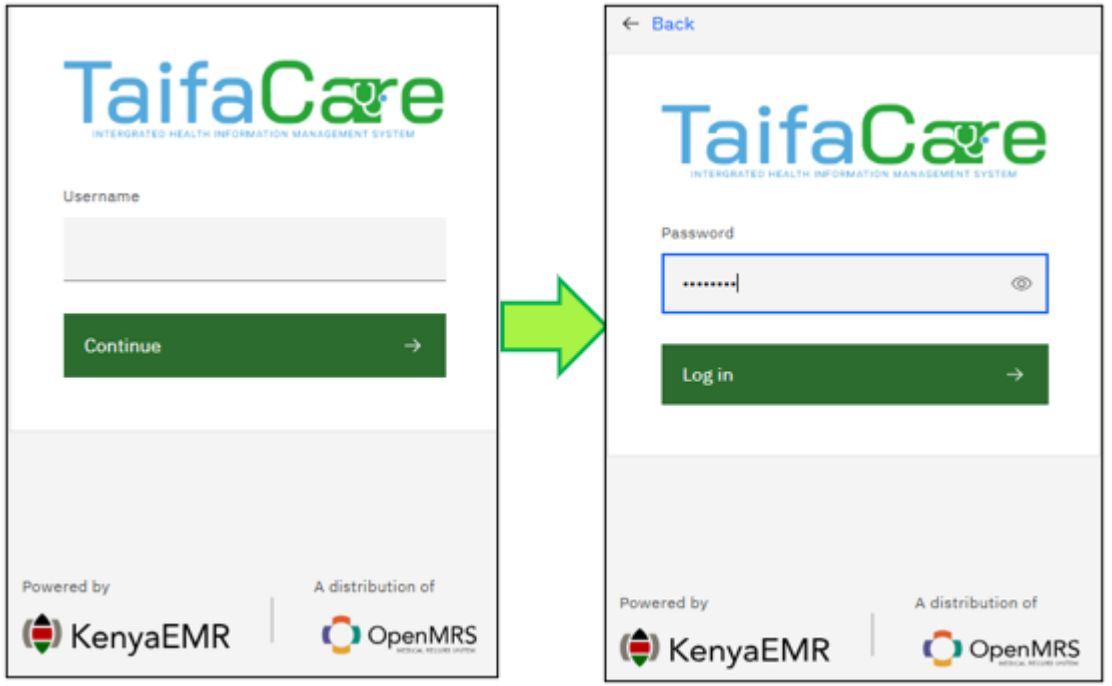
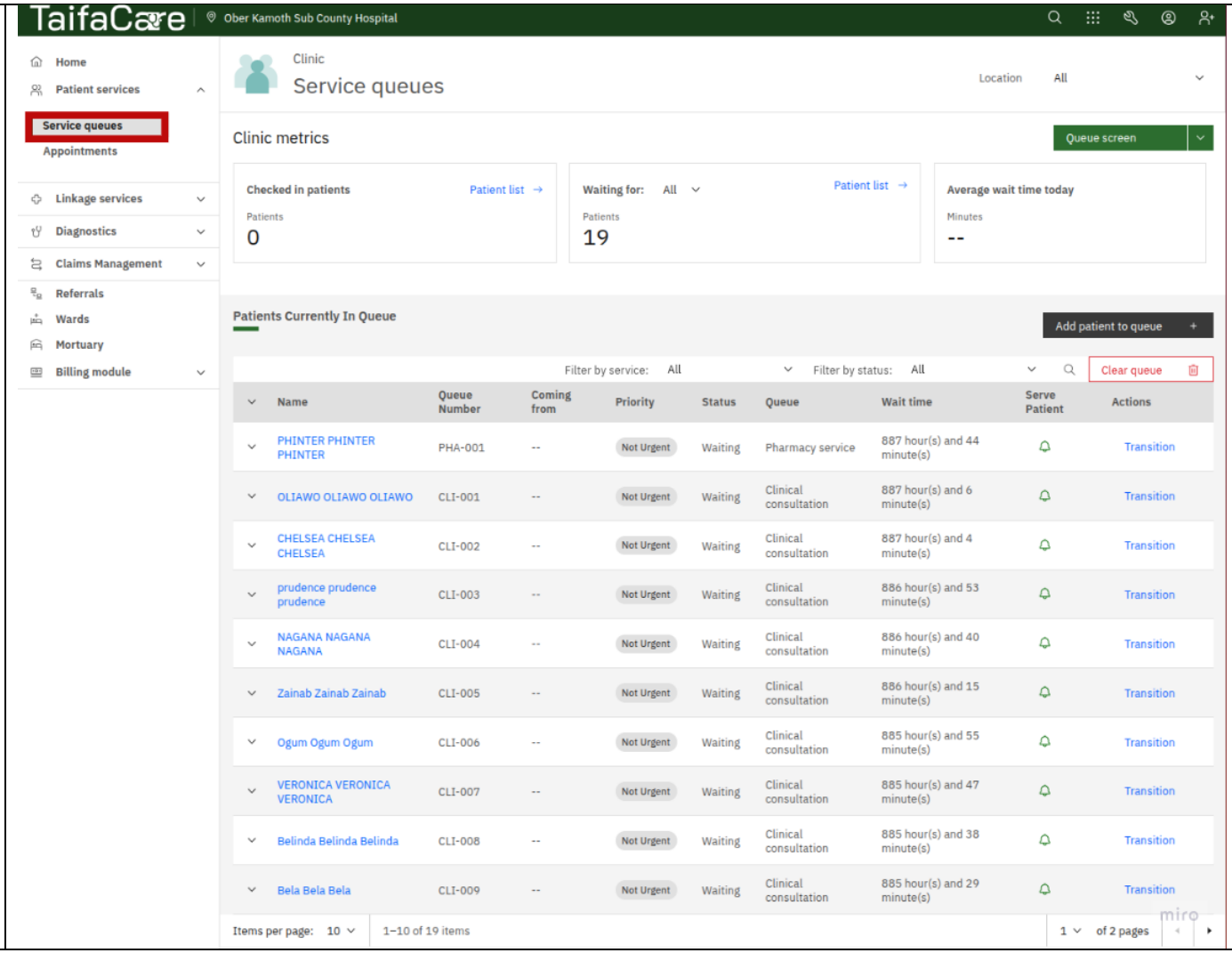
TaifaCare OPD Clinical Encounter Workflow User Guide

