Justice Health and
Forensic Mental Health Network

NSW GOVERNMENT

Justice Health NSW Policy

Tuberculosis - Surveillance and Management of Confirmed and Suspected Cases

Issue Date: 02 May 2024

Together for
Healthier Tomorrows

Tuberculosis - Surveillance and Management of Confirmed and Suspected Cases

Policy Number 1.422

Policy Function Continuum of Care

Issue Date 02 May 2024

Next Review Date 02 May 2027

Risk Rating High

Summary This policy provides an evidence-based framework for the surveillance and management of tuberculosis in NSW Correctional Centre's, Youth Justice Centre's, Long Bay Hospital and the Forensic Hospital by preventing the transmission of tuberculosis through early diagnosis, effective treatment, managing confirmed or suspected tuberculosis cases and contact screening.

Responsible Officer General Manager, Population and Preventative Health

Applies to
☐ Administration Centres
☐ Community Sites and programs
☒ Health Centres - Adult Correctional Centres or Police Cells
☒ Health Centres - Youth Justice Centres
☒ Long Bay Hospital
☒ Forensic Hospital

CM Reference POLJH/1422

Change summary
- Minor updates – including link updates and resources

Authorised by Chair, Policy Steering Committee

Revision History

#	Issue Date	Number and Name	Change Summary
9	May 2024	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Minor updates – including link updates and resources
8	November 2019	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Updated relevant NSW Ministry policy directives • Updated roles and responsibilities • Clarity on case management

7	October 2016	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Recent relevant NSW MoH PDs • Includes information from Reception Screening Assessment • Updated TB surveillance data • Delete Public Health Coordinator; replace with CNC Infection Prevention
6	December 2012	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Wording changes to simplify & clarify • Changes to layout
5	May 2010	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Amendments made to the TB Poster in Appendix 1
4	December 2008	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Minor updates
3	February 2006	1.422 Tuberculosis – Surveillance and Management of Confirmed and Suspected Cases	• Allocated new policy number – moved from Safe Practice to Continuum of Care • Emphasis now on the type of infection control precautions required, rather than the name of the suspected disease
2	June 2005	5.160 Tuberculosis – Surveillance & Management	• Minor updates
1	September 2000	5.160 Tuberculosis – Surveillance & Management	• New policy

PRINT WARNING

Printed copies of this document, or parts thereof, must not be relied on as a current reference document.

Always refer to the electronic copy for the latest version.

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1. Preface

Tuberculosis (TB) continues to be a disease of public health significance in Australia. Each year there are over 1300 cases of active TB notified in Australia and approximately 40% of these cases live in NSW. TB is the terminology for 'active' disease due to the Mycobacterium tuberculosis complex. The disease most commonly occurs in the lungs (pulmonary TB), although it can affect any region of the body (extrapulmonary TB).

The pulmonary form is most infectious. Latent TB infection refers to infection only, without active disease (i.e., a dormant infection not able to be transmitted) and is referred to as LTBI. A patient with LTBI has no symptoms and is not infectious.

TB is associated with multiple social determinants.

Justice Health and Forensic Mental Health Network (Justice Health NSW) are responsible for coordinating contact investigations in NSW correctional centres in consultation with the NSW TB Program. Individual arrangements will need to be made for contact investigations involving NSW privately operated correctional facilities.

This Justice Health NSW policy outlines key principles to ensure best practice management for patients with confirmed or suspected TB in NSW Correctional Centres, Youth Justice Centres, Long Bay Hospital and the Forensic Hospital.

The most important priorities for TB control and prevention are:

- the timely identification and treatment of persons with active TB.
- the detection and management of infection in contacts of TB cases.
- detection and prevention of TB in populations:
    - with latent TB infection (LTBI), and
    - high-risk groups (e.g., close contacts of TB case, Healthcare workers (HCW) born or worked in TB high incidence countries, migrants, people living in overcrowded conditions where TB cases are known to occur (e.g., Aboriginal and Torres Strait Islander communities or correctional facilities).

The objectives of the policy are to:

- Implement a system for the identification and management of confirmed and suspected TB cases.
- Prevent the transmission of TB by early diagnosis, effective treatment and management of confirmed or suspected TB cases.
- Identify contacts of the case and determine the extent of contact screening, and
- Minimise the risk of people in custody introducing and transmitting TB into health / correctional / detention facilities.

