SOP FOR DATA REVIEW AT FACILITY LEVEL

INTRODUCTION:

This SOP provides guidance on how to attest identified data quality challenges including data irregularities that may require further follow-up; how to conduct on-site investigations, the tools for those investigations, investigate the route cause and a tool for creating a follow-up action plan. The tool is meant to be used by manager and supervisors at the facility level in collaboration with immediate staff at the facility. IP staff at the regional or district level can also use this too to quickly identify and fix data quality challenges at the facility level.

Objective:

The overall objective is to conduct causal analysis to find the root cause of a problemm and plan for remediation and prevention. This will help in rectifying identified data error as well as preventing future data quality changes on the same indictor.

Specific objectives

1. To identify data quality challenge for specific indicator
2. To understand the root causes of the challenge
3. To understand individual and system level drivers that led to data quality challenge.
4. To determine what could be done to avoid the identified data quality challenge.

Circumstances that might prompt a review:

This SOP is intended to be used when a data challenge have been identified or anticipated. The following are circumstances that may lead the manager to consider conducting a swift data review at the facility level.

1. When indicator data deviate excessively from the target
2. When stakeholders or implementers suggest there may be issues with indicator data.
    a. Result of variance analysis showing unexpected trend like decrease in cumulative numbers, sharp downward or upward change in trend.
    b. Unexpected change in positivity for HTS
3. When staff seek to confirm that a previously identified data quality problem has been resolved; and
4. When the indicator data are critically or strategically important to the program and hence need of continuous or verification and verification.

Conducting data quality review:

Data quality review at the facility level will be conducted by the site manager using Facility **Data quality Assessment Tool.** If more than one data quality challenge is identified an

individua data quality assessment tool will be used for part 1 and 2 for each indicator. For Part 3 one same tool can be used especially for indicators are similar or are derived from same source documents (i.e., HTS_TST & HTS_POS etc.)

STEPS CONDUCT DATA REVIEW AND CAUSAL ANALYSIS.

Once data challenge has been identified, the following are the steps that are to be followed by the facility manager to review data at the facility level.

1. Ascertain the indicator to be reviewed. (select and agree on indicators to be reviewed- NB. Do not have to work on all indicators on the same time. Some of the problem might be resolved when concentrating on KEY indicators)
2. Establish standard indicator definition as it currently known in current guidelines. *(Make sure you also find out the definition of the indicator as it is known/used by the facility)*
3. List and review availability and completeness of various source documents for the period in question using "Data Quality Assessment Tool - Health Facility Level."
4. Recount results from registers, compare the verified numbers to the facility reported numbers and explain discrepancies (if any)
5. **Triangulate**: Cross-check reported results with other data sources (use other source depending on indicator to triangulate results reported in standard resisters *(i.e HTS_TST – HTS registers, Monthly summary forms, and DHIS 2 , HIT kit registers, TX_New etc.)*
6. **Perform M&E system review:** Using the causal effect, perform causal analysis to determine what could have led to the data challenge identified.
7. Once the cause of the problem has been identified suggest the remediation mechanism and fille the action plan.

Data Quality Assessment Tool - Health Facility Level

Date of Assessment:	
Name of Health Facility:	
Name of District:	
Indicator being Reviewed:	
Data quality challenge being addressed **(***i.e.- Number of TX_CURR for current quarter is less than TX_CURR for previews quarter)*	
Source documents: List all source and triangulator documents involved in the review process:	

