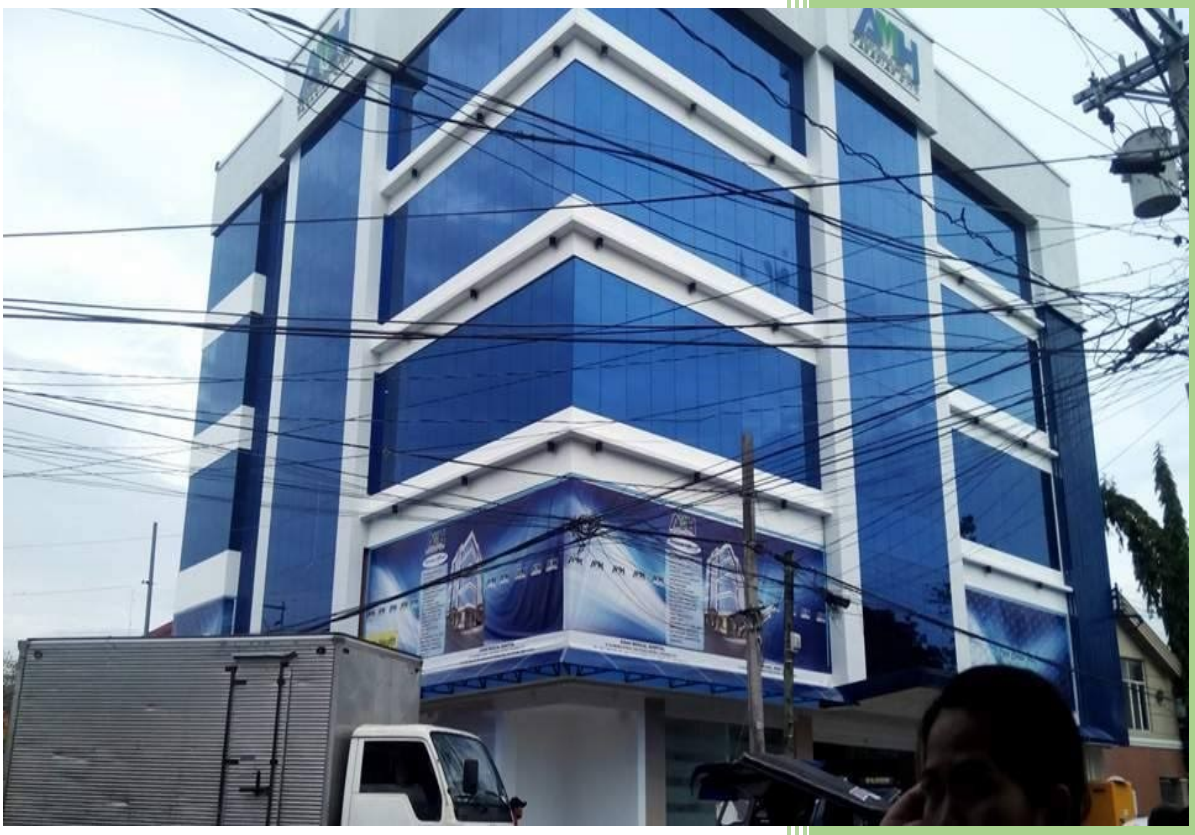
AISAH MEDICAL HOSPITAL



The HANDBOOK for HOSPITAL DOTS

With Assistance from:

Culion Foundation, Inc.
Strengthening Health Systems and Empowering Communities since 1976

AISAH MEDICAL HOSPITAL
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The Aisah Medical Hospital Handbook for Hospital DOTS

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CHAPTER 1. ENHANCED HOSPITAL DOTS

One of the current key initiatives to respond to the TB problem is Enhanced Hospital TB DOTS. It aims to strengthen the internal and external referral system and quality of TB diagnosis and treatment in hospital. Hospital could either act as a referring hospital or DOTS providing hospital. All or most of the TB cases are referred to the DOTS facilities and the outcomes are tracked. A pilot study from 2010-2012 show that 73% of around 13000 TB cases were successfully referred to health centers and RHUs.

Hospitals through the Hospital TB Coordinators are expected to:

- Develop and implement plans and policies on TB DOTS implementation
- Establish, strengthen and maintain the internal and external TB referral system
- Provide Tb diagnostic, treatment and counselling services to patients according to national policies and international standards
- Participate in the EQA for DSSM
- Collaborate with other DOTS facility to ensure that referred TB cases are properly managed
- Coordinate with the regional, provincial or city TB coordinators to ensure adequate drugs and supplies
- Submit quarterly NTP reports to CHOs/PHOs.
- Mobilize resources to support TB control

The MOP Mandate

The Manual of Procedures seeks to accomplish the following: (a) provide technical policies and guidelines on the diagnosis, treatment and counselling of TB patients, (b) specify procedures on how to put in place important NTP support health systems such as logistics, recording and reporting, and monitoring and evaluation systems (c) guide the different organizational levels on how to conduct monitoring, evaluation and supervision, and (d) prescribe the roles and tasks of those involved in the management of the TB control program including TB service provision.

Case Finding

Case finding is the identification and diagnosis of TB cases among individuals with signs and symptoms presumptive of tuberculosis. The current approach to case finding includes passive and intensified cases findings. The available tests utilize by the program for diagnosing TB are as follows:

- Direct sputum smear microscopy (DSSM) is fundamental to the detection of infectious disease and is recommended for case finding among adults and children who can expectorate.
- Chest x-ray (CXR) is used to complement bacteriologic testing in making a diagnosis. However, it has low specificity and does not differentiate drug susceptible from drug resistant disease.
- TB Culture and drug susceptibility tests (DST) using solid (Ogawa or Lowenstein Jensen) or liquid media (MGIT) is a routine diagnostic test for drug-resistant TB cases under the NTP.
- Tuberculin skin test (TST) is a basic screening tool for TB infection among children using purified protein derivative (PPD) tuberculin solution to trigger a delayed hypersensitivity reaction among those previously infected.

TB Disease Classification

The following table provides guidelines in disease classification based on anatomical site and bacteriological status

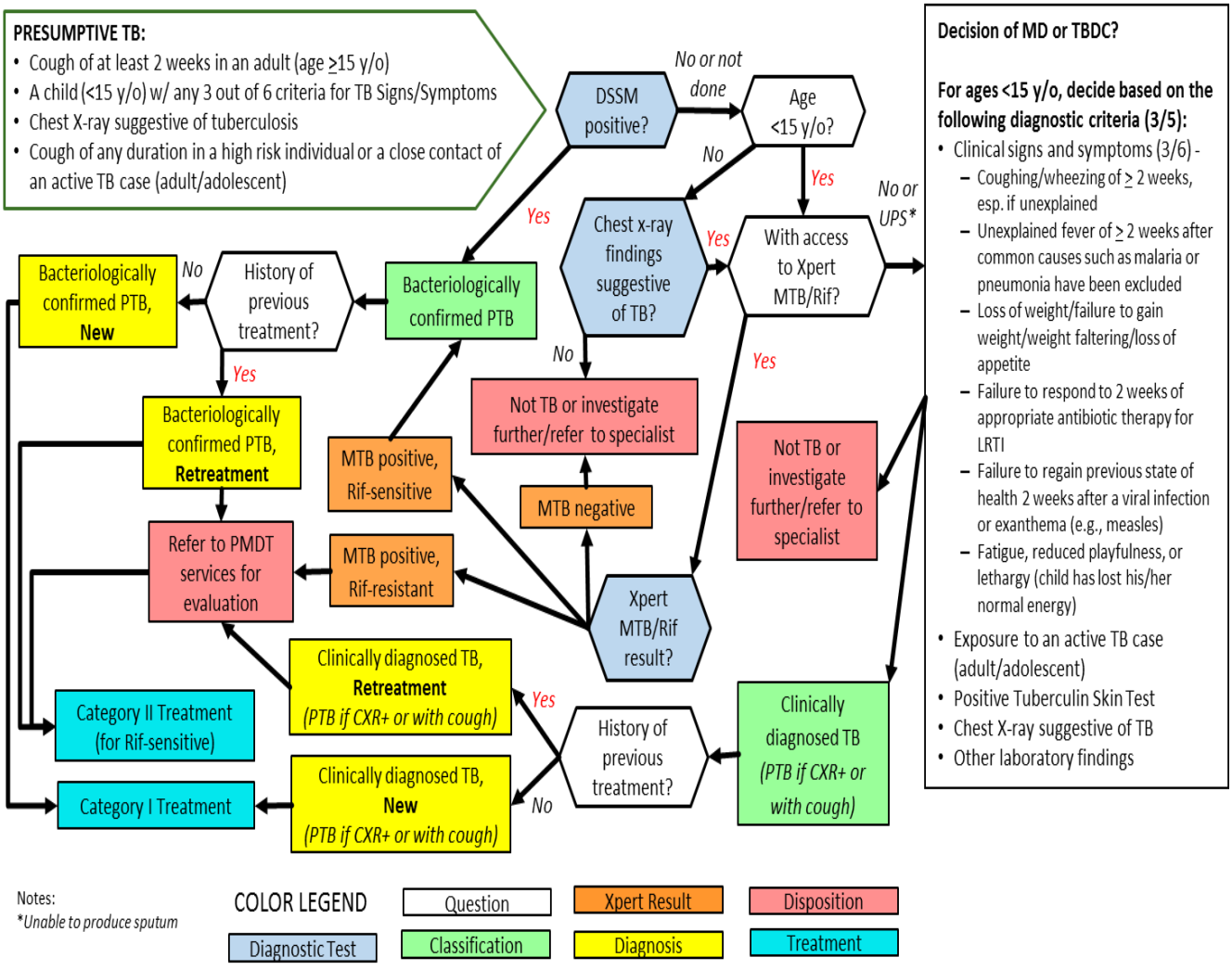
Anatomical Site	Bacteriological Status	Definition of Terms	
Pulmonary (PTB)	Bacteriologically-confirmed	Smear-positive	A patient with at least one (1) sputum specimen positive for AFB, with or without radiographic abnormalities consistent with active TB
		Culture-positive	A patient with positive sputum culture for MTB complex, with or without radiographic abnormalities consistent with active TB
		Rapid Diagnostic Test Positive	A patient with sputum positive for MTB complex using rapid diagnostic modalities such as Xpert MTB/RIF, with or without radiographic abnormalities consistent
	Clinically-diagnosed	A patient with two (2) sputum specimens negative for AFB or MTB, or with smear not done due to specified conditions but with radiographic abnormalities consistent with active TB; and there has been no response to a course of empiric antibiotics and/or symptomatic medications; and who has been decided (either by the physician and/or TBDC) to have TB disease requiring a full course of anti-TB chemotherapy **OR** A child (less than 15 years old) with two (2) sputum specimens negative for AFB or with smear	

		not done, who fulfils three (3) of the five (5) criteria for disease activity (i.e., signs and symptoms suggestive of TB, exposure to an active TB case, positive tuberculin test, abnormal chest radiograph suggestive of TB, and other laboratory findings suggestive of tuberculosis); and who has been decided (either by the physician and/or TBDC) to have TB disease requiring a full course of anti-TB chemotherapy **OR** A patient with laboratory or strong clinical evidence for HIV/AIDS with two (2) sputum specimens negative for AFB or MTB or with smear not done due to specified conditions but who, regardless of radiographic results, has been decided (either by physician and/or TBDC) to have TB disease requiring a full course of anti-TB chemotherapy.
Extra-Pulmonary (EPTB)	Bacteriologically-confirmed	A patient with a smear/culture/rapid diagnostic test from a biological specimen in an extra-pulmonary site (i.e., organs other than the lungs) positive for AFB or MTB complex
	Clinically-diagnosed	A patient with histological and/or clinical or radiologic evidence consistent with active extra-pulmonary TB and there is a decision by a physician to treat the patient with anti-TB drugs

Diagnostic Algorithm

The following figure shows the ideal systematic steps in diagnosing TB disease:

Procedures (Decision on Diagnosis based on Laboratory Results)



Case Holding

Case holding involves assignment of the appropriate treatment regimen based on diagnosis and previous history of treatment, supervised drug intake with support to patients, and monitoring responses to treatment through follow-up sputum smear microscopy

TB Disease Registration Group

Cases are assigned a registration group based on history of previous treatment in addition to classification based on anatomical site and bacteriologic confirmation. The registration groups of TB cases is necessary in determining the correct treatment regimen.

