

Roles and Responsibilities within TB Management

February 2015

The TB Assistant/DOT Worker

Assists the nurse managing the TB program using their knowledge of the community and community members. Carries out tasks delegated and supervised by the nurse. The worker dispenses medication as a delegated task under the license of the supervising nurse who is responsible for ensuring correct patient, medication, dose, route and day.

The TB Nurse

Is responsible for running the TB program in the community that involves, education, assessment, screening, treatment, documentation and reporting. The nurse uses their clinical judgment and assessment skills to make decisions regarding testing, treatment, and follow up action. The TB nurse has the knowledge and skill to assess, make decisions and take action in general uncomplicated daily management of the program. They refer to the current Interim Guidelines for Management of Active TB, the Nunavut TB Manual, and the Canadian TB Standards to inform their practice. The TB nurse uses their critical thinking skills to decide when to seek advice from RCDC who in turn communicates with the TB MD, and when to refer back to CHN and community MD for comprehensive medical follow up. The TB nurse is responsible for ensuring good patient care is carried out and reporting unsafe situations or clinical errors to their supervisor. In Iqaluit an MD sees all clients before starting on treatment. In the communities most clients do not see an MD before or throughout their whole assessment and treatment - the TB nurse is taking on this delegated role which assumes a high level of knowledge, judgment and clinical practice.

The Supervisor of Community and Health Programs (SCHP)

Is responsible for overseeing the TB Program, TB nurse's practice and the DOT workers. The TB nurse is currently hired as a staff nurse not as a 'Supervisor of Community TB Programs' in the manner that the Homecare nurse is a 'Supervisor of Home Care Services'

The Regional Managers and Directors (ie of Baffin, Kivalliq, Iqaluit)

Are responsible for staffing communities in their region that have TB cases to adequately address the workload and provide both quality patient care in treatment as well as prevention services. Education and orientation of staff hired is currently the responsibility of the region into which staff is hired and comes out of the regional budget.

Region Communicable Disease Coordinators (at Iqaluit Public Health)

Are the go-to persons for advice on unusual cases and act as the conduit to the TB MD in Baffin. The coordinator advises on exceptional cases or situations, consults with the TB MD, the Territorial Communicable Disease Consultant (Office of the CMOH) and the external TB Physician Consultant (Dr. Alvarez) as appropriate.

TB Educator and Program Support (out of Iqaluit Public Health - temporary position)

This position is hired and funded out of Iqaluit Public Health under the Iqaluit Regional Department. The purpose is to develop orientation and education materials for training and support of staff working in TB programs in Nunavut to support RCDC who is currently shouldering the burden of education. Areas of need are standard TB case management and monitoring, contact investigation, screening for active TB, completion of reports and knowledge as to appropriate information to provide when requesting basic medical advice and ensure that patient treatment and monitoring are being carried out . The TB educator also fields calls regarding routine practice and receives referrals from RCDC for specific support and education for staff.

TB Physician (based in Iqaluit)

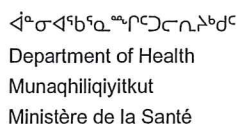
Is the medical resource and 'expert' for TB related concerns generated by nurses and physicians throughout Baffin. Reviews patient information, makes recommendations, writes prescriptions for treatment, advises on care. The TB MD depends on the TB nurse doing a thorough assessment of all clients and communicating this and all other relevant information accurately and in a timely fashion. In Iqaluit the TB MD sees all clients before recommending they start on any TB treatment (active or latent).

Territorial Communicable Disease Consultant (Office of the CMOH)

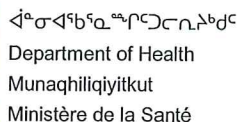
Develops policy and procedures regarding tuberculosis management in Nunavut, provides advice to RCDC on request, helps interpret policy and protocols in complicated situations, advises on outbreak management, communicates with health units outside Nunavut regarding patients travelling in and out of Baffin, receives reports from the regions, submits numerous reports to Public Health Agency of Canada. Works with the CMOH.

