex:** M☐F☐
Body measurements:				
Weight:……kg	Height:……cm	Desired weight between…..and …… (For BMI (18.5)(23)		BMI:
WC: …… (cm)	Desired WC (cm): M <90 , F: <80	BP:……./…….	RBS: (mg/dl)	CVDR:

Medical Conditions (in self and among immediate family members:

☐ Arthritis	☐ FH	☐ Gastritis/Ulcer	☐ FH	☐ Liver Disease	☐ FH
☐ Asthma/COPD	☐ FH	☐ Heart Disease *	☐ FH	☐ Neurological illness	☐ FH
☐ Cancer	☐ FH	☐ Hepatitis	☐ FH	☐ Psychiatric illness	☐ FH
☐ Chronic Anemia	☐ FH	☐ Hypertension	☐ FH	☐ Stroke *	☐ FH
☐ Diabetes	☐ FH	☐ Hypothyroidism	☐ FH	☐ Thalassemia	☐ FH
☐ Dyslipidemia	☐ FH	☐ Kidney disease *	☐ FH	☐ Others (specify)	☐ FH

* (specify):

Allergies:

☐ Yes*	☐ No	☐ Unknown

*(specify):

Surgeries (operations):

☐ Yes*	☐ No	

*(specify):

Admissions:

☐Yes*	☐ No	*(specify): (year)

Remarks:

a. Taking regular medication (good compliance):	Y☐ N☐
b. Unhealthy Diet – Above healthy limits	
➢ High Fat (> 2 tablespoons / d)	Y☐ N☐
➢ Refined Sugar (> 6 teaspoons / d)	Y☐ N☐
➢ High Salt (> 5 g (1 teaspoon) / d)	Y☐ N☐
➢ Other relevant food (specify)	Y☐ N☐
➢ Areca nut use	Y☐ N☐
c. Inadequate Physical Activity (<150 min per week):	Y☐ N☐
d. Tobacco use (any type, any amount within last 1 year)	Y☐ N☐
e. Too much stress	Y☐ N☐
Remarks:	

Annex 2 - Facility Quarterly NCD Summary Report

	<39 years				40 - 70 years				>70 years				
	New		Old		New		Old		New		Old		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
Coronary heart diseases													
Stroke													
Other CVDs													
Hypertension													
Diabetes													
CRDs													
COPD													
Bronchial asthma													
Cancers													
Oral													
Breast													
Cervical													
Other cancers													
10-year CVD risk score for age group (40-70 years)													
			Total										
Risk %	**M**	**F**											
▪ <10													
▪ 20-30													
▪ >30													

Roashanee Building (4Th floor) Sosun Magu, Male', Republic of Maldives
Tel: +960 3014494 Email: hpa@health.gov.mv Fax: +960 3014484
Website: www.hpa.gov.mv

Annex 3 - Daily NCD Diseases Registry

Sl. No.	Date	Name	Age (In years)	Address/Telephone	Type of case (O=Old ; N= New)	Gender (M = male, and F =female)	10- year CVD risk score (Percentage)	Diagnosis - Cardiovascular diseases (Hypertension, etc) • Diabetes • Suspected cancer (O= oral; B=breast; C=cervical; and Other cancer; write O and specify	Treatment