Registration Group		Definition of Terms
New		A patient who has never had a treatment for TB or who has taken anti-TB drugs for less than one (<1) month.
RETREATMENT	Relapse	A patient previously treated for TB, who has been declared cured or treatment completed in their most recent treatment episode, and is presently diagnosed with bacteriologically-confirmed or clinically-diagnosed TB.
	Treatment after Failure	A patient who has been previously treated for TB and whose treatment failed at the end of their most recent course. This includes: A patient whose sputum smear or culture is positive at 5 months or later during treatment A clinically diagnosed patient (e.g. child or EPTB) for whom sputum examination cannot be done and who does not show clinical improvement anytime during treatment.
	Treatment after Lost to Follow-up (TALF)	A patient who has previously treated for TB but was lost to follow-up for two months or more in their most recent course of treatment and is currently diagnosed with either bacteriologically-confirmed or clinically-diagnosed TB.
	Previous Treatment Outcome Unknown (PTOU)	Patients who have been previously treated for TB but whose outcomes after their most recent course of treatment are unknown or undocumented.
Other		Patients who do not fit into any of the categories listed above

Recommended Treatment Regimen for Adults and Children

Category of Treatment	Classification and Registration Group	Treatment Regimen
Category I	Pulmonary TB, new (whether bacteriologically-confirmed or clinically-diagnosed)	**2HRZE/4HR**
	Extra-pulmonary TB, new (whether bacteriologically-confirmed or clinically-diagnosed) except central nervous system (CNS)/bones or joints	
Category Ia	Extra-pulmonary TB, new (CNS/bones or joints)	**2HRZE/10HR**
Category II	Pulmonary or extra-pulmonary, Previously treated drug-susceptible TB (whether bacteriologically-confirmed or clinically-diagnosed) -relapse -treatment after failure -treatment after lost to follow-up (TALF) -Previous treatment outcome unknown -other	**2HRZES/1HRZE/5HRE**
Category IIa	Extra-pulmonary Previously treated drug susceptible TB (whether bacteriologically-confirmed or clinically-diagnosed (CNS/bones or Joints	**2HRZES/1HRZE/9HRE**
Standard Regimen Drug Resistant (SRDR)	Rifampicin Resistant-TB or Multidrug Resistant TB	**ZKmLfxPtoCs** -Individualized once DST result is available -Treatment duration for at least 18 months
XDR TB Regimen	Extensively Drug Resistant-TB	Individualized based on DST result and history of previous treatment

Category I – 2HRZE/HR

Body Weight (kgs)	Intensive Phase 2 months of HRZE daily	Continuation Phase 4 months of HR daily**
	No. of tablets per day	
30-37	2	2
38-54	3	3
55-70	4	4
>70	5	5

Category II – 2HRZES/HRZE/5HRE

Body Weight	Intensive Phase (daily)			Continuation Phase (daily)
	First 2 months			4^{th} To 8^{th} month
	HRE No. of tablets	S (1g/2ml)	HRE No. of tablets	HRE No. of tablets
30-37	2	1 g***	2	2
38-54	3		3	3
55-70	4		4	4
>70	5		5	4

*** 4^{th} to 12^{th} month for Category IIa*

**** For patients with BW <50 kgs and those >60 years old consider 500-700 mg or 10mg/kg/day*

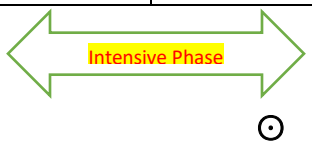
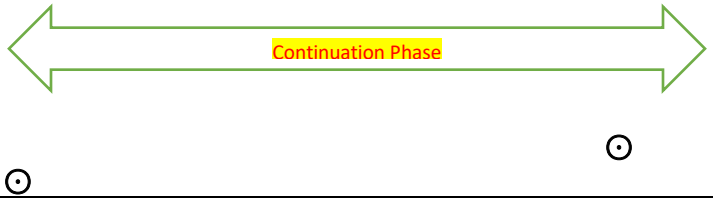
Drug Dosage per Kg Body Weight (if using Single Dose Formulations [SDFs])

Drug	Adults	Children
Isoniazid (H)	5 (4-6) mg/kg, not to exceed 400 mg daily	10 (10-15) mg/kg, Not to exceed 300mg daily
Rifampicin (R)	10 (8-12) mg/kg Not to exceed 600 mg daily	15 (10-20) mg/kg, Not to exceed 600 mg daily
Pyrazinamide (Z)	25 (220-30) mg/kg, Not to exceed 2g daily	30 (20-40) mg/kg, Not to exceed 2g daily
Ethambutol	15 (15-20) mg/kg, Not to exceed 1.2g daily	20 (15-25) mg/kg, Not to exceed 1.2g daily
Streptomycin	15 (12-18) mg/kg, Not to exceed 1 g daily	30 (20—40) mg/kg Not to exceed 1 g daily

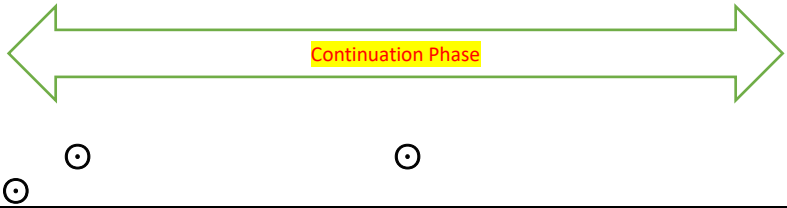
Monitoring Response to Treatment

Treatment response of PTB patients shall be monitored by follow-up DSSM (i.e. one specimen for each instance) according to the standard schedule below.

Schedule of follow-up DSSM for Category I Patients

Months of Treatment					
1	2	3	4	5	6
					
If smear+ at month 2, obtain sputum again at month 3.		**If smear+ If sm+, label as failed at month 3, refer to PMDT**			

Schedule of follow-up DSSM for Category II patients

Months of Treatment							
1	2	3	4	5	6	7	8
							
		If smear+ refer to PMDT		**If sm+, label as failed**			**If sm+, label as failed**

GUIDE IN MANAGING ADVERSE REACTIONS TO ANTI-TB DRUGS

- Closely monitor the occurrence of minor and major reactions to drugs, especially during the intensive phase.
    - Manage minor reactions appropriately.
    - Major side effects necessitate withdrawal of the responsible drug and the need to switch to single-dose formulation (SDF).
    - **Report all cases of ADRs** by filing the **Adverse Drug Reaction(s) Form (FDA form)**

Adverse Reactions	Drugs Probably Responsible	Management
Minor		
1. Gastro-intestinal intolerance	Rifampicin/Isoniazid/Pyrazinamide	Give drugs at bedtime or with small meals
2. Mild or localized skin reactions	Any kind of drugs	Give anti-histamines.
3. Orange-/red-colored urine	Rifampicin	Reassure the patient
4. Pain at the injection site	Streptomycin	Apply warm compress. Rotate sites of injection.
5. Burning sensation in the feet due to peripheral neuropathy	Isoniazid	Give Pyridoxine (Vitamine B6): 550-100 mg daily for treatment 110 mg daily for prevention
6. Arthralgia due to hyperuricemia	Pyrazinamide	Give aspirin or NSAID. If symptoms persist, consider gout and request for blood chemistry (uric acid determination) and manage accordingly.
7. Flu-like symptoms (fever, muscle pains, inflammation of the respiratory tract)	Rifampicin	Give anti-pyretics
Major		
1. Severe skin rash due to hypersensitivity	Any kind of drugs (especially Strptomycin	Discontinue anti-TB drugs and refer to appropriate specialist
2. Jaundice due to hepatitis	Any kind of drugs (especially Isoniazid, Rifampicin, and Pyrazinamide)	Discontinue anti-TB drugs and refer to appropriate specialist. If symptoms subside, resume treatment and monitor clinically
3. Impairment of visual acuity and color vision due to optic neuritis	Ethambutol	Discontinue ethambutol and refer to an ophthalmologist.

4. Hearing impairment, ringing of the ear (tinnitus), and dizziness due to damage of the eighth cranial nerve	Streptomycin	Discontinue streptomycin and refer to appropriate specialist.
5. Oliguria or albuminuria	Streptomycin/Rifampicin	Discontinue anti-TB drugs and refer to appropriate specialist
6. Psychosis and convulsion	Isoniazid	Discontinue Isoniazid and refer to appropriate specialist.
7. Thrombocytopenia	Rifampicin	Discontinue anti-TB drugs and refer to appropriate specialist.

Reintroduction of Anti-TB Drugs Following Drug Reaction

- Once the ADR has resolved, reintroduce anti-TB drugs one by one

Drug	Likelihood of Causing A Reaction	Challenge Doses		
		Day 1	Day 2	Day 3
Isoniazid	Least likely	50 mg	300 mg	Full dose
Rifampicin		75 mg	300 mg	Full dose
Pyrazinamide		250 mg	100 mg	Full dose
Ethambutol		100 mg	500 mg	Full dose
Streptomycin	Most likely	125 mg	500 mg	Full dose

A reaction after adding in a particular drug identifies that drug as the one responsible for the reaction.

Once confirmed, the offending drug must be replaced.

For patients with major ADRs to all first line drugs, refer to PMDT or specialist for proper treatment regimen.

Treatment Modifications for Special Situations

- **Pregnancy**
  - Ascertain whether or not a woman is pregnant before she starts TB treatment.
  - anti-TB drugs (HREZ) are safe for pregnant women, **except streptomycin**
  - Supplemental pyridoxine (Vitamin B6) at 25mg/day

- **Breastfeeding**
  - Mothers with TB can still breastfeed (feed infants before taking medications).
  - Supplemental pyridoxine (Vitamin B_6) for infants taking INH or whose breastfeeding mother is taking INH

- **Oral Contraceptives**
  - Rifampicin interacts with oral contraceptive medications with a risk of decreased protective efficacy against pregnancy.
    1. take an oral contraceptive pill containing a higher dose of estrogen (50μ), following consultation with a clinician; or
    2. use another form of contraception

- **Liver disease or history of liver disease**
  - HRZ are all associated with hepatitis.
  - In the presence of hepatitis and elevation of liver enzymes, treatment should be interrupted and, generally, a modified or alternative regimen used
  - Wait for liver function tests (LFTs) to revert to normal and clinical symptoms to resolve before reintroducing the anti-TB drugs.
  - Usual regimens if no clinical evidence of chronic liver disease (e.g., hepatitis virus carriage, a past history of acute hepatitis, and excessive alcohol consumption)
  - **Established Chronic Liver Disease**
    1. Avoid PZA
       - 2SHRE/6HR
       - 9RE
       - 2SHE/10HE
  - **Acute Hepatitis**
    1. Defer TB treatment until resolved
    2. Safest option is 3SE while waiting for hepatitis to resolve then 6HR continuation phase.
    3. 12SE if hepatitis is unresolved

- **Renal Failure**
  - FDC-A (HRZE) 3x/wk + FDC-B (HR) for the rest of the week during the intensive phase.
    1. Continuation phase may proceed with 4HR.

