



# **Components of TB Patient Assessment**

Debbie Davila, MSN, RN

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Introduction to TB Nurse Case Management Online Course

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## ***Debbie Davila MSN, RN* has the following disclosures to make:**

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- No conflict of interests
- No relevant financial relationships with any commercial companies pertaining to this educational activity



# Objectives

- Identify components of TB Patient Assessment
  - Medical History
  - TB History
  - TB signs and symptoms
  - Co-morbidities



# Purpose of the Nurse Assessment

- Identifies the needs, preferences, and abilities of a patient
- Includes an interview with and observation of a patient and considers the symptoms and signs of the condition, the patient's verbal and nonverbal communication, the patient's medical and social history, and any other information available
- Provides the scientific basis for a complete nursing care plan

<http://medical-dictionary.thefreedictionary.com/nursing+assessment>



# Nurse Assessment

- Done Initially
- Updated and ongoing
  - Physically view patient
  - Appearance (i.e., thin, frail)
  - Assess symptoms
    - Clinically improving or worsening
    - Manage side effects/toxicities
    - Prevent adverse reactions
- Intervene rapidly
- Address issues immediately

**UPDATE**



# Assessment

- **Gather Data**

- Collect medical history from all medical providers to determine onset of symptoms

- **Hospital**

- H&P, admission notes, discharge summaries, microbiology results, lab reports, radiology reports

- **Health Dept. records**

- Prior screenings
- Prior CXR
- Treatment of LTBI or TB disease

- **PCP notes**

- Prior c/o TB symptoms
  - Allergies
  - Cough

STATE OF ILLINOIS - DEPARTMENT OF CORRECTIONS

Medical Progress Notes

Inmate's Name: [REDACTED] Inmate's Number: [REDACTED]

Date/Time	S.O.A.	PLANS
4.20.12	[REDACTED]	P.O. [REDACTED] in SIC
0830	S. Cough & difficulty breathing this am - smoke in next cell from resident during T.P.	stat
8	Chest: Insp & Exp coarse crackles	
A	Bronchitis	P.O. [REDACTED] us noted
5/24/12	[REDACTED]	Myocardial inf 5/24/12 0837
1440	S. Lat 5/18/12 Thorax 2.5 Just re-started on Theolus	P. ① Report theophylline level 5/22/12
A	Possibly not on drug long enough	Relax: us

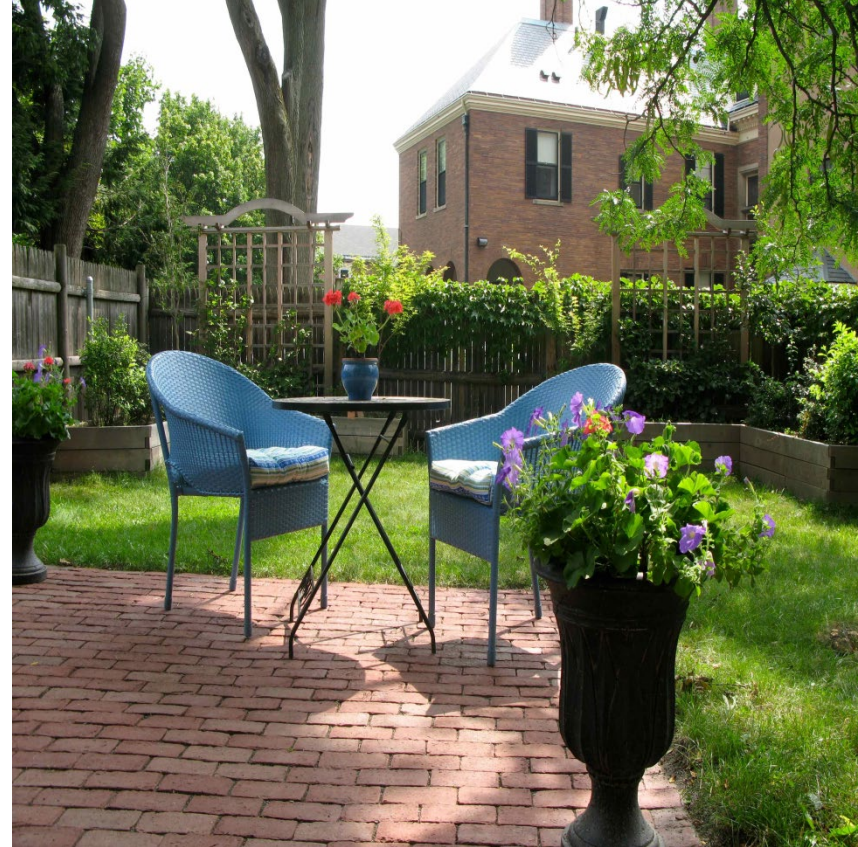
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noted 5/20/12 1440



