Policy 2.2  Case Management of Tuberculosis

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<td>28 August 2014</td>
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Related Policy

1.1  Diagnosis of tuberculosis – Laboratory
1.2  Diagnosis of tuberculosis – Clinical
2.1  Medical treatment of tuberculosis (adults)
2.2  Case management of tuberculosis
3.1  Diagnosis of latent tuberculosis infection
3.2  Treatment of latent tuberculosis infection
4.1  Tuberculosis (active and latent) in children
4.2  Management of tuberculosis in a custodial setting
4.3  Tuberculosis (active and latent) in pregnant women
4.4  TB and HIV
5.1  BCG Vaccination
6.1  Contact tracing for tuberculosis
6.2  Active surveillance for tuberculosis in recent migrants
6.3  Active surveillance for tuberculosis in health care workers
6.4  Active surveillance for tuberculosis prior to anti-TNF alpha treatment
7.1  Management of notification of tuberculosis and enhanced surveillance data
8.1  Diagnosis and management of Hansen’s disease
9.1  Management of confidential information for the WA tuberculosis control program
9.2  Client record management policy for the WA tuberculosis control program
9.3  Fees and charges associated with tuberculosis and leprosy treatment

Document Control

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Policy 2.2  Case Management of Tuberculosis

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Policy 2.2   Case Management of Tuberculosis

1.0 Introduction

Case Management is essential to the success of the WA TB Control Program’s management of tuberculosis (TB). This is the nurse-led, individual patient-based activity that ensures that treatment is adhered to and completed satisfactorily, and that contacts are identified and screened. In the treatment of TB it is never enough to prescribe the correct drug therapy alone. The prescription must always be accompanied by case management.

Rationale: Cure of TB requires a large number of tablets to be taken for an extended period of time. Adherence with prescribed drug regimens can be further hampered by the stigma and immigration implications associated with the diagnosis, the resolution of symptoms well before the course of treatment is completed, the fact that many clients are recent migrants with limited English and the potential for side effects from the medications. Some well informed and intentioned, busy people with competing priorities equally present a problem with adherence. Patients left to take treatment unsupervised are therefore likely to not adhere to the treatment regime. Case management is primarily to protect an individual from this, but is also a public health measure to reduce transmission and the development of drug resistance caused by poor compliance. Furthermore, TB is transmitted passively by breathing i.e. the person being infected is not active in acquiring the infection. This means the onus of preventing this transmission lies more with health care providers than the infected individuals. Contact tracing, a secondary part of case management, aims to further reduce future TB by diagnosing early active secondary TB cases, and identifying and treating latent TB infection.

All patients undergoing treatment for active and latent TB in Western Australia are assigned a case manager from the WA TB Control Program based at the Anita Clayton Centre, Perth. This includes patients diagnosed and treated for TB by both private and public physicians outside the WA TB Control Program. The case manager is allocated according to the index case’s home address and pre-defined regions that the case managers are assigned. This allocation can be altered at the case managers’ discretion and by agreement e.g. to even workloads, family groups are managed together etc. The case manager works closely with medical staff and other professionals involved with the care of the patient to support the patient to completion of his or her TB treatment.

Case management is a form of healthcare delivery in which a management plan is individualised for the patient according to their personal circumstances and developed by a multidisciplinary team to achieve a specific and measurable outcome, in this case successful completion of tuberculosis treatment (Global Tuberculosis Institute 2012).
2.0 Components of case management

Case management in tuberculosis involves a range of activities from the identification of tuberculosis patients through contact tracing, assessment and education of patients early after the diagnosis, support and care coordination during the treatment period and case closure once treatment is completed. The components of case management include (Ross, Curry, & Goodwin, 2011):

1. Case detection, including contact tracing investigation
2. Assessment
3. Care planning
4. Care coordination
   • Medication management
   • Self-care support
   • Advocacy and negotiation
   • Psychosocial support
   • Monitoring and review
5. Case closure

3.0 Case detection, including contact tracing

Case detection is the early identification of patients with TB to ensure that TB control activities can be initiated as soon as possible. This will involve:

- Liaison, networking and communication with both hospital-based and private physicians and infection control practitioners to ensure the early identification of patients diagnosed with tuberculosis.