- 2HRZ/4HR is another option
- Take meds after hemodialysis

Drug	Change in frequency?	Recommended dose and frequency for patients with creatinine clearance <30mL/min or for patients receiving hemodialysis
INH	No change	300mg once daily; or 900mg three times per week
RIF	No change	600mg once daily; or 600mg three times per week
PZA	Yes	25-35mg/kg per dose 3 times per week (not daily)
ETH	Yes	15-25mg/kg per dose 3 times per week (not daily)
Strep	Yes	12-15mg/kg per dose 2 or 3 times per week

- **TB/HIV Co-infection**
  - Isoniazid preventive therapy (IPT) with 6H for HIV+ individuals who, after careful evaluation, do not have active TB.
  - Priority is to treat TB, especially bacteriologically confirmed PTB to stop transmission.
  - start ART concomitantly with TB treatment (if with high risk of death)
  - Defer ART (if not high risk of dying)
  - Co-TMX as prophylaxis for other infections

- **Drug Interactions during TB Treatment**

  - Elderly individuals with significant comorbidities, as well as the immune-compromised patients (e.g., HIV/AIDS patients) at higher risk.
  - To minimize drug interactions, it is advisable that drugs be administered 12 hours apart.
  - Listing of drug-drug interactions is available in the MOP

Rifampicin interactions with various drug categories	
Drug category	**Rifampicin interaction**
Anti-hypertensive medications	• Markedly reduces levels of Calcium channel blockers (nifedipine, amlodipine, verapamil) • Reduces levels of B-blockers (propranolol, carvedilol) • Isolated reports of interaction with ACE inhibitors (captopril, enalapril, lisinopril) but minor clinical significance • No interactions found with Diuretics (thiazides, spironolactone, furosemide)
Analgesics	• Increases clearance of paracetamol (but clinical importance not yet established) • Decreases levels of diclofenac; • no interaction with aspirin and ibuprofen Reduces opioid levels(morphine, codeine)

Rifampicin interactions with various drug categories	
Drug category	**Rifampicin interaction**

Antifungals	• Markedly reduces serum concentration of antifungals (Ketoconazole, itraconazole) • Serum rifampicin levels can also be reduced with concurrent use of ketoconazole.
Anti-retroviral agents (ARV)	• Reduces levels of Efavirenz (EFV), ritonavir and nevirapine • Increases clearance of Zidovudine • No interactions found with Didanozine, Lamivudine
Anti-epileptics	• One report of increased level and toxicity of carbamazepine when H and R is given together • Reduces levels of phenytoin and valproic acid

Isoniazid interactions with various drug categories	
Drug category	**Isoniazid interaction**
Antacids	INH absorption is reduced with concurrent use of luminium hydroxide (give INH at least one hour before the antacid)
Carbamazepine	Increases levels of carbamazepine markedly and rapidly
Oral contraceptives	Few cases of failures reported; risk of contraceptive failure is low with concurrent use of INH.
Paracetamol	Potential toxicity of paracetamol even at normal dose when used with INH; more studies are needed
Phenytoin	Increased levels of phenytoin with concurrent use of INH
Theophylline	Plasma level of theophylline may be increased

Drug category	Other Drug-Drug Interactions
ETH and PZA	• May interact with thiazide diuretics to cause elevated serum uric acid levels
PZA	• May interact with allopurinol and probenicid and cause elevated uric acid levels
Strep	• Increased risk of ototoxicity or nephrotoxicity when used with oto – or nephrotoxic drugs • Exercise caution when used with anesthetics and neuromuscular blocking agents as streptomycin can prolong the neuromuscular blockade and potentially lead to respiratory depression
FQs (2nd line treatment)	• Increases serum theophylline level • Increased anticoagulant effect of Warfarin • Concurrent use with sucralfate and antacids (containing Al, Ca, or Mg) may reduce absorption of quinolones • Serum level of ciprofloxacin is reduced with concurrent use of didanosine

Length of interruption?	Do DSSM if >1 month interruption	How long has patient been treated?	Disposition
Less than 1 month			Continue treatment and prolong to compensate
More than 1 month (but < 2months)	Negative DSSM		Continue treatment and prolong to compensate
	Positive DSSM	Less than 5 months	Continue treatment and prolong to compensate
		More than 5 months	Classify as “Treatment Failed”
More than 2 months			Classify as “Lost to Follow-up”

Deciding when a PTB patient is no longer infectious during treatment

MOP also provides instructions on deciding when a PTB patient is no longer infectious during treatment both for bacteriologically-confirmed patients and clinically-diagnosed patients. Moreover, protocols on management of cases with interrupted treatment and treatment modifications on special situations (e.g. pregnancy, breastfeeding, oral contraceptives, liver disease, chronic liver disease, acute hepatitis, renal failure and TB/HIV co-infection) are comprehensively discussed. *(Please indicate the page numbers)*

- For **clinically diagnosed patients** (smear negative or smear not done), it is possible to clear him **after 2 weeks**
    - as long as **treatment compliance is assured**
    - There is **clinical improvement or no clinical deterioration**.
- Once appropriate, issue a certificate that the patient is no longer infectious and can safely return to work.

Management of Cases Who Interrupted Treatment

- Patients who fail to follow-up as scheduled should be immediately traced through: **telephone call, text message or home/workplace visit**.
    - Assess the cause of interruption and agree on solutions.

Treatment Outcomes

Based on completion of treatment regimen, DSSM follow-up results and clinical improvement or lack of clinical deterioration.

- Record the treatment outcome in the **Form 4. TB treatment/IPT Card** and the **Form 6a. TB Register**.
- Using the completely filled-out **Form 5. NTP ID Card**, issue a Certificate of Treatment Completion/Cure as a form of recognition for the patient's achievement.

Treatment Outcomes for Drug Susceptible TB Cases

Outcome	Definition
Cured	A patient with bacteriologically-confirmed TB at the beginning of treatment and who was smear- or culture-negative in the last month of treatment and on at least one previous occasion in the continuation phase
Treatment completed	A patient who completes treatment without evidence of failure but with no record to show that sputum smear or culture results in the last month of treatment and on at least one previous occasion were negative either because tests were not done or because results are unavailable. This group includes: - A bacteriologically-confirmed patient who has completed treatment but without DSSM follow-up in the last month of treatment and on at least one previous occasion.

	- A clinically diagnosed patient who has completed treatment
Treatment Failed	A patient whose sputum smear or culture is positive at five (5) months or later during treatment Or A clinically diagnosed patient (child or EPTB) for whom sputum examination cannot be done and who does not show clinical improvement anytime during treatment.
Died	A patient who dies for any reason during the course of treatment
Lost to follow-up	A patient whose treatment was interrupted for two (2) consecutive months or more.
Not evaluated	A patient for whom no treatment outcome is assigned. This includes cases transferred to another DOTS facility and whose treatment outcome is unknown.

Treatment Outcomes for RR-TB/MDR-TB/XDR-TB Patients

Outcome	Definition
Cured	A patient with bacteriologically-confirmed a *RR-TB/MDR-TB/XDR-TB* who has completed at least eighteen (18) months of treatment without evidence of failure **and** three or more consecutive cultures taken at least thirty (30) days apart are negative after the intensive phase.
Treatment completed	A patient who completes at least eighteen (18) months of treatment without evidence of failure **but** no record that three or more consecutive cultures taken at least thirty (30) days apart are negative after the intensive phase
Treatment Failed	Treatment terminated or need for permanent regimen change of at least two anti-Tb drugs because of: • Lack of conversion** by the end of the intensive phase* or • Bacteriological reversion** In the continuation phase after conversion** to negative, or • Evidence of additional acquired resistance to fluoriquinolones or second-line injectable drugs, or • Adverse drug reactions (ADRs)
Died	A patient who dies for any reason during the course of treatment
Lost to follow-up	A patient whose treatment was interrupted for two (2) consecutive months or more.
Not evaluated	A patient for whom no treatment outcome is assigned. This includes cases transferred out to another treatment unit and whose treatment outcome is unknown.
Treatment Success	The sum of cured and treatment completed.

**For Treatment failed, lack of conversion by the end of the intensive of phase implies that the patient does not convert within the intensive phase applied by the program. The intensive phase is a minimum of six (6) months of second line anti-TB treatment. If the patient does not convert, a cut-off of eight (8) months of treatment is applied to determine the criteria for treatment failed.*

*** The terms "conversion" of and "reversion" of culture as used here are defined as follows:*

Conversion (to negative): culture is considered to have converted to negative when two consecutive cultures, taken at least thirty (30) days apart, are found to be negative. In such a case, the specimen collection date the first negative culture is used as the date of conversion.

Reversion (to positive): culture is considered to have reverted to positive when, after an initial conversion, two consecutive cultures, taken at least thirty (30) days apart, are found to be positive. For the purpose of defining Treatment failed, reversion is considered only when it occurs in the continuation phase.

Comprehensive Tuberculosis Elimination Plan Act (R.A. 10767)

Sec. 11. Regulation on Sale and Use of TB Drugs. The Food and Drug Administration (FDA) shall strengthen its implementation of the "No prescription, No Anti-TB drugs" to regulate the sale and use of anti-TB drugs in the market. It shall also ensure the quality of TB drugs distributed in the market.

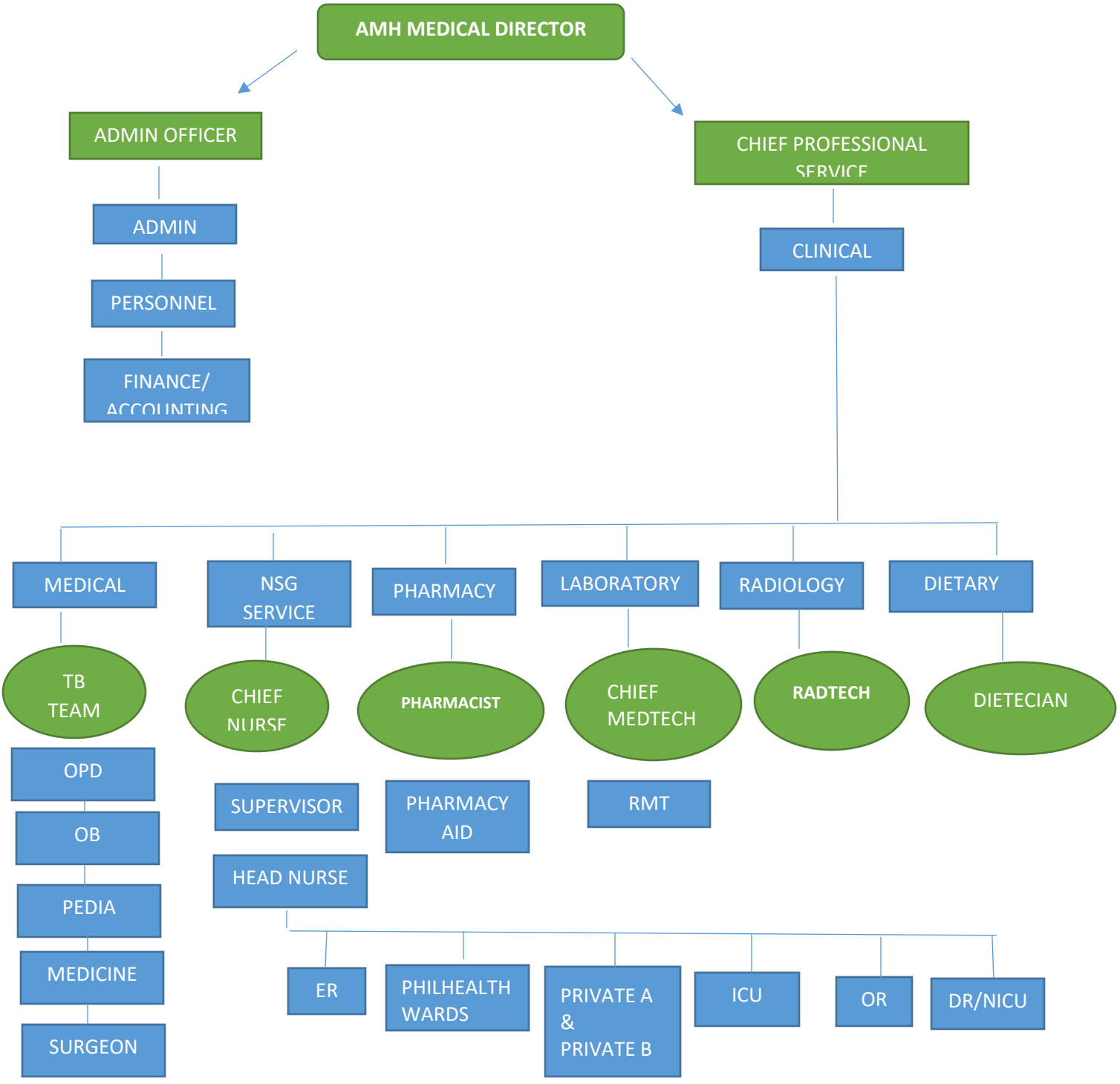
Sec. 12. Notification of TB Cases. All public and private health centers, hospitals and facilities shall observe the national protocol on TB management and shall notify the DOH of all cases as prescribed in the Manual of Procedures of the National TB Program and the Philippine Plan of Action on Tuberculosis Control.