2. Policy Content

2.1 Mandatory Requirements

- Every patient must be screened at reception or admission for symptoms of TB (refer to Section 4.1) using the Reception Screening Assessment form in Justice Health electronic Health System (JHeHS).
- Within 24 hours of a patient being admitted to the Forensic Hospital patients must have a physical health assessment completed according to the Forensic Hospital Procedure 6.093 *Physical Health Assessment and Care*.
- Population Health must be notified as soon as possible of any confirmed or suspected case of TB. Clinical staff must promptly contact the Clinical Nurse Consultant Infection Prevention & Communicable Diseases (CNC IP&CD) on [redacted] or [redacted] **(during business hours)**; or after hours contact the After-Hours Nurse Manager on [redacted] or **Forensic Hospital After Hours Nurse Manager on** [redacted]
- TB is a notifiable condition to NSW Ministry of Health (the Ministry), and the CNC IP&CD will notify the NSW Health Protection Branch of any patient confirmed or suspected with TB. In accordance with Ministry guidelines, the CNC IP&CD will liaise directly with the NSW TB Program Manager to ensure the implementation of appropriate treatment strategies and public health actions including contact screening.
- The NSW TB Program recognises and acknowledges the CNC IP&CD as the Network TB Coordinator, refer to *The role of Tuberculosis Coordinators in NSW* factsheet.
- When a patient is suspected or confirmed with active TB disease, in addition to Standard Precautions, all staff must implement Airborne Precautions (refer to section 4.3 in this policy), and advise Corrective Services NSW (CSNSW), Youth Justice NSW (YJNSW) and other contract staff to comply with Airborne Precautions through the Health Problem Notification Form (HPNF) 1.231 *Health Problem Notification Form (Adults)* and 1.235 *Health Problem Notification and Escort Form (Adolescents)*.
- All cases of active TB must be referred to a specialist in respiratory / TB medicine for appropriate TB treatment and this will be coordinated with the CNC IP&CD and the NSW TB Program Manager
- Prescribed treatment must be given in accordance with relevant Ministry policies. In the Network all chemotherapeutic regimens for TB are prescribed by a physician with specialised training in TB to ensure accordance with Ministry policy directives for the treatment of TB.
- All patients on TB chemotherapy must have their drug administration supervised and Directly Observed Treatment (DOT) (see section 3.6.1 Supervised Directly Observed Therapy (DOT) according to Ministry policy directives and the Network 6.049 *Medication Guidelines*.
- No change to the patient's medication regime may occur unless directed by the treating respiratory / TB specialist.
- If required, contact screening will be undertaken to identify and investigate potential contacts of the index case (i.e., the case with confirmed TB). The CNC IP&CD will coordinate and manage contact screening with the NSW TB Program Manager.
- To minimise the transmission of infection, patients with confirmed or suspected TB, patients may be required to be isolated in negative pressure rooms, located at Silverwater

Women's Correctional Centre and the Medical Subacute Unit (MSU) at Long Bay Hospital. The CNC IP&CD will communicate specific accommodation requirements for patients to relevant Nurse Managers and Nursing Unit Managers.

- Network policy 1.037 *Admission Policy - (Aged Care Unit / Medical Unit) Long Bay Hospital (Referral, Admission and Assessment)* states for all referrals and admissions to the MSU at Long Bay Hospital all patients must be accepted to Long Bay Hospital by the Senior Medical Officer (business hours) or Clinical Director/Deputy Clinical Director, Primary Care (outside business hours). Furthermore, in the case of patients with a communicable disease, the Service Director Population Health may make a referral for admission to the MSU.
- The air handling system in a negative pressure room provides negative pressure by air flow into the room and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter before returning to circulation. The air handling systems designed for airborne infection isolation should be connected to the emergency backup power in case of power failure. These rooms have additional seals to prevent inadvertent escape of pathogens, therefore with no ventilation in the event of sustained power failure; isolation of airborne patients with infectious conditions becomes a patient safety risk.
- All services related to diagnosis and treatment of suspected or confirmed TB are available at no charge to patients within the NSW public health system. This includes the provision of services for TB-related investigations, care and treatment. This applies to (but is not limited to) all Australian residents, including patients in custody and persons in youth detention centres.

2.2 Implementation – Roles & Responsibilities

2.2.1 Chief Executive

- Must provide managers with the resources to support compliance with this policy and its associated procedures.

2.2.2 Executive Director Clinical Operations

- Must review all reported incidents of non-compliance with this policy.

2.2.3 Clinical Nurse Consultant Infection Prevention & Communicable Diseases, Population Health

- Responsible for providing consultancy and expert advice to all Network staff on the prevention and control of TB, contact screening and active support for the implementation of this policy.
- Responsible for coordinating case management model of care within the Network in consultation with NSW TB Program. CNC is part of the NSW TB Program that through a network of dedicated TB services across the state, continue to focus on active case finding, early diagnosis, and effective treatment of cases and contacts to minimise local transmission of TB in NSW. Surveillance of TB in NSW is conducted under the NSW Public Health Act 2010.

