
 <b>health</b> Department: Health <b>REPUBLIC OF SOUTH AFRICA</b>		Effective Date:[STARTING DATE]
	Assessing Eligibility for Vaccination	Next Revision [REVISION DATE]

## STANDARD OPERATING PROCEDURE – Pre-Vaccination COVID-19 Screening


<b>INSTITUTION</b>	National Department of Health		
<b>SECTION</b>	COVID 19 Vaccine - Assessing eligibility for vaccination		
<b>OBJECTIVE</b>	<ul style="list-style-type: none"> <li>- To provide basic guidelines to the Healthcare Workers (HCW) on basic steps in the COVID 19 screening pre-vaccination</li> </ul>		
<b>SCOPE</b>	<ul style="list-style-type: none"> <li>- Pre-Vaccination COVID 19 Screening</li> </ul>		
<b>COMPILED BY</b>		<b>ORIGINAL DATE:</b>	
<b>AUTHORISED BY</b>			
<b>DEFINITIONS</b>	<ul style="list-style-type: none"> <li>- <b>Personnel responsible for COVID-19 screening</b> means the person responsible for routine COVID 19 screening at vaccination sites.</li> <li>- <b>Vaccinee</b> means a person who is vaccinated with a Covid-19 vaccine.</li> <li>- <b>Screening</b> means the process of helping health care workers decide if a client has symptoms of COVID-19 and may need a coronavirus test. It is based on a series of basic questions about the client’s health and recent history and may include taking his/her temperature</li> </ul>		
<b>ABBREVIATIONS</b>	<ul style="list-style-type: none"> <li>- <b>GP:</b> General Practitioner</li> <li>- <b>HCW:</b> Healthcare Workers</li> </ul>		
<b>POLICIES, REFERENCES, SOURCE MATERIAL</b>	<ul style="list-style-type: none"> <li>- Pharmacy Act, 1974 (Act 53 of 1974)</li> <li>- Medicines and Related Substances Act, 1965 (Act 101 of 1965)</li> <li>- Good Pharmacy Practice rules published in terms of the Pharmacy Act, 1974 (Act 53 of 1974)</li> <li>- Nursing Act 33 of 2005</li> <li>- Health Professions Act 56 of 1974</li> <li>- National Health Act 61 of 2003</li> </ul>		
<b>RELATED SOPs</b>	<ul style="list-style-type: none"> <li>- Administration and processing of client at vaccination site prior to vaccination</li> <li>- Enrolment Validation</li> <li>- Vaccination Site Readiness Assessment</li> </ul>		
<b>PRINCIPLES</b>	<ul style="list-style-type: none"> <li>- Efficient systems must be implemented and monitored on a daily, weekly, and monthly basis</li> <li>- On arrival at a vaccination site, all clients and staff working on the site will undergo COVID-19 screening. Clients who are screened and have no symptoms of COVID-19 will then move to a waiting area until marshals direct them to administration desks for confirmation of their details.</li> <li>- Cleaning at the screening station should be performed frequently, at least twice daily with special attention to high touch surfaces.</li> <li>- Personnel must use appropriate personal protective equipment (PPE).</li> </ul>		

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<b>FUNCTIONAL ROLES AND RESPONSIBILITIES</b>	- Personnel responsible for COVID-19 screening
<b>TOOLS/ MATERIALS/ EQUIPMENT</b>	- COVID 19 screening form - EVDS
<b>SAFETY WARNINGS</b>	- N/A
<b>MONITORING AND EVALUATION</b>	- KPIs to be defined
<b>RECORD KEEPING</b>	- COVID-19 vaccine records shall be kept by the COVID-19 Vaccine Unit for a period of 5 years

## 1. PROCEDURE:

No	PROCEDURE	RESPONSIBLE
1	<b>Pre-vaccination COVID 19 screening</b>	
1.1	On arrival at a vaccination site, client is ushered to the screening station	Marshall
1.2	Build rapport with the client by introducing yourself	Personnel responsible for COVID-19 screening
1.3	Screen client for COVID 19 signs and symptoms. The Health worker must ask the following questions: <b>Refer Annexure 02 for sample questionnaire</b> <ul style="list-style-type: none"> <li>• If the client has travelled to a high-risk country in the last 14 days</li> <li>• If the client has had contact with anyone with confirmed COVID-19 in the last 14 days</li> <li>• If the client has symptoms such as fever, cough and difficulty in breathing</li> </ul>	Personnel responsible for COVID-19 screening
1.3.1	Proceed to take temperature reading and record on the form. <i>NB: Red alert for fever of more than 38°C</i>	Personnel responsible for COVID-19 screening
1.3.2	Review symptom guideline for two or more of the following symptoms and decide if the client is healthy or should be referred for testing: <ul style="list-style-type: none"> <li>• Fever of more than 38°C</li> <li>• Cough (especially a dry cough)</li> <li>• Difficulty breathing</li> <li>• Sore throat</li> <li>• Muscle pain</li> </ul>	Personnel responsible for COVID-19 screening

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	<ul style="list-style-type: none"> <li>Loss of smell or /taste</li> </ul>	
1.3.3	<p>If the client is deemed healthy i.e. displays 0/6 or 1/6 of above stated symptoms, confirm client registration for vaccination and direct client to the administration desk for confirmation of enrolment on the EVDS or to join the assisted enrolment queue to get registered on EVDS</p>	Personnel responsible for COVID-19 screening
1.3.4	<p>If the health worker thinks that the client may have COVID-19, refer the client to a health facility to be tested</p> <p><i>i.e. Client displays 2/6 or more of above stated symptoms</i></p>	Personnel responsible for COVID-19 screening
1.3.5	<p>If vaccination takes place at an outreach site, arrange for transport to the nearest Healthcare facility if client looks very ill and are displaying two or more symptoms, especially if they are struggling to breathe.</p>	Personnel responsible for COVID-19 screening

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<b>ANNEXURES</b>	Annexure 1: Process Flow
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## 2. REVISION DATA

Revision No	Pages	Revision Details	Date	Approved

<b>TRAINING REQUIRED</b>	
<ul style="list-style-type: none"> <li>• Training to be conducted post SOP sign-off and prior to the effective date as per above</li> <li>• Training to be administered to relevant responsible parties after each SOP revision</li> </ul>	
<b>Trainees</b>	<b>Type of training</b>


## 3. SOP AUTHORISED

	Name	Signature	Date
Compiled by			
Checked by			
Approved by			

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**Annexure 1: Process Flow**


*\*Please insert\**

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### Annexure 2: Sample COVID 19 Vaccination Form

Name and Surname	
Telephone Number	
Reason for Visit	

Are you above the age of 60?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you travelled internationally in the last 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been in contact in the last 14 days with someone who is confirmed to have COVID-19	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you suffer from any of the following conditions in a non-medicated or non-controlled manner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently suffering from any of the following symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Body pains / headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Smell	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness or tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Temperature Recording	
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DECLARATION I hereby declare to the best of my knowledge that the information disclosed is correct at the time of completion.

Name	Signature

Please note, the Department of Health reserves the right of access to our facility.