

Health Service Directive – Tuberculosis Control

Protocol for the Control of Tuberculosis

1. Purpose

This protocol describes the mandatory requirements for the control of tuberculosis (TB) in Queensland. The term “TB” refers to active disease. Where latent TB is being discussed, it will be made explicit.

2. Scope

This Protocol applies to all Hospital and Health Services (HHS).

3. Roles and Responsibilities for Control of Tuberculosis

3.1 Department of Health

The Office of the Chief Health Officer and Deputy Director-General, Prevention Division is responsible for strategic oversight and systems support for TB control in Queensland HHSs. This is facilitated by:

- strategic leadership to support policy planning, development and implementation of effective TB control that is in alignment with the current National Tuberculosis Advisory Committee *Strategic Plan for TB Control in Australia*
- coordination of expert advice forums to support clinical and public health management of TB
- coordination of state-wide programs and peer network forums to support information sharing, capacity building and effective best practice management of TB
- monitoring and analysing state-wide epidemiological data to inform TB control management and strategic planning
- monitoring State and Commonwealth regulatory and legislative obligations that are relevant to TB control services
- facilitating relevant State and Commonwealth Partnership Agreements
- facilitating access to educational resources and requirements that support attainment of knowledge and skills for registered nurses working in TB control including:
 - public health management of TB and BCG vaccination and tuberculin skin testing (TST)
 - contact tracing officer certification



- custodianship and maintenance of a contact tracing officer register
- contributing to quality assurance initiatives and where practicable, research that contributes to the continued delivery of evidence-based clinical practice, including methodologies and frameworks used to prevent, identify, manage or minimise infection events from occurring
- monitoring issues impacting on the ability of TB control units to perform their role.

3.2 Hospital and Health Services

HHSs will:

- ensure clinical and public health management of TB cases and contacts is in accordance with published relevant state and national guidelines.
- ensure diagnosis and treatment of latent TB in those at risk of progression to active TB is in accordance with Queensland Health guidelines.
- ensure that all TB diagnostic services and treatment result in no out-of-pocket expenses to the patient.
- ensure that all new cases of TB are notified to the Department of Health (DOH) Communicable Diseases Branch (CDB) as per the *Public Health Act 2005* and *Public Health Regulation 2018*. This includes notifying cases where, in the absence of laboratory confirmation, a clinical diagnosis of TB is made.
- ensure the Post Notification form is completed as soon as possible and forwarded to the CDB to facilitate data entry into the Notifiable Diseases Register. This data is required to meet the mandatory reporting requirements of the National Notifiable Diseases Surveillance System (NNDSS).
- ensure that TB patients are tested for co-infection with human immunodeficiency virus (HIV) with an appropriate pre-test and post-test discussion and subsequent management as per the Queensland Health *Guideline for the treatment of TB in patients with HIV co-infection*.
- ensure all TB patients are assessed and followed up to the completion of therapy and have post-treatment follow up for at least 2 years (or as long as clinically required) by a medical officer with appropriate specialist college or equivalent qualifications who is trained and experienced in TB management.

3.3 Tuberculosis Control Units within Hospital and Health Services

3.3.1 Urgent Advice to the Department of Health

The Department of Health, Communicable Diseases Branch are to be informed as soon as possible within one business day via the NDPC@health.qld.gov.au email account where any of the following apply:

- there is suspicion or confirmation of a case of multidrug-resistant TB (MDR-TB) or extensively drug-resistant TB (XDR-TB)
- there are more than 30 contacts of an infectious TB case
- any cases of healthcare-associated transmission of TB
- where transmission to contacts who are not close household or close other contacts has occurred

- where a pattern of TB cases suggests a transmission cluster
- where contact tracing is to be conducted in an institution or organisation
- where there is potential for heightened community interest
- where a case spent eight hours or more in an aircraft
- where a plausible explanation for disease acquisition is absent
- where there is a potential or actual public health risk requiring involvement of, or having implications for, another jurisdiction, country or other governmental department or non-governmental organisation
- any factors that may result in significant delay in implementing appropriate public health management of TB.

TBCUs are to provide regular updates to the CDB on the progress with, and a summary of outcomes for those scenarios listed above.

3.3.2 Clinical information management

All data required to provide effective case and contact management and to meet surveillance requirements must be entered into a HHS approved electronic case management database.

Surveillance data for TB submitted to the CDB are stored in the Notifiable Conditions System (NOCS) for state-wide reporting and provision of data to the NNDSS under the *National Health Securities Act 2007*.

All clinical records will be managed as per the Queensland State Archives Health Sector (Clinical Records) Retention and Disposal Schedule. HHSs may have local procedures that exceed the Queensland State Archives Health Sector (Clinical Records) Retention and Disposal Schedule.

3.3.3 TB control surveillance

TBCUs are required to submit TB surveillance data as requested by the Department of Health CDB. The nursing interview form should be made available to the CDB with the initial notification form (S70 or Post notification form 1) to facilitate completeness of surveillance data.

