Policy Directive

NSW HEALTH

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Tuberculosis - Principles for Management of people with Tuberculosis in NSW

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Functional Sub group Clinical/ Patient Services - Infectious diseases
Clinical/ Patient Services - Medical Treatment
Population Health - Communicable Diseases

Summary Outlines services available and action to be taken in the treatment of TB patients with an expanded section on admission to isolation and a new section on discharge planning.

Replaces Doc. No. Tuberculosis - Management of Person [PD2005_141]

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Health System Support Division, Community Health Centres, Public Hospitals

Audience Administration, clinical, allied health, nursing, emergency departments

Distributed to Public Health System, Community Health Centres, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Private Hospitals and Day Procedure Centres

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Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

TUBERCULOSIS - PRINCIPLES FOR MANAGEMENT OF PEOPLE WITH TUBERCULOSIS IN NSW

This Policy Directive supersedes Policy Directive PD2005_141 *Management of Persons with Tuberculosis*

This Policy is to be read in conjunction with:

GL2005_030 *Role of TB Prevention & Control Services–Chest Clinics in NSW*
PD2008_018 *Tuberculosis Related Services - Charging*
PD2005_071 *Chemotherapy*
PD2005_072 *Preventive Therapy*
PD2007_036 *Infection Control Policy*
NSW Health Facility Guidelines 11 October 2004

Tuberculosis (TB) continues to be a disease of public health significance in Australia. Each year there are approximately 1000 cases of active TB in Australia and approximately 45% of these cases live in NSW.

The aim of the NSW Department of Health TB Program is to minimise the burden of TB and to prevent the transmission of TB through early detection and appropriate treatment of people with TB.

Patients with suspected TB should be referred for management in an Area Health Service (AHS) TB Prevention and Control Service - Chest Clinic.

TB Services

There is a network of TB Service providers across the NSW public health system where the following services are provided:

- Comprehensive diagnosis, management, care and treatment of active tuberculosis.
- Screening and investigations for people at increased risk of TB.
- Preventive therapy for people with TB infection.
- Education and counselling for patients with, or at risk of TB, and
- Professional development on all aspects of TB prevention and control for AHS staff.

All anti-tuberculosis treatment must be supervised by a physician with specialist training in tuberculosis management to ensure that high quality treatment and clinical care is provided.

Treatment for people with active TB is to be administered by directly observed therapy, which means that a health professional observes the person take their medication and documents the treatment administered. Supervised TB treatment is provided to minimise the development of drug resistance or reactivation of disease related to non-compliance or inappropriate TB treatment.

Fees

All services related to the screening, care and management of people with TB are available at no charge to patients within the NSW Public Health system for tuberculosis and tuberculosis related investigations, care and treatment – no Medicare card is required to access any tuberculosis related service.

Notifications

Doctors, hospitals and laboratories must notify their local public health unit of cases of active TB to facilitate immediate investigation and public health action where relevant.

Infection Control

Every health care facility that provides services to persons with suspected or confirmed TB disease should have an infection control plan that incorporates administrative and environmental controls and a respiratory protection program as outlined in the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005 MMWR Recommendations and Reports. December 30, 2005/Vol.54/No.RR –17 and in accordance with NSW Health Policy Directive PD2007_036 *Infection Control Policy*. These controls are necessary to minimise the risk of transmission of the disease within health care facilities.

Admission to hospital

It is recommended patients diagnosed or suspected of having active tuberculosis be admitted to hospital if:

- there is a clinical need, or
- essential investigations are only feasible as an in-patient basis, or
- the patient's tolerance and/or compliance with medication needs to be monitored closely, or
- the patient's doctor and public health unit consider that the patient is likely to expose other people who have not previously been exposed to TB, in particular children under 5 years old and immune suppressed household contacts.

When a patient with suspected TB is admitted to hospital the patient must be isolated in a single room, ideally with negative pressure. Airborne precautions must be taken.

All patients admitted with suspected infectious multi drug resistant TB must be isolated with airborne precautions in a single negative pressure room. Where a hospital does not have a room with negative pressure ventilation arrangements should be made to relocate the patient to a hospital with this facility as agreed by the treating physician, Area TB Coordinator and the patient. Airborne precautions must be implemented during transit.

Where a patient remains in hospital, airborne precautions must be maintained until an assessment of the patient's infectivity is undertaken. For patients with pulmonary TB, this assessment includes a review of treatment, clinical progress and an evaluation of the chest x-ray and sputum results. Unless the patient is unable to produce sputum, the patient should have a minimum of three consecutive acid fast bacilli (AFB) negative sputum smear results before isolation is ceased. The three sputum specimens should be collected 8 – 24 hours apart[1]. At least one is to be an early morning specimen.

The decision to cease isolation and airborne precautions should always be undertaken in collaboration with the specialist TB physician, the Area TB Coordinator and local Infection Control staff.

Patients who are sputum smear positive and who do not fall into the above categories for hospital admission may be allowed to stay at home following extensive counselling on the disease and prevention of its transmission. They must be instructed to stay at home until an assessment of their infectivity (as outlined above for hospitalised patients) is completed and the risk of transmission is assessed as being negligible.

Discharge planning

Provided the patient does not pose a risk of transmission to others, the patient can be discharged from hospital in the absence of acid fast bacilli free sputum provided:

- effective therapy has commenced,
- the patient has been counselled and agrees to remain at home
- the patient has agreed to receive directly observed therapy (by health care professionals),
- an assessment has been made that additional people will not be exposed, and
- children (aged less than 5 years) or immune suppressed persons do not live in the household or, if they do live in the household, they have already been commenced on treatment for latent TB infection.

Patients who do not complete TB treatment

It is essential that patients who commence on treatment for TB complete the course of medication prescribed for their disease to be adequately treated and to minimise the potential for development of drug resistant TB. Where patients default or discontinue their treatment prior to completing the prescribed course of treatment the Area TB Coordinator and treating physician need to develop a strategy to ensure recommencement and completion of treatment can occur.

Follow Up

As a general principle most people treated for active TB will be followed up for 2 years after completing their treatment except where there are specific circumstances that warrant further follow up. On completion of this follow up the person is counselled and discharged from care.

Reference

1. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005. MMWR Recommendations and Reports. December 30, 2005 / Vol. 54 / No. RR – 17.

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Director-General