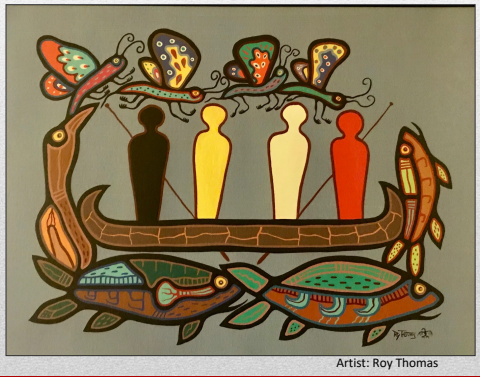
CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

Pharmaceuticals in Northern Communities, Controlled Substances Policy and Directly Observed Therapy for Tuberculosis



Artist: Roy Thomas

Module 5

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Objectives

PART ONE

1. Community Health Representative
2. Pharmaceutical Principles
   - Mixing Suspensions
   - Paediatric Calculations
3. Common Questions
   - Case Scenario calculations
   - Watchful Waiting
4. Dispensing & Labeling
5. Common errors/ near misses

PART TWO

1. Control Substances Policy and Forms
   - Narcotic Policy Highlights
   - Suboxone

PART THREE

1. Directly Observed Therapy (DOT) for Tuberculosis
   - Role of the Community Health Nurse
   - Treatment principles
   - Administration and Monitoring

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- CHRs provide up-to-date information and resources to their communities, to promote healthy lifestyles through education, immunization and clinics.
- They also monitor the community to identify any required resources and interventions.
- Prescriptions are filled in pharmacies in Sioux Lookout and Moosonee, and shipped to the communities 1-2 times per week.
- CHR sorts out these pre-packed prescriptions, and clients can retrieve them during clinic hours.
- Controlled substances are distributed by the NIC, signed for when picked up and kept in a secure location.

Community Health Representative

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What should I know about the medicine?

- Understand the mechanism of action of the medication
- Interactions
- Characteristics of clients at high risk
  - Elderly, paediatrics; Pregnant/ Lactating; Chronic Diseases; Immune Compromised; High ETOH intake
- Drug-Food interaction
  - Eg. Grapefruit juice or milk/dairy can interact with multiple medications
- Drug-Drug interaction
  - Eg. Traditional medicine; Meds which cause QT prolongations; abx; CNS drugs, narrow therapeutic range
- Drug-Lab interaction (increase or decrease)
  - Eg. Total Cholesterol ↑by OCP, ibuprofen, Vitamin C
  - PPI's - ? False positive for urine screening for THC.

Pharmacotherapy Basics

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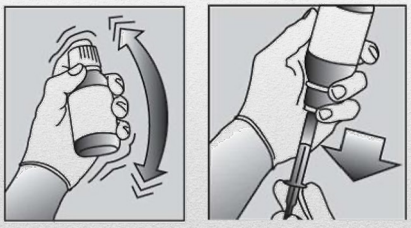
Pediatric medications often come in powder form, and need to be reconstituted with water to form a suspension. Follow the directions on the label for appropriate reconstitution.



Paediatric dosing is always done by weight, in mg/kg.
Important to weigh the child at each visit!

Mixing Suspensions

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Dx: Cystitis

<u>As per the doctor's order:</u>

TMP/SMX 5-10mg/kg/day Trimethoprim divided Q12h

RX: TMP/SMX 10mg/kg/day PO Q 12 h

On Hand use the Trimethoprim 40mg/5ml concentration.

Pediatric Calculations for BID dosing

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Total mg per day=10mgx10kg=100mg/day

Total mg per dose=50mg

On Hand use the Trimethoprim 40mg/5ml concentration.

Pediatric Calculations for BID dosing

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Total mg per day=10mgx10kg=100mg/day
Total mg per dose=50mg

On Hand use the Trimethoprim 40mg/5ml concentration.

Cross Multiply: 5ml x50 mg divided 40mg = 6.25ml
Label: 6.25ml PO by mouth, twice a day.
Mitte Calculation: 6.3x2=12.6x10=126ml
Dispense: 130mls
Round to 6.3mls use pediatric syringe.

Pediatric Calculations for BID dosing

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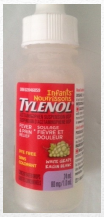
Children's Acetaminophen Dosing:
15mg/kg q4h



Note: - infant acetaminophen comes in concentrations of 80mg/1mL
- children's acetaminophen comes in concentrations of 160mg/5mL

always check the concentration when calculating the dose.

Children's Ibuprofen Dosing:
10mg/kg q6h

Note: Ibuprofen comes in concentrations of 100mg/5mL

Liquid Acetaminophen and Ibuprofen for kids

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What is the correct mitte for

- Pen V 300mg TID for 10 days? (300mg tabs)

Common Questions

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What is the correct mitte for

- Pen V 300mg TID for 10 days? (300mg tabs)

Mitte = 30 tabs

Common Questions

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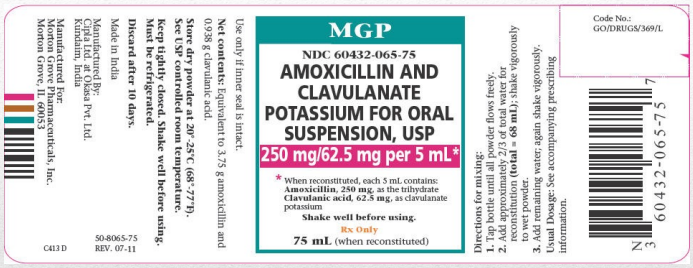
Tabs: Amox/Clav 875mg/125mg

Suspension: Amox/Clav 250ml & Clavulanic acid 62.5/5ml



Use the Amoxicillin concentration in divided doses

Tabs: TMP/SMX 160mg/800mg

Suspension: TMP/SMX 60mg/200mg in 5mL

Use the Trimethroprim concentration in divided doses

Dual Drugs

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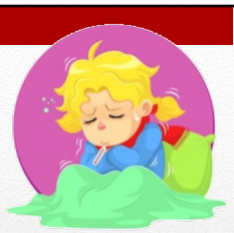

Sally is 1 year old, her weight is 15kg

Rx: Advil 10mg/kg/dose PO Q 6-8 hours PRN.

- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

Practice Questions

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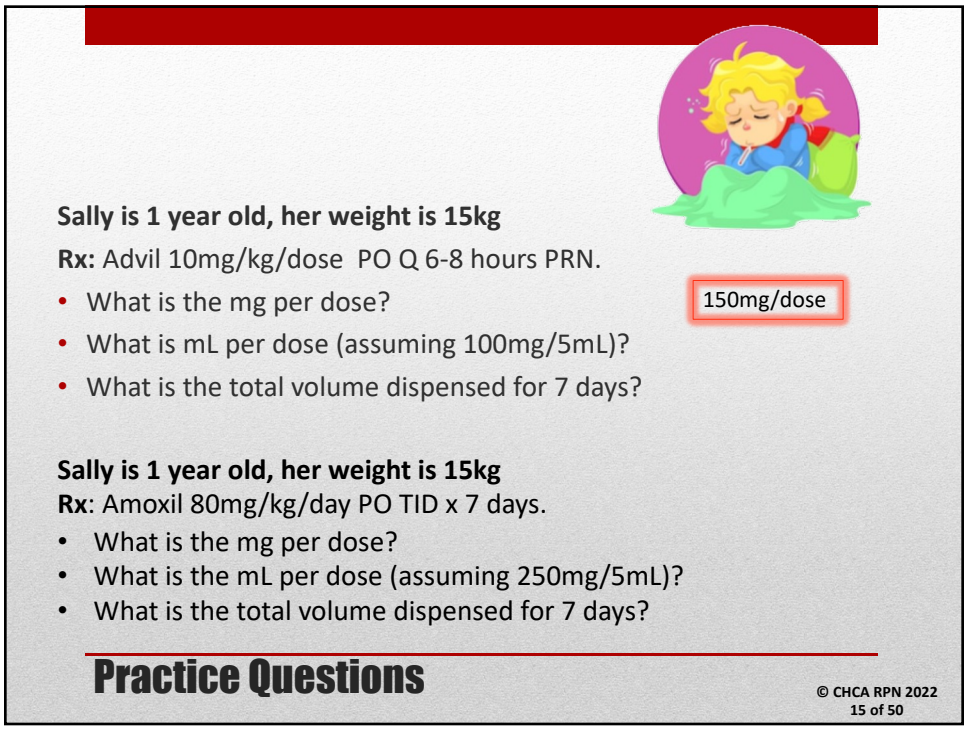
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Rx: Advil 10mg/kg/dose PO Q 6-8 hours PRN.
• What is the mg per dose?
• What is mL per dose (assuming 100mg/5mL)?
• What is the total volume dispensed for 7 days?
150mg/dose
Sally is 1 year old, her weight is 15kg
Rx: Amoxil 80mg/kg/day PO TID x 7 days.
• What is the mg per dose?
• What is the mL per dose (assuming 250mg/5mL)?
• What is the total volume dispensed for 7 days?
Practice Questions
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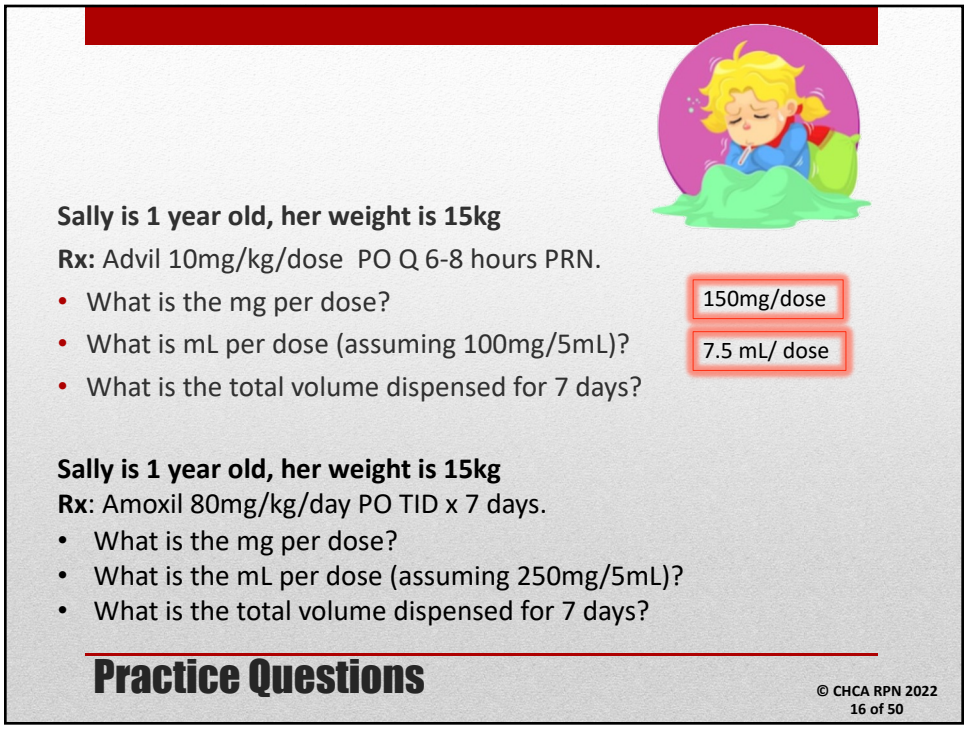
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• What is the mg per dose?
• What is mL per dose (assuming 100mg/5mL)?
• What is the total volume dispensed for 7 days?
150mg/dose
7.5 mL/ dose
Sally is 1 year old, her weight is 15kg
Rx: Amoxil 80mg/kg/day PO TID x 7 days.
• What is the mg per dose?
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Practice Questions
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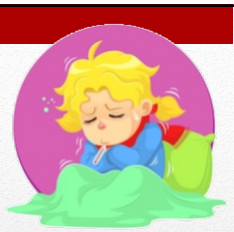

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Rx: Advil 10mg/kg/dose PO Q 6-8 hours PRN.

- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

150mg/dose

7.5 mL/ dose

210mL

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

Practice Questions

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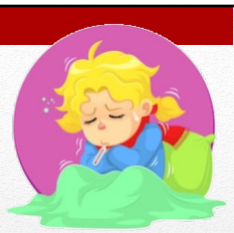

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- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

150mg/dose
7.5 mL/ dose
210mL

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

Practice Questions

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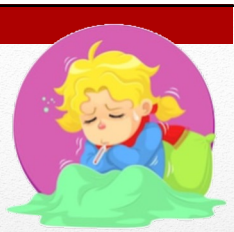

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Rx: Advil 10mg/kg/dose PO Q 6-8 hours PRN.

- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

150mg/dose
7.5 mL/ dose
210mL

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

400mg/dose

Practice Questions

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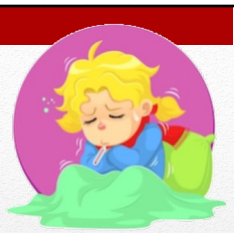

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Rx: Advil 10mg/kg/dose PO Q 6-8 hours PRN.

- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

150mg/dose
7.5 mL/ dose
210mL

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

400mg/dose
8mL/ dose

Practice Questions

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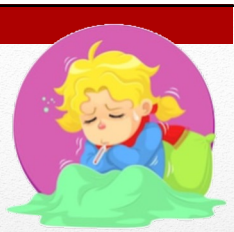

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- What is the mg per dose?
- What is mL per dose (assuming 100mg/5mL)?
- What is the total volume dispensed for 7 days?

150mg/dose
7.5 mL/ dose
210mL

Sally is 1 year old, her weight is 15kg

Rx: Amoxil 80mg/kg/day PO TID x 7 days.

- What is the mg per dose?
- What is the mL per dose (assuming 250mg/5mL)?
- What is the total volume dispensed for 7 days?

400mg/dose
8 mL/ dose
168mL

Practice Questions

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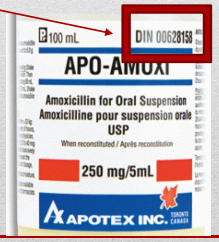
Medication Bottle :

Label Bottle, indicating:

- Name and Address of Facility
- First and Last name of patient
- Date dispensed
- GENERIC Drug name and strength
- Dosage Instructions (dose, route, frequency, duration)
- DIN (Drug Identification Number)
- Quantity dispensed (mitte)
- Expiration Date (where applicable)
- Name and Designation of prescriber
- Name and Designation of dispenser
- Auxiliary Labels (where applicable)

Quiet Moose Nursing Station, Quiet Moose, ON.
Phone: 807-555-1212 September 14, 2012
John Smith
Penicillin VK 300mg tablets
Take 1 tablet by mouth, three times a day for ten days.
DIN: 00642215
M= 30 tabs Prescribed by: Joe Doctor MD
Expiry: 2020-10-01 Dispensed by: Jane NurseRPN

- Label printer found in pharmacy
- Print two labels – one for bottle, one for chart
- If label printer breaks down, handwrite two labels.



Prescription Labelling

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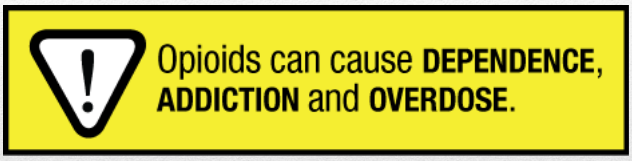
October 2019: new regulations mandating additional labelling for opioids



LINK: Opioid Q&A

Prescription Labelling

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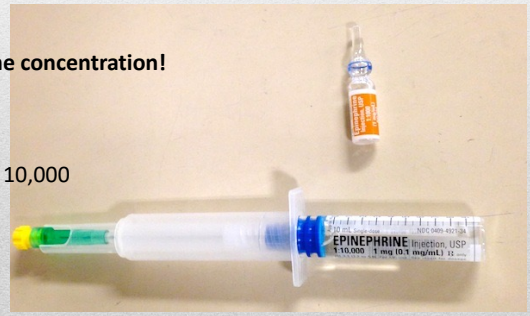
Administration Errors:
IMPORTANT: check date of birth
- Incident – two clients with same name, but different DOB.
- Client B was dispensed cardiology meds – adverse effect/ hospitalization

Check the medication name!
- Hydroxyzine vs. Hydralazine
- Dimenhydrinate vs. Diphenhydramine
- Ceftriaxone vs. Cefazolin

Check the concentration!

1000 vs. 10,000



Common Errors and Near Misses

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Controlled Substances Policy

CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

Module 5 – Part 2

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First Nations and Inuit Health Branch

POLICY AND PROCEDURES ON
CONTROLLED SUBSTANCES
FOR FIRST NATIONS HEALTH FACILITIES

Effective Date: July 2015

Cancels and Supersedes : August 2013

Office of Primary Interest : Office of Primary Health Care within the Population Health and Primary Care Directorate

Controlled Substances

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- Read section 3.2 to 3.2.7
- Read section 3.6 prescribing
- Read section 3.7 on waste

Definition of Controlled Substance:

- Substances that alter mental processes and may lead to dependence.
- Include narcotic and non-narcotic substances
- High risk for addiction and abuse

- All CHNs must complete the Controlled Substance online Modules
- Controlled Substance audits occur twice/yr and PRN.

Narcotic Policy Highlights

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FNIHB POLICY AND PROCEDURES ON CONTROLLED SUBSTANCES (CS) FOR FIRST NATIONS HEALTH FACILITIES

ANNEX 1 -
CONTROLLED SUBSTANCES SIGNATURE AND ACKNOWLEDGEMENT FORM

NAME OF HEALTH FACILITY_____ PAGE No. _____

It is mandatory to complete Annex 1 for ALL employees who have been granted access to CS by the nurse in charge and who will make entries in the CS Register Forms. Your signature is required for identification purposes and to indicate you have read and understood the FNIHB Policy and Procedures on Controlled Substances. This form must be signed before making any entries in other CS Register Forms.

