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|  | **Regional TB Audit Paediatric Case Form (v1)** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **1. Patient details** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Date form completed: 25/08/2017 | | | | | | | | Case manager: *«CaseManager»* | | | | | | | | | | | | | | | |  |
|  | Clinic: *«Hospital»* | | | | | | | | PHE Centre: *«HPU»* | | | | | | | | | | | | | | | |  |
|  | ETS no: *«Id»* | | | | | | | | Date of notification: *«CaseReportDate»* | | | | | | | | | | Age: *«Age»* | | | | | |  |
|  | Sex: *«Sex»* | | | | | | | | Ethnic group: *«EthnicGroup»* | | | | | | | | | | UK born: *«UKBorn»* | | | | | |  |
|  | Country of birth: *«BirthCountry»* | | | | | | | | Entered UK (year): *«UKEntryYear»* | | | | | | | | | | If UK born, hospital of birth:  Non UK hospital of birth | | | | | |  |
|  | Date of symptom onset: *«SymptomOnset»* | | | | | | | | Date of first contact with health service while symptomatic, if known: 24/08/2017 | | | | | | | | | | Referred to TB service by: | | | | | |  |
|  | Date 1st seen by team initiating treatment: 23/08/2017 | | | | | | | | Date 1st seen by TB nurse: 22/08/2017 | | | | | | | | | | Date treatment commenced: *«StartOfTreatment»* | | | | | |  |
|  | **2. Clinical details** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Site of disease: All over the place | | | | | | | | | | Pulmonary infection: *«SitePulmonary»* | | | | | | | | | | | | | |  |
|  | Previous BCG: *«BcgVaccinated»* | | | | | | | | | | Was the child eligible for BCG vaccination in the UK? | | | | | | | | | | | | | |  |
|  | Spontaneous sputum smear status: | | | | | | | | | | Other respiratory samples: | | | | | | | | | | Smear status (other than spontaneous sputum): Not spontaneous | | | |  |
|  | CXR / chest CT at diagnosis: | | | | | | | | | | Culture at any site: | | | | | | | | | | Culture sensitivities: | | | |  |
|  | PCR resistance done: | | | | | | | | | | Histological diagnosis: | | | | | | | | | | Empirical/clinical diagnosis: | | | |  |
|  | HIV test offered: «HIVTesting» | | | | | | | | | | Outcome of HIV test: | | | | | | | | | | Year of test: 1911 | | | |  |
|  | **3. Risk factors requiring Enhanced Case Management** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Standardized Risk Assessment completed: | | | | | | | | | | | Enhanced Case Management:  *(See guidance notes)* | | | | | | | | | | | | |  |
|  | Previous TB diagnosis: *«PreviouslyDiagnosed»* | | | | | | | | | | | Unstable housing: *«Homeless»* | | | | | | | | | Mental health: | | | |  |
|  | Clinically complex: | | | | | | | | | | | MDR: | | | | | | | | | Loaded onto BTS MDR website: | | | |  |
|  | Non-adherence: | | | | | | | | | | | Gipsy / traveller: | | | | | | | | | Hard to reach group: | | | |  |
|  | Language barrier: | | | | | | | | | | | Child/adult protection issues: | | | | | | | | | Patient with no recourse to public funds: | | | |  |
|  | Other: Details Shmetails | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Was the child previously identified as a contact of one or more cases of pulmonary/laryngeal TB? | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | If yes: | Did any case have a positive sputum smear? | | | | | | | | | | | | | | Was the child a household contact of any case? | | | | | | | | |  |
|  |  | Was the child screened as a contact? | | | | | | | | | | | | | | Did any case have drug resistant TB? | | | | | | | | |  |
|  |  | Details of drug resistance, if any: MDR details  Let's see what happens  If I add several  lines of text | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Was the child previously diagnosed with LTBI? | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | If yes: | Was the child offered LTBI treatment? | | | | | | | | | | | | | Was there non-compliance or refusal of LTBI treatment? | | | | | | | | | |  |
|  | Was the child eligible for new entrant screening? | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | If yes: | Was the child invited for new entrant screening? | | | | | | | | | | | | | Did the child attend new entrant screening? | | | | | | | | | |  |
|  | Was an attempt made to obtain a specimen for microbiological analysis? | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | If no, please give details: Even more details  etc | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **4. Treatment plan** | | | | | | | | | | |  | | | | | | | | |  | | | |  |
|  | Self administered treatment:  *(Including treatment administered by parent/carer/family member)* | | | | | | | | | | | | | | | | | | | | Treatment as inpatient: | | | |  |
|  | Weekly supervised: | | | | | | | | | | | Tablet count: | | | | | | | | | Urine test: | | | |  |
|  | DOT required: | | | | | | | | | | | DOT from start of treatment: | | | | | | | | | % doses observed: | | | |  |
|  | DOT offered: | | | | | | | | | | | If not from Rx start, DOT started: 20/05/2017 | | | | | | | | | % doses self-administered: 10 | | | |  |
|  | DOT refused: | | | | | | | | | | | No. of weeks on DOT: 20 | | | | | | | | | % doses missed: 30 | | | |  |
|  | **5. Treatment outcome at time of cohort** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Post-mortem diagnosis: «PostMortemDiagnosis» | | | | | | | | | | | Completed treatment: | | | | | | | | | | | | |  |
|  | **If treatment not completed:** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | If still on TB medications: no. of completed weeks treatment 10 and total planned treatment period equals  (time from treatment start date) | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Died prior to completion of treatment: | | | | | | | Planned exit from UK (with full or partial meds): | | | | | | | | | | | | Transferred to another TB service within UK: | | | | |  |