- Coordination of contact tracing (see the WA TB Control program policy 6.1 Contact tracing for tuberculosis) and its completion in a timely manner. The aims of contact tracing are:
  i) To detect a case of active tuberculosis that transmitted TB to the diagnosed index case,
  ii) To detect and treat latent tuberculosis infection (LTBI) or active TB (a secondary case) due to transmission from the index case, and
  iii) To identify other cases that have TB acquired from a common, but unidentified source index case (cohort effect).
4.0 Assessment

The assessment phase involves the gathering of information about the patient’s disease and social circumstances to assist with the planning of TB treatment. Information may be gathered from a variety of sources as well as the patient including other health care providers, community based agencies, and other government departments e.g. housing, and schools. Assessment should be initiated as early as possible after diagnosis whether that occurs in an outpatient setting or in hospital. It may take place at the first clinic appointment or at the first home visit by the case manager.

During the assessment phase the case manager should aim to (Global Tuberculosis Institute):

- Complete TB Nursing Assessment on the database (see Appendix A: TB Nursing Assessment);
- Collect and record surveillance data as a requirement for statutory medical notifications (see the WA TB Control policy 7.1 Notification of tuberculosis and enhanced surveillance data).
- Obtain or review previous medical history;
- Determine the period of potential infectiousness which will then guide contact tracing activity (see the WA TB Control policy 6.1 Contact tracing for tuberculosis);
- Evaluate the patient’s knowledge and beliefs of TB;
- Assess any TB medication regimen that has been prescribed;
- Identify any barriers to treatment adherence e.g. difficulty swallowing tablets, transportation problems to attend appointments, issues that may require directly observed therapy (see 6.1 below); and
- Develop an understanding of the patient’s social circumstances that might impact on completion of treatment i.e. living arrangements, housing issues, employment, education, residency status, welfare issues, cultural background and presence of any drug or alcohol misuse.

Patient assessment should continue throughout the treatment period in order to detect any changes in the patient’s circumstances that might affect treatment compliance e.g. social issues, communication and language difficulties, transport problems, medication side effects or interactions, travel plans etc.

5.0 Care planning

The patient’s care plan is pivotal to case management and should be developed with consideration to the individual’s personal circumstance, their health needs and service provision. The plan should be developed in consultation with the patient and their medical team. The care plan will change according to the patient’s individual situation and how much progress is being made in the patient’s condition. Care planning should be an ongoing process throughout the treatment duration and should include the commencement of the contact tracing investigation (see the WA TB Control policy 6.1 Contact tracing for tuberculosis)Case managers are required to complete the TB Nursing Management Plan on the database (see Appendix B: TB Nursing Management Plan).
5.1 Case management meeting

A case management meeting is held at least monthly, to plan and review the care of active TB cases. The purpose is to document new cases, discuss issues that may be a barrier to successful treatment, discuss the extent of contact tracing, problem solve, peer review and ensure that critical outcomes are achieved. Case histories are collated by the assigned case managers on a shared spreadsheet, with new cases added at time of diagnosis. All new notifications in the interval since the last meeting are discussed. In addition, any case identified as a problem, defaulting on treatment, lost to follow up, transferred out of WA or completing treatment is reviewed. All cases requiring extensive contact tracing should be discussed and reviewed at the meeting. Problem cases are at the discretion of the case manager, but MDR TB or patients that are not adherent with treatment are always included. Attendance at the meeting is open, but it is primarily for the TB physicians and case managers of the WA TB Control Program. The meeting is chaired by the Clinical Nurse Manager (or Medical Director of TB in her/his absence), but is an open forum format with decision making by discussion & consensus.