External TB Physician Consultant

Is a TB expert who provides advice to the Territorial CDC, RCDC, and the TB MD when requested and helps clarify best practice in complicated situations or extenuating circumstances.



Last Name: _____
 First Name: _____
 Sex: ☐ M ☐ F
 Date of Birth: ____ (DD) ____ (MM) ____ (YY)
 Chart #: _____
 HCP #: _____
 Community of Residence: _____



Part 2: Screening Assessment and Outcome

Community of Residence:

TST Eligible

| TST #1 | | |
|------------------------------------|----------------------------------|--|
| Date placed: ____(dd/mm/yy)____ | Date read: ____(dd/mm/yy)____ | Result: _____ mm |
| Initials: _____ | Initials: _____ | <u>Interpretation</u> (circle): Positive / Negative |

| TST #2 | | |
|--------------------------------------|------------------------------------|---|
| Date placed: ____ (dd/mm/yy) ____ | Date read: ____ (dd/mm/yy) ____ | Result: _____ mm |
| Initials: _____ | Initials: _____ | Interpretation (circle): Positive / Negative |

TST Ineligible – CXR and Sputum

| | |
|---|--------------------|
| CXR | |
| Requisition date: | ____(dd/mm/yy)____ |
| Date done: | ____(dd/mm/yy)____ |
| Result date: | ____(dd/mm/yy)____ |
| Result: | |
| <input type="checkbox"/> Normal | |
| <input type="checkbox"/> Abnormal, (specify): | _____ |
| | _____ |
| | _____ |

| Sputum | Sputum Results |
|--|---------------------------------|
| Date Sputum Bottle Given: <u> (dd/mm/yy) </u> | Smear: Pos.: <u> </u> / Neg |
| Collection #1 Date: <u> (dd/mm/yy) </u> | Culture: Pos / Neg |
| Collection #1 Result Date: <u> (dd/mm/yy) </u> | Cultured @ <u> </u> days |
| Date Sputum Bottle Given: <u> (dd/mm/yy) </u> | Smear: Pos.: <u> </u> / Neg |
| Collection #2 Date: <u> (dd/mm/yy) </u> | Culture: Pos / Neg |
| Collection #2 Result Date: <u> (dd/mm/yy) </u> | Cultured @ <u> </u> days |
| Date Sputum Bottle Given: <u> (dd/mm/yy) </u> | Smear: Pos.: <u> </u> / Neg |
| Collection #3 Date: <u> (dd/mm/yy) </u> | Culture: Pos / Neg |
| Collection #3 Result Date: <u> (dd/mm/yy) </u> | Cultured @ <u> </u> days |

☐ **Discharged:** ☐ Negative on all screening, no further follow-up required
☐ Transferred (*specify*): _____
☐ Died, TCDC/RCDC notified: dd/mm/yyyy ☐ Lost to follow-up

☐ **Referral (*specify*):** _____

☐ **TST Negative**, window prophylaxis indicated: ****start DOPT Record, complete LTBI Tx Outcome Form, TST#2 after WPP****

☐ **LTBI identified:** ☐ Preventive LTBI treatment offered: ☐ Accepted (****do blood work and start DOPT Monitoring Form****)
☐ Not accepted: Surveillance initiated (F/U q6mo x 2yrs: CXR/sputum)

☐ Preventive LTBI treatment **not** offered, *specify*: _____
 └─→ ☐ Surveillance initiated (F/U q6mo x 2yrs: CXR/sputum)