2.2.4 Nurse Managers and Nursing Unit Managers

- Must ensure compliance with this policy and its associated procedures.

- Must bring this policy and its associated procedures to the attention of all Network staff.

2.2.5 Nursing Unit Managers at Silverwater Women's Correctional Centre and Medical Sub-Acute Unit, Long Bay Hospital

- Must ensure all negative pressure ventilation rooms have preventative maintenance carried out according to the contract.

3. Procedure Content

3.1 Clinical Presentation, Assessment and TB Surveillance

Reception Screening on entry to Correctional Environment:

Every patient must be screened at reception or admission for the symptoms of TB using the Reception Screening Assessment form in JHeHS.

Screening questions include:

- Was the patient born overseas in a high TB-burden country?

As per the NSW Health List of Counties where tuberculosis (TB) is common.

Regions and Countries include (but are not limited to):

South-East Asian countries and Western and Southwestern Pacific Regions: India, Vietnam, Philippines, China, Indonesia, Cambodia, Thailand, Afghanistan, Pakistan, Papua New Guinea, Sri Lanka, South Africa, South Sudan.

For the full list of currently listed 'high risk' countries click on list of TB Common countries at above link).

- Has the patient had residence for 3 or more months in a high-risk country (that was not the person's country of birth)?
- Has the patient had a health condition causing immunosuppression, or been on immunosuppressive therapy?
- Has the patient come from an immigration detention centre, overseas prison or refugee camp in the last 2 years?
- Has the patient come directly from an international airport?
- Has the patient a temperature / fever?
- Has the patient had a cough which has lasted more than 2 weeks, associated with night sweats and/or unexplained weight loss or blood-stained sputum?

Patients presenting with such a history at any stage of their incarceration / admission within Justice Health NSW should be considered as a suspected TB case and should be assessed urgently by a medical officer (at the correctional health centre or inpatient unit) and any suspected case of TB must be notified to the Network TB Coordinator (IP&CDC CNC).

Increase your level of suspicion if any of the following apply:

- a history of living in a country with a high prevalence of TB (See List of Countries)

- close household-like contact with a known case of TB disease
- a history of previous treatment for TB
- Patient has any of the following risks factors associated developing with active TB disease.
    - immune compromised (e. g. HIV infection, transplantation, immune-suppression therapies, specific malignancies)
    - chronic renal failure / severe kidney disease.
    - diabetes.
    - low weight or malnutrition
    - previous gastric surgery, silicosis, and some haematological disorders.

Non-pulmonary TB (disease involving organs other than lungs) can present with a wide range of symptoms, depending on the site of disease, and is often accompanied by intermittent fever and/or weight loss.

3.2 Notification of Confirmed or Suspected Cases of TB

All cases of possible and confirmed TB are to be managed in conjunction with a TB service. Population Health must be notified promptly of any suspected or confirmed TB case.

Contact the CNC IP&CD (during business hours) on [redacted] or alternatively the **After-Hours Nurse Manager on** [redacted] for patient management advice.

Forensic Hospital notifications are to be made to the relevant Nursing Unit Manager (NUM) contacted (during business hours) or the Forensic Hospital After Hours Nurse Manager (after hours), NUM will follow up including reporting to the TB Coordinator and / or the medical officer for further management advice, including around isolation plan.

As a priority, the patient must be isolated in a one-out cell/room with Airborne Precautions implemented without delay.

3.3 Infection Prevention and Control

When a patient is confirmed or suspected with TB, all staff must implement Airborne Precautions (in addition to Standard Precautions). Airborne Precautions are designed to interrupt the airborne transmission route of the disease.

The CNC IP&CD will advise health centre and hospital staff regarding relevant patient management matters including appropriate placement or accommodation for the patient, diagnostic work-up and the requirement for implementing Airborne Precautions.

For patients in the correctional environment, use the Health Problem Notification form (HPNF) and write ‘respiratory symptoms’ and tick the Airborne Precautions box on the adult form. On the adolescent Health Problem Notification and Escort Form (HPNEF) write ‘Airborne Precautions’.

3.3.1 Airborne Precautions

- The CNC IP&CD will advise Network staff about appropriate placement or accommodation requirements for suspected or confirmed TB patients.