# Confidentiality & Privacy

- Maintain confidentiality & privacy
- Ensure that the patient is comfortable
  - If done at the clinic or home
    - Can do assessment outdoors
      - Do not have to use mask
- Build rapport



# Building Rapport

- Obtaining essential information to develop a treatment plan specific to that patient
  - Medical
  - Social
- **Do Not Interrogate**
- **Do Not use judgmental tone**

## **Rapport**

[rā-pôr', rə-]

-noun

1. An expected amount of mutual cooperation and understanding established on trust between two or more parties.

If the patient feels interrogated or judged, the patient is likely to be closed and unresponsive to questions and may disregard advice and instructions

***Keep an Open Mind!!!***





# Nurse Assessment

WHAT  
HOW  
WHY  
WHOSE  
WHERE  
WHICH  
WHEN

## Texas Department of State Health Services Tuberculosis Initial Health Risk Assessment/History

SSN	Medicaid#	DOB	Sex	Phone 1
Last	First	Middle	Phone 2	
Street Address		City	County	State Zip

ATS Classification	
<input type="checkbox"/> 0-No M. TB exposure, not infected	<input type="checkbox"/> 3-M. TB disease, clinically active
<input type="checkbox"/> 1-M. TB exposure, no evidence of infection	<input type="checkbox"/> 4-Previous M. TB disease, not clinically active
<input type="checkbox"/> 2-M. TB infection, no TB disease	<input type="checkbox"/> 5-M. TB suspect, diagnosis pending

Initial Assessment	
Primary reason evaluated for TB: <input type="checkbox"/> Contact investigation <input type="checkbox"/> Immigration medical exam <input type="checkbox"/> Health care worker	
<input type="checkbox"/> Employment/administrative testing <input type="checkbox"/> Targeted testing <input type="checkbox"/> TB symptoms <input type="checkbox"/> Abnormal chest radiograph (consistent with TB) <input type="checkbox"/> Incidental lab result <input type="checkbox"/> Unknown	
Date of assessment:	Assessment conducted by:
Location of the assessment: <input type="checkbox"/> Clinic <input type="checkbox"/> Patient home <input type="checkbox"/> Hospital <input type="checkbox"/> Jail/prison	
<input type="checkbox"/> Long term care facility <input type="checkbox"/> Other, specify other:	

Pediatric TB Patients (<15 years old)	
Country of birth for primary guardian(s):	Primary guardian relationship:
Patient lived outside US for >2 months:	Countries:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Demographics	
Country of birth:	Born in the US (or born abroad to a parent who was a U.S. citizen):
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of arrival in the US:	
Races: <input type="checkbox"/> American Indian or Alaskan Native	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic or Not Latino
<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Unknown <input type="checkbox"/> Refused
<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander	
<input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse	Middle Eastern: <input type="checkbox"/> Yes <input type="checkbox"/> No
Extended race(s):	If yes, specify country(ies):