		Component of the M&E System	**Answer Codes:** Yes - completely / Partly / No - not at all / N/A	**REVIEWER COMMENTS** (Please provide detail for each response not coded "Yes - Completely". Detailed responses will help guide strengthening measures.)
Part 1: Data Verifications				
A - Documentation Review: *Review availability and completeness of various source documents for the past 3 months.*				
1		Review available source documents (i.e. registers, patient folders, copies of summary reports) for the past 3 months. Is there any indication that there are source documents missing?		
		If yes, comment on how this might have affected reported numbers. /identified data quality challenge.		
2		For the indicator being assessed, review data from the current quarter: in available registers. Are these data complete? (i.e., complete means that all required data fields are filled)		
B - Recounting Reported Results: *Recount results from registers, compare the verified numbers to the facility reported numbers and explain discrepancies (if any).*				
6		Recount the number of people, cases or events recorded during the		

	reporting period by reviewing the appropriate register(s). **[A]**		
7	Copy the number of people, cases or events reported by the site during the reporting period from the facility summary report. **[B]**		
8	**Percentage of recounted to reported numbers. [A/B]**	-	
9	What are the reasons for the discrepancy (if any) observed (i.e., data entry errors, arithmetic errors, missing source documents, other)?		
C - Cross-check reported results with other data sources			
Cross-checks can be performed by examining separate records documenting patient data (e.g. patient laboratory results or records of dispensed medication) to see if these numbers corroborate the reported results. Cross-checks could include, for example, randomly selecting **10%** of patient folders and verifying if these patients were recorded in the unit, laboratory, or pharmacy registers, or in the electronic database where applicable. To the extent relevant, the cross-checks should be performed in both directions (for example, from the CTC2 card to the Register and from the Register to the CTC2 card, From HTWS registers, HTS monthly Summary from and DHIS2).			
10	List the documents used for performing the cross-checks.		
11	Describe the cross-checks performed.		
12	For the cross-checks performed, how many data records were reviewed? **[C]**		
13	Of those data records reviewed, how many had discrepancies when compared with the relevant register(s)? **[D]**		
14	Percentage of **discrepant data records [D/C]**		
15	What are the reasons for any discrepancies observed?		

Part 2: M&E system review			
Use direct observation and document review)			
1	Are there SOP at this facility to guide HCW on how to document and complete report for this indicator?		
2	Are there enough staff for management of services and reporting at this facility?		
3	Have the relevant staff received training on recording, data processing and reporting?		
4	Is this facility using current versions of the printed forms?		
5	Do HCW use same definition as it is stipulated in the MER indicator definitions?		
6	Are all registers and forms available at the service delivery point?		
7	Are standard registers/logbooks filled out correctly?		
8	Are all required recording and reporting electronic system and system support available and functioning? (i.e., Electricity, Computer, and internet)		

Part 3: Action plan

Action plan				
*Based on the findings of the data verification exercise, please describe any challenges and or R**oot Cause** identified and recommended strengthening measures, with an estimate of the length of time the improvement measure could take. **(Please use the root cause analysis sheet)***				
	Identified Gaps/Weaknesses/ROOT CAUSE	**Description of Action Point**	**Person(s) Responsible**	**Timeline**
1				
2				
3				
4				
Additional notes:				
Date of next follow up visit (if applicable): __ __ / __ __ / __ __				

ROOT CAUSE ANALYSIS

1. **Minimal or insufficient training:** staff were either never trained or staff may have been trained previously, but those trainings may have been insufficient in scope or too long ago.
2. **Low motivation of staff:** staff may have been trained, but they may lack motivation to follow proper procedures; this may be a result of not understanding the value of data.
3. **Staff turnover**: staff who were trained may no longer be at the facility due to shifts in staffing or turnover.
4. **Lack of on-site supervision/support:** staff may not have oversight by supervisors or nurses in-charge to ensure they are following SOPs and protocols.
5. **Insufficient staff:** there are not enough staff at the health facility; staff may not have enough time to concentrate on reporting and recording.
6. **Lack of proper printed forms or registers**: there may be problems related to the planning, organization, allocation, and use of printed forms and registers necessary for recording and reporting. Facility may also be using outdated versions of the printed forms.
7. **Lack of job aids/SOPs:** there may be problems related to the planning, organization, allocation, and use of job aids and/or standard operating procedures (SOPs)
8. **Technology issues:** if using electronic data collection, there may be issues with the technology itself; this may be in the form of malfunctioning tablets/computers (e.g., broken tablet) or data collection forms (e.g., bug in form that won't allow proper data collection)