Department of Health Government of Nunavut	Medical Directives and Delegation Tuberculosis (TB) Programming	
TITLE:	**SECTION:**	**POLICY NUMBER:**
LPN Medical Directive: TB program	Nursing Practice	07-028-00
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APPLIES TO:		
All Department of Health staff		

1. **BACKGROUND:**

The Department of Health, Professional Practice Unit acts as the regulator for Licensed Practical Nurses (LPN) in Nunavut, as authorized through legislation. This unit is responsible for setting the standards and scope of practice for LPNs working in the territory. The Department of Health has adopted the Scope of Practice and Practice Standards from the College of Licensed Practical Nurses of Alberta, which provides the foundation for LPN practice in Nunavut. The training received through Canadian LPN educational programs, coupled with the LPN practice standards, prepare LPNs to carry out the functions required to administer communicable disease programming in the territory.

This policy provides an authorizing mechanism in which LPNs may perform duties, within the context of the Tuberculosis (TB) program, which are sanctioned to another regulated health care professional (e.g. physician, nurse practitioner, public health nurse (PHN), TB nurse (TBN) and pharmacist) without a direct order from that health care professional with the purpose of supporting safe and efficient delivery of local TB programs. LPNs are not to be assigned to work independently in TB programs; rather, LPNs are to be assigned to work collaboratively with a local registered nurse (RN) trained in TB and public health programs (i.e. PHNs or TBNs).

The LPN will be operationally supervised by the SCHP; however, overall TB program leadership is the responsibility of the PHN/TBN. The PHN/TBN and LPN work collaboratively with the RCDC team to provide timely screening and control of TB in the territory. LPNs have a role in supporting patients on DOT, ensuring safe administration and monitoring of patients on TB program while working collaboratively with the DOT worker and the PHN/TBN and implementing delegated tasks from the PHN/TB in contact investigations.

2. **MEDICAL DIRECTIVE:**

2.1 SCREENING AND TESTING:

2.1.1 LPNs may perform tuberculin skin test (TST) without a direct Physician (MD) or Nurse Practitioner (NP) order for children over 5 years of age, as directed by the patient screening criteria TB Testing Flowcharts described in the *TB Manual*.
LPNs are authorized to perform tuberculin skin tests only after they have received TST training and meet the required TST competencies.

2.1.2 LPNS, working in the TB program, may initiate sputum test requisitions without a direct MD or NP order for the purpose of screening, diagnostic testing, or monitoring as outlined in the *TB Manual*.

2.1.3 Patients meeting the criteria outlined in the *TB Manual* for needing a chest x-ray or blood work, for the purpose of screening, diagnostic testing or monitoring, will be

referred to the PHN/TBN for initiation of the x-ray and blood work requisitions.
NOTE: When a PHN/TBN is not available in the community, the LPN may consult the CHN/SCHP for the required test requisitions; however, the CHN/SCHP must have completed the GN TB Training program.

2.1.4 LPNs working in the TB program may perform clinical procedures related to the collection of sputum specimens as directed by the *TB Manual* and in accordance with relevant GN Lab Manuals and GN policies and procedures.

2.2 DIAGNOSIS:

2.2.1 LPNs are authorized to read a TST result after receiving TST training and meeting the required TST competencies. All abnormal results are to be reported immediately to the PHN/TBN or SCHP and Regional Communicable Disease Coordinator (RCDC), as per established local TB program protocols.

2.2.2 All abnormal test results are to be reported to the PHN/TBN, RCDC, and/or TB MD, as per established local TB program protocols.

2.2.3 LPNs are not authorized to make medical diagnoses. Once a diagnosis is confirmed, the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) will review the diagnosis with the patient and provide support and follow-up as per established local TB program protocols and per the Nunavut TB Manual.

2.3 TREATMENT:

2.3.1 It is within the LPN scope of practice to administer TB drug therapy, once an order has been received from the TB MD. The LPN is not authorized to initiate drug therapy without such direct order.

3. LEGISLATIVE AND REGULATORY SUPPORTING DOCUMENTS:

3.1 Licensed Practical Nurses Act
3.2 Standards of practice
3.3 Scope of practice document
3.4 CNA code of ethics
3.5 Medical professions act

4. AUTHORIZED IMPLEMENTERS:

4.1 LPNs who are assigned to the TB program and possesses the knowledge, skill and judgment to do so. The LPN is required to demonstrate competency to implement this medical directive through the standard TB orientation, training and certification process.