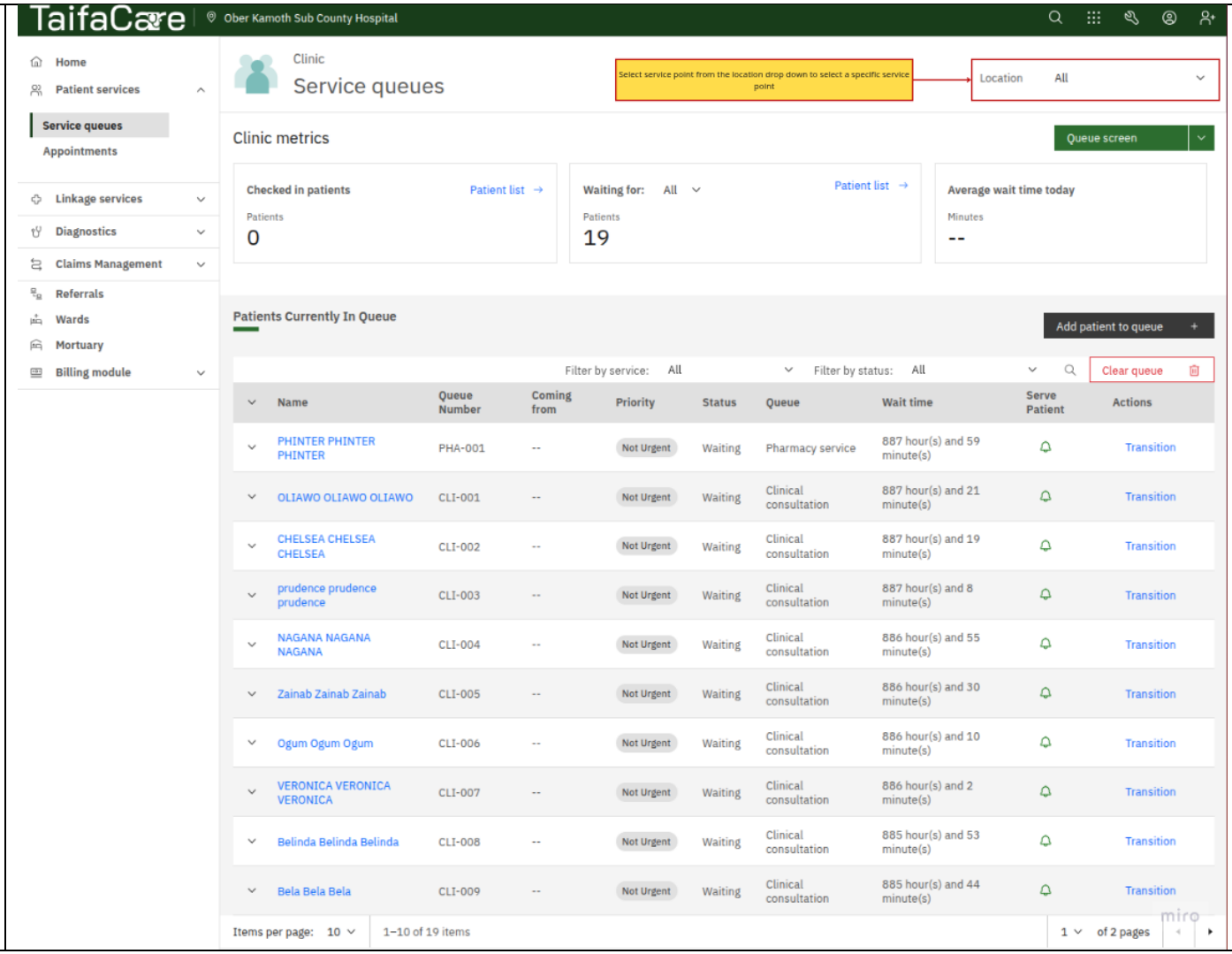
[Last updated: Aug 2025]

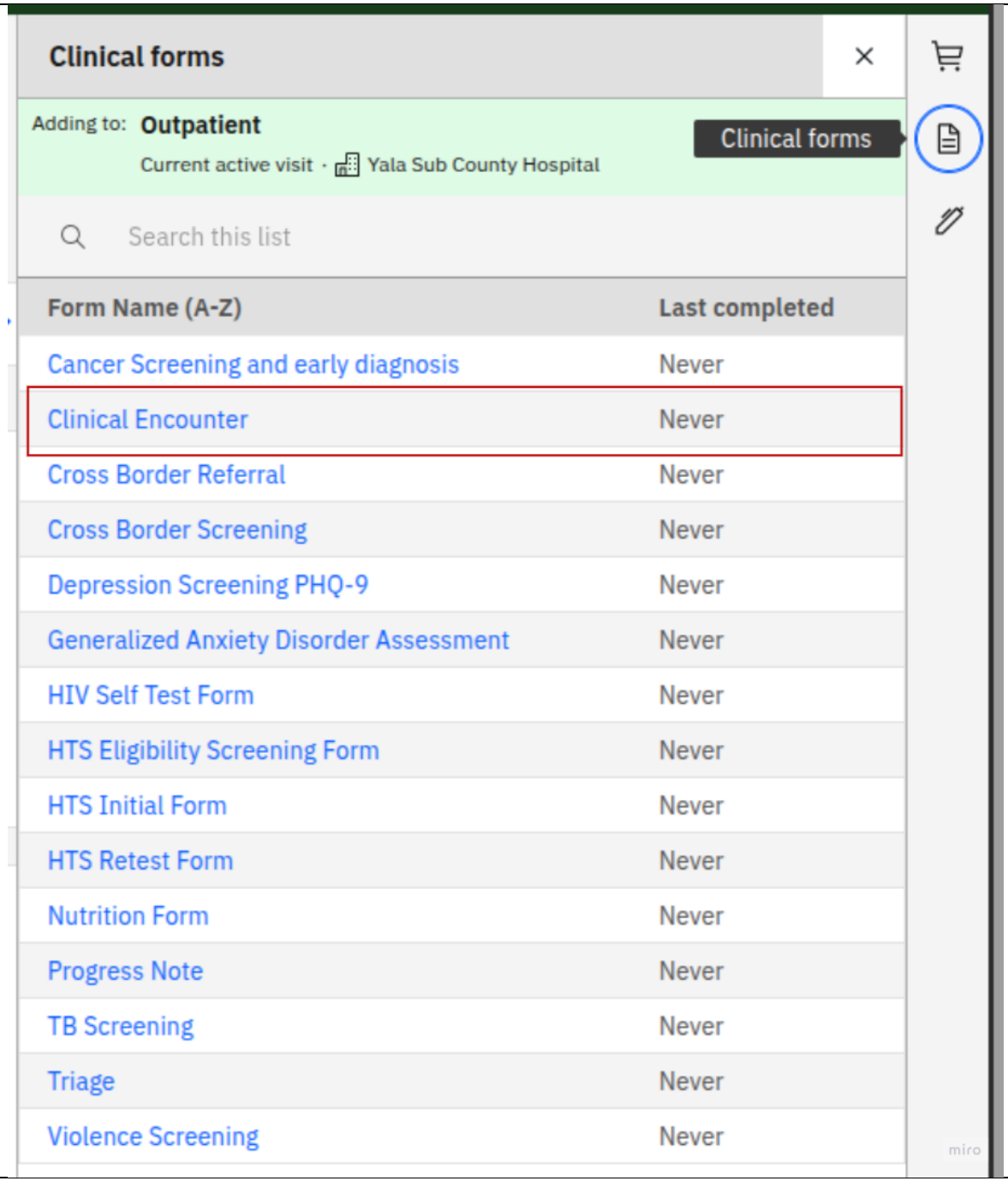
Tasks:	End to end navigation of the OPD Clinical Encounter in Taifa Care
Objective:	Navigation skills
Who:	EMR users
Required Materials:	Username, password, computer installed with the latest version of Taifa Care