Date	Name (PRINT)	Designation	Signature	Initials

Keep sheet for 2 years after last entry. Personnel must re-sign every 2 years.
Blank forms to be reproduced locally.

(Rev. Feb 2013)

3.2.1: Signature and Acknowledgment Form

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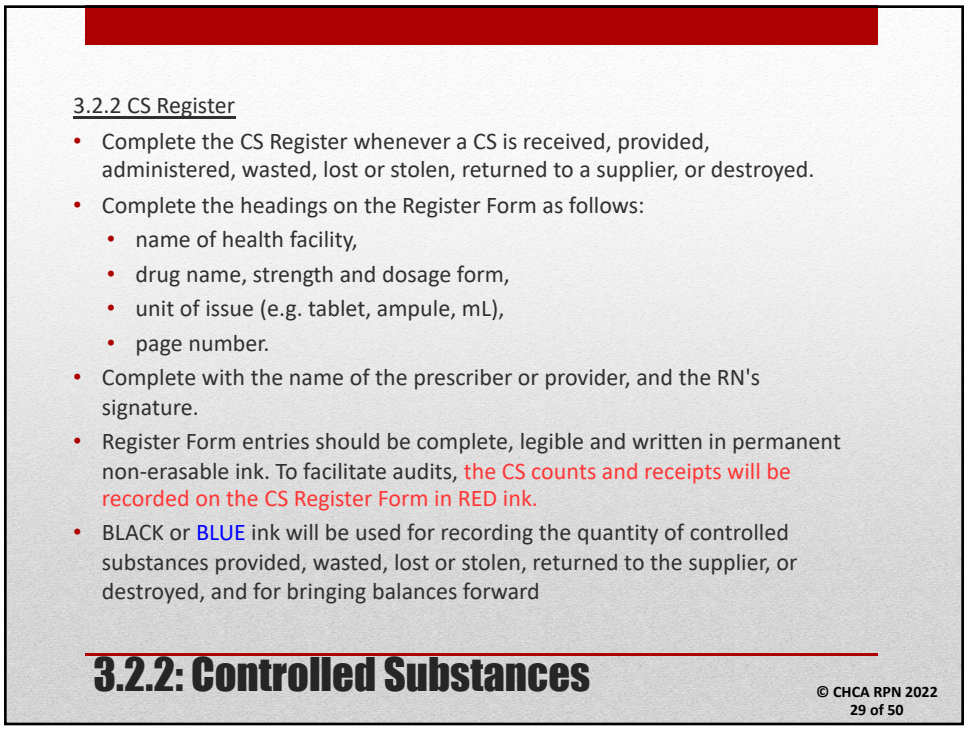
3.2.2 CS Register
• Complete the CS Register whenever a CS is received, provided, administered, wasted, lost or stolen, returned to a supplier, or destroyed.
• Complete the headings on the Register Form as follows:
• name of health facility,
• drug name, strength and dosage form,
• unit of issue (e.g. tablet, ampule, mL),
• page number.
• Complete with the name of the prescriber or provider, and the RN's signature.
• Register Form entries should be complete, legible and written in permanent non-erasable ink. To facilitate audits, the CS counts and receipts will be recorded on the CS Register Form in RED ink.
• BLACK or BLUE ink will be used for recording the quantity of controlled substances provided, wasted, lost or stolen, returned to the supplier, or destroyed, and for bringing balances forward
3.2.2: Controlled Substances
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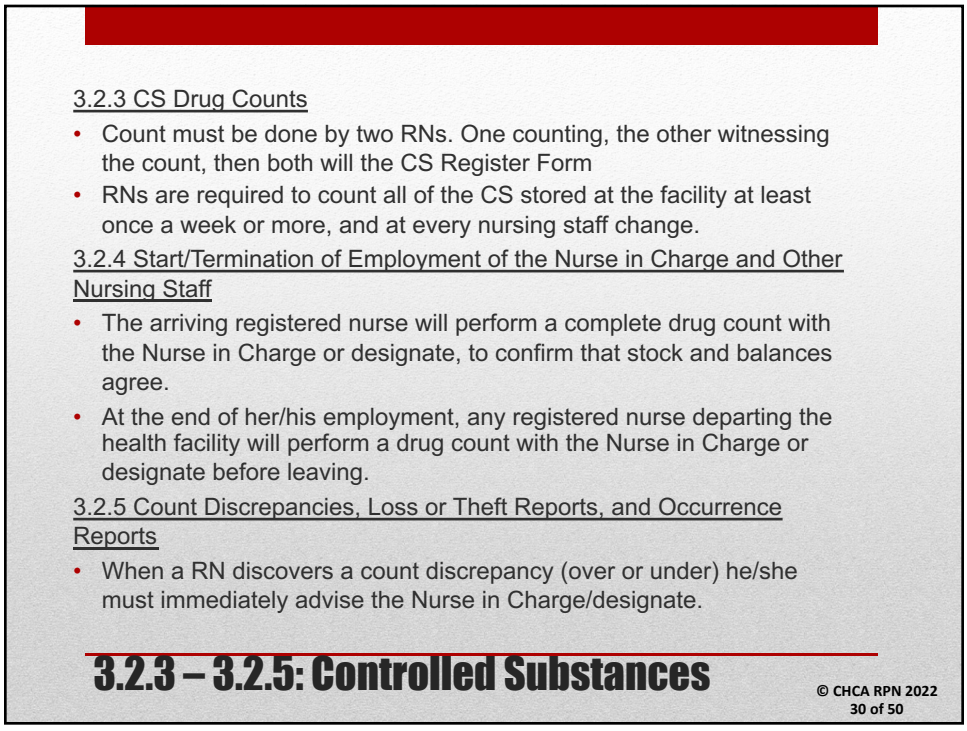
3.2.3 CS Drug Counts
• Count must be done by two RNs. One counting, the other witnessing the count, then both will the CS Register Form
• RNs are required to count all of the CS stored at the facility at least once a week or more, and at every nursing staff change.
3.2.4 Start/Termination of Employment of the Nurse in Charge and Other Nursing Staff
• The arriving registered nurse will perform a complete drug count with the Nurse in Charge or designate, to confirm that stock and balances agree.
• At the end of her/his employment, any registered nurse departing the health facility will perform a drug count with the Nurse in Charge or designate before leaving.
3.2.5 Count Discrepancies, Loss or Theft Reports, and Occurrence Reports
• When a RN discovers a count discrepancy (over or under) he/she must immediately advise the Nurse in Charge/designate.
3.2.3 – 3.2.5: Controlled Substances
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First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances
ANNEX 2B
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – COMBINED FORM

