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.

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Department of Health
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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 ASSESSMENT FORM

Part 1: Client Assessment

PERSONAL CLIENT INFORMATION

House/Building #: ____________________ P.O. Box: ____________________
Home Phone: ( ) _____ - ________ Work Phone: ( ) _____ - ________ Cell Phone: ( ) _____ - ________
Parent/Guardian: ____________________ School: ____________________
Work: ____________________ Occupation: ____________________

BOX 1.1 – REASONS FOR SCREENING CLIENT (check *all* boxes that apply)

☐ Walk-in ☐ School screening ☐ Work ☐ TB Referral (*specify*): ____________________
☐ Surveillance ☐ Other (*specify*): ____________________
☐ **Contact of a confirmed case (*continue below*):**
Name of Source Case: ____________________ **Source Case HCP #:** ____________________
Date of diagnosis: _(dd/mm/yy)______ **If known, date of last contact:** _(dd/mm/yy)___
Bacterial status of source case: **Smear**: ☐ Pos: +__ ☐ Neg ☐ Unknown **Culture**: ☐ Pos @ ____d ☐ Neg ☐ Unknown
Type of contact: ☐ Close household ☐ Close non-household ☐ Casual ☐ Community
Specify relationship: ____________________

BOX 1.2 – SYMPTOMS AND CLINICAL CHARACTERISTICS

Note symptom duration in weeks:

Cough	☐ Yes, ________	☐ No	Fever	☐ Yes, ________	☐ No
Night sweats	☐ Yes, ________	☐ No	Sputum	☐ Yes, ________	☐ No
Fatigue	☐ Yes, ________	☐ No	Blood in sputum	☐ Yes, ________	☐ No
Other (*specify*)	☐ Yes, ________	☐ No	Weight loss (kgs)	☐ Yes, _# of kg_____	☐ No
Weight (kgs)	________		Pregnant: ☐ N/A	☐ Yes, EDC: ________	☐ No

BOX 1.3 – PREVIOUS TB SCREENING AND VACCINATION HISTORY

BCG Immunization: ☐ Yes, *year given:* ________ ☐ No ☐ Unknown
TST History: Previously tested? ☐ Yes ☐ No ☐ Unknown
Two most recent TSTs: Date read: ___(dd/mm/yy)___ Result: ______mm Interpretation: ☐ Pos ☐ Neg ☐ Unknown
Date read: ___(dd/mm/yy)___ Result: ______mm Interpretation: ☐ Pos ☐ Neg ☐ Unknown

BOX 1.4 – PAST TB DIAGNOSIS AND OUTCOME

Previous diagnosis of TB? ☐ Yes, *year*: ________ ☐ No ☐ Unknown
If yes, type of TB: ☐ Latent TB Infection ☐ Active TB (*specify*): ____________________
Treatment received?: ☐ Yes, *year*: ________ ☐ # Doses: ________ ☐ No ☐ Unknown
If yes, was treatment completed: ☐ Yes ☐ No ☐ Unknown
If treatment not completed, reason(s) why: ____________________
If more than one diagnosis: Year of previous diagnosis: ________ Type(s) of TB: ____________________
Year of previous diagnosis: ________ Type(s) of TB: ____________________
Adverse reactions to treatment: ☐ Yes, *specify*: ____________________ ☐ No ☐ Unknown

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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 ASSESSMENT FORM

Part 2: Screening Assessment and Outcome

BOX 1.5 – SCREENING TESTS PERFORMED *(ALL ABNORMAL RESULTS MUST BE SENT TO REGIONAL CDC)*

TST Eligible

TST #1		
Date placed: __(dd/mm/yy)__ Initials: ______	Date read: __(dd/mm/yy)__ Initials: ______	Result: ______ mm Interpretation (circle): Positive / Negative

TST #2		
Date placed: __(dd/mm/yy)__ Initials: ______	Date read: __(dd/mm/yy)__ Initials: ______	Result: ______ mm 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: ☐ Normal ☐ Abnormal, (*specify*): ______________

Sputum	Sputum Results
Date Sputum Bottle Given: __(dd/mm/yy)__ Collection #1 Date: __(dd/mm/yy)__ Collection #1 Result Date: __(dd/mm/yy)__	Smear: Pos.: ___ / Neg Culture: Pos / Neg Cultured @ _____ days
Date Sputum Bottle Given: __(dd/mm/yy)__ Collection #2 Date: __(dd/mm/yy)__ Collection #2 Result Date: __(dd/mm/yy)__	Smear: Pos.: ___ / Neg Culture: Pos / Neg Cultured @ _____ days
Date Sputum Bottle Given: __(dd/mm/yy)__ Collection #3 Date: __(dd/mm/yy)__ Collection #3 Result Date: __(dd/mm/yy)__	Smear: Pos.: ___ / Neg Culture: Pos / Neg Cultured @ _____ days