|  | Lost to follow up: | | | | | | | If lost to FU, actions taken: What they did when  lost to FU | | | | | | | | | | | | | | | | |  |
|  | Other: Don't know what to put here | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **6. Contact screening - DO NOT COMPLETE if this case has been identified through contact tracing, and contact tracing details are a duplication of data from the index case. \*Please complete separate Paediatric Contacts Form for all contacts aged <17yrs. (Complete contacts table below for all contacts exactly as before – the separate contacts form only captures the additional information needed on paediatric contacts.)** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | Contacts screened by clinic | | | | | | | Contacts referred elsewhere | | | | | | | | | **Notes from ETS:** | | |  |
|  |  | | | | | Adults | | | | Children (<16yrs)\* | | | Adults | | | | | Children (<16yrs)\* | | | |  | | |  |
|  | Identified: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | | *«Comments»* | | |  |
|  | Assessment completed: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | Still under investigation: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | No. with active disease: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | No. with LTBI: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | No. started LTBI Rx: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | No. completed LTBI treatment: | | |  | | 1 | | | | 1 | | | 1 | | | | | 1 | | | |  | | |  |
|  | Discontinued LTBI treatment due to: | | | Adverse FX: | | 1 | | | | 11 | | |  | | | | | 1 | | | |  | | |  |
|  |  | | | Death: | | 1 | | | | 1 | | | 11 | | | | |  | | | |  | | |  |
|  |  | | | Moved: | | 1 | | | | 11 | | | 1 | | | | | 1 | | | |  | | |  |
|  |  | | | Refused: | | 1 | | | | 11 | | | 1 | | | | | 1 | | | |  | | |  |
|  | If any contact was a previous TB case (adequately treated), record ETS numbers: lfdsjkals;dfsa  sadfsdfsdfsa  fdsfsadf  fsfdsa  fds | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Is the patient part of a cluster?  (if yes, ) | | | | | | | | | | | Cluster ID: sdfadsjfksadl;fjasd  sdfsadfsa | | | | | | | | |  | | | |  |
|  | HPU incident meeting held?  (if yes, ) | | | | | | | | | | | HPZone No: ksldjfsadkl;fsakd;fksad  sdfklsadjflkdsa;fasd | | | | | | | | |  | | | |  |
|  | **Space for additional notes:** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | Police investigating the Manchester Arena bomb attack have stopped sharing information with the US after leaks to the media, the BBC understands.  UK officials were outraged when photos appearing to show debris from the attack appeared in the New York Times.  It came after the name of bomber Salman Abedi was leaked to US media just hours after the attack, which killed 22 - including children - and injured 64.  Theresa May is to raise concerns with Donald Trump at a Nato meeting later.  Greater Manchester Police hopes to resume normal intelligence relationships - a two-way flow of information - soon but is currently "furious", the BBC understands.  The force - which is leading the investigation on the ground - gives its information to National Counter-Terrorism, which then shares it across government and - because of the Five Eyes intelligence sharing agreement - with the US, Australia, Canada and New Zealand.  In total eight men are now in custody following the attack, carried out by Manchester-born Abedi, a 22-year-old from a family of Libyan origin.  It has also emerged two people who had known Abedi at college made separate calls to a hotline to warn the police about his extremist views.  Pictures of debris  Home Secretary Amber Rudd had said she was "irritated" by the disclosure of Abedi's identity against the UK's wishes and had warned Washington "it should not happen again".  However, the pictures of debris - which appear to show bloodstained fragments from the bomb and the backpack used to conceal it - were subsequently leaked to the New York Times, prompting an angry response from within Whitehall and from UK police chiefs. | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | **Guidance notes for completion of TB cohort review presentation form** | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | * This is an electronic form for completion by case managers. * Using an electronic form allows us to instantly analyse the data returned to us. This form should work with any version of Microsoft Word from version 2003 onwards. If you have a very old (>10 years) version of Word and are unable to complete the form, please let us know. * To enter data, simply enter your information in the areas marked in the grey areas. * You can enter four types of data: dates, numbers, free text, a selection from a drop down list, or a tick in a box. If you are not sure what to enter at any point, click on the grey area and press the F1 key – a box will pop up with a reminder. * You can use the mouse to move between questions. You can also use the Tab and arrow keys. * Arrows indicate linked questions. If you have answered one question a particular way, you may need to provide additional information, and this will be indicated by an arrow. * Once you have entered your data, save the form as you would normally save a Word file (tip: Ctrl-S, followed by Alt-F4 is a useful shortcut). * Please, as far as you are able, complete the electronic form and return it securely to the cohort coordinator, by the deadline given. * Please make sure to order case notes well in advance to allow enough time for completing the form. * Please advise the cohort coordinator as soon as possible of any likely problems with returning completed forms in time. * If there is any information you wish to record but cannot find a suitable place for, please record it in the additional notes section. * Some fields should