EXAMPLE

Name of Health Facility:
Little Beaver NS

Drug counts and additions (receipts) in **RED** ink
Issues (Dispensed, returned or destroyed) in **BLACK** ink
Errors – strike out and initial

Page # 14

				Units issued/received by tabs, amp or ml (for syrup only)	Codeine 30 mg tabs min 10 – max 25	Codeine syrup 5 mg/ml min 20 – max 100 mL	Meperidine (Demerol) 50 mg tabs min 10 – max 25 tabs	Meperidine (Demerol) 50 mg/mL amps min 5 – max 25	Morphine 10 mg/mL amps min 2 – max 10	Morphine syrup 5 mg/mL supply on demand	Phenobarbital 120 mg/mL amps min 10 – max 20				
			Forwarded Balance →	25	50 mL	10	20	8	32 mL	20				Prescriber's name	Nurse's signature
Date (yy-mm-dd)	**Time**	**Full First & Last Name Band #, & DOB**	**Drug Name/Strength/ Unit of Issue**	**Quantity**											
04-06-04	4:44 pm	Barbara. Hurt, 67 LB, 20/12/61	Demerol 50 mg tabs I tab q6h PRN for pain	4			6							Dr. Doright	J. Pond RN sign
04-06-04	4:59 pm	Drug Count			25	50	6	20	8	32	20			J. Pond RN sign	B. Hill RN sign
04-06-05	4:30 pm	Drug Count			25	50	6	20	8	32	20			J. Pond RN sign	B. Hill RN sign
04-06-06	7:30 am	Matthew. Etoo, 57 LB, 21/08/80	Meperidine 50 mg, 75mg IM	1.5				18.5						J. Pond, RN	J. Pond RN sign
04-06-06	1:00 pm	Wested	Meperidine 50 mg, 25 mg IM	0.5				18						B. Hill, RN	J. Pond RN sign
04-06-06	1:24 pm	MHC Pharmacy	Demerol 50 mg tabs	10			16							B. Hill, RN	J. Pond RN sign
04-06-06	4:30 pm	Ette. Knownow, 2 LB, 25/9/55	Morphine 10 mg IM stat	1					7					B. Hill RN	B. Hill RN sign
04-06-06	4:40 pm	Drug Count			25	50	16	18	7	32	20			J. Pond RN sign	B. Hill RN sign
04-06-07	10:35 am	Robert. Happy, 134 LB, 08/05/97	Codeine syrup 2 ml stat	2		48								Dr. Visiting	J. Pond RN sign

3.2.2 - Controlled Substances Register Form

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First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances

ANNEX 2A
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – SINGLE DRUG

Page # _____

Name of Health Facility:	Drug Name (Generic) & Strength:	Unit of issue:

DATE (YY-MM-DD)	TIME	PATIENT NAME (or Supplier's Name)	Quantity Rec'd	Issued	Bal.	Practitioner Physician/ Nurse	Nurse's Signature

Note:
- Drug Counts and Drug Received in RED ink
- Issued (Quantity of drug dispensed, returned or destroyed) in **BLACK** ink
- Errors: Strike out and initial