Foreign Birth or Travel	
Immigration status at first entry to the US: <input type="checkbox"/> Not applicable <input type="checkbox"/> Immigrant visa <input type="checkbox"/> Student visa <input type="checkbox"/> Employment visa	
<input type="checkbox"/> Tourist visa <input type="checkbox"/> Family/fiance visa <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee or parolee <input type="checkbox"/> Other immigration status <input type="checkbox"/> Unknown	
Specify other:	
Notice of arrival of alien with TB class: <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	Alien number:
Binational status: <input type="checkbox"/> Contacts <input type="checkbox"/> Laboratory/radiologic testing <input type="checkbox"/> Counter Border Crosser or Transnational	
<input type="checkbox"/> Not Counted Border Crosser <input type="checkbox"/> Counted by Binational Program Only/Binational	
Residence or travel in country with high prevalence of TB in last 2 years:	Country:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of travel:	Approximate length of stay/residence:
Have you traveled for 8 consecutive hours while symptomatic?	Method of transportation: <input type="checkbox"/> Flight <input type="checkbox"/> Bus <input type="checkbox"/> Train
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Ship/boat
Specify:	
Comments:	



# Demographics

Get as much information as you can about where patient can be located

- How long at this address
- Previous address
- Alternate address
- Get emergency contact information
  - Who can be contacted to locate patient
    - Unable to locate
    - In case patient moves

Texas Department of State Health Services  
**Tuberculosis Initial Health Risk Assessment/History**

SSN	Medicaid#	DOB	Sex	Phone 1	
Last	First	Middle	Phone 2		
Street Address	City	County	State	Zip	



Demographics	
Country of birth:	Born in the US (or born abroad to a parent who was a U.S. citizen): <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of arrival in the US:	
Races: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic or Not Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refused
Extended race(s):	Middle Eastern: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify country(ies):

Foreign Birth or Travel	
Immigration status at first entry to the US: <input type="checkbox"/> Not applicable <input type="checkbox"/> Immigrant visa <input type="checkbox"/> Student visa <input type="checkbox"/> Employment visa <input type="checkbox"/> Tourist visa <input type="checkbox"/> Family/fiancé visa <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee or parolee <input type="checkbox"/> Other immigration status <input type="checkbox"/> Unknown Specify other:	
Notice of arrival of alien with TB class: <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	Alien number:
Binational status: <input type="checkbox"/> Contacts <input type="checkbox"/> Laboratory/radiologic testing <input type="checkbox"/> Counter Border Crosser or Transnational <input type="checkbox"/> Not Counted Border Crosser <input type="checkbox"/> Counted by Binational Program Only/Binacional	
Residence or travel in country with high prevalence of TB in last 2 years: <input type="checkbox"/> Yes <input type="checkbox"/> No	Country:
Date of travel:	Approximate length of stay/residence:
Have you traveled for 8 consecutive hours while symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of transportation: <input type="checkbox"/> Flight <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Ship/boat Specify:
Comments:	

## Medical History

Date medical history collected: _____	
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Arthritis/gout: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Use of <input type="checkbox"/> Remicade <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel	
Autoimmune: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Cancer: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Other	Comments: _____
Specify other: _____	
Chronic malabsorption syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Chronic renal failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Corticosteroids (received equivalent of >15 mg/d Prednisone for >1 month): <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Diabetes mellitus: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	Comments: _____
Diabetes controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Comments: _____
Controlled through: <input type="checkbox"/> Pills <input type="checkbox"/> Insulin <input type="checkbox"/> Unknown	Comments: _____
GI/gastrectomy or jejunioleal bypass: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Gynecological: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Heart disease/PVD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Hypertension/CVA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Intellectual disability/developmental delay: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Leukemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Liver disease/hepatitis (risk factors HepB/C: IDU, HIV+ or birth in Asia, Africa or Amazon basin): <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Lymphoma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Mental illness(es): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> Unknown Specify other: _____ When (select all that apply): <input type="checkbox"/> Currently <input type="checkbox"/> Within past 12 months <input type="checkbox"/> Ever	Comments: _____
Neurological/seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Organ transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Post partum: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Respiratory problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Silicosis/asbestosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Skin disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
STD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Surgeries/hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Thyroid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Vision/hearing disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Other medical history: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____