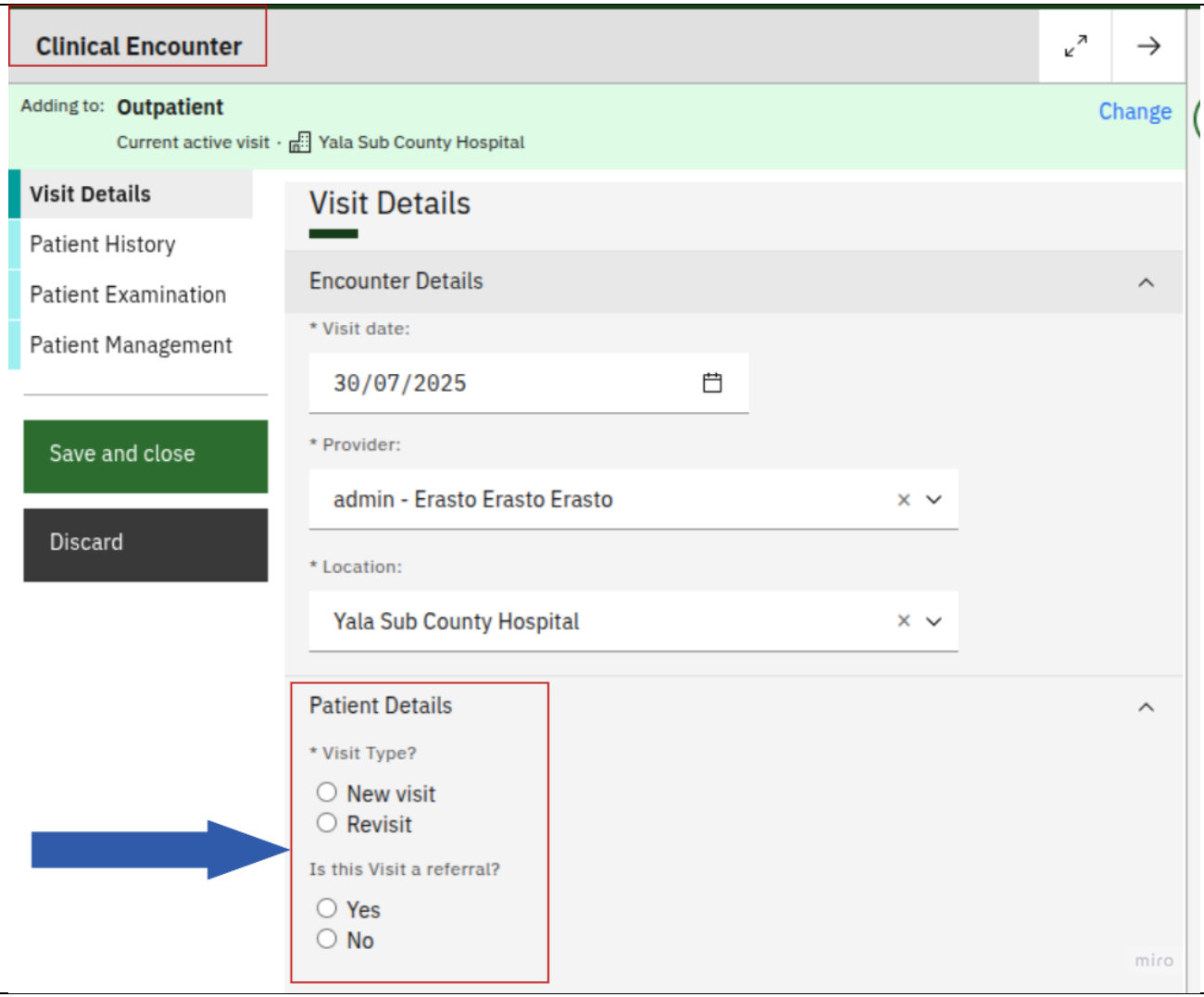
Step	Action	Screen Shots
Learning Objective	By the end of this session, you will be able to • Successfully log into Taifa Care • Successfully document a OPD clinical encounter in Taifa Care	

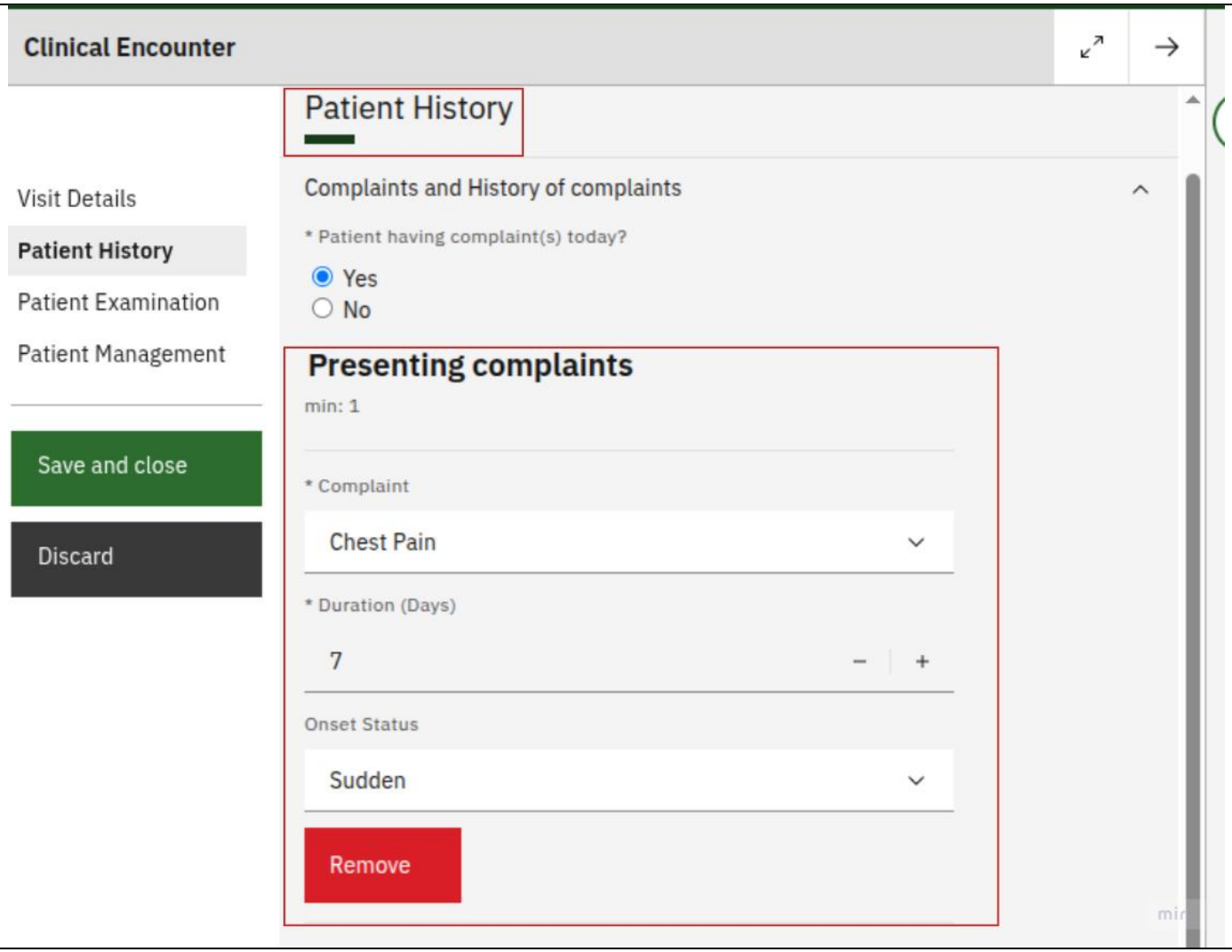
Step 1	**Login to Taifa Care** Enter the application server URL System "**localhost:8080/openmrs/spa/login**" and click on the load b button or Enter key from the keyboard. On successful loading, you should be navigated to the system login page. Authenticate entry by providing username and password on the fields, then. click "Login" button	