4.2 Sub delegation is not permitted to another regulated or non-regulated health care professional (i.e. to DOT workers in communities).

5. PRINCIPLES:

5.1 LPNs are expected to practice within their own level of competence and seek guidance from PHN/TBN, their supervisor (SCHP), RCDC, CHN, physician and/or NP as needed. Decision making model is included in Appendix A to assist with the decision to perform additional skills and delegated functions. Guidelines set out in the TB manual must be followed.

5.2 As described in the *Licensed Practical Nurses Act*, LPNs are authorized to provide practical nursing services:

(a) Independently, for patients considered stable with predictable outcomes (i.e. Routine screening (school screening/employment screening/walk-ins and low risk contacts); and

(b) Under the guidance or direction of a registered nurse (ie, PHN/TBN, CHN, SCHP, nurse practitioner, medical practitioner or other health care professional) authorized to provide such guidance or direction, for patients considered unstable with unpredictable outcomes.

5.3 In the community health centre settings, the LPN works under the supervision of the SCHP, with support and guidance on the TB program from the PHN/TBN; while the regional TB team provides the specific TB program expertise and guidance to both the LPN and the PHN/TBN. All health center staff including the PHNs, TBNs and LPN report to the SCHP.

5.4 During instances when a PHN/TBN is not available in the community for consultation, the LPN will consult a CHN/SCHP who has completed the GN TB Training program.

5.5 Guidelines do not replace clinical judgement. Management decisions regarding patient care must be individualized.

6. **CONTRAINDICATIONS:**

Consult the PH/TBN, MD, NP, SCHP, or RCDC before enacting this medical directive when any of the following conditions exist:

6.1 The LPN cannot confirm all conditions of this directive and the *TB Manual* have been met.

6.2 The patient's history or physical exam does not match the criteria described in the *TB Manual* for specific investigations, interventions and/or treatment.

6.3 The patient has contraindication to the recommended test, treatment or clinical procedure, as outlined in the *TB Manual*.

6.4 The *TB Manual* recommends physician consultation first.

7. **DEFINITION:**

Practical Nursing Services: means the application of practical nursing theory in the

(a) Assessment of patients;
(b) Collaboration in the development of a nursing plan of care for a patient;
(c) Implementation of a nursing plan of care for a patient; and
(d) Ongoing evaluation of a patient

8. **PROCEDURE:**

Patient Assessment

8.1 For stable, low risk patients, the LPN, as per legislative scope of practice, conducts comprehensive patient history and physical, as per the screening and monitoring guidelines in the *TB Manual*.

(a) The LPN references the *TB Manual* to determine if the conditions of this directive have been met (e.g. the patient's presenting condition meets the screening criteria in the *TB Manual*). The Algorithm in Appendix A provides guidance to the LPN when determining if the medical directive is appropriate to enact.

(b) If the LPN determines the conditions have not been met, or is unsure if the patient's history and physical meets the criteria for screening, diagnostic testing, or monitoring or for complex care then the PHN/TBN, SCHP, RCDC, MD or NP shall be consulted, as per established local TB program protocols.

TST, Lab and Diagnostic Imaging

8.2 *Tuberculin Skin Test*: TST competencies (planting and reading) must be met per NU TB program standards.

(a) When directed by the guidelines in the *TB Manual*, LPNs may perform a tuberculin skin test (TST) without a direct MD or NP order for patients over 5 years of age. PHN/TBN shall be promptly notified for all patients under the age of 5 years of age who require a TST. The LPN is authorized to read TST results in patients of all ages (including children under 5 years of age), as per their scope of practice and training.

(b) The LPN is to promptly report to the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) all cases where induration is noted – regardless of size. The PHN/TBN will assess the TST result, document findings, and provide guidance to the LPN on reporting and next steps – as per *TB Manual*.

8.3 *Sputum Specimens*:

(a) When directed by the guidelines in the *TB Manual*, LPNs may initiate a requisition for sputum specimens without a direct MD or NP order for patients of all ages.

(b) In conditions where sputum specimens are warranted, the LPN may collect and prepare the specimens as per the procedures outlined in the *TB Manual* and relevant GN Lab Manuals as well as provide all patient collection instructions.