- Appropriate placement or accommodation for adult correctional patients must be discussed with the CNC IP&CD before possible transfer or placement in a negative pressure room (with access to an ensuite or designated bathroom) located at Silverwater Women's Correctional Centre and MSU, Long Bay Hospital.
- Appropriate placement or accommodation for young people with suspected or confirmed TB must be discussed with the CNC IP&CD.
- Appropriate placement or accommodation for Forensic Hospital patients must be discussed with the CNC IP&CD before possible transfer to an external health facility.
- The 'Airborne Precautions' signage must be displayed at the entrance to the patient's cell/room. Refer to 9.041 *Infection Prevention and* Control.
- Every person entering the patient's room must wear a properly fitted P2 mask (particulate filtration mask).
- NB: Patients are never to wear a P2 mask.
- If the patient can tolerate wearing a surgical mask, this should be worn when the patient is outside of the isolation room (including transport, outpatient, and emergency settings).
- Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows).
- All staff must wear a P2 mask on entering the isolation / negative pressure room. P2 masks must be properly fitted, used once, and disposed in the anteroom or outside the patient's room. A mask must be removed by touching the strings/ties or loops only.
- Transport of the patient should be restricted, and a medical hold placed on the patient for a defined period as discussed with the CNC IP&CD. If it is deemed necessary to transport the patient, the patient must be transported in a single-person transport vehicle.
- Any request to move the patient from the negative pressure room must be done in consultation with the CNC IP&CD in the first instance.
- Airborne Precautions and isolation may be ceased only when the patient's status is documented as no longer infectious. This must be done in consultation with the CNC IP&CD.
- Airborne Precautions must remain in place until pathology results document absence of the pathogen or until effective treatment has been commenced and maintained for the appropriate period or until the patient's signs and symptoms indicate that he or she is no longer infectious. The CNC IP&CD will advise when isolation and Airborne Precautions can be ceased.

3.4 Transport of Suspected and Confirmed TB Cases

Consultation with the CNC IP&CD must occur prior to any transport of the patient.

A referral from the treating medical officer to the admitting medical officer in Long Bay Hospital must occur for all patients who require a Medical Unit LBH (MU-LBH) placement. Post referral, the admitting medical officer will notify the Nursing Unit Manager MU-LBH of the outcome of the referral (to organise acceptance to Long Bay Hospital). Contact the Nurse Manager

Operations Access and Demand (NMOAD) or delegate to coordinate access to LBH with all stakeholders (e.g., Local Health District (LHD) facilities, Medical Escort Unit, CSNSW).

For patients in the correctional centre or youth justice setting, the NUM will discuss with the Operational Nurse Manager Long Bay Hospital (ONMLBH) advise the General Manager (GM) or Manager of Security (MOS) when a patient needs to be transported to Silverwater Women's Correctional Centre, Medical Unit LBH (MU-LBH) at Long Bay Hospital or specialist appointment and who are waiting to be moved from LBH1.

The Nurse Manager Operations Access and Demand (NMOAD) or delegate and State-wide After-Hours Nurse Manager (AHNM) (after hours) should be the 'single point of access' contact to facilitate and coordinate all admissions to the ACU-LBH and MU-.

The NUM must also notify the Correctional Centre General Manager or Manager Of Security (MOS) of the transport requirements and Airborne Precautions required on the Health Problem Notification Form (HPNF): 1.231 *Health Problem Notification Form (Adults)* and 1.235 *Health Problem Notification and Escort Form (Adolescents)*.

NB: The disease must not be disclosed to CSNSW or YJNSW staff but the requirement for Airborne Precautions must be disclosed.

For patients within the Forensic Hospital transport to an external facility via ambulance should occur as soon as possible. The NUM (during business hours) or the Forensic Hospital After Hours Nurse Manager must follow the guidance outlined in the Forensic Hospital Procedure 6.070 *Code Blue (Medical Emergency) - Management* regarding transport and notification processes.

If a vehicle with separate air-conditioned compartments or with separate ventilation is not available, then the escorting officers must also wear a P2 particulate filter mask; during transport the patient should wear a surgical mask.

The infection prevention and control precautions also apply to the transport arrangements for the Forensic Hospital patients and young people in custody.

3.5 Investigations

Prior to any initial investigations and/or diagnostic 'workups' being undertaken advice must be sought from the CNC IP&CD in the first instance, regarding appropriate location and the required precautions.