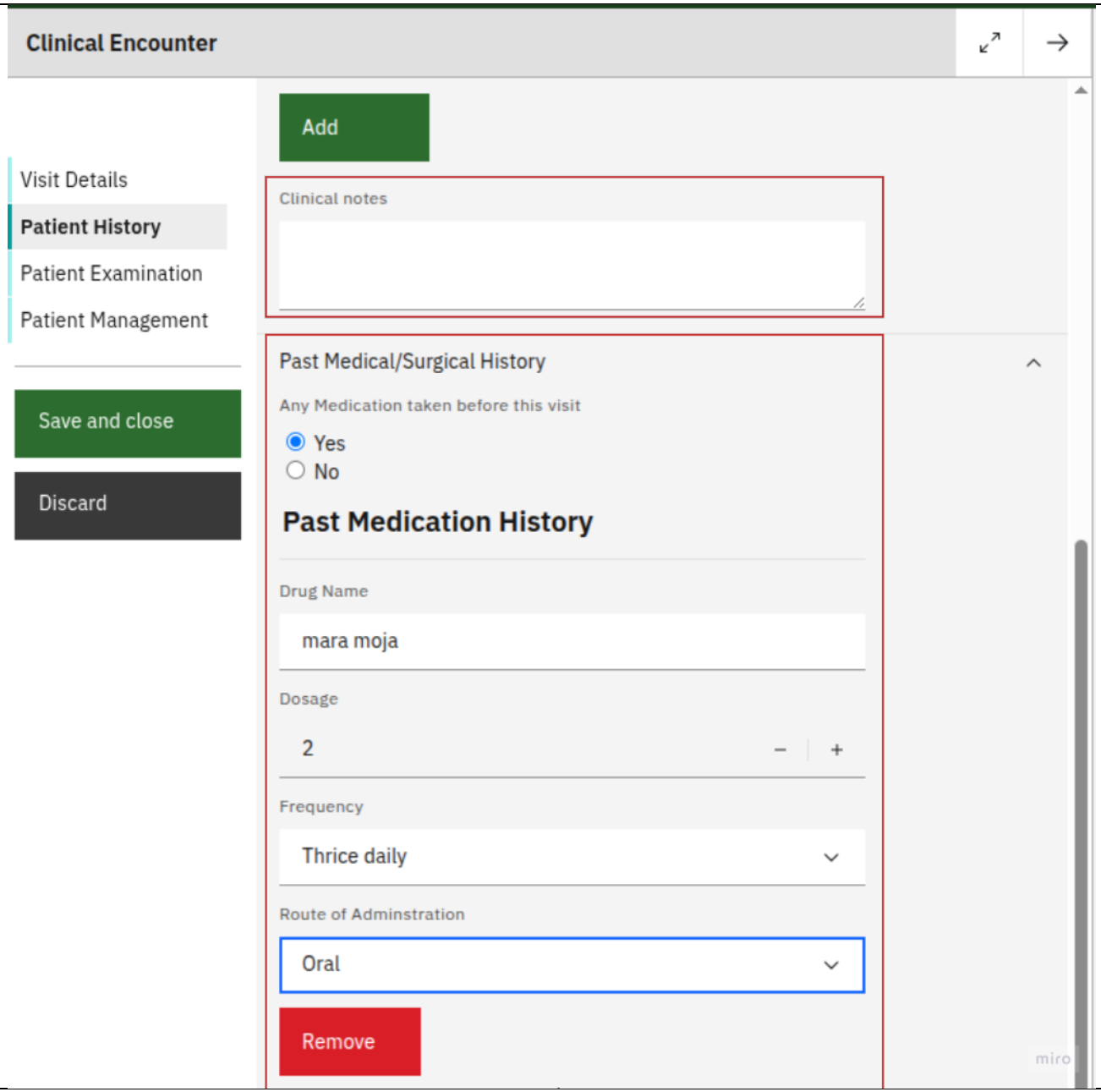
Step 2	Upon successful login, you shall be navigated to the Active visits page of the facility Click on the “Service Queues” option from the menu items available on the left side of the screen to find the client if they are already enrolled and are in queue. If they are not enrolled refer to client’s **enrolment manual on how to enroll clients to Taifa Care**	

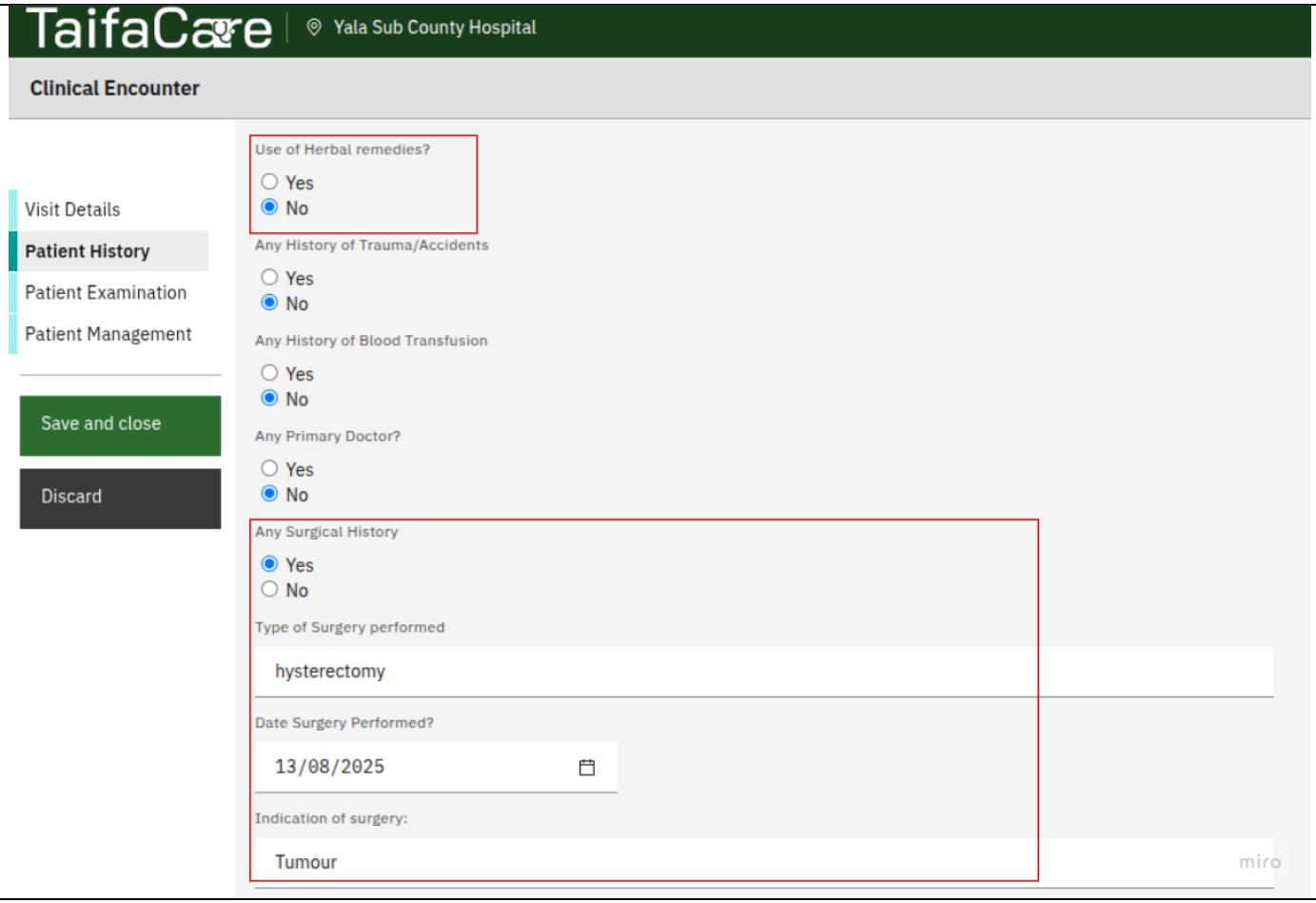
Step 3	**Taifa Care Service Queues Page** To find clients who are in queue for the different services points**.** Pick on the client you want to offer service from the service queue.	