Sec. 13. PhilHealth TB Package. The Philippine Health Insurance Corporation, otherwise known as the PhilHealth, shall, as far as practicable, expand its benefit package for TB patients to include new, relapse and return-after-default cases, and extension of treatment.

CHAPTER 2. DOTS IMPLEMENTATION & MANAGEMENT

A. Management Structure

i. Organizational Structure



Aisah Medical Hospital

Nursing Service

Manual & Procedure

Code No. 000-001	Title	Effective Date : 8/8/16
	TB Team Mandate	Revised Date :

As per requirement of the Department of Health- National Tuberculosis Program, pursuant to RA 10767 mandated by section 12 9 That, Tuberculosis as a notifiable disease by all public and private hospitals). Thereby, as per Resolution No. 01 issued by the Medical Director of the Aisah Medical Hospital mandating the creation of TB team to address the call for TB control by the Department of Health.

Description of Roles:

Responsible Person	Roles/Functions	Collaborating Units
A. Hospital Management ➢ Medical Director ➢ Chief of Clinical Professional Services (CCPS) ➢ Hospital Administrator	• Shall mandate via a Resolution Institutionalization of Hospital DOTS Initiative for full enforcement & implementation. • Shall allocate budget for logistics for the creation of TB facility	• All Units • Finance/Accounting Department

B. Hospital TB Team ➢ TB Physician ➢ TB Nurse ➢ TB Medtech	• Evaluate presumptive TB based on clinical and laboratory evidence. • Manage the process of detecting TB cases in coordination with other staff. • Assist the physician in counseling and initiating treatment of TB patient. • Maintain and update the presumptive TB master list and TB register. • Prepare and submit the quarterly reports. • Make referral slip to RHU. • Do DSSM for diagnosis and follow-up. • Perform HIV testing for TB patients as needed. • Maintain and update the NTP Laboratory register. • Prepare and submit quarterly report. • Ensure the microscope are properly maintained and functional. • Store sputum smear to allow sampling by the provincial or City NTP coordinator for blinded re-checking as part of the external quality assessment	Peripheral DOTS facility All hospital units
C. Ancillary/Support Services Laboratory (Chief of Lab)	1. Responsible for getting clear imaging results. 2. Responsible for getting accurate and correct laboratory results. 3. Do internal quality control in the laboratory	4. Hospital Management 5. Department Heads 6. MD

Prepared by:	Approved by:
JOCELYN P. ELMEDORIAL, RN, MN Head Nurse	**Ma. Celina D. Gaspar, RN,MN** Chief of Hospital

Aisah Medical Hospital

Nursing Service

Manual & Procedure

Code No.	Title	Effective Date : 8/8/16
000-002	**AMH TB DOTS Team / Functions**	Revised Date : 8/5/16

TB MD: Dr. Modassir Calalagan

TB Nurse: Jocelyn P. Elmedorial, RN, MN

Members :

Ward Focal Person:

Emergency Room : Nurkida A. Ismael, RN, MN

Philhealth Ward : Jamaica E. Betonio, RN, MN

Private Rooms 3rd floor: Jenn G. Calanda, RN, MN

Private Room 4th floor: Jocelyn P. Elmedorial, RN, MN

Functions of the TEAM:

- Assist the Director in overseeing the management of hospital-based TB-DOTS
- Develop annual plan with budgetary requirement and ensure integration in the hospital plans, programs and budget.
- Facilitate development, issuance and dissemination of hospital TB policies and guidelines.
- Ensure continuous capability-building of hospital staff on TB.
- Establish a functional two-way referral system between hospital and field health units/ private sector.
- Ensure continuous availability of logistics.
- Develop mechanism/s to ensure patient's compliance to referral and treatment.
- Monitor/ supervise hospital staff compliance to TB policies and procedures.
- Collaborate and coordinate with LGUs, NGO's, other government offices and other partners.
- Submit necessary reports to hospital to hospital management and to CHO/PHO.
- Meets regularly

Additional tasks for hospital TB team in TDPH:

1. Register, treat and report TB cases.
2. Monitor outcome of treatment.
3. Set-up a mechanism for contact investigation and defaulter tracing mechanism (either by the hospital staff of health centers)

Frequency of meeting

- Meeting every last week of the month

Wards:

- Refers presumptive TB patients to TB clinic
- Ensures that DSSM examination is done
- Directly observes patients to take anti-TB meds daily while admitted
- Counsel TB patients

OPD:

- Refers presumptive TB patients to TB clinic
- Ensures that DSSM and other diagnostic TB test are done

Emergency Room:

- Refers presumptive TB patients to TB clinic or admits depending on the evaluation

Laboratory:

- Conducts DSSM and other diagnostic tests
- Records and report number of cases examined

Radiology:

- Performs chest X-ray examination
- Provides information on the availability of TB services in the hospital

Pharmacy:

- Refrain from selling anti-TB drugs without prescription
- Refer self-medicating presumptive TB patients to DOTS clinic
- May manage the anti-TB drugs from the NTP

Social Service:

- Recommends appropriate hospital support to deserving patient
- May refer TB patient (eg. PDAF initiative) to the TB clinic
- May help in retrieving TB patient

Administrative/ Finance unit

- Help the team manage the funds and logistics received from DOH

Nursing Department

- Ensure that nurse of the DOTS clinic is trained and supervised

Prepared by:	Approved by:
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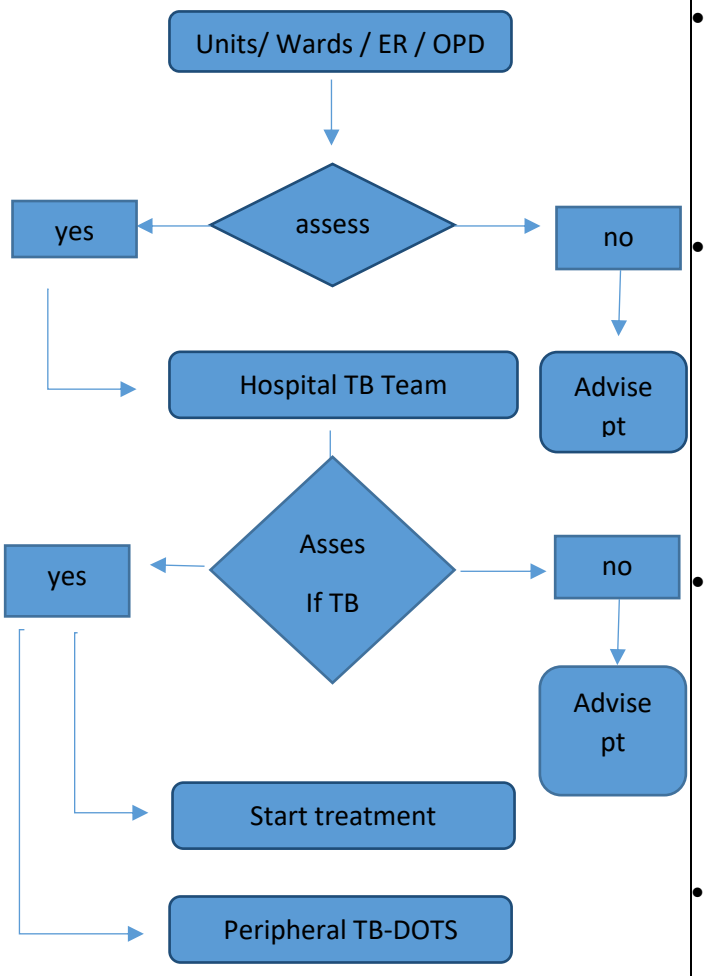
Aisah Medical Hospital

Nursing Service

Manual & Procedure

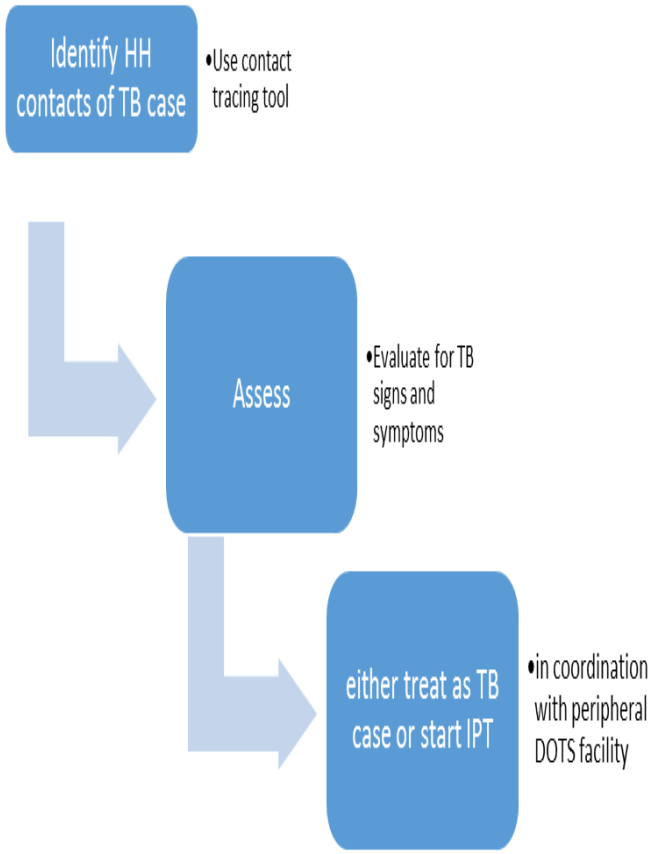
Code No. 000-003	Title	Effective Date : 8/8/16
	AMH TB Case Finding *(Adopted from DOH NTP MOP)*	Revised Date : 8/5/16

a.Passive Case finding

Process Algorithm	Process Description	Key Process Owner
	• Presumptive TB cases are identified in the wards/units or ER upon initial admission or seeking for medical attention • If patient identified as presumptive TB case, unit nurse will refer to TB team • TB physician will assess the referred case and will facilitate referral or treatment if found out to be TB case • TB team facilitates referral to peripheral providing TB-DOTS and follows-up the	• Unit/Ward Nurses • Unit Nurse • TB physician • Hospital TB team