☐ **Active case identified** (****proceed to Boxes 1.7 and 1.8 below, do blood work, and start DOT Monitoring Form****)

| | | | | | | | |
|-----------------------------|--|-----------------------------|------------------------------|-------------------------------|--|-----------------------------|------------------------------|
| Previous abnormal CXR | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K | Contact of case in last 2 yrs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Steroid use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K | HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Diabetes | <input type="checkbox"/> Yes, <i>type</i> : _____ | <input type="checkbox"/> No | <input type="checkbox"/> U/K | End-stage renal disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K | Peripheral neuropathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Cancer | <input type="checkbox"/> Yes, <i>specify</i> : _____ | <input type="checkbox"/> No | <input type="checkbox"/> U/K | COPD | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Incomplete Tx of LTBI | <input type="checkbox"/> Yes, <i>year(s)</i> : _____ | <input type="checkbox"/> No | <input type="checkbox"/> U/K | Transplant immunosuppression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Corrections facility inmate | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K | Smoking (<u>daily</u>) | <input type="checkbox"/> Yes: ____ <i>sticks/packs</i> | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Alcohol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K | Drug(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> U/K |
| Travel abroad last 2 yrs | <input type="checkbox"/> Yes, <i>specify below</i> : _____ | <input type="checkbox"/> No | <input type="checkbox"/> U/K | | | | |

Current housing situation: ☐ Stable ☐ Unstable If unstable, reside in shelter: ☐ Yes, *specify*: _____ ☐ No
people living in the house: _____ **# people sleeping in the house:** _____ **# of bedrooms:** _____
Do people smoke in your residence: ☐ Yes* remind client of NU Quit line ☐ No
Communities lived in the past year (*specify all*): _____
If visiting Nunavut, community/city and territory/province of residence: _____

Date: 02/06/2015



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Department of Health
Munaqiliqiyitkut
Ministère de la Santé

Please fill in OR addressograph/affix label:

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F
Date of Birth: ____ (DD) ____ (MM) ____ (YY)
Chart #: _____
HCP #: _____
Community of Residence: _____

TUBERCULOSIS SURVEILLANCE & OUTCOME

ALL ABNORMAL RESULTS MUST BE REPORTED TO REGIONAL CDC

| | | | | | | | | |
|--|--|--------|------------|--------|------------|--------|------------|--------|
| 6 Month Surveillance Screening DUE dd/mm/yy | Cough <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Chest pain <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fever <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Night sweats <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Short of breath <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Blood in sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes, ____ kg Other (specify) _____ x ____ weeks since: (mm/yy) ____ | | | | | | | |
| | Chest X-Ray* | | Sputum #1* | | Sputum #2* | | Sputum #3* | |
| | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result |
| DONE dd/mm/yy | Comments: CHN/PHN Name/Signature: _____ Date: ____ dd/mm/yy ____ | | | | | | | |
| 12 Month Surveillance Screening DUE dd/mm/yy | Cough <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Chest pain <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fever <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Night sweats <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Short of breath <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Blood in sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes, ____ kg Other (specify) _____ x ____ weeks since: (mm/yy) ____ | | | | | | | |
| | Chest X-Ray* | | Sputum #1* | | Sputum #2* | | Sputum #3* | |
| | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result |
| DONE dd/mm/yy | Comments: CHN/PHN Name/Signature: _____ Date: ____ dd/mm/yy ____ | | | | | | | |
| 18 Month Surveillance Screening DUE dd/mm/yy | Cough <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Chest pain <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fever <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Night sweats <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Short of breath <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Blood in sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes, ____ kg Other (specify) _____ x ____ weeks since: (mm/yy) ____ | | | | | | | |
| | Chest X-Ray* | | Sputum #1* | | Sputum #2* | | Sputum #3* | |
| | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result |
| DONE dd/mm/yy | Comments: CHN/PHN Name/Signature: _____ Date: ____ dd/mm/yy ____ | | | | | | | |
| 24 Month Surveillance Screening DUE dd/mm/yy | Cough <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Chest pain <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Fever <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Night sweats <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Short of breath <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Blood in sputum <input type="checkbox"/> No <input type="checkbox"/> Yes x ____ weeks Weight loss <input type="checkbox"/> No <input type="checkbox"/> Yes, ____ kg Other (specify) _____ x ____ weeks since: (mm/yy) ____ | | | | | | | |
| | Chest X-Ray* | | Sputum #1* | | Sputum #2* | | Sputum #3* | |
| | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result | dd/mm/yy | result |
| DONE dd/mm/yy | Comments: CHN/PHN Name/Signature: _____ Date: ____ dd/mm/yy ____ | | | | | | | |