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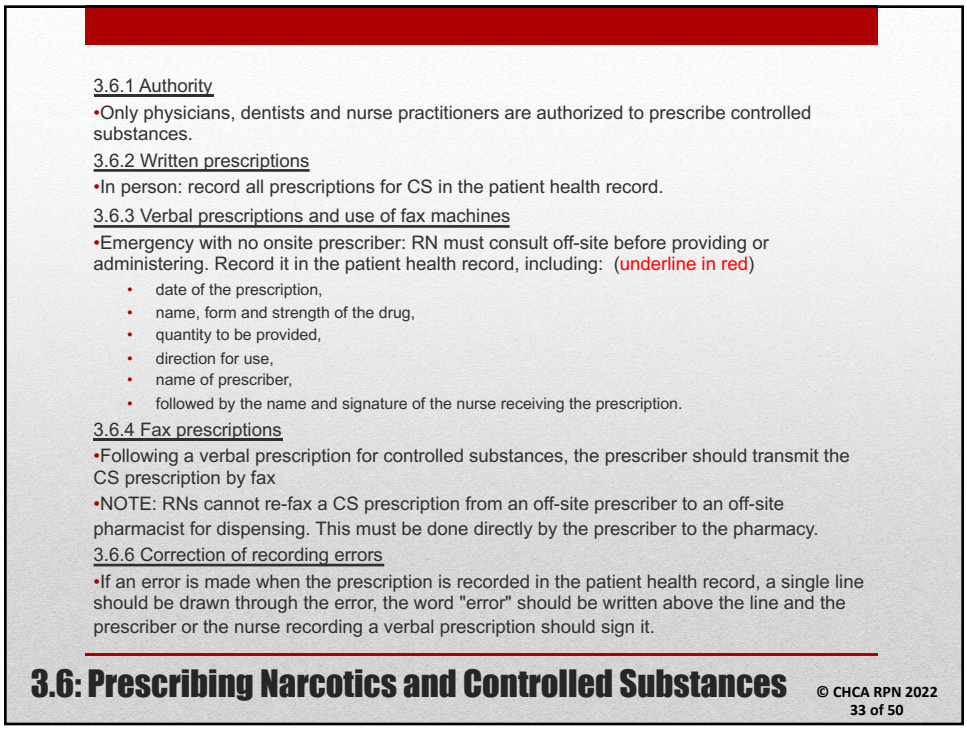
3.6.1 Authority
•Only physicians, dentists and nurse practitioners are authorized to prescribe controlled substances.
3.6.2 Written prescriptions
•In person: record all prescriptions for CS in the patient health record.
3.6.3 Verbal prescriptions and use of fax machines
•Emergency with no onsite prescriber: RN must consult off-site before providing or administering. Record it in the patient health record, including: (underline in red)
• date of the prescription,
• name, form and strength of the drug,
• quantity to be provided,
• direction for use,
• name of prescriber,
• followed by the name and signature of the nurse receiving the prescription.
3.6.4 Fax prescriptions
•Following a verbal prescription for controlled substances, the prescriber should transmit the CS prescription by fax
•NOTE: RNs cannot re-fax a CS prescription from an off-site prescriber to an off-site pharmacist for dispensing. This must be done directly by the prescriber to the pharmacy.
3.6.6 Correction of recording errors
•If an error is made when the prescription is recorded in the patient health record, a single line should be drawn through the error, the word "error" should be written above the line and the prescriber or the nurse recording a verbal prescription should sign it.
3.6: Prescribing Narcotics and Controlled Substances
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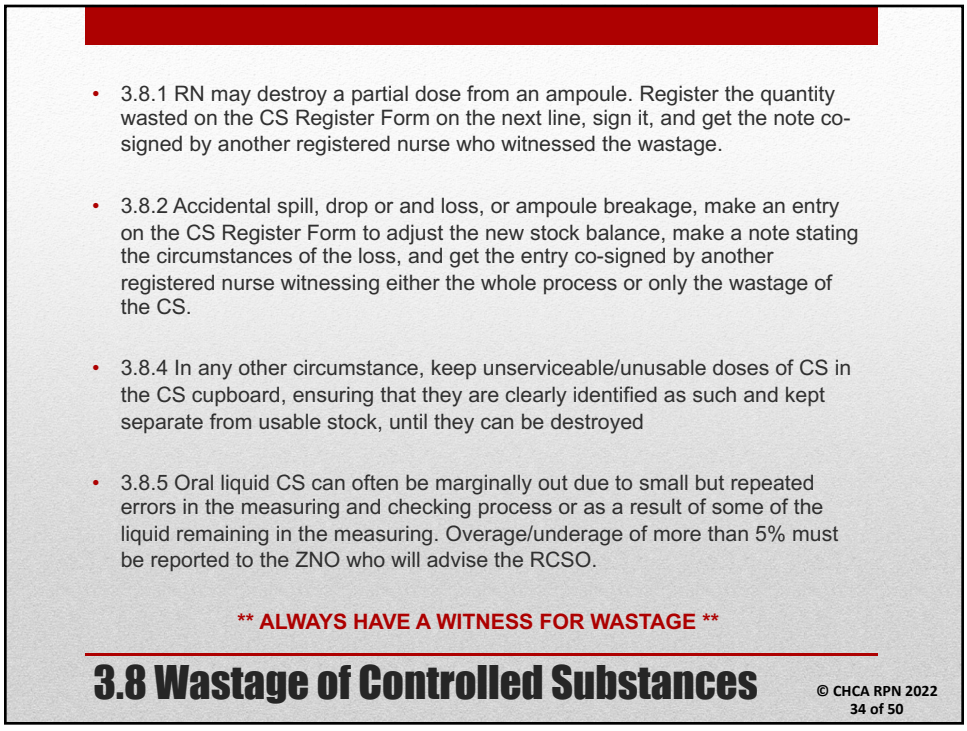
• 3.8.1 RN may destroy a partial dose from an ampoule. Register the quantity wasted on the CS Register Form on the next line, sign it, and get the note co-signed by another registered nurse who witnessed the wastage.
• 3.8.2 Accidental spill, drop or and loss, or ampoule breakage, make an entry on the CS Register Form to adjust the new stock balance, make a note stating the circumstances of the loss, and get the entry co-signed by another registered nurse witnessing either the whole process or only the wastage of the CS.
• 3.8.4 In any other circumstance, keep unserviceable/unusable doses of CS in the CS cupboard, ensuring that they are clearly identified as such and kept separate from usable stock, until they can be destroyed
• 3.8.5 Oral liquid CS can often be marginally out due to small but repeated errors in the measuring and checking process or as a result of some of the liquid remaining in the measuring. Overage/underage of more than 5% must be reported to the ZNO who will advise the RCSO.
** ALWAYS HAVE A WITNESS FOR WASTAGE **
3.8 Wastage of Controlled Substances
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- 3.9.1 The destruction of CS must not be confused with wastage described in section 3.8.

Unserviceable stock means any drug product inventory that is unusable, expired and/or that cannot be dispensed.

3.9 Destruction of Controlled Substances

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- Suboxone (buprenorphine/ naloxone) has recently been added to stock
- Two different concentration
- Use caution/ Gloves if handling (absorbed through skin)
- Dispensing Suboxone carry (non DOT) is at the discretion of the prescriber.

Suboxone

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- Every time a Controlled Substance is removed or added to the locked cupboard stock, you must complete an entry in the Register (Annex 2B)?
- Only transient staff, not regular employees, must count Controlled Substances upon arrival and departure from community?
- The pharmacy door can remain open as long as there are nurses in the nursing station?

True or False?

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- Every time a Controlled Substance is removed or added to the locked cupboard stock, you must complete an entry in the Register (Annex 2B)?

TRUE

- Only transient staff, not regular employees, must count Controlled Substances upon arrival and departure from community?
- The pharmacy door can remain open as long as there are nurses in the nursing station?