# Medication List

- Assessment should also collect information about all medications your patient is taking
  - Collect information about both prescribed and over the counter medications
  - Start date
  - Dose
  - Schedule
  - Prescribing physician
  - Update as needed



Medications taking (excluding TB drugs)				
Medication	Start date	Dosage/schedule	Stop date	Prescribing Provider/Facility
(Attach additional medication list, if needed)				
Name of person taking history:				
Name of interpreter (if used):				
Barriers to compliance: <input type="checkbox"/> Yes <input type="checkbox"/> No    Comments:				
Live virus immunization in last 6 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date:				
Immunizations received: <input type="checkbox"/> FluMist (influenza) <input type="checkbox"/> MMR (measles, mumps, rubella) <input type="checkbox"/> MMRV (measles, mumps, rubella, varicella) <input type="checkbox"/> Rotavirus <input type="checkbox"/> Herpes zoster (shingles) <input type="checkbox"/> Smallpox <input type="checkbox"/> Varicella <input type="checkbox"/> Yellow fever				



# TB History

- May have to contact local health department in city/county that patient lives in
  - May have previously been screened as a contact to a case
    - Contact to an MDR case
- Determine if patient previously treated for LTBI or TB disease
- How long ?
  - **6, 9, 12, 18, 24 months**
- What drugs?
- Supporting Documentation

Last	First	Middle	DOB
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Previous History of TB and TB Infection	
Recurrence or previous diagnosis of TB or TB infection: <input type="checkbox"/> TB Disease <input type="checkbox"/> TB Infection <input type="checkbox"/> No <input type="checkbox"/> Unknown	
History: <input type="checkbox"/> Documented <input type="checkbox"/> Self report Previous TB occurred in US: <input type="checkbox"/> Yes <input type="checkbox"/> No	
State/Country:	State case number (if reported in Texas after 1993):
Most recent year of previous diagnosis:	More than one previous episode: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Start date previous TB treatment:	Start date previous TB infection treatment:
Stop date previous TB treatment:	Stop date previous TB infection treatment:
Previous TB drug regimen/Dosage (mg):	Previous TB infection drug regimen/Dosage (mg):
Previous TB treatment documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Previous TB infection treatment documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Previous TB treatment considered complete: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Previous TB infection treatment considered complete: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Previous positive IGRA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> QFT <input type="checkbox"/> T-SPOT Date:	Date of chest X-Ray: Result: <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Unknown
Previous positive TST: <input type="checkbox"/> Yes <input type="checkbox"/> No Induration: mm Date:	Abnormal result: <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-cavitory
Comments:	

History of TB Exposure	
Known exposure to active TB case: <input type="checkbox"/> Yes <input type="checkbox"/> No How many years: <input type="checkbox"/> Greater than 3 years <input type="checkbox"/> 3 years or less	
Date:	Relationship to patient:
Comments:	



# Radiology

- Gather all radiology reports
  - X-rays, CT-Scans, Pet Scans, MRI's
- Reports show cavities? Infiltrates? Scarring?
- Films for comparison?