6.0 Care coordination

The case manager should act as the central point of contact for the TB patient for the duration of their treatment. The case manager is the coordinator of care and primary source of support for the patient and should be in continuous communication with the patients, via telephone, home visits or clinic attendances, throughout the treatment duration. Care coordination for drug sensitive non-complicated TB can be structured as follows:

<table>
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<th>Diagnostic Assessment</th>
<th>Initial medical assessment and relevant investigations</th>
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<tr>
<td>Start of Treatment</td>
<td>Clinic visit – Seen by physician and case manager, begin discussions on contact tracing, supply one month’s medications</td>
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<tr>
<td>One week</td>
<td>Home visit – assess environment, complete management plan including contact tracing</td>
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<tr>
<td>Two weeks</td>
<td>Clinic visit – physician and case manager, supply one month’s medications</td>
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<tr>
<td>Four to Six weeks</td>
<td>Clinic visit – physician and case manager</td>
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<tr>
<td>Two months</td>
<td>Clinic visit – physician and case manager – sensitivities reviewed, treatment changed from intensive to continuation phase, supply one month’s medications</td>
</tr>
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<td>Three months</td>
<td>Clinic visit – physician and case manager, supply one month’s medications</td>
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<tr>
<td>Four months</td>
<td>Clinic visit – physician and case manager, supply one month’s medications</td>
</tr>
<tr>
<td>Five months</td>
<td>Clinic visit – physician and case manager, supply one month’s medications</td>
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</table>
Six months Clinic visit – physician and case manager – treatment ceased and outcome reported

Aspects of care coordination include:

6.1 Medication management

An essential part of successful TB treatment is the completion of the relatively long antibiotic therapy. Case managers are essential to monitor compliance of the patient in adhering to the prescribed medication regimen, to support the patient through medication side-effects, to identify and address promptly any barriers to medication compliance. The treatment can be either self-administered or directly observed. The case manager should work closely with the medical team to ensure that the medication is being taken according to the prescription and policy standards (see Policy 2.1: Medical treatment of tuberculosis adults).

Case managers are responsible to ensure that patients have an adequate supply of medication through the WA TB Control Program, this includes patients living in rural and remote areas. Patients treated by physicians outside the WA TB Control Program can, and usually will, also receive their medication from the WA TB Control Program. All patients supplied with TB medication from the Anita Clayton Centre must have a medication chart.

Patients requiring first line treatment regimens:
The first line oral TB drugs are available and supplied by the WA TB Control Program, including Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. Moxifloxacin and adjuvant agents such as Pyridoxine and Prednisolone may also be supplied by the WA TB Control Program.

Patients requiring injectables or non first line oral drugs:
Injectable drugs and other non-first line oral drugs are usually obtained from Royal Perth (RPH) Hospital Outpatient Pharmacy. A RPH Pharmacy Prescription is required. Non-first line agents often require Special Access Scheme (SAS) approval. Medical staff must complete a Category A SAS form to ensure timely commencement of medication and a Category B SAS form to ensure ongoing supply of the medication. The Category B SAS form needs to be repeated after 12 months if the drug is to continue. Patients requiring injectable drugs are usually hospitalised to establish treatment and are then managed by Hospital in the Home (HITH) after discharge while the injectables continue.

The WA TB Control Program provides the medication at no cost to the patient (refer to OD 0229/09 Fees and Charges related to the Diagnosis and Management of Tuberculosis and Leprosy).

6.2 Non-compliance and Directly Observed Therapy (DOT)

Case managers must encourage adherence by thorough education outlining the indication and importance of treatment, management of adverse effects, the use of dosette boxes or
Webster packing as required, and ensuring a regular supply of medication. Compliance should be checked regularly by direct questioning of patients, pill counts, urine drug testing and rapid contact whenever a patient does not attend planned appointments. If there is evidence of non-compliance it should be discussed with the treating physician as soon as possible, and a plan made between the case manager and physician for enhanced monitoring, timelines for tolerance of unacceptable adherence and measures to be taken if this threshold is reached.