True or False?

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- Every time a Controlled Substance is removed or added to the locked cupboard stock, you must complete an entry in the Register (Annex 2B)?

TRUE

- Only transient staff, not regular employees, must count Controlled Substances upon arrival and departure from community?

FALSE

- The pharmacy door can remain open as long as there are nurses in the nursing station?

True or False?

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- Every time a Controlled Substance is removed or added to the locked cupboard stock, you must complete an entry in the Register (Annex 2B)?

TRUE

- Only transient staff, not regular employees, must count Controlled Substances upon arrival and departure from community?

FALSE

- The pharmacy door can remain open as long as there are nurses in the nursing station?

FALSE

True or False?

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DIRECTLY OBSERVED THERAPY FOR THE TREATMENT OF TUBERCULOSIS

Module 5 – Part 3

41

Directly Observed Therapy

- Directly Observed Therapy (DOT) is the World Health Organization (WHO) standard for treatment of Tuberculosis disease; and has been adopted as the standard for delivery of all TB medications whether they are for treatment of active TB disease or latent TB infection (LTBI).
- A Community Health Nurse or DOT Community Health Worker meets with clients to watch clients swallow each dose of anti-TB medication, help them to understand their TB medication, and provide support and education.
- DOT has been shown to reduce the risk of drug resistance and to provide better treatment completion rates, therefore DOT is the standard for providing TB medication to all clients taking TB therapy,

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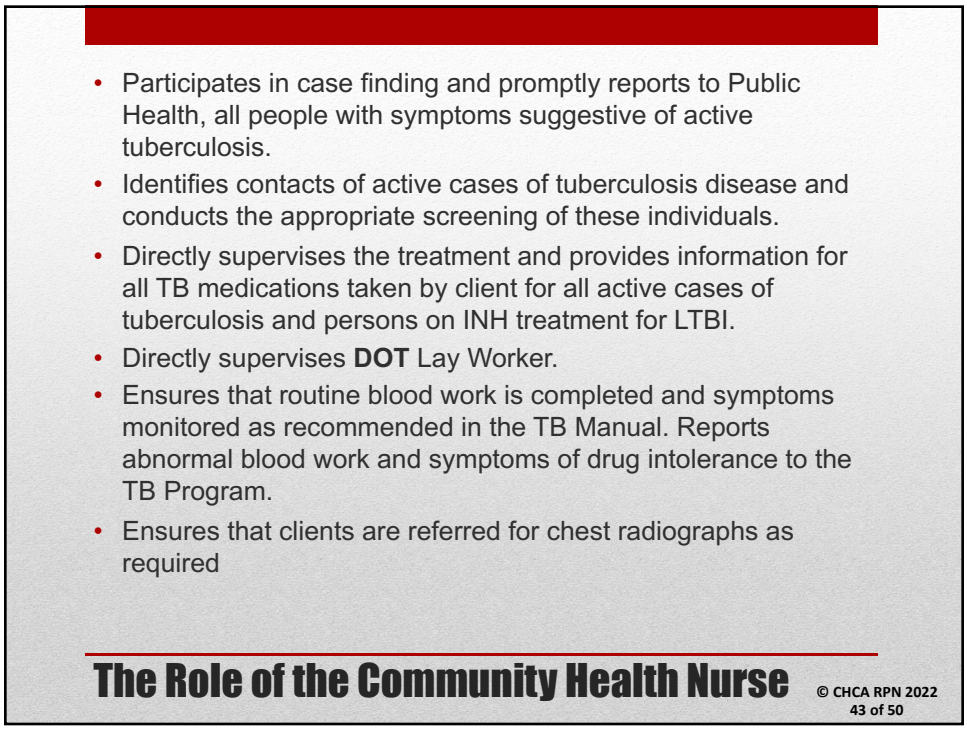
• Participates in case finding and promptly reports to Public Health, all people with symptoms suggestive of active tuberculosis.
• Identifies contacts of active cases of tuberculosis disease and conducts the appropriate screening of these individuals.
• Directly supervises the treatment and provides information for all TB medications taken by client for all active cases of tuberculosis and persons on INH treatment for LTBI.
• Directly supervises **DOT** Lay Worker.
• Ensures that routine blood work is completed and symptoms monitored as recommended in the TB Manual. Reports abnormal blood work and symptoms of drug intolerance to the TB Program.
• Ensures that clients are referred for chest radiographs as required
The Role of the Community Health Nurse
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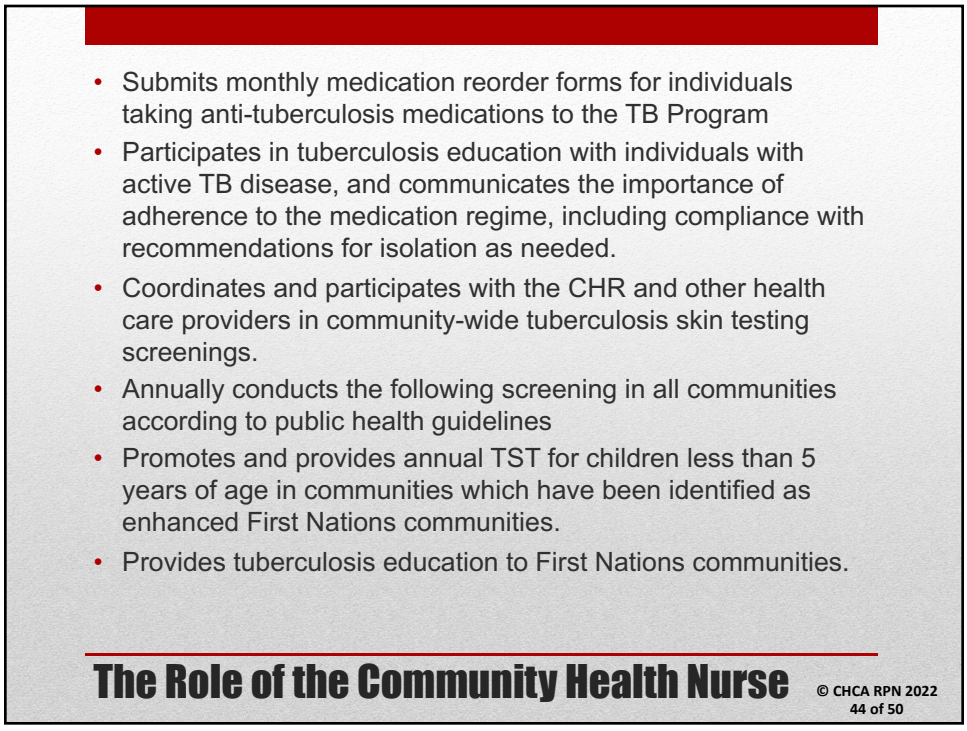
• Submits monthly medication reorder forms for individuals taking anti-tuberculosis medications to the TB Program
• Participates in tuberculosis education with individuals with active TB disease, and communicates the importance of adherence to the medication regime, including compliance with recommendations for isolation as needed.
• Coordinates and participates with the CHR and other health care providers in community-wide tuberculosis skin testing screenings.
• Annually conducts the following screening in all communities according to public health guidelines
• Promotes and provides annual TST for children less than 5 years of age in communities which have been identified as enhanced First Nations communities.
• Provides tuberculosis education to First Nations communities.
The Role of the Community Health Nurse
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- Treatment of latent TB infection (LTBI) is also called prophylaxis or preventative therapy.
- Treating TB infection with medication kills the bacteria and significantly decreases the chance that TB disease will develop in the future.
- TB infection may progress to TB disease if the immune system cannot keep the bacteria asleep.
- This process can occur anywhere in the body, but usually occurs in the lungs and cause damage to the tissues in which they are growing.
- Possible Sites of TB Disease:
  - Kidneys
  - Bone
  - Brain
  - Spinal cord
  - Lymph nodes
  - Lungs (this is the most common type in adults)
  - TB can occur anywhere