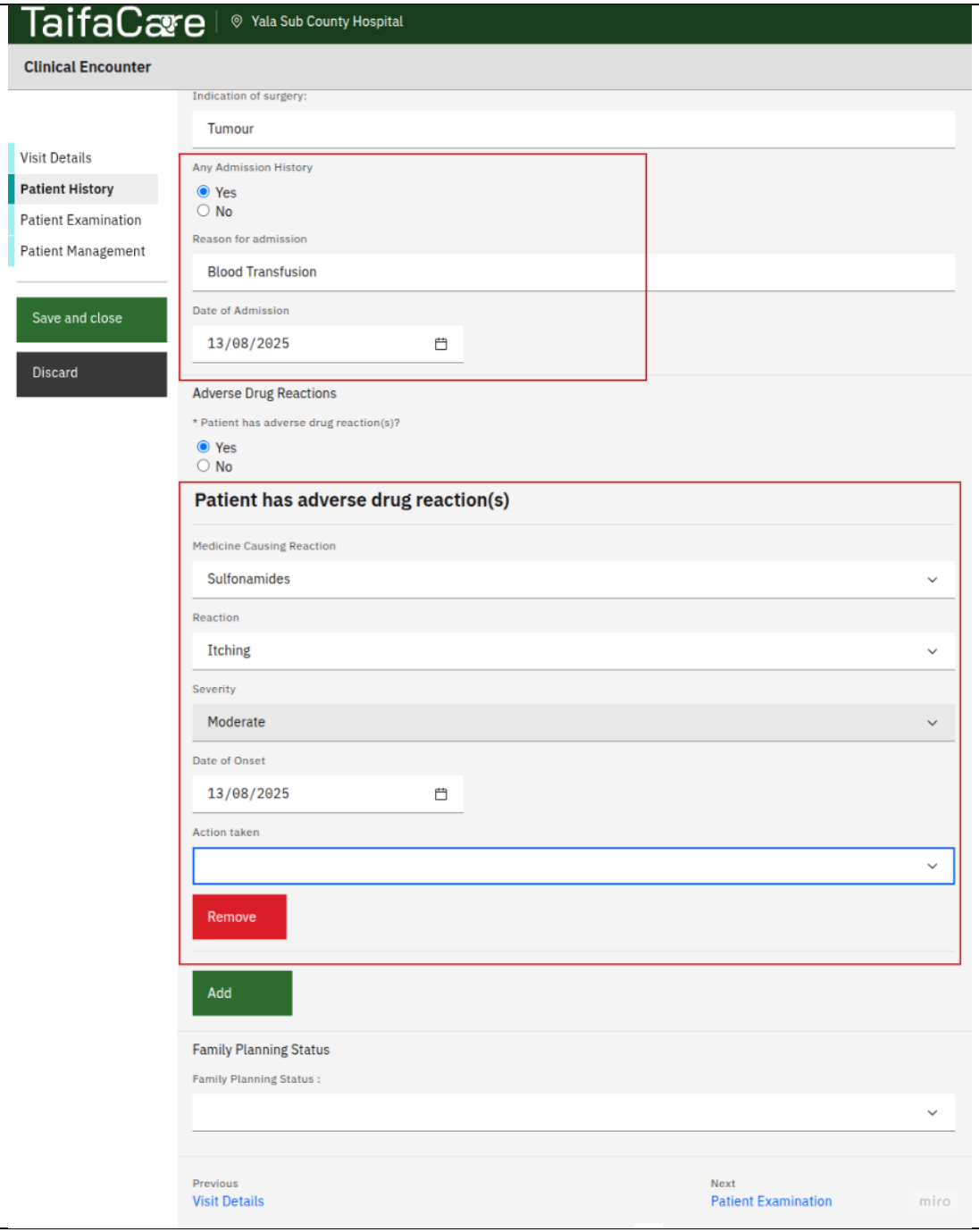
Step 4	**Clinical Encounter Form availability** From the clinical suite of forms, the OPD clinical encounter form is one among the many available forms as captioned on the next column	

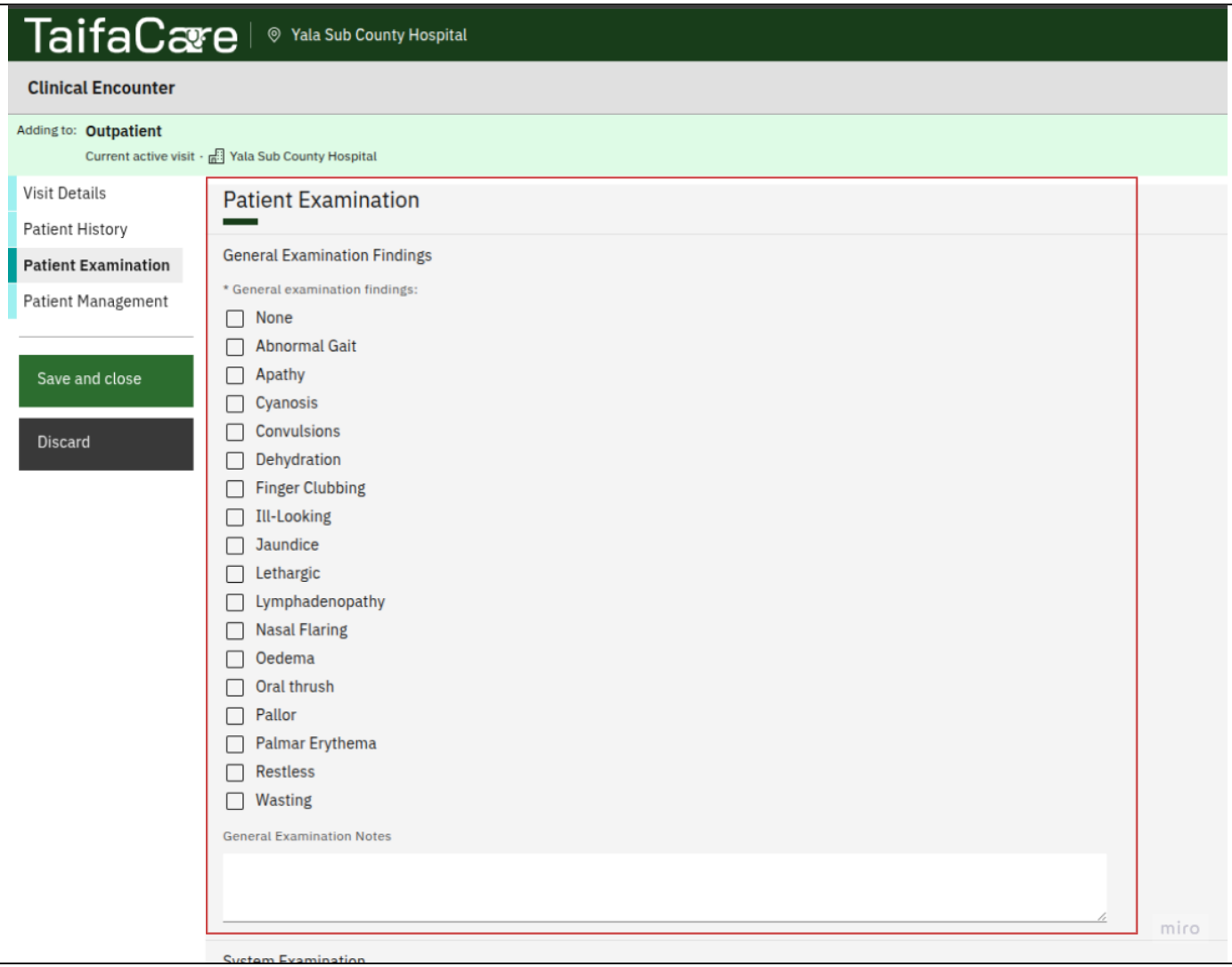
Step 5	By default, the form opens with the Visit Details prepopulated. The users can however change this to reflect the desired details Fill in the visit type details from the choice available indicated	