Directly observed therapy (DOT) is not utilized on all patients treated for TB in WA. Rather it is used selectively in the following circumstances:

- demonstrated poor compliance that jeopardises successful TB treatment
- relapse TB where non-compliance is considered a possible reason for relapse
- all MDR TB cases
- all hospital inpatients (while in hospital)
- all patients within correctional services
- any other patient where the case manager considers there to be a high risk of non-compliance.

DOT involves observing the patient swallowing every dose of treatment.

If possible DOT should be established at the start of TB treatment as patients who are switched to DOT can see this as a disciplinary measure resulting in increased resistance and possible non-adherence. The value of DOT should be reinforced by the treating physician and the case manager. DOT may also need to be introduced if a patient is clinically deteriorating while on treatment, still culture positive two months into treatment or experiencing adverse effects to the medication.

DOT is established and managed by the case managers at the WA TB Control Program. The DOT is most commonly provided by the case manager, but with consent from the patient can be provided by a community nurse or service, local doctor, local pharmacist, correctional staff or hospital staff. The external DOT providers should be given information and instruction on DOT and a Directly Observed Therapy Log sheet (see Appendix C), the log should be returned to the service on a monthly basis. It is not recommended that family members observe therapy as they are not typically neutral or objective about the patient’s health.

When DOT is required the patient should complete a Directly Observed Therapy Agreement (see Appendix D) that clearly states the agreed time and location for DOT and includes the public health implications of not taking the treatment as prescribed. The contract should be added to the patient’s records and the original given to the patient. The DOT can be arranged for any location convenient and safe to the patient and the provider. It is preferable for DOT to be provided at the clinic however this may not be possible for all patients. Community based DOT can be provided more efficiently by establishing partnerships with services based in the community.
The WA TB Control Program advocates for daily DOT especially during the intensive phase, three day DOT with a larger dose may be considered after the intensive phase. It is common practice for some patients to self-administer medications on the weekends and send an SMS message to a designated number. Virtually observed therapy via internet based programs can be adopted for some patients.

When a patient refuses treatment and cannot be managed by routine case management or DOT, there is provision in the Health Act 1911 Part IX – Infectious Diseases, to isolate the patient. The provisions for doing this are very limited, and broadly can only be used in two circumstances:

- a patient where there is reasonable suspicion of infectious TB, but the patient will not submit to testing. The patient is hospitalised until the test is done and proves or disproves TB.
- a patient with proven, infectious (sputum AFB smear positive) pulmonary TB (not any other form of TB) who refuses treatment. The patient is isolated in hospital until treatment is taken and the patient is rendered non-infectious.

This ‘Public Health Order’ is arranged by the Medical Director of the TB Control Program and requires sign-off by the Executive Director of Public Health at the Department of Health. It is a measure of last resort and should only be considered when all other measures have been unsuccessful.

Incentives and enablers may assist with adherence. Incentives are small rewards given to patients to encourage them to take their medications or attend their allocated appointments. Incentives may include balloons, stickers, toys, books, movie tickets or personal care items. Enablers can assist clients to take treatment and attend appointments by overcoming barriers such as transportation issues. Incentives and enablers can be provided after consultation with the Clinical Nurse Manager.

### 6.3 Self-care support

The level of support offered to TB patients by their case manager will vary according to the needs of the individual. While patients are supported to manage their own condition, the case manager may:

- Ensure the patient has a good understanding of his or her condition and provide continuous education regarding TB and its treatment;
- Provide and/or make referrals for general health education and advice e.g. diet, exercise, smoking cessation;
- Provide and/or make referrals for advice on health conditions specific to the patient’s circumstances e.g. ensuring general practitioner involvement for diabetes;
- Provide education on navigating the healthcare system and services to contact regarding non-urgent issues;

### 6.4 Advocacy and negotiation

A key role in case-management is advocating for and negotiating on behalf of the patient for access to services and needs identified in the care plan. This may involve liaising with
other government departments e.g. housing, social security; liaising with employers on behalf of the patient; ensuring appointments for referrals made to other providers; and often importantly education for the patient's family and friends regarding the nature of tuberculosis and its treatment.