	outcome of the referral	

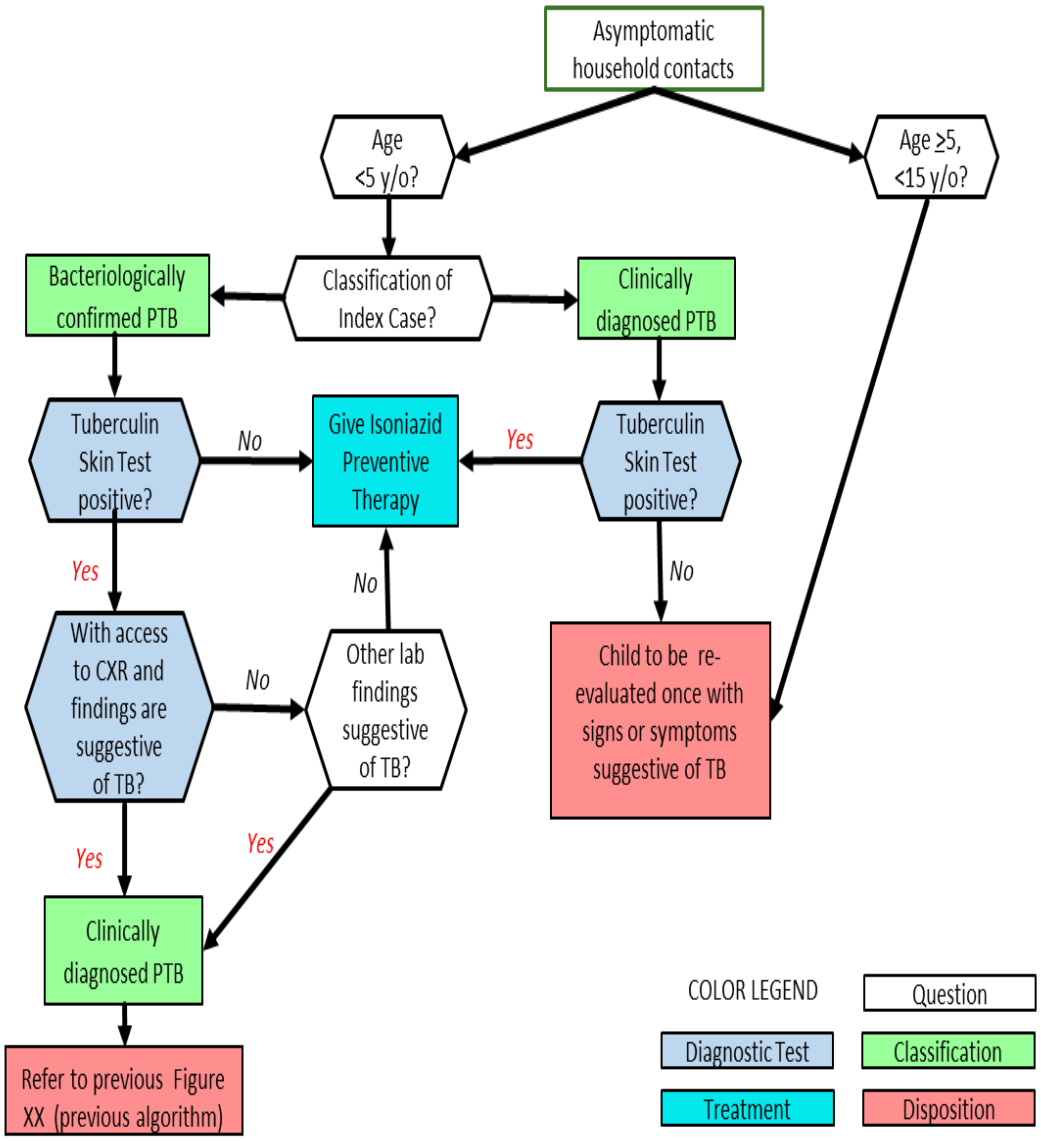
b. Active Case Finding

Process Algorithm	Process Description	Key Process Owner
	• Identify Household/close contacts of the TB case; follows-up referred presumptive cases to peripheral TB-DOTS • Assess HH contact if needs treatment or IPT • Hospital TB team and peripheral DOTS facility; coordinate who will provide treatment or IPT	• Hospital TB Team • Hospital TB Team • Hospital TB Team and Peripheral TB-DOTS

Contact Tracing Tool

Name	Age	Relationship	History of Exposure (Yes/No)	History of Treatment (Yes/No)	Onset of Exposure

Procedures (Household Contacts of Drug-susceptible TB)



Assessment and Diagnosis (see Diagnostic Algorithm in Chapter 1 page 4)

All referred presumptive cases from all units will be seen by the TB physician and will be evaluated accordingly.

TB case, register and start treatment as per MOP.

TDRH: If upon assessment patient is a new presumptive case, referral form (Form 7) to peripheral TB-DOTS will be filled up and patient will be referred to the RHU with DOTS facility where the patient resides. The TB nurse will facilitate the referral by calling the peripheral TB-Dots for the said referral. In the event that the TB physician is not available, the TB nurse will fill up the referral form and facilitate the referral to the peripheral TB-DOTS

**If upon assessment patient is a presumptive multi-drug resistant case, referral form (Form 7) will be filled up and patient will be referred to PMDT centers or Xpert site.*

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Aisah Medical Hospital

Nursing Service

Manual & Procedure

Code No.	Title	Effective Date :
000-003		8/8/16
	TB DOTS Internal/External Referral System	Revised Date : 8/5/16

To ensure that all TB cases is seen or diagnosed in the hospital are properly managed in accordance with the national and international standards. All TB cases seen must be referred to the TB clinic.
Hospital TB clinic serve as the hub for coordinating TB referrals within and outside the hospital. It ensure that that patient avail of DOTS services such as diagnostic examination and free TB drugs.

Internal TB Referral System

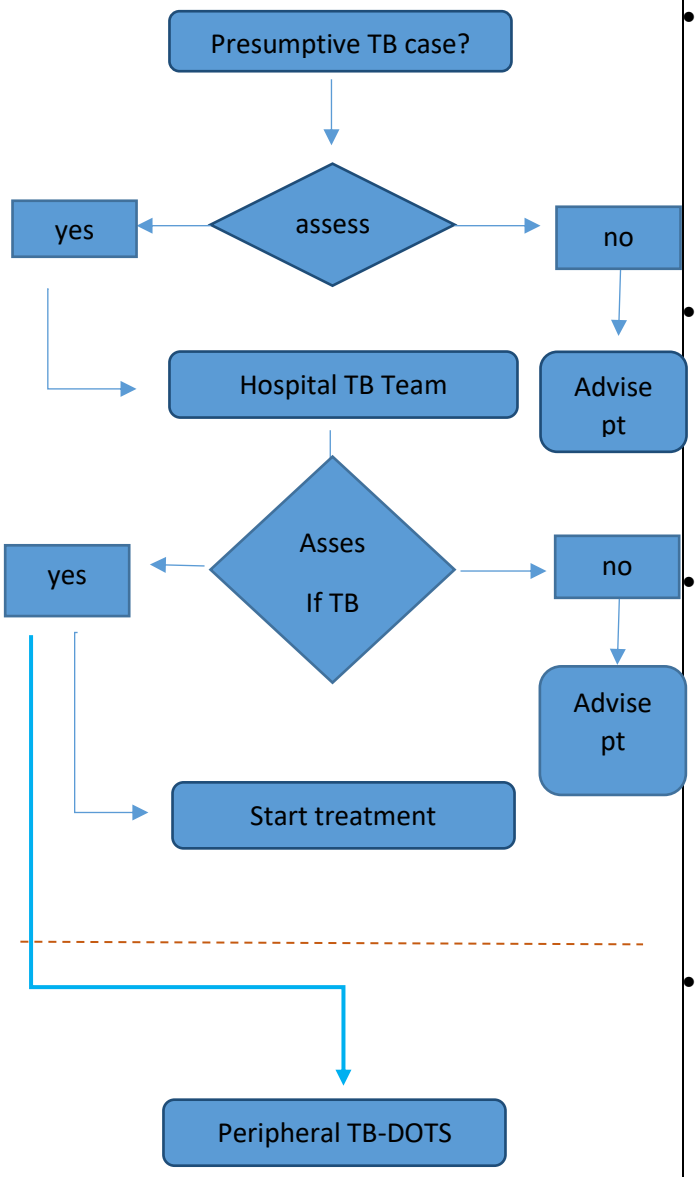
All presumptive TB cases identified by the OPD, ER, wards or any department and other units of the hospital or sections must be referred to the hospital TB Team or point person.

- Referring staff (e.g. attending physician, nurse on duty) fills up and intra-hospital referral form with the pertinent documents attached and send this to the hospital TB Team or point person.
- Hospital TB Team evaluates the patient fills up the reply form and records the patient in the hospital TB referral logbook.
- Green form - is used for intrahospital referral.
- The following data to write:
  1. Hospital case number copy from patients chart /record.
  2. Date referred write month,day ,tear format
  3. Referring unit /ward or area. Where patient came from specify room number.
  4. Write patients full name, family name first followed by first name and middle initial, age in years, sex,status and weight.
  5. Write complete address street, Barangay, town, city and province.
  6. Patients contact number landline or cellphone.
  7. Check yes, if patient is a known case of TB and is undergoing treatment and registered in a DOTS facility or NO if the patient is not.
  8. If the patient is registered in DOTS facility. Write name and complete address of dots facility.

b. Diagnostic exam results check the appropriate box and fill-out the additional information needed. Other examination results could be histopath/biopsy,tuberculin skin test etc.
c. The following is to be filled out by the attending/referring physician:

a. Write the Diagnosis/Impression
b. Write the name, signature and position/designation of the referring/attending physician.

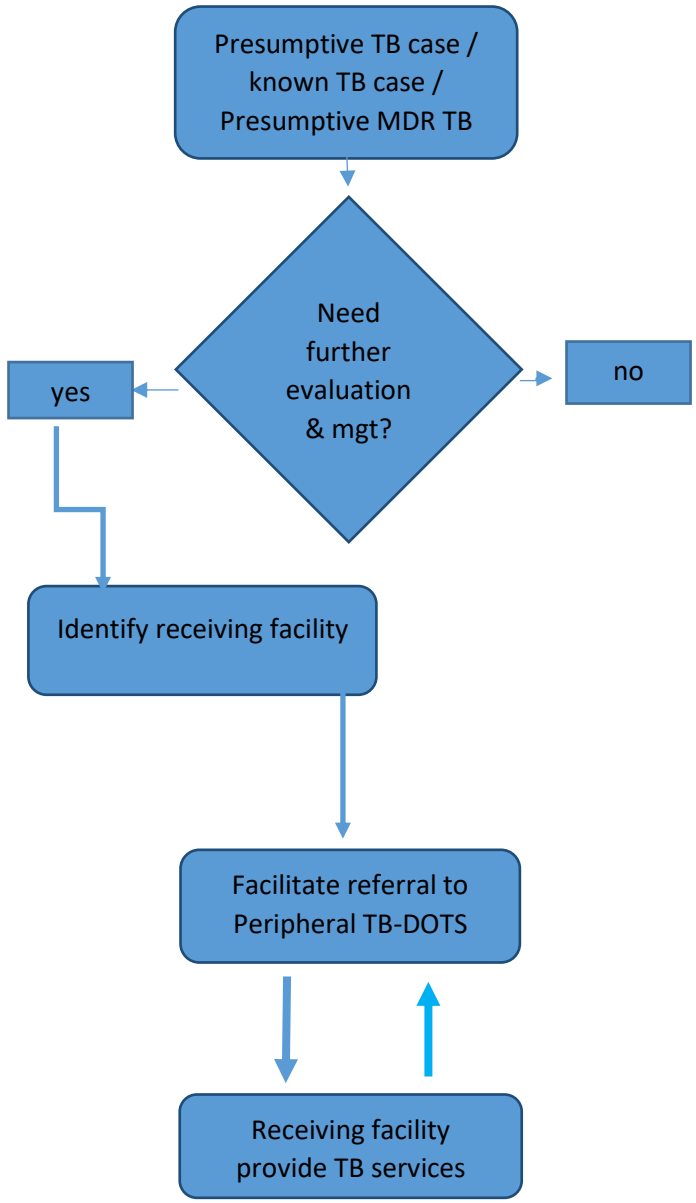
d. Patient may be provided with NTP drugs while at the hospital. Drugs may come from the health center where the patient reside or from the hospital TB Team.