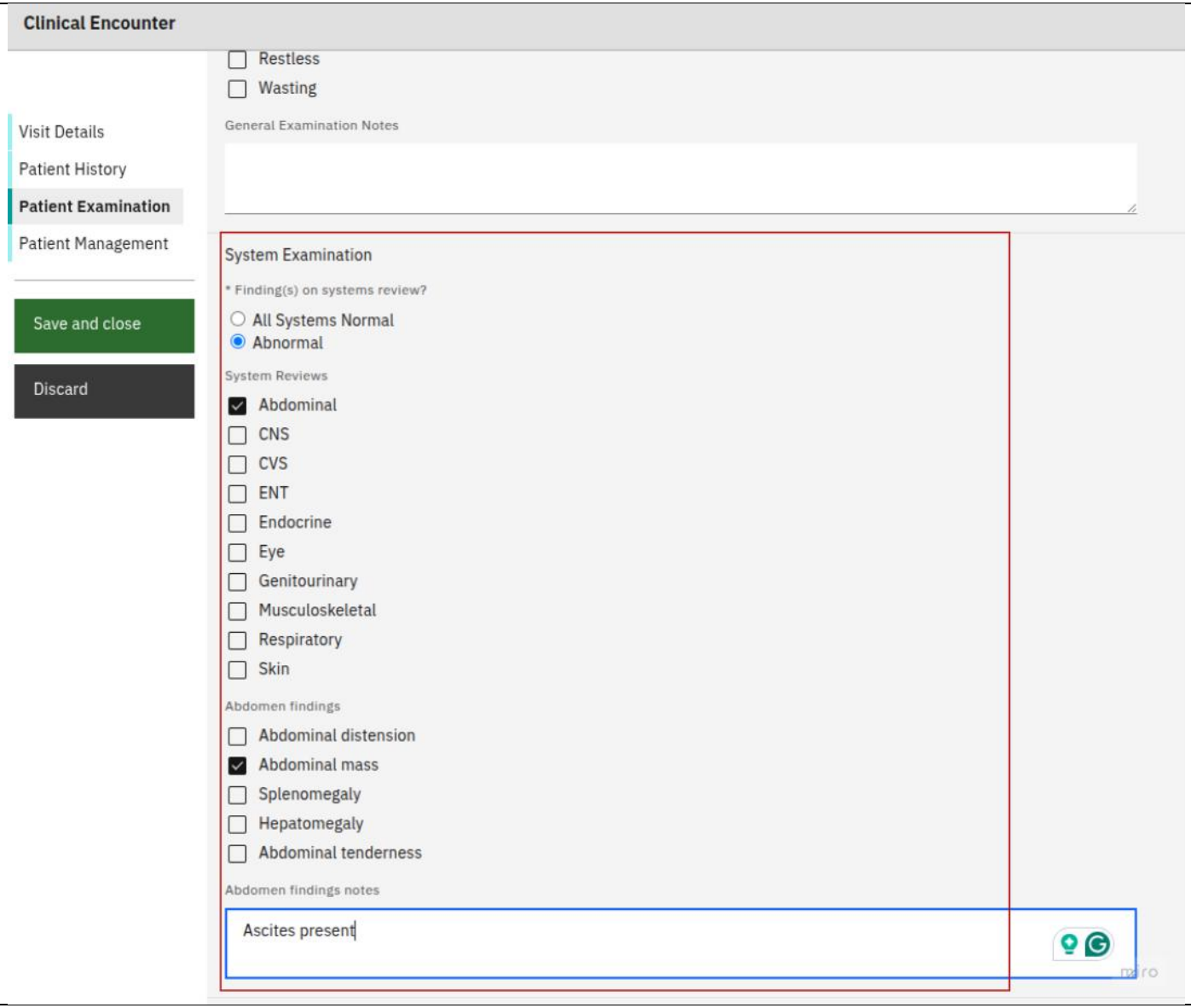
Step 6	Document **Patient History** usually presents and history of complaints from the select list and add to the grid. Numerous complaints can be added to the grid as reported by the patient. Include the duration of the complaint in days, Onset date and onset status.	

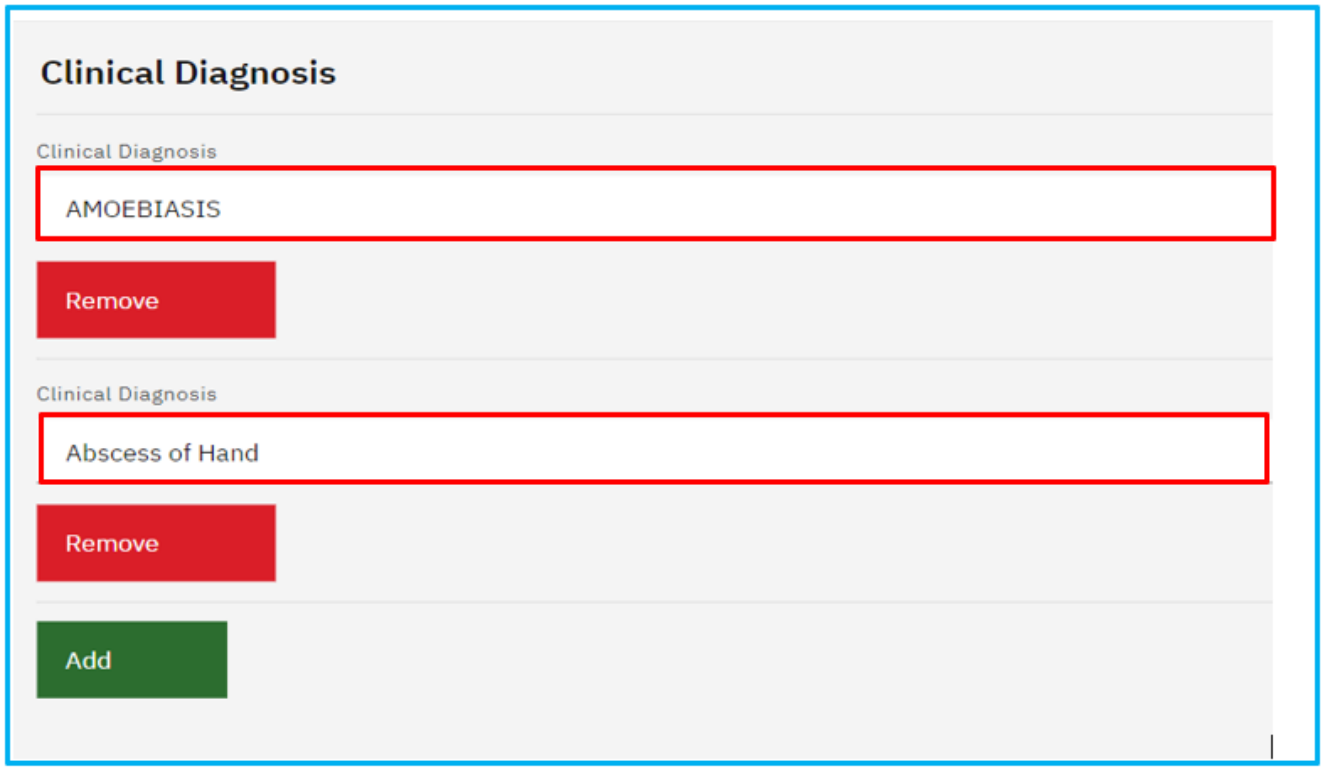
Step 7	Record clinical notes Record any medication taken before the visit detailing drug name, dosage, frequency and route of administration	