The main advocacy of the case manager on behalf of the TB patient is with the patient's treating physician. This is especially important if this physician works outside the TB Control Program. The case manager can ensure the physician is aware of any difficulties or non-compliance with treatment, and assist with patient's understanding and compliance with the physician's recommendations.

When TB treatment is prescribed by a physician outside the TB Control Program and the case manager has concerns with regard to the TB treatment regimen or the treatment progress, these must first be raised with the treating physician. If the case manager remains concerned that the perceived problem is not addressed, it should be raised with the Medical Director of the TB Control Program who will discuss the concerns with the treating physician if required.

6.5 Psychosocial support

The TB case manager has the most contact with the patient and should remain with the patient from time of diagnosis to discharge from the program. The case manager should provide continuity of care throughout the treatment duration. This regular contact ensures support for the patient and promotes completion of therapy. Being diagnosed with TB and the social stigma associated with the diagnosis can be a source of great distress for the patient, and the case manager has an important role to help them through this difficult time. The aim of case management beyond the successful treatment of TB is to rehabilitate the patient to full pre-morbid health and function.

6.6 Clinical Handover

It may be necessary for case managers to handover the care of their patients when they go on leave. The patient should be made aware of the handover and given contact details for the relieving case manager. The handover should be documented in the patient records. If a client is transferred into regional Western Australia, interstate or outside of Australia a nursing summary with a management plan should be provided to the receiving health service (see Appendix E). This document can be sent with the medical summary, acknowledgement that the document has been received by the health service should be documented in the patient records.

6.7 Monitoring and review

A case-manager’s role is to determine if a patient is receiving and complying with appropriate TB treatment and revising the care plan as necessary. The frequency of monitoring is dependent on the patient’s circumstances and level of need. It may vary during the treatment program i.e. more frequently at the beginning of treatment, or
increase in times of personal crisis or treatment issues e.g. medication side effects. Monitoring may take place daily, weekly or monthly and may occur in a variety of forms i.e. direct contact through clinic appointments, home visits or telephone contact. Email can be used, but only for simple information e.g. confirming appointments, and not for collecting of personal medical details or conveying of medical advice. All contacts with patients and other care providers should be recorded in the patient’s record.

**Home visiting:** can be used to evaluate the patient’s home environment and social situation and is a tool to monitor patients and provide support to promote adherence. Not all patients require regular home visiting, but it is recommended that the case manager meets with patients taking treatment for active TB on a monthly basis, this can be done at home or the clinic. Prior to any new site or home visit a risk assessment is to be completed and reviewed by the Clinical Nurse Manager or Area Manager. The Risk Assessment tool can be found on the patient database. If it is not possible to carry out a risk assessment two people are required to attend the site or home.

### 7.0 Case Closure

The process for discharge of patients from the case management program or ‘case-closure’ should be clear and defined in time. The aim for case management for tuberculosis should be the successful completion of medical treatment. The decision to discharge a patient should be determined by the case manager and treating physician. Case closure after routine active TB treatment generally occurs 2-3 months after the successful completion of TB therapy. Prolonged follow up may be required if there were concerns with compliance, a non standard treatment regimen was used or the patient had extensive disease. The decision on follow up and case closure is made by the medical physician and case manager (see WA TB Control Policy 2.1 *Medical management of tuberculosis*).

At case closure the case manager updates the Western Australian Notifiable Infectious Disease Database (WANIDD) (see the WA TB control policy 7.1 *Notification of tuberculosis and enhanced surveillance data*) and ensures all contacts have been assessed, screened and managed (see WA TB Control program Policy 6.1 *Contact tracing for tuberculosis*). The TB summary is then completed for all cases, this summary includes outcomes for contacts see Appendix F.