Process Algorithm	Process Description	Key Process Owner
INTERNAL TB REFERRAL SYSTEM  	• Presumptive TB cases are identified in the wards/units or ER upon initial admission or seeking for medical attention • If patient is identified as presumptive TB case, unit nurse will refer to TB team using appropriate forms • TB physician will assess the referred case and will facilitate referral or treatment, if found out to be TB case • TB team facilitates referral to peripheral providing TB-DOTS and follows-up the outcome of the referral	• Unit/Ward Nurses • Unit Nurse • TB physician • Hospital TB team

External TB Referral System

- Explain to the patient the reason for referral.
- Identify the DOTS/health facility where he will be referred depending on the type of services needed. Mutually agree with the patient where she/he will be referred.
- Accomplish the appropriate referral form (NTP FORM 7). Attach pertinent documents and laboratory results.
- Instruct the patient/watcher and emphasize the importance of giving feedback to the referring unit.
- Health education and counseling shall be imparted to patients and watchers.
- Discuss with patient the referral process.

- Upon discharge, refer to DOTS facility.
- For patients who started treatment in the hospital, give at least one or two weeks supply of anti TB drugs. Provide and fill up the ID card.
- Write on remarks column on the TB registry or Presumptive TB masterlist where the patient was referred
- List all referred patients to referral logbook
- Inform/communicate with the receiving facility.
- Receiving facility gives feedback to the referring facility.
- Referring unit updates record upon receipt of feedback.
- Follow up patient who did not show up at the receiving health facility within five days from date of referral

Process Algorithm	Process Description	Key Process Owner
EXTERNAL TB REFERRAL SYSTEM  	• Identify Presumptive TB cases needing referral to complete diagnosis and those confirmed TB cases that will be treated by outside DOTS facilities • Assess whether TB patient will be treated by the hospital or referred to outside DOTS facilities for further evaluation or mgt • Determine the appropriate facility where patient will be referred (health center/ PMDT/ Xpert site) • Accomplish proper referral forms and attach pertinent records/lab results • Receiving facility provides the needed services and provides feedback to referring facility • Referring facility communicates with receiving facility if no feedback received after 2 weeks	• TB team • Hospital TB team • Hospital TB team • Hospital TB team • Receiving DOTS facility (HC/PMDT/Xpert site) • Hospital TB team

Aisah Medical Hospital

Nursing Service

Manual & Procedure

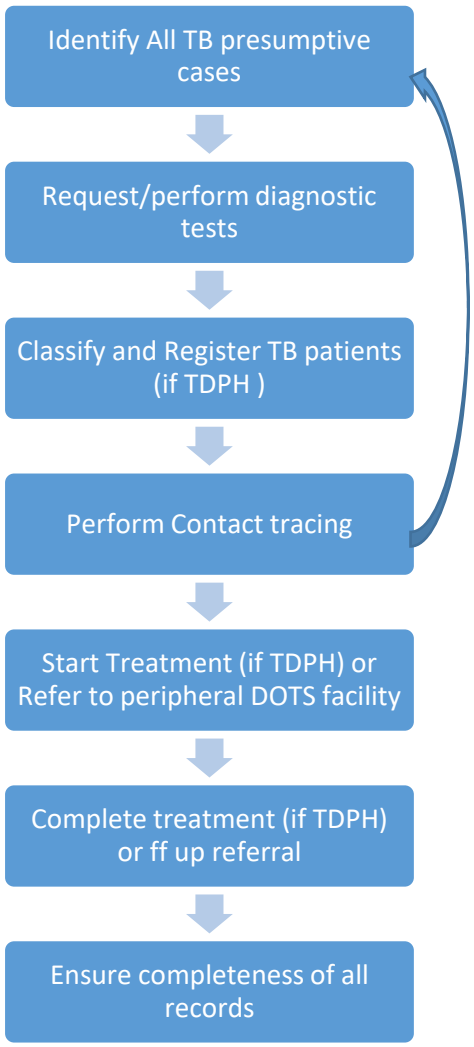
Code No. 000-003	Title	Effective Date : 8/8/16
	Recording and Reporting	Revised Date : 8/5/16

Recording and Reporting

- Classify TB according to internationally accepted case definitions by the NTP nurse
- Use NTP Forms issued by DOH.
- NTP Referral Form
- Presumptive TB Masterlist Logbook
- Hospital TB Referral Logbook
- TB Register

- Quarterly Report should be sent to the DOH through channels as agreed upon.
    - DOTS facility to PHO/CHO to CHD to NCDPC-DOH based on agreed timeline.

Reports	Person Responsible	Tools to be Utilized	Source	Reporting To	Time & Frequency	Means
1. Quarterly	TB Nurse	Quarterly Report (Report 6)	Hospital TB Registry	RHU NTP	Quarterly	Hard copy/ Soft Copy
2. Laboratory Registers	N/A	---------	---------	---------	--------	----------
3. Drug Supply	N/A	---------	---------	---------	---------	----------

Process Algorithm	Process Description	Record/ Forms to use	Key Process Owner
	• Identify all presumptive TB cases • Submit patient for lab tests • Classify patients based on MOP; register all TB cases • Identify & Screen Household/close contacts of the TB case; • Start treatment based on Registration group • Performs DOTS including sputum monitoring • follows-up referred cases • Regular updating of records	• Presumptive TB masterlist (Form 1) ; TB referral logbook • Lab request form (Form 2); • Lab register • Drug-susceptible TB register (Form 6); Treatment card (form 4); NTP ID card (Form 5) • Drug-susceptible TB register (Form 6); Treatment card (form 4); NTP ID card (Form 5) • Drug-susceptible TB register (Form 6); Treatment card (form 4); NTP ID card (Form 5) • Lab register • Presumptive TB masterlist • All records	• All hospital Units/Hospital TB Team • All hospital Units/Hospital TB Team • Med tech • TB nurse • TB nurse • TB nurse • Med Tech • Hospital TB Team • Hospital TB team

FOR TDPH

Reports	Person Responsible	Data Sources	Reporting To	Time & Frequency	Means
Report 1. Quarterly Report on TB Microscopy	Med Tech	Lab Register	PHO or City NTP	Quarterly	Hard copy/ Soft Copy
Report 3a. Quarterly report on case finding of Drug Susceptible TB cases	TB Nurse	Hospital TB Registry	PHO or City NTP	Quarterly	Hard copy/ Soft Copy
Report 4. Quarterly report of Drug Supply and Inventory requirement	TB Nurse/ Pharmacist	Drug Inventory	PHO or City NT	Quarterly	Hard copy/ Soft Copy
Report 5a. Quarterly report on Treatment Outcome of Drug Susceptible TB cases	TB Nurse	Hospital TB Registry	PHO or City NTP	Quarterly	Hard copy/ Soft Copy
Report 6. Quarterly Report on Hospital TB referral	TB Nurse	Hospital TB Registry	PHO or City NTP	Quarterly	Hard copy/ Soft Copy

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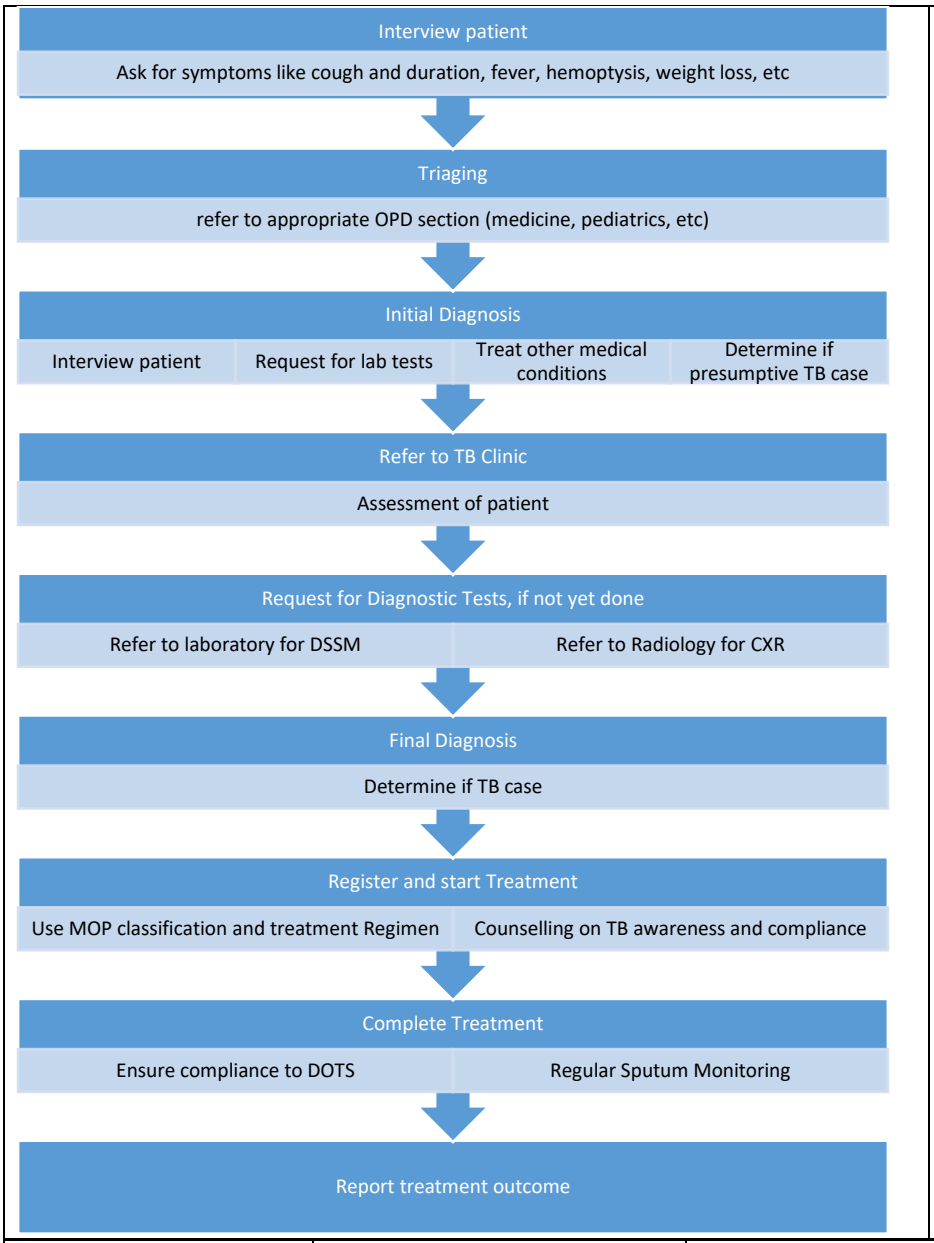
AISAH MEDICAL HOSPITAL
Nursing Service
Manual & Procedure

Code No.	Title	Effective Date :
000-004		8/8/16
	Cough to Cure Pathway (TDPH)	Revised Date : 8/5/16

Process Algorithm	Process Description	Key Process Owner
		• Triage Staff • Physician in Charge • Hospital TB Team



	Steps	Responsible Unit/person	Form/record
	Ask chief complaints/s of patient, give patient card and	Staff assigned at the triage (eg. Nurse, residents, interns)	Patients card
	Prepare OPD chart and list patient at the consultation logbook of the concerned OPD clinic	Nurse/attendant	Patient chart/ Logbook of consultations
	Prepare request for DSSM as one of the diagnostic work-	Physician on duty of the clinic	NTP Laboratory request form, other laboratory

	ups (either done at the OPD or TB clinic)	Or member of the TB Team	forms for other request
	For DSSM		
	Give sputum cup and advise patient on correct way of sputum collection	Nurse in TB clinic or Medtech of the laboratory	
	Submit sputum specimen to the laboratory	Patient	
	Examine the specimen and record	Laboratory staff	NTP laboratory registry
	Release result to the patient TB clinic staff counsel the patient	Laboratory staff TB clinic	Laboratory result
	If there is other diagnostic work-ups refer to concerned units.	Physician on duty	
	If a TB patient goes back to OPD clinic, refer to TB clinic	Physician on duty	NTP Intra-hospital referral form
	If clinically diagnosed, refer to Tb clinic or Hospital TB team who will decide whether to initiate treatment or refer to DOTS trained physician/ TBDC	Physician on duty	NTP Intra-hospital referral form
	List presumptive TB/TB patient in the TB referral logbook, record in the patient's chart and send back part of the intra-hospital referral form.	DOTS clinic staff or hospital TB coordinator	Hospital TB referral logbook Patients chart