3.5.1 Laboratory testing for pulmonary TB

- Sputum microscopy for Mycobacterium tuberculosis is a specific test for diagnosing pulmonary TB disease. Demonstration of Mycobacterium tuberculosis in sputum (by culture (or PCR- except where this is likely to be due to previously treated or inactive disease.) establishes a definitive diagnosis of pulmonary TB disease.
- For the highest sensitivity, sputum should be collected as early-morning samples on 3 separate consecutive days prior to the patient having anything to eat, drink or cleaning their teeth.
- Sputum induction (using nebulised hypertonic saline) may be attempted in appropriate patients unable to expectorate.

- Sputum collection from patients at high-risk of having TB should be performed in negative-pressure ventilation rooms. Sputum collection from low-risk patients should be performed in well-ventilated areas away from other patients.
- Sputum samples should be collected in sterile, wide-opening containers with a screw-cap lid.
- Due to the unique situation in correctional health environments, sputum specimens must be taken in the presence of clinical staff, to validate the source of the specimen.
- While observing and assisting the patient during the sputum collection, all staff must comply with Airborne Precautions including the wearing of a P2 mask.
- Microscopy and culture results: Initial smear results should be available within 24-48 hours of specimen receipt at the laboratory and provide a measure of the infectivity of the patient (i.e., smear-positive cases have a heavy burden of acid-fast bacilli (AFB) in their sputa that can be transmitted by coughing, singing, etc.). Microscopy therefore lacks sensitivity (so a negative result does not exclude TB) and specificity ("false-positive" results may occur due to the presence of NTMs).
- Smear positive cases should be treated as TB until proven otherwise. Culture remains the definitive 'gold standard' investigation for TB and in contrast to microscopy, culture, is highly sensitive.

  Every effort should be made to collect adequate laboratory specimens from pulmonary and extrapulmonary sites to establish a microbiological diagnosis. Detection of TB by culture remains the most sensitive method for detecting *M. tuberculosis* complex and enables drug susceptibility testing and genetic typing to be performed.
- **Results**: The initial culture and identification of Mycobacterium tuberculosis still takes an average of 10-14 days with the subsequent susceptibility final culture results expected within 42 days (6 weeks) from time of specimen receipt.

3.5.2 Diagnosis and Treatment of Tuberculosis

TB is a multi-faceted disease and there is no one size fits all test for diagnosis. Demonstration of Mycobacterium tuberculosis in sputum (by culture or PCR) establishes a definitive diagnosis of pulmonary TB disease.

Treatment of TB is in accordance with Ministry policy directives and all chemotherapeutic regimens for TB are prescribed by a physician with specialist training in TB. All diagnosed TB cases are required to promptly commence on effective multi-drug anti-TB therapy.

In usual circumstances, the patient may be considered non-infectious after two weeks of fully supervised directly observed therapy – although the treatment course can be expected to continue for six to nine months.

The patient may be released from Airborne Precautions only after discussion and written authorisation by the CNC IP&CD. Ceasing Airborne Precautions must be documented in the patient's Health Record.

A combination of medications is used to treat TB and all may potentially cause adverse effects, and may interact with other medications, including non-prescription drugs such as paracetamol. Monitoring of treatment is required and includes monitoring of potential side

effects, regular blood tests and follow-up visits to the patient's treating specialist and Chest Clinic.

Staff must refer to the Networks Medication Guidelines and Procedures available on the intranet, to follow the clinical protocol for management of patients receiving TB medication.

Justice Health NSW, through the TB services, are responsible for supporting the patient to the successful completion of treatment to achieve cure for the patient and decrease the risk of disease recurrence, minimise the risk of developing antimicrobial resistance and the risk of infection to others.

The importance of developing a therapeutic relationship with patients at the beginning of treatment to ensure optimal treatment outcomes is acknowledged. This relationship provides the basis for ongoing clinician-patient rapport, effective case management, and the timely identification and management of adverse drug reactions. Treatment adherence monitoring is particularly important for Aboriginal patients who experience higher rates of TB than non- Aboriginal people and have specific cultural and community obligations which may at times hinder treatment compliance.

3.5.3 Other Investigation

All patients diagnosed with TB in NSW are to be tested for human immunodeficiency virus (HIV).

All rifampicin resistant and multidrug resistant TB cases in NSW are to be reviewed by an expert panel.

In situations where suspected TB cases are unable to produce sputum, other procedures such as induction of sputum, bronchoscopy and/or fine needle aspiration may be indicated. Invasive techniques will be conducted in a public hospital or Chest Clinic. The CNC IP&CD will advise clinical staff about other procedures and investigations when indicated.

3.5.4 Chest X-Ray

- Chest x-ray is one of the most widely used tools in the diagnosis of TB. However, its value is limited by the fact that other chest conditions may be accompanied by radiographic abnormalities and be misread as TB. In patients with suggestive symptoms, a plain chest x- ray is indicated which must be reported by a radiologist and reviewed by a respiratory physician.