### 8.0 Works Cited


**Endorsing Authority**

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**References (Standards)**

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Appendix A:

**TB Nursing Assessment (TBNA) – Please note - MEDTECH DOCUMENT**

**County of birth:**

**Language:**

**Interpreter required:**

**Literate own language:**
- [ ] Yes
- [ ] No

**Literate in English:**
- [ ] Yes
- [ ] No

**Date of Arrival:**

**Visa status:**
- Permanent Resident
- Humanitarian Visa
- Unauthorised person
- Student visa
- Work Visa
- Tourist Visa
- Other

**Australian born**
- [ ] Y
- [ ] N

**Marital status:**

**Household:**

**Significant other:**

**Does the patient care for others in the home?**
- [ ] N
- [ ] Y

**Religion:**

**Cultural needs:**

**Disabilities:**
- Vision
- Hearing
- Mobility
- Cognitive
Occupation:
- F/T employed
- P/T employed
- Casual
- Home duties
- School student
- Tertiary student
- FIFO
- Unemployed

Accommodation:
- House
- Share house
- Nursing home
- Hostel
- Student house
- Boarding school
- Homeless
- Jail
- Detention Centre
- Other

Relevant History:
- Diabetes
- Renal Disease
- Immunosuppression
- Anti TFN treatment
- Neurological Deficit
- Cardiovascular
- Genitourinary
- Integument
- Gastrointestinal
- Nutrition
- Psychiatric
- Pregnancy
- Contraception
- Other

Alcohol & Other Drugs
- Smokes tobacco
- N  Y  .......... per day
- Alcohol use
- N  Y  .......... per day
- Non prescription drugs
- N  Y  Specify ..........................

Medications – current
- N  Y  Specify..........................

Community Support Services in Use
- Home help
- HITH/RITH
- Silver Chain
- Other .............................
Appendix B:

**TB Nursing Management Plan (TBNMP) – Please note – MEDTECH DOCUMENT**

**Presentation:**
- Symptoms □
- Screening □
- Incidental □
- New □
- Relapse □

Date of onset of symptoms ............

**Site:**
- Pulmonary □
- Extra Pulmonary □
- Both □
- Site □ ............

**Micro:**
- Smear positive □
- Date.............
- Culture positive □
- Date.............

**Hospital Admission:**
- Yes □
- No □
- Date admitted .............
- Date discharged .............
- Hospital .............

**Medical Management:**
- ACC □
- External Provider .............
- Other .............

**Education:**
- Written information provided □ Y □ N

**Social:**
- Family aware □ .............

**Transport:**
- Independent □
- Family Assist □
- ACC Assist □
- DVA □
- PATS □
- DCS/Detainees □

**Medication:**
- Supplied by ACC □
- Supplied by other □ .............
- Side effects discussed □ Y □ N
- ETOH discussed □ Y □ N □ NA
- Contraception discussed □ Y □ N □ NA
- Dosette box given □ Y □ N
- Webster Pack □ Y □ N

**Medication Adherence:**
- Is the patient likely to be compliant with medication? □ Y □ N
  - Defaulter □
  - Previous Treatment □
  - MDR □
Public Health and Ambulatory Care, North Metropolitan Health Service
Policy 2.2 WA TB Control Program

☐ Known substance abuse
☐ Recent Mental Illness
☐ Homeless/social

Is Supervised Therapy required? ☐ Y ☐ N

Appropriate supervisor:
☐ TB Case Manager
☐ Regional Health Unit RN ☐ ............
☐ Domiciliary Care/ HITH ☐ ............
☐ Private Pharmacy ☐ ............
☐ Other ☐ ............

Contact Tracing:
Discussed ☐ Y ☐ N
Contacts identified ☐ Y ☐ N
☐ Household (Close)
☐ Casual
☐ Other............

Other contacts for screening:
☐ Airline:
☐ Other transport:
☐ Nursing home:
☐ Hostel:
☐ Educational:
☐ Hospital:
☐ Workplace:
☐ Other Institution:

Contact tracing to be completed by: ☐ ACC ☐ Other ............