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Code No. **000-005**	Title	Effective Date : 8/8/16
	Communication/Coordination Protocol	Revised Date : 8/5/16

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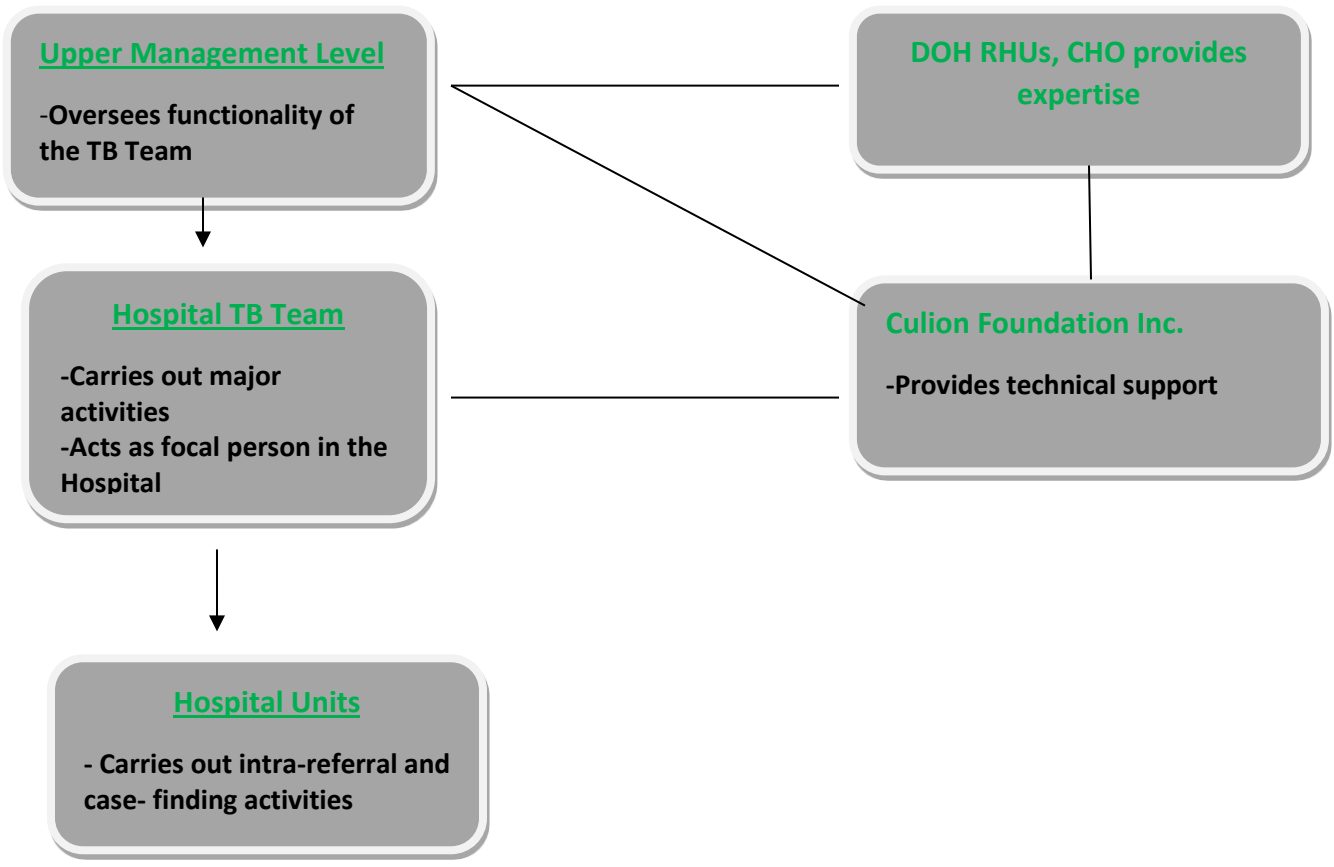

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Aisah Medical Hospital

Nursing Service

Manual & Procedure

Code No.	Title	Effective Date : 8/8/16
000-006	**Program Tracking & Adjustment**	Revised Date : 8/5/16

Program Tracking & Adjustment

- Tracking of target set (i.e. 5 cases/month) and provide timeline

Tracking Sheet Use

Task	Responsible (R) Accountable (A)	Dependent on (from PWP)	Planned Start	Planned Finish	Actual Start	Interim Review	Actual Finish	Corrective Actions Required
1.Case Finding	TB RN (A) Unit RN (R)		Sept. 2016		Dec.2016	Semi-annually		-
								-
2.Assessment and Diagnosis	TB Physician(A)							

- **Analysis of Monitoring and Evaluation**
  (This is done to achieve outcomes as well as double checking achievement against the schedule)
- **Carry out Quality Assurance** (Evaluate completeness and accuracy of records. Does the nurse fill out the form completely)

- **Mentor and Monitor Program Partners- How? Return slips or referrals slips?**

Partners	Areas for Monitoring and Mentoring	Responsible Person
1.Physicians	Assessment and Diagnosis Treatment and Management	TB Physician
2.Unit RNs	Case Finding	TB Physician
3.Health Care Workers	Case Finding IEC	TB Nurse

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AISAH MEDICAL HOSPITAL

Nursing Service

Manual & Procedure

Code No. 000-006	Title	Effective Date : 8/8/16
	Managing Program HR	Revised Date : 8/5/16

Managing Program HR

1. Identification of human resources for TB Team

Team Member	Job Specification	Succession Plan
1.TB Physician	Trained on MOP; others depending on specifications of the facility/mgt.	Hospital TB Team shall follow succession plan. Refer to Chapter 4 on succession plan.
2.TB Nurse	Trained on MOP	
3.TB Medtech	Trained on MOP Trained on DSSM	

2. Team Member Training

- Training needs assessment (Assess team member performance)
- Orientation
- Mentoring

▪ Assess TB Team Performance

(Align with performance appraisal survey; Administrative- Additional recording and Reporting.

- Does the TB Physician/TB nurse know how to accurately assess a presumptive TB client?)

- What is the performance of the medtech based on the EQA results?
- What is the intra-hospital referral rate?
- What is the treatment success rate of the hospital?

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AISAH MEDICAL HOSPITAL

Nursing Service

Manual & Procedure

Code No. 000-007	Title	Effective Date : 8/8/16
	Managing Issues	Revised Date : 8/5/16

a. Managing Issues

Issues in Aisah Medical Hospital that may hinder the success of implementation of the program.

Define and carry out corrective or mitigating actions.

3. Diagnostic/Laboratory Services
4. Human Resources: Fast staff turnover
5. Patient Factor
6. Local Implementation
7. Drug Supply: No Cat ll drugs
8. Records Management

Arising Issues	Actions to be taken
Human Resources ➢ Fast turnover ➢ Work overload, multi-tasking allocation.	A. Intensive coaching and expand supervision and preceptorships. B. Oriented more hospital/nurse TB coordinators per ward.
Diagnostic and Laboratory Services Delayed chest X-ray result Required payment to DSSM OPD patient	Lobby with hospital management for scheduling and diagnostic services. Inform the receiving DOTS facility of the incoming referrals and monitor the referred cases.
Patient Factor Stigmatization Poor patient compliance to the referral Incomplete and inaccurate personal data	Recommended protocol for proper handling of patients to avoid stigma. Continues mentoring and coaching of Tb Nurse/Team for proper and accurate filling out of NTP forms and logbooks.

	Maintained coordination with RHUs to help in communication activities to ensure proper information dissemination.
Local Implementation	Inform Director of Hospital
Drug Supply	Regular updating of drug inventory; Coordinate with CHO/PHO/NTP
Records Management	
Referral System Lack/weak feedbacking return slips; no follow-up	Scheduled continuous mentoring and coaching of TB partners for proper filling out of NTP forms and logbook.
Logistics and Support	All Nurses shall conscientiously, accurately, completely record the data in the logbook. It should be written with no erasures and alterations.
Forms	Ensure all forms are available at all times
Incomplete and Inaccurate Data	Verify to the patient the data is correct Regular updating of Records
Poor Patient Compliance	Maintain coordination on RHU to help in communication in activities
MD's rendering Private Management	Advocacy visits for private clinicians Endorse the issue and concerns in the Management.
Referral System	Review Hospital internal and external referral system

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AISAH MEDICAL HOSPITAL

Nursing Service

Manual & Procedure

Code No. 000-008	Title	Effective Date : 8/8/16
	Managing Patient Records	Revised Date : 8/5/16

- **Managing Patient Records**

Proper recording and referral; ensure completeness and accuracy.

1. The TB Nurse shall ensure completeness and accuracy of all records and reports.
2. The TB nurse should maintain a copy of all reports provided or submitted to PHO NTP.
3. All information contained in the logbook must be consistent with patients' records, referral forms test results, reply slips and other data SOURCES.
4. TB Nurse should ensure no alteration, erasure or no tear of the records and reports.
5. TB Nurse should maintain confidentiality of the record of the patient.
6. Logbooks must be filled up with following information,

1. Contact number of patient and relatives.
2. Source of referral.
3. Address and contact number of receiving DOTS facility.
4. Ensure that the blanks in the logbook are filled up with information.
5. Make sure referred cases has corresponding TB case number.

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Head Nurse	Chief of Hospital

AISAH MEDICAL HOSPITAL

Nursing Service

Manual & Procedure

Code No.	Title	Effective Date :
		8/8/16
000-009	**Managing Organizational Capacities**	Revised Date :
		8/5/16

Managing Organizational Capacities

1. Infrastructure:
   a. A space or an area provided for Assessment located in the OPD with table and chair as TB clinic
   b. Space with good ventilation

2. Infection Control implementation
   - Existing Policies

3. Organizational procedures and requirements
   Patients' satisfaction survey form is given to patient to assess if they are satisfied with the services

4. Ventilation
5. Infection Control Implementation

A space or an area provided for Assessment

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Head Nurse	Chief of Hospital

CHAPTER 3. MONITORING, SUPERVISION & EVALUATION

Monitoring - regular, systematic and purposeful observation of program performance to determine whether activities are implemented as planned and according to schedule. It also involves giving feedback to implementers, program managers, donors and beneficiaries of the program. (MOP, 2014)

It is best to conduct monitoring activities at least **quarterly before the submission of the Quarterly Report.**

Internally, monitoring should be done by the hospital TB team to ensure that the Hospital DOTS protocol is being followed in all departments or units.

Steps:

- Conduct Data quality check (DQC) (Adapted from the IMPACT-USAID project)

Objectives of DQC:

- To identify issues in data quality in terms of completeness, accuracy and consistency
- To compute core NTP indicators applicable to the hospitals

COMPLETENESS:

- Check the following (Form 1. Presumptive TB Masterlist)

For the period, are the entries for each row/patient in the Presumptive Masterlist complete? Yes or No?

- Count the number of entries that are complete
- Count the number of entries that are incomplete
- Indicate the numbers in the DQC form
- Make a conclusion: example - out of 20 entries/patients, 15 (75%) had complete entries while

5 (25%) had incomplete entries. The most common missing data are _____.

- Check the following (Form 3. NTP Laboratory Register)

For the period ____, are the entries for each row/patient in the NTP laboratory register complete? Yes or No?

- Count the number of entries that are complete
- Count the number of entries that are incomplete
- Indicate the numbers in the DQC form
- Make a conclusion: example - out of 20 entries/patients, 15 (75%) had complete entries while 5 (25%) had incomplete entries. The most common missing data are _____.

For TDPH:

- Check the following (Form 4. Treatment Cards and Form 6a.TB Register)

For the period _____, are all treatment cards completely filled-up? Yes or No?