(c) For symptomatic patients, the LPN can collect sputum specimens using airborne precautions and collect specimens for GeneXpert under the advisement of the PHN/TBN and RCDC.

8.4 Chest X-rays:

(a) When a patient requires a chest x-ray, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the x-ray requisition in accordance with the *TB Manual* and *CHN Manual* policy: *CHN Initiating X-Ray Requests.*

(b) The LPN will arrange the x-ray appointment and follow up to confirm the test is completed.

8.5 *Blood Work*:

(a) When a patient requires blood work, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the blood work requisition in accordance with the TB Manual and CHN Manual policy: *Requisitioning Laboratory Studies.*

(b) The LPN will arrange for blood work to be drawn and follow up to confirm test completed. Note: LPNs who completed competency training for phlebotomy can perform blood draws.

8.6 Follow up of Test Results:

(a) The LPN is responsible for receiving and reviewing all lab and diagnostic imaging reports which were generated within the TB program.

(b) The PHN/TBN (or CHN/SCHP) who initiated the lab and x-ray requisitions are also required to review the reports and ensure appropriate follow up care is instituted, as per *TB manual* baseline assessment and routine monitoring guidelines as well as the *CHN Manual* policies: *Acknowledgement of Diagnostic Test Results* and *Follow-up of Abnormal Diagnostic Test results.* The LPN will consult with the ordering PHN/TBN (or CHN/SCHP) once the report is received to ensure each report has been reviewed and direction is provided to the LPN on next steps.

(c) It is not within the role of the LPN to interpret lab and DI results; therefore, all abnormal test results are to be reported promptly to PHN/TBN (or CHN/SCHP when the PHN/TBN is not available) who will report abnormalities to RCDC, as per established local TB program protocols.

Treatment:

8.7 LPN requires a direct TB MD order for the administration of medications, which in most cases will be in the form of a physician prescription. The LPN shall refer to the textbook *Clinical Nursing Skills and Techniques* (Perry and Potter) for instruction on basic nursing medication administration procedures as well as the *Nunavut TB Manual* for guidelines on Direct Observed Therapy.

Note: For medications to be administered by the LPN via Intravenous, intramuscular, intradermal or subcutaneous routes, the LPN must have either (1) completed a post-graduate

medication administration course if the LPN graduated prior to 2001 or (2) have graduated from a Canadian LPN educational program after 2001, whereby the competency training for these medication administration routes were considered part of the basic educational curriculum.

8.8 LPNs are authorized to verify blister packs cross referenced with the current prescription for the DOT workers. It is a shared responsibility between the LPN and PHN/TBN to review all incoming blister packs (BBP) from pharmacy against the prescription orders and verify BBPs are correct by initialling and dating the back of the blister packs, as per Nunavut TB program protocols and outlined in the *Nunavut TB Manual.*

Documentation:

8.9 All patient encounters are to be documented in the patient's chart, using the appropriate forms as described in the *TB Manual (*e.g. DOT medication records and TB Assessment Form).

8.10 All TB documentation is to be submitted to RCDC in accordance with the procedures described in the *TB Manual.*

Contact Investigations and Public Health Follow up

8.11 Contact Investigations and public health follow up are advanced practice nursing skills and the LPN role in contact investigations are to follow up with tasks delegated by a PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community) trained in public health contact investigations.

8.12 The LPN can be delegated tasks for following up in contact investigations that include assessing patients who have been identified as high risk by the PHN/TBN and following protocols outlined in the *TB Manual.*

8.13 Patient risk assessments and contact investigation including public health follow up must be overseen by the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) and in collaboration with RCDC as outline in the *NU TB Manual.*

School Screening

8.14 LPNs will work in collaboration with the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) in school screening programs. Follow up actions from the screening initiative may be delegated to the LPN by the PHN/TBN; except for collating the data from the school screening program, which will remain the PHN/TBN responsibility.

9. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

APPENDIX A: Algorithm for Assessing Appropriateness of the Medical Directive
APPENDIX B: Decision-Making Model Performing Additional Functions & Transferred Functions
Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut TB Manual
Community Health Nursing Manual: Documentation Standards Policy
Community Health Nursing Manual: Transferred Functions
Community Health Nursing Manual: CHN Initiating X-Ray Requests
Community Health Nursing Manual: Requisitioning *Laboratory Studies*
Nunavut Formulary
Licensed Practical Nurses Act

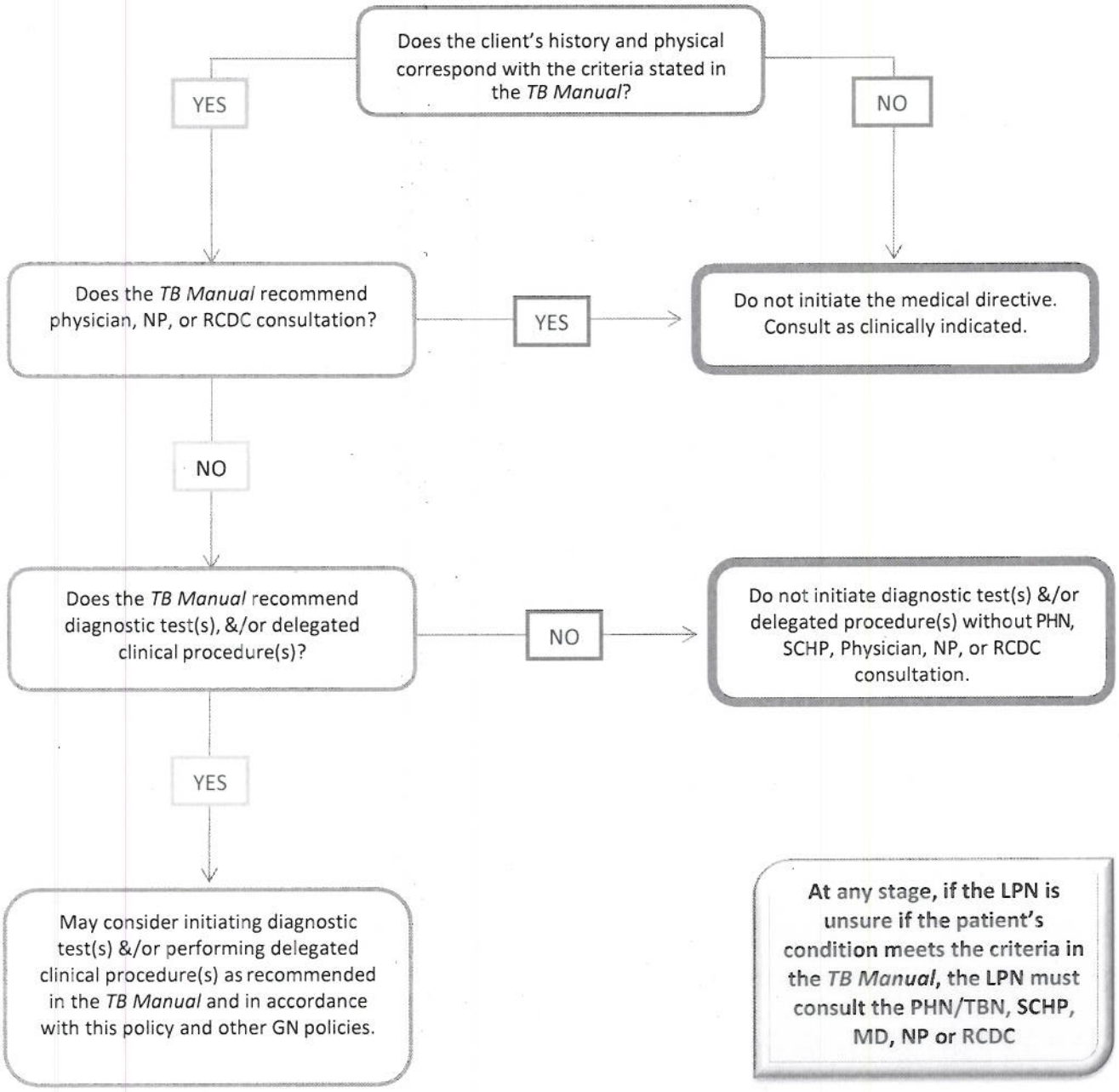
10. **REFERENCES:**

Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut (2010). *Community Health Nursing Standards, Policies and Guidelines*
Government of Nunavut. *Tuberculosis Manual*. (2017)
Licensed Practical Nurses Act