A PHA-S70 Notifiable conditions report form must be completed where a clinician experienced in TB makes a clinical diagnosis of TB, including (wherever possible) clinical follow-up assessment to ensure a consistent clinical course.

https://www.health.qld.gov.au/_data/assets/pdf_file/0023/444245/notif-conditions-rpt.pdf

The Post Notification Form 1 is required as soon as possible and within seven days of diagnosis for smear positive pulmonary cases and within 14 days for smear negative pulmonary cases and all extra pulmonary only cases. The Post Notification Form 1 can be found at the following link:

https://www.health.qld.gov.au/_data/assets/pdf_file/0033/648609/tb-post-notification-form1.pdf

The Post Notification Form 2 is to be submitted to the CDB at 3 months post treatment commencing and at the end of treatment. The Post Notification Form 2 can be found at the following link: www.health.qld.gov.au/_data/assets/pdf_file/0025/648610/tb-post-notification-form2.pdf

For MDR-TB, Post Notification Form 2 is required at 3 months, 6 months and at the end of treatment.

3.3.4 Visa health assessments

TBCUs are required to:

- perform triaging and provide TB diagnostic and management services to all clients that fall within their geographical region who are referred to them as part of the health undertaking and health manifest processes
- provide TB diagnostic services to meet visa requirements, and where appropriate, recoup these costs from a third party such as a private health insurer. The HHS must ensure no out-of-pocket expenses to the client occurs
- provide a clinic attendance report via email to the Department of Home Affairs (DHA), copying in the CDB via cdu_tbadmin@health.qld.gov.au following clinical review of a referred patient
- ensure the timely notification of all 'failures to present' of Health Undertaking clients to the appropriate referring entity (Department of Home Affairs or Bupa Medical Visa Services) via email and copying in the CDB via cdu_tbadmin@health.qld.gov.au.

3.3.5 Case management

All patients diagnosed with active TB are to be commenced on treatment.

- Smear positive pulmonary TB patients should commence treatment as soon as possible, waiting no longer than three days for treatment to commence.
- Smear negative, culture positive and extra-pulmonary TB cases should commence treatment within seven days.
- Where deviation from these timelines are made, the reasons should be clearly documented e.g. drug resistance suspected and further laboratory testing is required.

Each TB patient, regardless of public or private status, must have an allocated case nurse from a TBCU. This role is to provide a supportive partnership and advocacy role between the patient and treating medical officer to deliver quality, timely and client focussed management.

The use of Public Health Orders (behavioural or detention) under the *Public Health Act 2005* can assist in the management of TB patients that are non-compliant with their treatment and pose an immediate public health risk. However, public health orders should only be used when all efforts to gain voluntary compliance, such as working collaboratively with non- government agencies in the community and the use of incentives and enablers have been exhausted.

3.3.6 Infection Control

Clinicians managing patients in HHS facilities should ensure that, upon clinical suspicion of pulmonary TB, airborne precautions are implemented immediately. Young children (particularly under 5 years of age) are very rarely infectious; hence immediate implementation of airborne precautions is not necessary in this group but should be considered within 24 hours. If not already in place respiratory isolation (airborne precautions) should be implemented upon notification of sputum smear positive pulmonary TB. Patients with HIV-TB co-infection may not have typical symptoms. Pulmonary TB should be considered in the differential diagnosis of HIV positive patients who are at higher risk of TB (e.g. from higher burden TB countries) with respiratory symptoms or undiagnosed systemic illness.

Clinicians managing patients with a clinical suspicion and/or confirmation of pulmonary TB who are managed in the community (e.g. home isolation) must ensure the patient and family are provided with appropriate education and counselling about minimising the risk of transmission of infection; cough hygiene, avoiding new contacts and restricting movements away from home. The patient should be isolated until assessed as being at minimal risk of transmitting infection. Adequate social support and supervised therapy should be provided to patients in the home environment to increase adherence and compliance with infection control and treatment requirements.

For further detail refer to the current National Tuberculosis Advisory Committee *Infection control guidelines for the management of patients with suspected or confirmed pulmonary tuberculosis in healthcare settings* online at www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi4003i.htm

3.3.7 Tuberculosis Expert Advisory Group

The Tuberculosis Expert Advisory Group (TEAG) exists to provide expert advice on the management of complex TB cases to ensure that such cases are peer reviewed and best practice principles are recommended. If the treating team does not implement TEAG recommendations, feedback including the rationale for deviation from TEAG recommendations is to be provided to the TEAG via the Chair or via the NDPC@health.qld.gov.au email account.

HHSs are required to alert TEAG via the NDPC@health.qld.gov.au email account where there is:

- a new case of rifampicin resistance (includes MDR-TB & XDR-TB)
- where it is proposed that the *Public Health Act 2005* be utilised to make an application for either a behavioural order or a detention order for a patient that poses an immediate risk to public health.