3.6 Treatment

3.6.1 Supervised Directly Observed Therapy (DOT)

- Treatment for patients with active TB must be administered by directly observed therapy / treatment (DOT); this means clinical staff must observe the patient take their medication and records the treatment that was administered.
- Supervised TB treatment is a supportive measure provided to minimise the risk of development of drug resistance or reactivation of disease attributable to non-adherence, as well as facilitating early detection and attention to side-effects of TB treatment.

3.6.2 Inadequate or Interrupted Treatment

Appropriate treatment is required to minimise the risk of drug resistance, treatment failure

and/or relapse. Adverse reactions to anti-TB drugs must be promptly identified and managed by clinicians.

- Inadequate or interrupted treatment can result in relapse, continued transmission, and the development of drug-resistant disease. Therefore, after effective therapy has commenced, continued treatment without interruption is critical until the entire course of treatment is completed.
- If treatment lapses for any reason, prompt action should be taken to ensure recommencement of therapy. If treatment cannot be resumed, the CNC IP&CD must be informed.

3.6.3 Patients on Both Opioid Substitution Therapy (OST)

- Patients on opioid substitution therapy (OST), who also receive anti-TB medications (especially rifampicin), must have their methadone dosage assessed by a Drug and Alcohol Specialist, as rifampicin induces metabolism of methadone, reducing its concentration and activity.

3.6.4 Management of Multi-Drug Resistant TB

- Multi-drug resistant TB (MDR-TB) is defined as disease caused by Mycobacterium tuberculosis bacilli that are resistant to isoniazid and rifampicin, with or without resistance to other first-line anti-tuberculous agents.
- MDR-TB represents an important public health concern for the effective control on tuberculosis. To ensure best practice management of MDR-TB, an expert panel will be convened by Health Protection NSW to review all identified cases of MDR-TB in NSW. The expert panel will review and provide advice on the clinical and public health management and develop a case management plan for each case of MDR-TB.

3.6.5 Transfer of Patients on Anti-TB Medication to Other Centres

Transfer of patients with TB must be done in consultation with the CNC IP&CD. When a correctional patient with confirmed or suspected TB is transferred to another correctional or detention centre, the transfer form must advise the receiving staff that the patient is on anti- TB treatment and the requirement for DOT must be communicated clearly to the receiving staff. All medication that the patient is prescribed must be sent with the patient to ensure continuation of treatment.

3.6.6 If a patient is due for release or discharge

If a patient is due for release or discharge before completing TB treatment, including preventative treatment for a known contact, the CNC IP&CD must be advised (and should be advised as far in advance as possible) in order to enable coordination with the NSW TB Program Manager for discharge planning and transfer of care to community Chest Clinic staff or to an international agency as required upon release.

3.7 Other Issues

3.7.1 Reception of People from Immigration Detention Centres or from Overseas Prisons

- Patients received into the custodial or inpatient environment from overseas may be at greater risk of presenting with TB disease.

- At reception / screening, a full history regarding TB must be taken. The CNC IP&CD must be notified of the reception of patients from immigration detention centres or from overseas prisons, regardless of history.

3.7.2 Attendance in Court

- The question of attendance at court will arise in some persons with suspected or confirmed TB. The court must be advised that the patient requires respiratory isolation and, although the patient and those in contact with him or her could wear masks, it is not desirable for this to occur.
- However, in cases of active TB disease, after two weeks of anti-TB medication a person is usually considered to be non-infectious. This scenario must be discussed with the CNC IP&CD or the After-Hours Nurse Manager or the Deputy Director of Nursing Forensic Hospital (during business hours) or After-Hours Nurse Manager Forensic Hospital (after hours) for appropriate advice and notification to the Executive Director Clinical Operations.

3.8 Contact Screening and Management

Contact screening is an essential aspect of the management of active TB patients. A 'contact' of an infectious case of TB is a person who is closely associated with the index case in terms of proximity and/or duration during the infective period.

- Each contact screening activity needs to be developed and evaluated on an individual basis.
- The CNC IP&CD will coordinate screening of identified patient contacts (in custody) in accordance with Ministry guideline GL2019_003 *Tuberculosis Contact Investigations* and in collaboration with the NSW TB Program and the Nursing Unit Manager. Contact screening may involve a simple blood test.
- The NSW TB Program will coordinate screening patient contacts now living in the community, CSNSW, Network, YJNSW and G4S (Forensic Hospital) staff who may have been in contact with the TB case including recommendation of a visit to their local Chest Clinic in the community.
- Network, CSNSW and YJNSW staff who have been identified as a potential contact of the index case will be referred to their local Chest Clinic for assessment and management as required.