BOX 1.6 – CURRENT ASSESSMENT OUTCOME

☐ **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****)

Box 1.7 – RISK FACTORS (complete ONLY for suspect or known active cases)

Previous abnormal CXR	☐ Yes	☐ No	☐ U/K
Steroid use	☐ Yes	☐ No	☐ U/K
Diabetes	☐ Yes, *type*: ______	☐ No	☐ U/K
Liver disease	☐ Yes	☐ No	☐ U/K
Cancer	☐ Yes, *specify*: ______	☐ No	☐ U/K
Incomplete Tx of LTBI	☐ Yes, *year(s)*: ______	☐ No	☐ U/K
Corrections facility inmate	☐ Yes	☐ No	☐ U/K
Alcohol	☐ Yes	☐ No	☐ U/K
Travel abroad last 2 yrs	☐ Yes, *specify below*:	☐ No	☐ U/K

____

Contact of case in last 2 yrs	☐ Yes	☐ No	☐ U/K
HIV infection	☐ Yes	☐ No	☐ U/K
End-stage renal disease	☐ Yes	☐ No	☐ U/K
Peripheral neuropathy	☐ Yes	☐ No	☐ U/K
COPD	☐ Yes	☐ No	☐ U/K
Transplant immunosuppression	☐ Yes	☐ No	☐ U/K
Smoking (daily)	☐ Yes: ___ *sticks/packs*	☐ No	☐ U/K
Drug(s)	☐ Yes	☐ No	☐ U/K

BOX 1.8 – HOUSING AND SOCIAL STATUS (complete ONLY for suspect or known active cases)

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: ______________

CHN Signature: ______________ **Date:** ______ dd/mm/yy ______

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Nunavut

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 ☐ No ☐ Yes x ___ weeks	Chest pain ☐ No ☐ Yes x ___ weeks	Fatigue ☐ No ☐ Yes x ___ weeks					
	Fever ☐ No ☐ Yes x ___ weeks	Night sweats ☐ No ☐ Yes x ___ weeks	Short of breath ☐ No ☐ Yes x ___ weeks					
	Sputum ☐ No ☐ Yes x ___ weeks	Blood in sputum ☐ No ☐ Yes x ___ weeks	Weight loss ☐ No ☐ 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 ☐ No ☐ Yes x ___ weeks	Chest pain ☐ No ☐ Yes x ___ weeks	Fatigue ☐ No ☐ Yes x ___ weeks					
	Fever ☐ No ☐ Yes x ___ weeks	Night sweats ☐ No ☐ Yes x ___ weeks	Short of breath ☐ No ☐ Yes x ___ weeks					
	Sputum ☐ No ☐ Yes x ___ weeks	Blood in sputum ☐ No ☐ Yes x ___ weeks	Weight loss ☐ No ☐ 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 ☐ No ☐ Yes x ___ weeks	Chest pain ☐ No ☐ Yes x ___ weeks	Fatigue ☐ No ☐ Yes x ___ weeks					
	Fever ☐ No ☐ Yes x ___ weeks	Night sweats ☐ No ☐ Yes x ___ weeks	Short of breath ☐ No ☐ Yes x ___ weeks					
	Sputum ☐ No ☐ Yes x ___ weeks	Blood in sputum ☐ No ☐ Yes x ___ weeks	Weight loss ☐ No ☐ 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 ☐ No ☐ Yes x ___ weeks	Chest pain ☐ No ☐ Yes x ___ weeks	Fatigue ☐ No ☐ Yes x ___ weeks					
	Fever ☐ No ☐ Yes x ___ weeks	Night sweats ☐ No ☐ Yes x ___ weeks	Short of breath ☐ No ☐ Yes x ___ weeks					
	Sputum ☐ No ☐ Yes x ___ weeks	Blood in sputum ☐ No ☐ Yes x ___ weeks	Weight loss ☐ No ☐ 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

Qikiqtaaluq: 867-975-4833 **Kitikmeot: 867-983-4088** **Kivalliq: 867-645-8272**

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Department of Health and Social Services
Ministère de la Santé et des Services sociaux

TUBERCULOSIS CONTACT INVESTIGATION RECORD

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):** **Type of TB:**	**Bacteriological Status:** **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 Date (mm)	Previous TST Result	Post Exposure TST Date (mm)	Post Exposure TST Result	CXR Date / Result (N or Abn)	Sputum Date / Result (S and C)	Status
									1st TST / 2nd TST		date / result	date / result	☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed
													☐ On Tx ☐ F/U: ______ ☐ Closed

