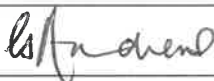


Document Control			
Document Name:		TB/HIV Information System (THIS) Implementation in District Hospitals Guidance	
Compiled By:		Health Systems Governance and HRH Branch	
For queries please contact:		Dr R Govender, Riona.Govender@health.gov.za	
Date Compiled:		April 2019	
Version Control			
Date Updated	Version	Updated by	Comment on changes
04/2019	1	National Implementation Team (NIT)	New document
Document Approval			
Date Approved	Version	Approved by	
01/04/2019	1	Dr G Andrews	

TB/HIV INFORMATION SYSTEM (THIS) IMPLEMENTATION IN DISTRICT HOSPITALS GUIDANCE

Background

In 2015, the National Department of Health took the decision to integrate DS-TB data into the existing HIV/ART information system, TIER.Net. This decision was in part framed as enabling the flow of routine TB and HIV performance data through the health system. Per the District Health Management Information Systems (DHMIS) 2011 guidelines, District Hospitals are required to report routine TB/HIV performance data into the webDHIS.

During 2018, it was identified that District Hospitals were contributing to the problem of unaccounted for or “missing” TB cases. There are an estimated 80,000 “missing” patients who are either diagnosed or undiagnosed who have not been reported. This is principally due to the fact that many District Hospitals have not accounted for all TB patients, using current monitoring strategies. Therefore, to mitigate the ‘missing’ TB cases, the recommendation is to include the implementation of the integrated TB/HIV Information System (THIS) in District Hospitals.

Purpose of this guide

This document provides guidance to District Hospitals digitising presumptive and DS-TB patient information into TIER.Net. Given that the majority of District Hospitals are currently digitising ART data in TIER.Net towards improved management of HIV/ART patients, therefore the focus of this document is primarily on processes to support digitisation of DS-TB patient data.

Overall this document directs that all potential TB cases, and subsequently all TB services, are documented and digitised in accordance with the THIS strategy. Moreover, this process seeks to ensure that all TB data flows from the facility into the routine health information system (webDHIS).

General Principles

- TIER.Net, a component of the broader TB/HIV information system (THIS) strategy, is a non-networked electronic patient monitoring tool used to support patient management and the reporting of HIV/ART and DS-TB routine monthly and quarterly performance data.
- It is expected that all information regarding TB identification and treatment are digitised at facility level in TIER.Net
- In order to facilitate digitisation of TB/HIV information, it is critical that all clinical service points are identified, and that the patient and data flow are integrated and streamlined in order to enable digitisation.
- All TB/HIV patient information must be documented, captured, and accounted for in TIER.Net regardless of where TB services are offered.
- All clinical stationery must be integrated into a single patient file per the Ideal Clinic prescription of ‘one patient, one folder, one folder number¹’.
- Presumptive TB information must be recorded in the TB Identification Register, which is the source document for capturing these data in TIER.Net

¹ As outlined in the Ideal Clinic Manual, July 2018; (Section 4; pg. 8)

- Presumed TB cases should not be referred outside of the District Hospital without first being recorded in the TB Identification Register and digitised in TIER.Net. Failure to account for these potential TB cases in the routine monitoring system contributes to challenge of “missed” TB cases
- HIV Testing Services (HTS) information must be recorded in the HTS Register, which is the source document for capturing of this information in TIER.Net
- TB and HIV treatment, and subsequent patient visit information, must be recorded in the TB and HIV clinical stationery. These are the sources for capturing ART and DS-TB treatment information in TIER.Net
- All TB/HIV information must be captured in TIER.Net, prior to patient discharge. All patients are to be transferred out (discharge, referred, etc.) with the Patient Summary letter, generated in TIER.Net

TB/HIV Information System patient management system (TIER.Net)

In most circumstances, digitisation of TB/HIV information in TIER.Net occurs primarily in the Wellness Clinic, where the majority of HIV/ART/TB services are rendered. However, if there is deviation from this norm in certain District Hospitals, then digitisation should be completed at these service points.

Please refer to the THIS Support Portal, www.tbhivinfosys.org.za for guidance on TIER.Net installation, system requirements, and IT support (including the linking of computers).

Please refer to the THIS training materials and TIER.Net User Guide for instructions on capturing of patient information².

TB/HIV source documents for the TB/HIV data digitisation

As previously indicated, the TB Identification Register, TB Blue Card, TB inpatient clinical stationery, HTS Register, ART clinical stationery and inpatient clinical stationery are used for digitisation of TB/HIV information and are considered the source documents for recording of TB/HIV patient information.

It is acknowledged that in some District Hospitals, in-patient clinical stationery may be used in addition to, or in lieu of the standardised TB/HIV stationery, in order to account for more complex patient clinical documentation. If alternative stationery is used, the clinician, together with the relevant managers must train the Administrative Clerk (AC), or alternative, on where to locate all information required for capturing in TIER.Net.

Patient and Folder Flow in District Hospitals

In order to understand how the TB/HIV data flows within District Hospitals, it is important to map-out each area where TB/HIV services are rendered. To get an accurate sense of the data flow, the following steps should be considered by the THIS Key Implementer (TKI) or other persons responsible for completing the District Hospital Based Assessment (DHBA):

²Refer to www.tbhivinfosys.org.za for all training materials and user guide information for capturing of TB/HIV patient information.

TB/HIV service points in District Hospitals:

- Identify all reception points, particularly where patient folders for TB/HIV services are retrieved, opened, and or filed.
- Identify within the hospital where TB/HIV services are rendered

Potential data capturing points for TB/HIV data:

- Document all services points where TB/HIV information is recorded and captured.
- Track the data flow for TB identification, treatment initiation and patient retention. This should include mapping data flow for TB/HIV co-infected patients.
- Document any potential 'gaps' in data recording, capturing, collection/folder flow.