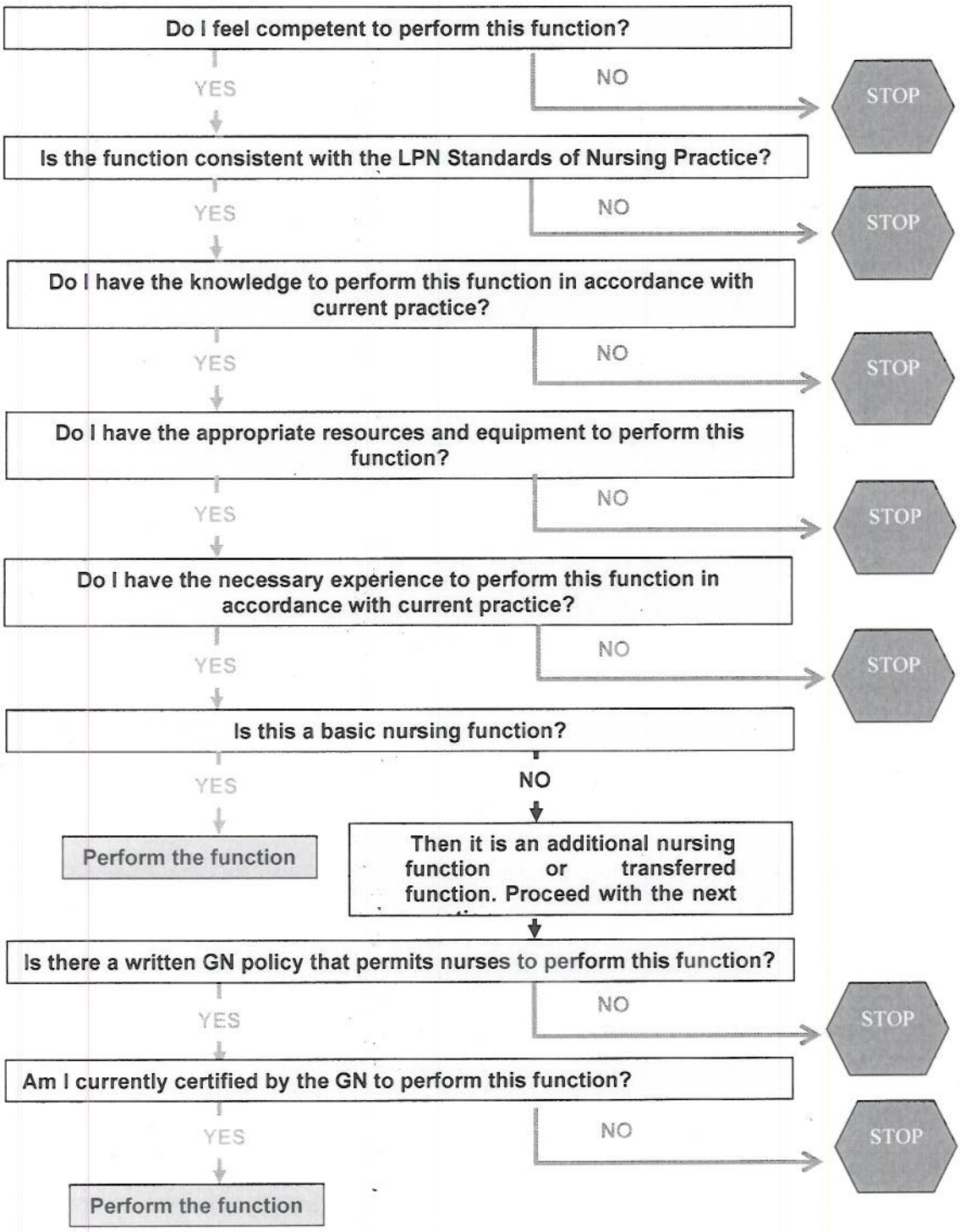
11. **APPROVALS:**

Approved By:	Date: 26-October - 2017
Dr. Kim Barker, Chief Medical Officer of Health – Department of Health	
Approved By:	Date: 26-October - 2017
Jennifer Berry, Chief Nursing Officer	

APPENDIX A: ALGORITHM FOR ASSESSING APPROPRIATENESS OF THE MEDICAL DIRECTIVE



APPENDIX B: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



Adapted from RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9