Home Visit Risk Assessment:
Completed ☐ Y ☐ N

Case Manager
Contact details provided: ☐ Y ☐ N
## Appendix C:

### DIRECTLY OBSERVED THERAPY LOG

**DIRECTLY OBSERVED THERAPY FOR THE MONTH OF:**

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<th>Patient Name:</th>
<th>Side effects /patient complaints – if present tick appropriate box and write comments – if nil tick none box</th>
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**Case manager contacted**

- Nausea
- Abdominal pain
- Headache
- Loss of appetite
- Jaundice / yellow colour
- Rash
- Fatigue
- Joint pain
- Vomiting

**UMRN:**
Appendix D:

Directly Observed Therapy Agreement – Please note – MEDTECH DOCUMENT

Active Tuberculosis (TB) Disease

Patient Name:.................................................................

Tuberculosis (TB) is a curable and preventable disease.

I have been told that I have TB and that I need to take medications for ............ months.

I understand that a TB nurse or ..........................................................will watch me take my medicine.

The nurse will come to my home or I will attend the ..................................between .............................hours so I can take my medicine.

The nurse will come to my home on the following days:

Monday ☐  Tuesday ☐  Wednesday ☐  Thursday ☐  Friday ☐
Saturday ☐  Sunday ☐

If I am required to take my medication unsupervised I will take my medication at the following time ....................... and then send a SMS message to the following phone..........................

I have been told that if I do not take my medicine my TB may get worse and I could spread the disease to my friends and family.

TB Nurse Signature.................................................................Date.................................

Patient / Guardian Signature................................................Date.................................

Interpreter Signature........................................................Date.................................

Copy for patient and Scan to notes
Appendix E:

Referral to Health Services – Pleased note – MEDTECH DOCUMENT

Surname:  
Given Name:  
Gender:  
Date of Birth:  

Address:  

Contact Numbers: (H)  (M)  

Next of Kin:  

Country of Birth:  

Date of Arrival in Australia:  

Language spoken at home:  
Interpreter required: Yes ☐ No ☐  

Diagnosis:  

Date commenced treatment:  
Expected completion date:  

Current Treatment:  

PPE Required for Home Visits: Yes ☐ No ☐  
Until:  

Relevant Medical / Surgical / Social History / Allergies:  
(Include any risks identified for home visiting)  

REQUEST FOR THE FOLLOWING ASSISTANCE:  

CONTACT TRACING:  
MEDICATION SUPPLY / COMPLIANCE:  
PATHOLOGY:  
OTHER:  

ACC Case Manager:  
ACC Dr in Charge:  

Patient’s current GP:  

**Appendix F:**

**TB Summary – please note -MEDTECH DOCUMENT**

### Contact Tracing

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<thead>
<tr>
<th>Category</th>
<th>Total no. identified</th>
<th>Total no. screened</th>
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<tbody>
<tr>
<td>Household / Close</td>
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<tr>
<td>Casual</td>
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</table>

### Household / Close:

- Total
- <5yrs

### Casual:

- Total
- <5yrs

### TB Discharge Summary

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<th>Site</th>
<th>Pulmonary</th>
<th>Extra Pulmonary</th>
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<th>Micro</th>
<th>Smear positive</th>
<th>Culture positive</th>
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<th>Drug Susceptibility known</th>
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<th>Fully sensitive</th>
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<tr>
<th>Referral to other agency</th>
<th>Y</th>
<th>N</th>
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### Date of treatment completion:

- Outcome:
  - Completed therapy
  - Lab conversion
  - Defaulted (failed to complete therapy)
  - Interrupted treatment
  - Died of TB
  - Died pre treatment
  - Died of cause other than TB
  - Transferred out

- WANIDDD completed: 

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Public Health and Ambulatory Care, North Metropolitan Health Service

Policy 2.2 WA TB Control Program