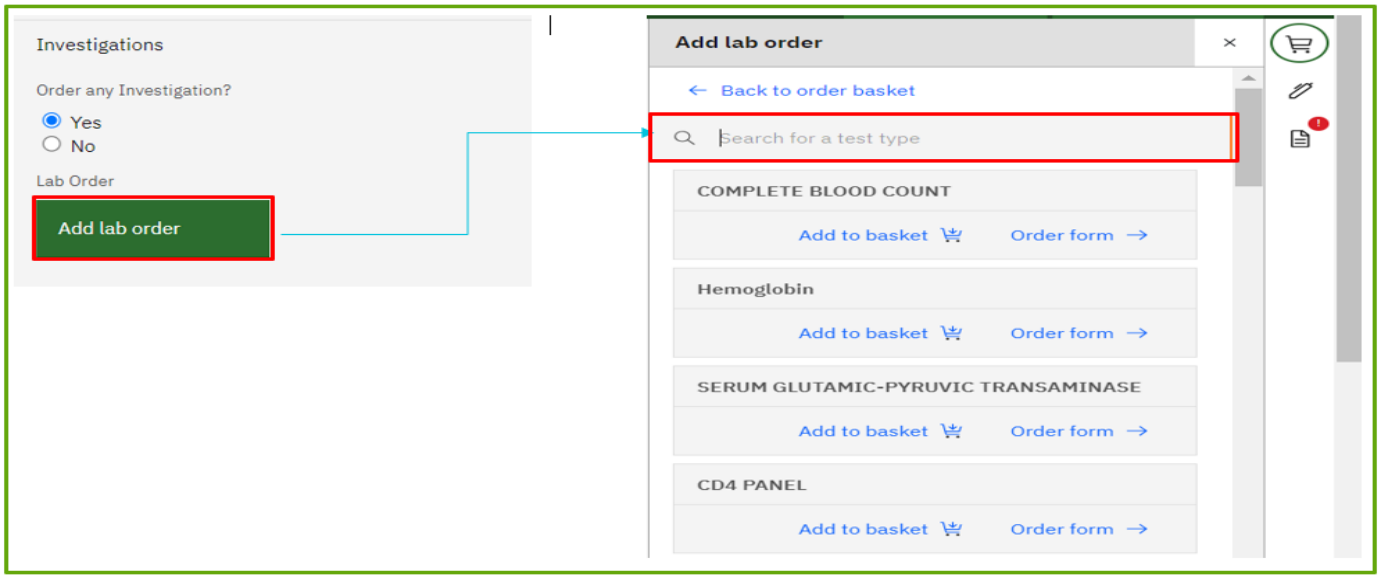
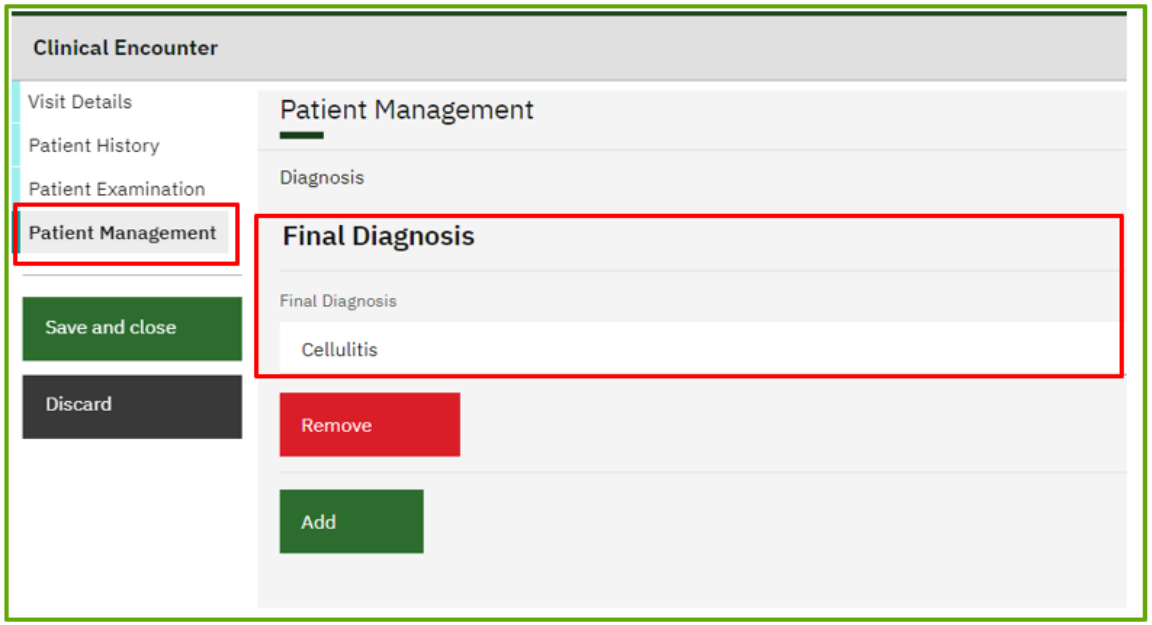
Step 8	Screen patient for use of Herbal remedies and document Record any medication taken before the visit detailing drug name, dosage, frequency and route of administration	

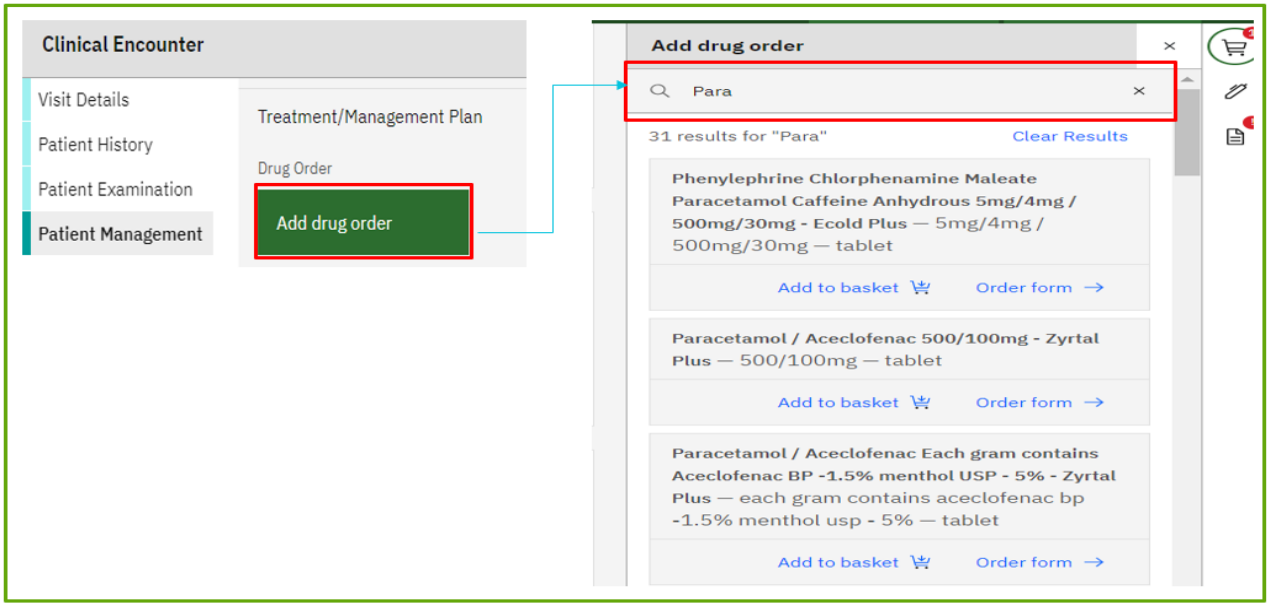
Step 9	Record any admission history indicating reason and date of admission Document any Adverse drug reactions the client might be having. Indicate the causative medicine, reaction type, severity, date of onset and action taken. Add as many adverse drugs as reported by the patient	