already be completed with ETS case data to minimise the amount of information to be collected. If you notice that any of this information is incorrect, then please inform one of the PHE representatives at the review. * All forms should be stored securely with due regard for patient confidentiality, using an encrypted USB disk to bring the forms to the cohort review. * Forms should not be sent by unencrypted email or left on non-NHS computers after use. * Forms should only be sent (i) from nhs.net account to nhs.net account, (ii) by another form of encrypted email or (iii) in a directly encrypted format (using software such as [dscrypt](http://www.softpedia.com/get/Security/Encrypting/dsCrypt.shtml)). * Key definitions used in the form:   + “Date first seen by TB nurse” should be the date first seen by any TB nurse, regardless of location (hospital or community based).   + “Enhanced case management” (ECM) commences from suspicion of disease and includes directly observed treatment (DOT) in conjunction with a package of supportive care tailored to patients' needs and should be available to patients in both high and low incidence areas. All socially and/or clinically complex TB patients must be able to access ECM and should be referred to specialist centres where necessary.   + “Clinically complex” cases are those with one or more of: renal impairment, HIV coinfection, diabetes, drug resistance, severe side effects.   + “Hard-to-reach” groups at risk of TB include children, young people and adults whose social circumstances or lifestyle, or those of their parents or carers, make it difficult to:     - recognise the clinical onset of tuberculosis     - access diagnostic and treatment services     - self-administer treatment (or, in the case of children and young people, have treatment administered by a parent or carer)     - attend regular appointments for clinical follow-up.   + “Lost to follow up” describes a patient on self-administered treatment who cannot be contacted within 10 working days of a missed appointment, or for someone on DOT, cannot be contacted within 10 working days of a missed DOT appointment. This does not include those patients who have a planned discharge out of country.   + For contact screening purposes, a child is defined as a person aged less than 16 years of age. * Enhanced Case Management:   + Select ‘None’ if case received Standard Case Management. Typically these patients would have:     - no language barriers     - no stigma related issues     - the ability to take their own medications - physically able and no CNS impairment     - no housing or finance issues impacting on their treatment     - no factors affected by their age     - no contact tracing requirements / all adults in the same household     - positive rifampicin or Isoscreen at reviews     - correct tablet count at reviews.   Enhanced Case Management is defined as care which is “co-ordinated by the named case manager working alongside a specialist multidisciplinary TB team  able to provide expert clinical and psychosocial care and to engage effectively with the client group in the community”.   * + Select ‘1’ if case meets the criteria for Level 1 Enhanced Case Management:     - fortnightly visits     - requires interpreter for first visit but has some understanding of English     - elderly to monitor for side effects     - children to ensure concordance of child and parent / adult     - requires medications from GP / community pharmacy due to blister packs - to check correct doses     - requires signposting for benefits / financial issues     - contact tracing from various areas / setting i.e. patient out of area, workplace, community group settings     - difficult access. Eg no front door bell, >1 address, problems getting time off work/college, those who refuse home visits etc.     - stigma that can be dealt with through 1:1 education     - complex meds / co-infection meds i.e. TB meds given when on ARV's already     - disease site eg smear positive pulmonary or central nervous system disease.   + Select ‘2’ if case meets the criteria for Level 2 Enhanced Case Management:     - weekly visits     - having complex side effects so requires regular LFT etc.     - needs more regular prompting with medications - blister packs / Isoscreen regularly / tablet counts     - financial difficulties prevent treatment compliance i.e. attending clinic apt / poor nutrition / heating     - stigma that requires more formal education i.e. community centres / work places     - transmission within contacts / children who are contacts     - language barriers throughout treatment requiring easily accessible interpreter either face to face or phone interpretation at each visit     - alcohol and/or drug dependency without LFT derangement     - difficult to reach - DNA at clinics / home for reviews     - HIV and TB co-infection starting both ARV and TB meds at the same time     - single drug resistance.   + Select ‘3’ if case meets the criteria for Level 3 Enhanced Case Management:     - difficult language to access throughout treatment     - DOT     - homelessness or housing issues due to finance     - illegal immigrants - difficult to access funding / benefits     - drug resistance     - more than one drug resistance     - needs reintroduction of medications i.e. deranged LFT's     - complex contact tracing - transmission within children / vulnerable groups / extensive transmission     - involvement of PHE for workplace / community screening     - potentially dangerous patients where more than one person is required to visit     - children who DNA and social service involvement is required     - difficult to reach - consistent DNA at clinics / home for reviews. | | | | | | | | | | | | | | | | | | | | | | | |  |
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