Treatment of Latent and Active TB

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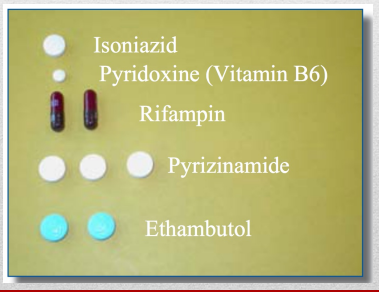
- Treatment is achieved with several antibiotics (i.e. Isoniazid™, Rifampin™, Pyrazinamide™ and Ethambutol™).
- Treatment usually lasts 6–9 months, but may be longer in some situations e.g. the client is not able to take one or more of the antibiotics; or if TB involves a part of the body that is diffcult to treat i.e. TB meningitis; or the TB germ is resistant to usual medications.
- Medication for TB disease is administered by DOT.
- Treatment of TB disease is mandatory under the Public Health Act. "Public Health Act; Part 4, Division 6 - Enforcement of Orders:
  - "Health officers may take enforcement measures in situations where individuals are not compliant with the Act, or pose a threat to their personal health or public health."



TB Treatment

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- The **DOT** worker watches the client swallow each dose of medication. Medication must never be left with the client.
- The **DOT** worker asks and observes the client for side effects with each dose of medication.
- The **DOT** worker documents all pertinent information of **DOT** administration in a timely fashion.
- The client is encouraged and supported to complete required check ups – blood work, chest x-rays, etc.
- A trust relationship often develops between **DOT** worker and the client. This relationship:
  - reduces fears about TB and its treatment
  - increases client's comfort level so he/she will ask questions
  - improves client's quality of health care as **DOT** workers can be an important link to other community resources for the client
  - reduces the possibility of TB germs becoming resistant to the medication

Principles of DOT

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- Most **DOT** is twice weekly. A Monday/Thursday schedule is recommended as it allows some leeway in the work week to still give both doses required should the client miss the Monday dose. There should be at least a 72 hour interval between twice weekly doses.
- Before the client starts their therapy, the CHN reviews the medication and any possible side effects or drug interactions with the client. The **DOT** worker must also be aware of possible side effects of each client's medications. The first 2 or 3 doses should be delivered and observed by the supervising nurse to allow the opportunity for teaching and observation for reactions and side effects.
- All doses of medication must be observed. It is NEVER acceptable practice to leave a dose of medication with a client to take on their own at a later time.

Administering Medication

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- The CHN is required to review each client's progress with the **DOT** Lay Worker on a weekly basis and the client should be assessed (signs & symptoms of TB, side effects of medications, general health) directly by the CHN on a monthly basis, but, possibly more often at the beginning of therapy.
- Regular communication between **DOT** team members is vital for the smooth and safe delivery of **DOT**. A plan for communication should be set in place. The CHN must be available in person or by telephone to the **DOT** Lay Worker in case of client side effects or other questions and concerns. If the CHN for any reason is not available, a designate nurse must be identified.
- The designate must agree to take on the supervising role and to be available to the **DOT** worker.
- **Should the client forget or choose NOT to take the medication, this can lead to treatment failure & the development of resistant TB.**

Monitoring the Client

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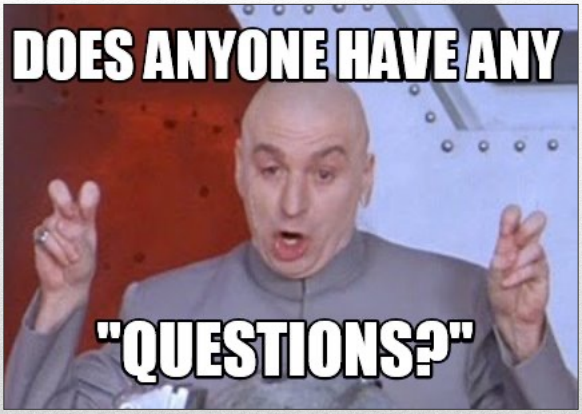

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