- Count the number of treatment cards that are complete
- Count the number of treatment cards that are incomplete
- Indicate the numbers in the DQC form
- Make a conclusion: *example - out of 20 treatment cards, 15 (75%) had complete entries while 5 (25%) had incomplete entries. The most common missing data are age of patient, history of treatment, BCG*

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Data Quality Check

Municipality/City: _____ Checked by: _____

DQC Form A: Assessing DATA COMPLETENESS

Recording Forms	*No. of entries Complete*	*No. of entries Incomplete*	*Remarks (provide details on missing data)*
1. Form 1. Presumptive TB Masterlist			
2. Form 3. NTP Laboratory Register			
3. Form 4. NTP Treatment Card			
4. Form 6a. Drug Susceptible TB Register			

Conclusion:

Finish checking of **completeness before proceeding!**

ACCURACY:

1. For data accuracy, check accuracy of the following:
    a. Assignment of TB classification (based on anatomic site and bacteriologic status)
    b. Assignment of TB registration group
    c. Assignment of treatment outcome (for patients registered 1 year ago)
    d. Identification of presumptive DRTB and compliance with screening policy

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DQC Form B: Assessing DATA ACCURACY

Labeling of TB cases [col. 1]	No. of patients with Accurate entries	No. of patients with Inaccurate entries	Remarks [col. 4]
1. Classification			
2. Registration Group			
3. Treatment outcome			
4. DRTB screening of retreatment cases			

Conclusion:

Finish checking of **accuracy before proceeding!**

CONSISTENCY

- Randomly select _ treatment cards.
- Check the consistency of entry into the register of the following variables
  - Classification
  - Registration group
  - Treatment outcome
  - Age and sex
  - Source of patient

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DQA Form C: Assessing CONSISTENCY OF DATA

NTP Forms	Consistent		Remarks
	Yes	No	
1. Treatment Card with TB Register	19	1	1 case with classification of relapse in treatment card was indicated as TALF in the TB register
2. Qtr. Report on Lab. Activities	/		
3. Qtr. Report on Case Finding	/		
4. Qtr. Report on Treatment Outcomes		/	Discrepancy in count of cured new cases--corrected

Conclusion:

A. Write the summary of your DQC findings using the following form:

DATA QUALITY CHECK: SUMMARY OF FINDINGS

Province: _____ Municipality/City: _____ Date :_____

1) What are the important findings in the DQA that you would like to address?

	FINDINGS
Completeness	
Accuracy	
Consistency	

- Review and analyze the appropriate Hospital DOTS indicators:

    - *Total Number of TB patients*
    - *Intra-hospital Referral Rate*

    (INSERT HOSPITAL REPORTING FORM HERE)

- Based on the above indicators, compare the **Quarterly Accomplishments vs Targets**:

Indicator	***Quarterly Target***	***Accomplishment for the Quarter***				***Remarks (Achieved or Not Achieved)***
		Month 1	Month 2	Month 3	Total	
Total Number of TB patients						
Intra-hospital Referral Rate						

- Determine factors or issues affecting poor performance (for indicators which are not achieved) and how can these be improved

Challenges	***Action Needed***	***Plans/Next Step***

Note:

- *Identify all factors that affects each of the low-performing indicators.*
- *Ensure that actions needed/next steps are doable within the Quarter as this will be re-assessed during the next Quarterly monitoring*

- Provide feedback to the units/departments/persons concerned IMMEDIATELY, for appropriate actions. Assist them, when and where, necessary. Coordinate with concerned facilities outside the hospital (health centers, CHO/PHO or DOH) for issues that concern them.

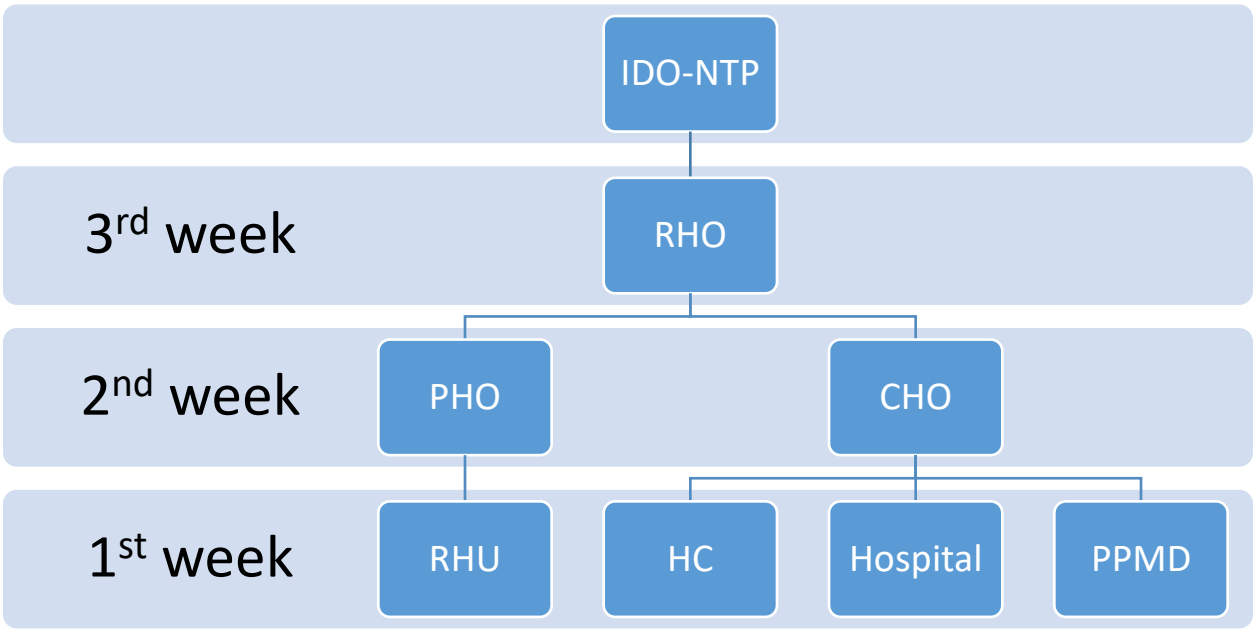
- Prepare summary of results /monitoring report and submit to hospital management.

CHAPTER 4. REPORTING

Policies and Procedures:

1. Recording and reporting for NTP shall be implemented in **all DOTS facilities** whether **public or private**.
2. Recording and reporting shall include **all cases of TB**, classified according to internationally accepted case definitions. **Quarterly Reports** should reflect the sex, age, type and source of cases reported from various units in the province/city/municipality.
3. Recording and reporting for NTP shall use the **FHSIS network** for routine reporting and feedback.
4. The **Integrated TB Information System (I-TIS)** shall be the official electronic TB information system.
5. Records and reports shall allow for the calculation of the **main indicators** for program evaluation.
6. All quarterly reports should be sent to the DOH through channels (**DOTS facility to PHO/CHO to RHO to NCDPC-DOH**) based on **agreed timeline.**
7. The NTP reporting forms are to be accomplished quarterly by all DOTS facilities or TB laboratories and submitted to the next higher level (i.e., Provincial or City Health Offices).
8. **All reports should be reviewed and approved by the DOTS facility physician before submission.**
9. The reports will be consolidated and analyzed by the PHOs/CHOs and submitted to the RHOs.
10. The RHOs will, likewise, analyze and consolidate the reports.
11. The laboratory reports (**Report 1a, 1b and 2a**) will be submitted to NTRL while the rest (**Report 3a, 3b, 4, 5a, 5b, 5c and 6**) will be submitted to IDO-NTP.

TIMELINE FOR SUBMISSION OF REPORTS:



CHAPTER 5. SUSTAINABILITY AND INSTITUTIONALIZATION OF HOSPITAL DOTS

To ensure sustainability of TB program effectiveness and impact:

- The focal persons in the ward must regularly conduct monitoring and follow –up of TB patients for referral.
- To conduct health education to ensure the patients will religiously comply and follow the instruction to go RHU for proper management and treatment.

Resource mobilization

- ✓ To maintain sufficient forms such as intra and extra referral form.
- ✓ Ensure sufficient and availability and NTP drug supply for the admitted TB patients.

Technical:

1. In service training of Doctors and nurses
2. TB clinic is open Mondays to Saturdays
3. Hospital TB Laboratory is part of EQA for DSSM

Governance:

1. Hospital TB management policy issued and disseminated
2. Hospital TB team is functional and meeting every quarter
3. Regular supervision by hospital TB Team
4. Monitoring by NTP
5. Linkage with PHO, CHO and Health Centers established

Financing:

1. TB clinic is Philhealth-accredited
2. Include budget for TB DOTS operation in the annual hospital plan/budget

Succession Plan:

1. Identify program coordinator 3 months prior to retirement
2. Program coordinator planning to resign should provide at least 1 month of notice.

3. Intensive coaching and expand supervision and preceptorship to the newly-assigned staff prior to retirement and or resignation.
4. Coordinate with CHO/PHO/NTP for formal training of newly-assigned staff

Business Continuity plan:

1. TB clinic may charge fees for services as agreed with NTP (e.g. professional and laboratory fees).
2. Drugs provided by the DOH should always be given for free.

Linkages and Networks:

1. Maintain a directory of NTP Case Provider
2. Actively participate in TB Multi Sectoral Alliance

Attach here….

1. Signed Hospital DOTS policy
2. MOA/MOU between hospital and peripheral DOTS facilities
3. Other hospital policies that can affect DOTS implementation
4. Philhealth sharing
5. Hospital memos
6. Infection Control policy
7. MSA/TB DOTS network agreement

RA 10767 Comprehensive TB Control Act of 2016

Republic Act No. 10767 "An Act Establishing A Comprehensive Philippine Plan Of Action To Eliminate Tuberculosis As A Public Health Problem And Appropriating Funds Therefore"

Sec. 1. Title
This Act shall be known as the "Comprehensive Tuberculosis Elimination Plan Act of 2016"

Sec. 2. Declaration of Policy

The State is mandated to:

• adopt an integrated and comprehensive approach to health development;
• support and expand efforts to eliminate tuberculosis as a public health problem by increasing investments for its prevention, treatment and control;
• adopt a multi-sectoral approach in responding to the disease.

Sec.3 Definition of Terms

• Comprehensive Philippine Plan of Action to Eliminate Tuberculosis refers to the Program of the national government for the elimination of tuberculosis in the country; and
• Tuberculosis or TB refers to an infectious but curable disease caused by bacteria called Mycobacterium tuberculosis. It is transmitted from a TB patient to another through coughing, sneezing and spitting and while the bacterium usually affects the lungs, it may also affect the bones and other organs like the kidney and the liver.

Sec. 4. Comprehensive Philippine Plan of Action to Eliminate Tuberculosis

The Secretary of the Department of Health (DOH) shall establish a Comprehensive Philippine Plan of Action to Eliminate Tuberculosis in consultation with appropriate public and private entities. The Philippine Plan of Action shall consist of the following:

• targets and strategies;
• prevention, diagnosis, treatment, care and support;
• appropriate technologies to diagnose and treat;
• linkages with local and international organizations for partnerships;
• review and monitoring system; and 4/25/2017
• anti-TB services during and after natural and man FOOTER GOES HERE -made disasters 8

Sec. 5. Strengthening of the NCC and RCC

- The National Coordinating Committee (NCC) and Regional Coordinating Committees (RCCs) of the DOH as the National TB control Program's arm for program operations and bridging collaborative efforts between the public and private sector.

- The Secretary of Health shall continue to improve the capability of the existing NCC and RCC in ensuring efficiency in the implementation, monitoring and evaluation of the Philippine Plan of Action and in the coordination of efforts of various sectors.

Sec. 6 Research, Demonstration Projects, Education Training

The SOH shall, directly or through grants to public or non-profit private entities, perform the following activities:
a) Basic and clinical research
b) Demonstration projects to generate evidence and develop regional capabilities

c) Nationwide public information campaign and education programs;
d) Education, training and clinical skills improvement activities for health care providers, e) Support for model centers to sustain their initiatives
f) Collaborate with local and foreign organizations for partnership in providing technical and funding support.