# TB Symptoms

Symptoms			
TB symptoms screening performed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient is symptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Date of TB symptoms assessment: _____			
<b>Symptom</b>	<b>Onset date</b>	<b>Symptom</b>	<b>Onset date</b>
Chest pain: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Weight loss (>10%): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Shortness of breath: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Frequent urination, bloody urine or flank pain: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Fever/chills: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Headache, decreased level of consciousness or neck stiffness: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Night sweats: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Swelling of joint/vertebra: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Cough (persistent x3 weeks): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Enlarged cervical lymph nodes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Productive cough: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Swelling of lymph nodes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Hemoptysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Eye pain or blurry vision: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Fatigue: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Pain swelling in other locations: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Loss of appetite: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable		Other: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Specify other: _____	
Source of symptom information: <input type="checkbox"/> Patient interview <input type="checkbox"/> Relative/friend <input type="checkbox"/> Medical record <input type="checkbox"/> Other Specify other: _____		Respiratory isolation indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No Date placed in respiratory isolation: _____	
Notes: _____			



# Gathering Information

- Gather chronological history of presenting signs and symptoms
  - Most patients will have difficulty remembering when symptoms began
- Refer back to important dates and times
  - Christmas, Thanksgiving, Birthday, Birth of a Baby

*These cues may prompt patient memory and give us more accurate dates as when symptoms began*

- *Important in determining infectious period and conducting contact investigations*



SOCIAL HISTORY	+/-	COMMENTS	
Tobacco use		_____ pks / day _____ years of use	<b>Education:</b> <input type="checkbox"/> Elem. Sch. <input type="checkbox"/> Jr. Hi. <input type="checkbox"/> Hi. Sch. <input type="checkbox"/> College
Alcohol		Current # alcoholic drinks per week	<b>Housing:</b> <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Inner city resident <input type="checkbox"/> Binational (US-Mexico) <input type="checkbox"/> Low Income <input type="checkbox"/> Live Alone <input type="checkbox"/> Live With Others
HIV/AIDS Risk			<b>Long-Term Care:</b> <input type="checkbox"/> Nsg. Home <input type="checkbox"/> Hosp.-Based <input type="checkbox"/> Residential <input type="checkbox"/> Mental Health Res. <input type="checkbox"/> Alcohol/Drug Treatment <input type="checkbox"/> Other
Drug Abuse		____ Non-injecting Drugs? ____ Injecting Drugs?	<b>Incarceration:</b> <input type="checkbox"/> Fed. Prison <input type="checkbox"/> State Prison <input type="checkbox"/> Local Jail <input type="checkbox"/> ICE <input type="checkbox"/> Juvenile Correctional <input type="checkbox"/> Other Corr. <input type="checkbox"/> Unknown. Incarceration date:
Malnutrition/Diet low in sources of B <sub>6</sub>			<b>Occupation:</b> <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional <input type="checkbox"/> Migrant/Seasonal <input type="checkbox"/> Other Occupation <input type="checkbox"/> Not employed in past 24 mo <input type="checkbox"/> Student <input type="checkbox"/> Child <input type="checkbox"/> Homemaker <input type="checkbox"/> Retiree <input type="checkbox"/> Institutionalized <input type="checkbox"/> Unk
Foreign Birth		If foreign-born, Country Mo/Yr Entry US	<b>If Pediatric TB Case/Suspect (&lt; 15 years old)</b> Country of birth for primary guardian(s) Patient lived outside US for > 3 months <input type="checkbox"/> Yes. <input type="checkbox"/> No If yes, country
Foreign Travel or Residence			<b>Locating Info:</b>
Barriers to Compliance			
<b>ADDITIONAL COMMENTS</b>			
Signature of person taking history		Signature of interpreter (if used)	

+ = If History Is Positive      - = If History Is Negative

TB-202 Tuberculosis Health Assessment/History – 01/08



# Summary

- The TB Case Manager should conduct a face-to-face interview with the patient in efforts to develop a plan of care
- Assessment is ongoing and dynamic and should be continuous throughout the course of the patient's treatment
- The purpose for assessment to development of a treatment plan with a goal for successful completion of treatment





THANK YOU  
for all you do!

# It's time to invest in nurses and healthcare workers

Nurses and health workers play a critical role in tuberculosis prevention and care. Enabling them to work to their full potential improves healthcare for all.