* Enter 1st **circle** of contacts **first**: **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)

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

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Record of DOT Providers		
Initial	Name	[illegible]

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:

ACTIVE TB DOT RECORD – INITIAL PHASE OF TREATMENT

Diagnosis:	Date of Diagnosis:	Treatment Start Date:	ALLERGIES:

PART 1: Prescription DOT 7 DAYS PER WEEK x ______ DOSES OR (specify): ______________________ **ALL DOSES MUST BE DIRECTLY OBSERVED (DOT). DO NOT ADJUST TREATMENT WITHOUT CONSULTING RCDC.** Initial phase of TB treatment continues until all prescribed doses have been taken.

Drug	Dose (mg)	Date Started (dd/mm/yy)	Date Stopped (dd/mm/yy)
Isoniazid (INH)			
Pyridoxine (Vitamin B6)			
Rifampin			
Pyrazinamide (PZA)			
Ethambutol			

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

PART 2: DOT Record Assess for side effects / symptoms of hepatotoxicity* with **EVERY DOSE**. Consult with RCDC **PRIOR TO ADMINISTERING NEXT DOSE** if any are noted, there are abnormal blood test results, or the client becomes pregnant. **Mark dates of observed doses with your initials. Mark dates of missed doses with an "O".** Consult RCDC as soon as adherence issues arise or barriers to adherence are identified. **At month end**, mark number of doses taken and number of doses that should have been taken (doses due), then submit DOT record to RCDC.

Month (specify)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Adherence: This Month DOT	This Month DUE	To Date DOT	To Date DUE

PART 3: Monitoring Record 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) *Follow Guidelines in Nunavut TB Control Manual*	Pregnant Y/N	Colour Vision / Visual Acuity Tests *(when taking ethambutol)*		Sputum Specimen(s) for TB Testing^		PA and Lateral Chest X-Rays^ *If pregnant, consult with RCDC first*
Baseline					Left Eye:	Right Eye:	3 specimens		dd/mm/yy
End of Week 1							1 specimen		
End of Week 2							1 specimen		
End of Week 3							1 specimen		
End of Week 4					Left Eye:	Right Eye:	1 specimen		
End of Week 8					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 RCDC about failure to gain weight in a growing child or weight loss in an adult or adolescent case, and when dosage adjustment indicated. ^ Sputum testing and chest x-rays **after baseline** required only for cases with respiratory TB disease.

Record of DOT Providers		
Initial	Na[illegible]	Designation

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Munaqhiliqiyitkut
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: _____

ACTIVE TB DOT RECORD – CONTINUATION PHASE OF TREATMENT

PART 1: Prescription DOT 3 DAYS PER WEEK (Mon/Wed/Fri) x 54 DOSES OR (specify): _____ ALL DOSES MUST BE DIRECTLY OBSERVED (DOT). DO NOT ADJUST TREATMENT WITHOUT CONSULTING RCDC. The continuation phase of TB treatment continues until all prescribed doses have been taken.

Drug	Dose (mg)	Date Started (dd/mm/yy)	Date Stopped (dd/mm/yy)
Isoniazid (INH)			
Pyridoxine (Vitamin B6)			
Rifampin			

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

PART 2: DOT Record Assess for side effects / symptoms of hepatotoxicity* with **EVERY DOSE**. Consult with RCDC **PRIOR TO ADMINISTERING NEXT DOSE** if any are noted, there are abnormal blood test results, or the client becomes pregnant. **Mark dates of observed doses with your initials. Mark dates of missed doses with an "O".** Consult RCDC as soon as adherence issues arise or barriers to adherence are identified. **At month end**, mark number of doses taken and number of doses that should have been taken (doses due), then submit DOT record to RCDC.

Month (specify)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Adherence			
																																This Month		To Date	
																																DOT	DUE	DOT	DUE

PART 3: Monitoring Record 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) *Follow Guidelines in Nunavut TB Control Manual*	Pregnant Y/N	Visual Acuity and Colour Tests *(when taking ethambutol)*		Sputum Specimen(s) for TB Testing^		PA and Lateral Chest X-Rays^ *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:			
Month 7					Left Eye:	Right Eye:	3 specimens		dd/mm/yy
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 RCDC 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.bccdclearning.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 surveillence, 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 Qikiqtaaluq & Iqaluit TB Educator & Program Support	
		email: ndavies@gov.nu.ca	
		cell: 604-646-2426	