*Chest X-Ray Results: Normal = N, Abnormal = ABN ♦Sputum Results: AFB Smear Neg = SM-, AFB Smear Pos = SM+, Culture Neg = C-, Culture Pos = C+

SURVEILLANCE OUTCOME (To be completed at end of surveillance period)

Surveillance Outcome (select ONE box only):
☐ Transferred out of territory prior to end of surveillance period – outcome of surveillance unknown
 Specify date and new location: _____
☐ Discharged - surveillance completed
☐ Lost to follow-up
☐ Active TB disease; date of diagnosis: ____ dd/mm/yy ____
☐ Died prior to end of surveillance period (specify date): _____
☐ Other (specify): _____

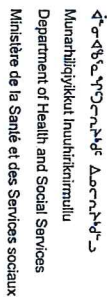
CHN/PHN Name / Signature: _____ Date: ____ dd/mm/yy ____

When complete, fax to Regional CD Coordinator

Qikiqtaaluk: 867-975-4833

Kitikmeot: 867-983-4088

Kivalliq: 867-645-8272



Community: _____

After 1st round contact tracing, again after 2nd round is complete, and as necessary, please date, save and email form to the Regional CDC

UPDATED on (dd/mm/yy) : _____

| Name: | | Date of Diagnosis (dd/mm/yy): | | Bacteriological Status: | | | | | | | | | |
|--------------------|-----------|-------------------------------|------------|--|-----------|---------------------------------|--------------|--------|---------------------|--------|------------------------|-----------------------|--|
| | | Type of TB: | | Smear + _____ C+ _____ | | | | | | | | | |
| Name (Last, First) | DOB M/D/Y | HCP # | Sex (M/F) | Type of Contact and Relationship to case (see below) | BCG (Y/N) | Date of Last Contact (dd/mm/yy) | Previous TST | | Post Exposure TST | | CXR | Sputum | Status |
| | | | | | | | Date (mm) | Result | Date (mm) | Result | Date Result (N or Abn) | Date Result (s and c) | |
| | | | | | | | | | 1 st TST | | date | date | <input type="checkbox"/> On Tx <input type="checkbox"/> F/U: _____ <input type="checkbox"/> Closed |
| | | | | | | | | | 2 nd TST | | result | result | <input type="checkbox"/> On Tx <input type="checkbox"/> F/U: _____ <input type="checkbox"/> Closed |
| | | | | | | | | | | | | | <input type="checkbox"/> On Tx <input type="checkbox"/> F/U: _____ <input type="checkbox"/> Closed |
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* Enter 1st circle of contacts five: close household contacts, people who live in same household with source

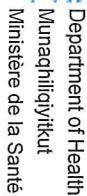
* Enter 2nd circle of contacts secondly: close non-household contacts, people who have prolonged daily contact with source

* Enter 3rd circle of contacts thirdly: casual contacts, people who spend time regularly but less frequently with source

* Enter 4th circle of contacts last: community contacts, people who have infrequent, occasional contact. (Refer to Canadian Tuberculosis Standards 6th edition pg 253 for further information)

GN DHSS TB Contact Investigation Record (April 24 2012)

CXR results write: N = Normal or A = Abnormal
Sputum result write: S-, S+, C- or C+



Please fill in OR addressograph/affix label:

Last Name: _____

First Name: _____

Sex: M _____ F _____

Date of Birth: ____ (DD) ____ (MM) ____ (YY)

Chart #: _____

HCP #: _____

Community of Residence: _____

ALL DOSES MUST BE DIRECTLY
doses have been taken.

| Drug | Dose (mg) | Date Started (dd/mm/yy) | Date Stopped (dd/mm/yy) |
|------|-----------|----------------------------|----------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

[illegible]