3.8.1 Non-Cooperation with Treatment or Management

- Most patients cooperate by taking medications and conforming to measures needed to stop the risk to others whilst they are infectious or are suspected of having active TB. However, if a patient is not cooperative, the Ministry provides guidelines on the management of people with TB who place others at risk. In addition, authority under the *Public Health Act 2010* as it applies to uncooperative persons in the community could also be invoked.

3.8.2 Tuberculosis and Human Immunodeficiency Virus (HIV) infection

- Globally, TB is the most important opportunistic infection complicating HIV infection and is the leading cause of AIDS-related deaths. Tuberculosis in a person infected

with HIV infection may represent reactivation of latent TB infection (LTBI) acquired in the past, or recent infection.

- An assessment of TB risk factors should be undertaken for all patients with HIV infection.

  The history should include recent or prolonged close contact with someone with infectious TB, previous treatment for TB disease or LTBI, birth or previous residence in a high burden TB country, signs and symptoms of TB, diabetes, chronic renal disease, cancer, silicosis, gastrectomy, corticosteroid treatment, immunosuppressive treatment or medication and pregnancy.

- Active TB has been associated with a higher HIV viral load, which might be expected to accelerate the loss of CD4 T-cells and promote HIV/ AIDS disease progression. Tuberculosis co-infection is associated with a doubling of the mortality rate in HIV-infected people. The most significant predictor of survival for HIV-infected persons with coexistent TB is the degree of immunodeficiency.

- It is essential that all TB patients diagnosed with HIV are referred to a HIV physician for assessment and care. All patients with suspected or confirmed TB should be offered HIV screening.

3.9 Patient Centred Care

Wherever possible, clinical care is to be delivered in a manner that allows patients to maintain normal employment and/or education activities once non-infectious.

Key strategies to engage patients in treatment include assessment of health literacy, health education on TB disease, treatment, and medication side effects and an assessment of physical, psychological, social, and economic factors that may impact treatment outcomes.

3.9.1 Culturally and linguistically diverse people

Individual approaches may be required to support culturally, and linguistically diverse people diagnosed with TB in NSW. Aspects to be considered include identifying appropriate cultural brokers, including working with health workers from the relevant cultural background. An accredited or certified interpreter must be engaged whenever language could potentially pose a barrier to effective care, including ensuring patient understanding of the disease, treatment, and importance of treatment adherence. Refer to the 1.230 *Health Care Interpreter Services*.

3.9.2 Aboriginal people

TB services must work in partnership with Aboriginal people refer to pages 8 of 12 PD2022_007 *Principles for the Management of Tuberculosis in New South Wales*.

3.10 TB Health Promotion Resources and Alert Posters

TB alert posters titled ‘Think TB’ must be displayed in prominent, accessible locations in every health centre, unit and hospital.

Refer to Appendix 1. Posters are also available in the 9.041 *Infection Prevention and Control* Procedure.

4. Definitions

Active tuberculosis disease

Illness caused by Mycobacterium tuberculosis complex (M. tuberculosis or M. TB).

Clinically diagnosed TB

When a clinician experienced in TB makes a clinical diagnosis of TB disease without a culture or PCR result. Other laboratory suggestive evidence such as smear results for acid fast bacilli or histology may be taken into account. Cases of latent TB infection are not included.

Extrapulmonary TB

Disease affecting any other region of the body, including the pleura.

Extensively drug-resistant TB (XDR-TB)

Cases in which isolates demonstrated resistance to isoniazid and rifampicin, as well as additional resistance to any fluoroquinolone, and to at least one injectable second-line drug (capreomycin, kanamycin or amikacin)

High risk countries

Those with an annual TB incidence of 40 cases per 100,000 population per year or more in 2020.

Interferon gamma release assay (IGRA)

An in-vitro tuberculosis screening technique that uses whole blood to identify people likely to be infected with M. tuberculosis.

Latent Tuberculosis Infection (LTBI)

Tuberculosis infection without evidence of active tuberculosis disease

Laboratory confirmed TB

Isolation of Mycobacterium tuberculosis complex (M. tuberculosis, M. bovis, or M. africanum, excluding M. bovis var BCG) by culture or detection of M. tuberculosis complex by nucleic acid testing except where this is likely to be due to previously treated or inactive disease.