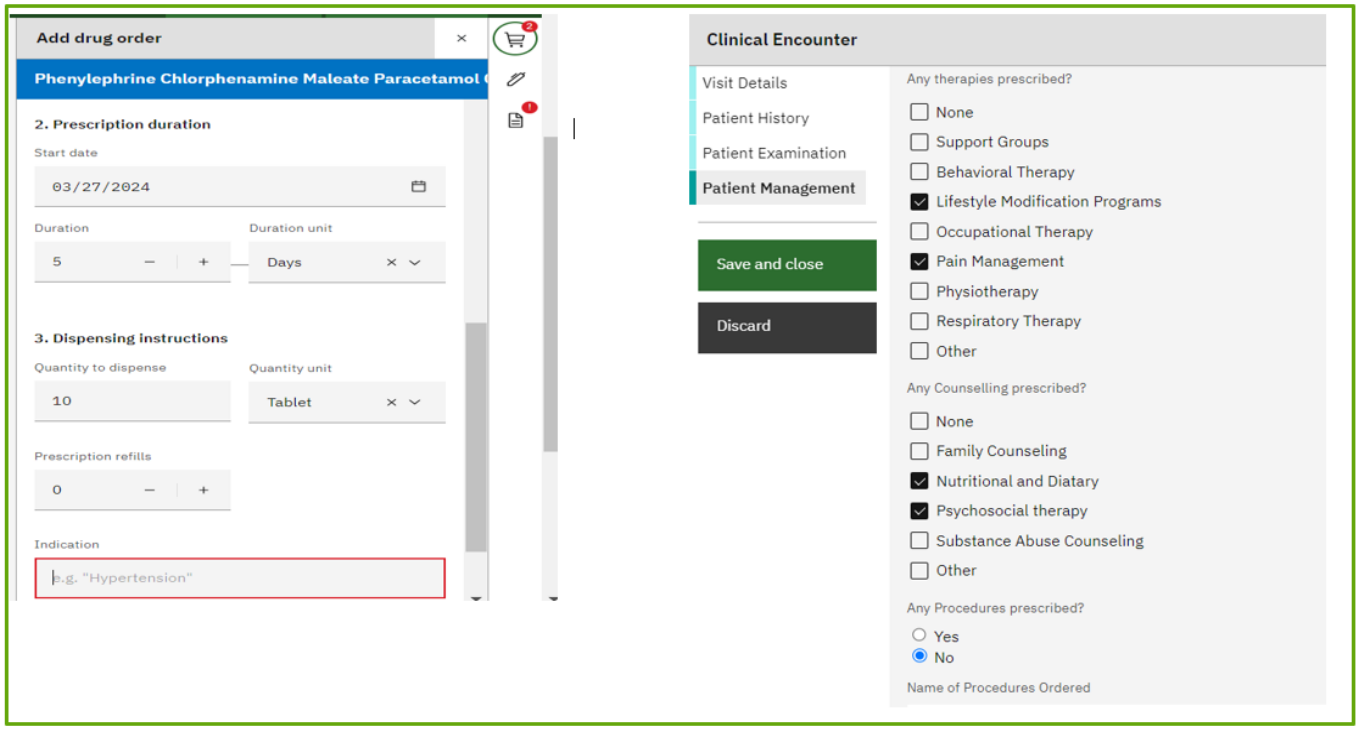
Step 10	**Patient Examination** Document the General Examination Findings as outlined and make additional notes not captured in the multi select list	

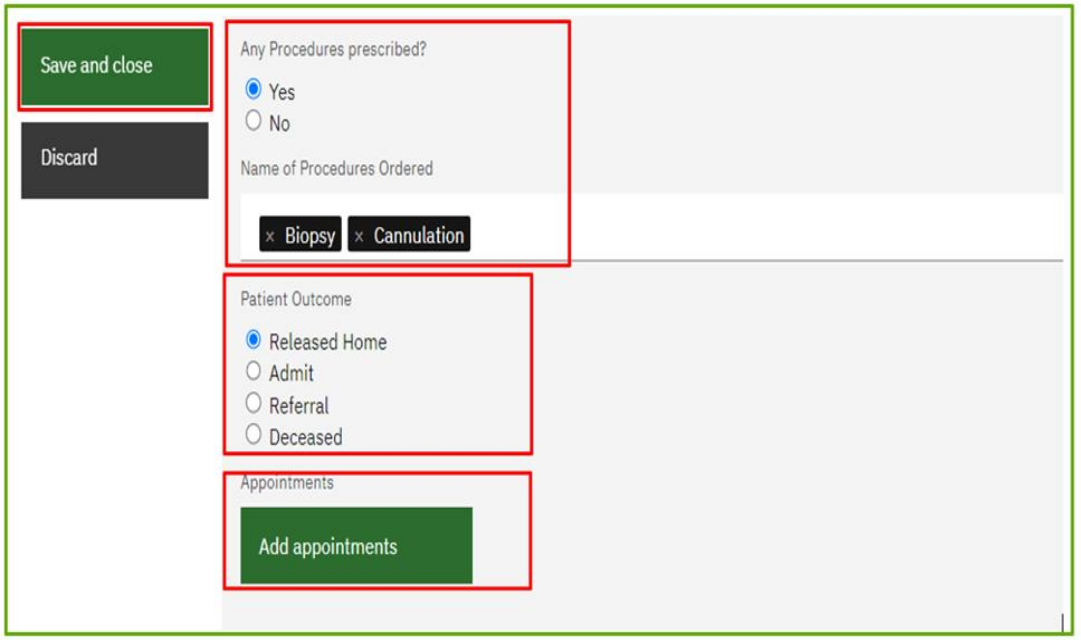
Step 11	**System Examination** After conducting systems reviews on the client, document all the findings as per screening tool. Type down notes to elaborate further the systems' findings.	

Step 12	**Clinical Diagnosis** From the available ICD 11 diagnosis picker, Select the ailments that client has been diagnosed with during this visit empirically, based on the presenting conditions.	

Step 13	Investigations open a window for the lab order to pop up to allow for ordering of requisite investigative tests as depicted	
Step 14	**Patient Management** allows for the documentation of the final diagnosis derived from laboratory investigation. ICD 11 diagnosis is utilized	

Step 15	**Add Drug Order** The Drug order button populates the drug order form as depicted. Select the drugs to prescribe from the select list	

	After ordering drugs get back to the clinical encounter to finalize the visit. Document any therapies, Counselling and procedures prescribed	

Step 16	Click on **Save and** close to save and exit the clinical encounter	

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