Maintain a growth chart for cases 5 years of age and under, and submit to RCDC each month with DOT record.

| Assessment Date (dd/mm/yy) | Weight (kg) | Blood Tests Done (date/list) <i>Follow Guidelines in Numanut TB Control Manual</i> | Pregnant Y/N | Visual Acuity and Colour Tests (when taking ethambutol) | Sputum Specimen(s) for TB Testing ^a | PA and Lateral Chest X-Rays ^a If pregnant, consult with RCDC first |
|-------------------------------|-------------|---|--------------|--|---|---|
| Month 3 | | | | Left Eye: _____ Right Eye: _____ | | |
| Month 4 | | | | Left Eye: _____ Right Eye: _____ | | |
| Month 5 | | | | Left Eye: _____ Right Eye: _____ | | |
| Month 6 | | | | Left Eye: _____ Right Eye: _____ | 3 specimens | dd/mm/yy |
| Month 7 | | | | Left Eye: _____ Right Eye: _____ | | |
| Month 8 | | | | Left Eye: _____ Right Eye: _____ | | |
| Month 9 | | | | Left Eye: _____ Right Eye: _____ | 3 specimens | dd/mm/yy |

* Extreme fatigue, stomach upset, nausea/vomiting, dark urine, yellow sclera, abdominal pain. ** Confirm dosing remains at a therapeutic level. Consult RCDG about failure to gain weight in a growing child or weight loss in an adult or adolescent case, and when dosage adjustment indicated. **▲ For respiratory cases only:** collect one sputum specimen each week until three consecutive specimens are AFB smear- and culture-negative. Collect three specimens and repeat PA and lateral chest x-rays within 1 month of anticipated treatment completion date (usually during Month 6).

TB Orientation Checklist

November 2014

Version 1.0

Please initial each section when completed and submit to the Clinical Educator and TB Educator (Naomi Davies - ndavies@gov.nu.ca).

- 1 Complete BCCDC Online TB course at www.bccdclearing.ca (create an account, sign in, select TB course, click 'enroll'. Submit completion certificate.
- 2 Know how to test for Active TB
- 3 Know how to test for Latent TB
- 4 Plant and read 3 TSTs accurately observed by preceptor or designate
- 5 Review info on 4 main TB meds: INH, RMP, PZA, EMB & know side effects
- 6 Review Guidelines for Active TB treatment
- 7 TB Assessment Form
 - a. when to complete TBAF
 - b. understand/discuss reasons for information requested in each section
 - c. when to submit to RCDC
 - d. when a new one needs to be completed
- 8 Review DOT record for Active & Latent Tx, review how to calculate monthly totals
- 9 Review and know where to find Ongoing Monitoring Tables and documentation for Active and Latent
 - a. Know what follow up is required (ie assess for S&S if elevated LFTs, repeat LFTs in 2 weeks if concerned re ongoing rise, collect sputa if cough reported)
 - b. Know when to report abnormal lab values, weight changes to RCDC
- ## Know how to fill out End of Treatment completion forms, reporting applicable test results and what forms to attach (DOT record).
- ## Understand what is Window Period Prophylaxis, who it applies to, importance of immediate reporting eligible clients.
- ## Review 'Ordering CXRs' info sheet
- ## Review 'TB meds administration and Food'
- ## Briefly explain the process of contact tracing, ie timing and tests
- ## Review Inter-Community Travel form and what documents to send with it
- ## Understand reason for surveillance, know where list is kept in community and timing

*some of these items are assessed by discussion with preceptor or the TB Educator

TBN name & signature:

| | | |
|--|--|--|
| | Date Completed: | |
| | Community: | |
| | Preceptor name & signature if applicable: | |
| | | |
| | Questions? | |
| | Contact: | |
| | Naomi Davies RN, BScN | |
| | Regional Qikiqtaaluk & Iqaluit TB Educator & Program Support | |
| | email: ndavies@gov.nu.ca | |
| | cell: 604-646-2426 | |