MDR-TB

Multidrug resistant TB (MDR-TB) occurs when TB bacteria are resistant to at least isoniazid and rifampin, the two most powerful TB drugs. Drug susceptible TB and drug resistant TB is spread in the same way.

Must

Indicates a mandatory action or requirement to be complied with.

Preventive therapy

A course of tuberculosis medications to treat latent tuberculosis infection, thereby preventing progression from tuberculosis infection to active TB disease. Preventative therapy is also known as LTBI treatment of chemoprophylaxis.

Pulmonary TB

Disease affecting the lung, excluding the pleura.

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

Tuberculosis infection

M. tuberculosis complex infection without disease/illness; also referred to as latent tuberculosis infection (LTBI).

Tuberculosis clinical review

Assessment by an experienced clinician to diagnose or exclude active tuberculosis disease in a person who has confirmed tuberculosis infection, and/or abnormal chest radiograph (CXR) and/or symptoms suggestive of tuberculosis disease.

Tuberculosis screening

Clinical assessment and testing by an experienced clinician to exclude tuberculosis disease and tuberculosis infection.

5. Related Documents

Legislations	*Public Health Act 2010* *Legal aspects of Tuberculosis control*
Justice Health NSW Policies, Guidelines and Procedures	1.037 *Admission Policy - (Aged Care Unit / Medical Unit) Long Bay Hospital (Referral, Admission and Assessment)* 1.230 *Health Care Interpreter Services* 1.231 *Health Problem Notification Form (Adults)* 1.235 *Health Problem Notification and Escort Form (Adolescents)* 6.049 *Medication Guidelines* 6.070 *Code Blue (Medical Emergency) - Management* 6.093 *Physical Health Assessment and Care* 9.041 *Infection Prevention and* Control
Justice Health NSW Forms	
NSW Health Policy Directives and Guidelines	GL2019_003 *Tuberculosis Contact Investigations* GL2023_003 *Bacille Calmette-Guerin (BCG) Vaccination* PD2015_012 *Tuberculosis Management of People Knowingly Placing Others at Risk of Infection* PD2022_007 *Principles for the Management of Tuberculosis in New South Wales*

	PD2026_004 *Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases* NSW Health List of Counties where tuberculosis (TB) is common
Other documents and resources	*Tuberculosis – CDNA National Guidelines for Public Health Units* The 'Airborne Precautions' signage *Chest x-ray monitoring for tuberculosis (TB)* *Interferon gamma release assay test (IGRA test)* *Instructions for collecting sputum for tuberculosis* *Tuberculosis fact sheet* *Tuberculosis (TB) – information for families and the community flyer*

Appendix 1 – TB Alert Poster

Think TB

Be Clinically Suspicious

- Was the patient born overseas in a high TB-burden country?

  (See footnote below for list of south-East Asian countries and Western Pacific Regions – or access link to see full List of Countries)

- Has the patient had residence for 3 or more months in a high-risk country (that was not the person's country of birth)?
- Has the patient a health condition causing immunosuppression, or been on immunosuppressive therapy?
- Has the patient come from an immigration detention centre, overseas prison, or refugee camp in the last 2 years?
- Has the patient come directly from an international airport?
- Has the patient a temperature / fever?
- Has the patient a cough which has lasted more than 2 weeks, associated with night sweats and/or unexplained weight loss or blood-stained sputum?

NOTIFY

- Contact the CNC Infection Prevention & Communicable Diseases on **on** [redacted] or alternatively the **After-Hours Nurse Manager on** [redacted] for patient management advice.
- OR Forensic Hospital After Hours Nurse Manager on [redacted]

Priority First Action – Isolate and Contain

- **Implement and maintain Airborne Precautions without delay** and restrict patient movement.
- Advise CSNSW, YJNSW and contract staff to implement Airborne Precautions; write 'respiratory infection' on HPNF and tick Airborne Precautions box.
- **Accommodate patient in a single room** with door closed, window open, turn off room air-conditioning (if it circulates to other areas) while awaiting transfer to a negatively pressurised room in a single-person transport vehicle. Patient to wear a surgical mask if coughing. The patient must never wear a P2 mask.
- **P2 mask must be worn** by every person entering the room. Transport of patients – patient must wear surgical mask if / when leaving the room. Notify the area receiving the patient.
- **Transport of Patients**- patient must wear surgical mask if/ when leaving the room. Notify the area receiving the patient.

1 South-East Asian countries and Western Pacific Regions – India, Vietnam, Philippines, China, Nepal, Indonesia, Cambodia, Thailand, Afghanistan, New Zealand, Sri Lanka (2015)