Once all service points have been identified, it is important to follow the process flow (clinical, patient, and folder) within each service point for each component of the TB/HIV cascade in accordance with the THIS implementation guide³. This will ensure that all TB/HIV cases are accounted for as this drives improved clinical patient management and data quality.

Data Management Processes for TB information

This section focuses on 3 common TB/HIV service points where TB services are provided to ensure digitisation of TB/HIV information into TIER.Net. These service points include; out-patient departments (OPD), wellness (HAST) clinics, and in-patient wards.

Although the focus is on the 3 service points, there may be other service points that need to be considered.

OPD:

- Clinician or counsellor to screen patient for TB and record information on screening tool or in screening register.
- Record Presumptive TB cases in the TB Identification register.
 - All TB Identification Registers must flow to ACs for capture in TIER.Net.
- Presumptive TB patients must be referred, with the patient folder and/or referral document, to the Wellness Clinic for further management.

Wellness Clinic:

- Patient screened for TB (if not previously screened and referred by OPD), with screening activities documented in patient folder.
- If presumptive for TB, Clinician to conduct TB investigations according to clinical guidelines
 - Clinician to complete laboratory form and then send sample and form to laboratory.
- Clinician must record patient information, including TB investigation information, in the TB Identification Register.

³ Available on the TB/HIV information system support portal: www.tbhivinfosys.org.za

- Once laboratory results are returned, the results must be triaged⁴ and recorded in the TB Identification Register against previously recorded test request.
- TB Identification Register must be given to the AC for capturing in TIER.Net.
- AC must capture presumptive TB patient information in TIER.Net.
- If the patient is diagnosed with TB, the clinician must initiate TB treatment.
 - Clinician to open TB Blue Card, record clinical findings, and then insert the TB Blue Card into the patient folder.
- After the clinical visit, the patient folder must be given to AC for capturing into TIER.Net.
- AC captures information in TIER.Net.
- Once captured, patient folder must be returned to registry for filing.
- At the time of a transfer out (TFO) to a primary health care (PHC) facility, clinician must request the AC to generate Patient Summary letter from TIER.Net.
 - The clinician to review and sign the Patient Summary letter and provide the patient with a copy for presentation at the transferring facility.
 - Clinician to document TFO outcome in the TB Blue Card, with the date and name of the transferring facility.
 - Clinician to return patient folder to AC for capturing
- AC to capture TFO outcome, date and name of transferring facility in TIER.Net
- Patient folder must be returned to registry for filing.

Note: At the end of the month, all patients who are transferred out (TFO) will appear on the TFO line list in TIER.Net. This list can be used to follow up with the respective facilities to determine if the patients arrived.

In-patient Ward:

- Patient screened for TB (if not previously screened) with screening activities recorded in patient folder.
- If presumptive for TB, Clinician to conduct TB investigations according to clinical guidelines
 - Clinician to complete laboratory form and then send sample and form to laboratory.
- Clinician to ensure that all presumptive TB cases (including laboratory investigations) are documented and recorded.
 - In some instances, the clinician may record information in both the TB Identification Register (if available in the in-patient ward) and the patient folder, OR
 - The in-patient ward may have an allocated dedicated staff person responsible for recording all in-patient presumptive TB cases into the TB identification register.
 - All presumptive TB patients must be accounted for in the TB identification register as it is the source for all TB presumptive patients.

⁴Refer to the guidance document for THIS Management of TB/HIV Laboratory Results Guidance available on the TB HIV information system support portal: www.tbhivinfosys.org.za

- Once laboratory results are returned, the results must be triaged⁵ and recorded in TB Identification Register against the previously recorded test requested in TIER.Net.
- The TB Identification Register must be given to for the AC for capturing into TIER.Net.
 - AC must capture all presumptive TB patient information into TIER.Net.
- If patient is diagnosed with TB, the clinician must initiate TB treatment.
 - Clinician must open a TB Blue Card (or in-patient clinical stationery), record clinical findings, and then file into the patient folder.
- On discharge from the in-patient ward, the patient must be referred to the Wellness Clinic (or other end service point) with complete information in the patient folder for discharge/continued care.
 - On arrival at the Wellness Clinic, the patient folder must be given to AC for capturing into TIER.Net
- At the time of a transfer out (TFO) from the District Hospital to the Primary Health Care (PHC) facility, the clinician must request that the AC generate a Patient Summary letter from TIER.Net.
 - The clinician must review and sign the Patient Summary and then provide the patient with a copy for presentation at the transferring facility.
 - The clinician must document TFO outcome in the TB Blue Card and the name of the transferring facility.
- Clinician must return patient folder to AC for capturing.
 - AC to capture TFO outcome and date and name of transferring facility into TIER.Net.
- Patient folder must be returned to registry for filing.

NOTE: In some instances, the patient folder may be retained in the in-patient ward through the duration of the patient's clinical stay, resulting in non-capturing of information in TIER.Net.

NOTE: All information is to be captured into TIER.Net *prior* to the patient leaving the hospital. This will ensure that all TB information has been accounted for, and will provide the receiving facility with a complete patient treatment history via the Patient Summary letter.

NOTE: If the patient is being discharged from the in-patient ward directly to an external facility, the information will need to be captured prior to the patient leaving the hospital. This is to ensure the patient leaves with a Patient Summary letter in hand.

⁵Refer to the guidance document for THIS Management of TB/HIV Laboratory Results Guidance available on the TB HIV information system support portal: www.tbhivinfosys.org.za