HHSs are encouraged to refer clinical cases where there is:

- complex drug intolerance or other drug resistance
- complex co-morbidities including a new case of TB-HIV coinfection.
- complex cases (other complex clinical or social factors impacting on treatment)
- paediatric diagnosis (cases or contacts)
- where evidence is lacking to guide clinical practice
- failure of sputum cultures to convert to negative following two months of therapy for drug sensitive TB.

For further information contact the TEAG via NDPC@health.qld.gov.au

3.3.8 Principles of treatment

Key principles of treatment include:

- The design of a treatment regimen should include the results of Xpert MTB/RIF testing for rifampicin resistance (RR) and/or phenotypic TB drug susceptibility testing (DST).
- Active TB must never be treated with a single drug and a single drug should never be added to a failing TB treatment regimen.

- Clinicians must identify and manage barriers to successful adherent treatment including ensuring diagnosis and treatment is cost free to the patient and ensuring directly observed therapy (DOT) or other aids to adherence are provided as required.
- TB diagnostic services and treatment may be charged to a third party i.e. private health insurer. However, the HHS must ensure there will be no out-of-pocket expenses to the client.

For pulmonary TB, sputum AFB, smear and culture should be tested at the end of the intensive phase (2 months) for drug sensitive TB.

If culture is still positive for non-MDR-TB, monthly cultures of at least two sputa collected should be performed until culture conversion is documented. For MDR-TB cases, monthly sputum monitoring should be performed until three or more consecutive cultures taken at least 30 days apart are negative.

Treatment should be consistent with the current QLD Health clinical practice guidelines for treatment of adults and children found at the following link www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/tuberculosis/guidance/guidelines

- Wherever possible, sputa should be tested at the end of treatment to document culture negativity, consistent with WHO definition of cure.
- All TB clinicians must keep accurate records of the drug regimen used including agent, doses, duration and any changes which are made. Such records need to be made readily available to other clinicians, including the TEAG as required for patient management.

3.3.9 Directly observed therapy

Decisions regarding use and mode of DOT should be based on local and individual patient circumstances. DOT is strongly encouraged for patients at high risk of suboptimal therapy due to the following:

- any form of rifampicin resistance including MDR-TB and XDR-TB
- patients on three times per week therapy*¹
- any patient who has demonstrated they do not have capability to self-administer or are not able to maintain compliance with the recommended medication regimen
- smear positive cavitory disease
- anyone with a history of previous TB treatment.

¹ *For three times per week therapy, one or two defaults from attendance for the DOT dose(s) amounts to a loss of efficacy disproportionate to the number of dosages missed. Even a single failure from attendance must be followed up to investigate the reason for non-adherence and identify where other strategies or community support services may be of benefit.

The decision whether to use DOT, and whether it should be delivered in the community or health clinic, should be made in consultation with the patient, treating doctor, TBCU case nurse and other relevant HHS staff as required.

3.3.10 Patient movement

Each newly notified TB patient must be interviewed about possible movements within Queensland, interstate or outside the country. Contact details for patients must be sought to ensure the patient is contactable if the need arises. During the TB treatment consent process, the TB clinician will inform the patient of the patient's requirement to notify the TBCU/regional unit of any travel plans so that appropriate arrangements can be made.

If a patient with active infectious or incompletely treated active TB leaves the state or country without providing notice, the CDB will act on the advice of the TBCU/peripheral unit and facilitate appropriate communication to the National Incident Room or, alert other jurisdictional counterparts as appropriate. It is the responsibility of the case management team to notify the CDB by email to NDPC@health.qld.gov.au as soon as possible within one business day to ensure timely and appropriate public health management.

When a patient with active TB is transferred out of Queensland, the Post Notification Form 2 must be used to immediately communicate the transfer outcome to the CDB.

In the Treaty areas of the Torres Strait Islands and Papua New Guinea patient movement will be managed in accordance with Torres and Cape HHS endorsed procedures.

3.3.11 Contact Management

Contact management is to be undertaken by TBCUs in accordance with the Communicable Diseases Network Australia (CDNA) *National Guidelines for the Public Health Management of TB*.

Contact tracing assessment for contacts of sputum smear positive, pulmonary TB notifications should begin within seven working days of receipt of notification, with investigation of household contacts to commence as soon as possible.

All other cases should be followed up within fourteen days of receipt of notification.

3.3.12 Contact Tracing

Contact tracing activities must only be undertaken by staff who have been appointed as a contact tracing officer (CTO) under the *Public Health Act 2005*.

Anyone seeking to be appointed as a Contact Tracing Officer (CTO) should refer to the Contact Tracing Guideline and complete the Application for Appointment form, [located in the Public Health Operational and Regulatory toolbox](#) (<https://qheps.health.qld.gov.au/ehpom/phro-toolbox>).

Eligible applicants meeting the requirements of the *Public Health Act 2005* will be assessed and subsequently appointed by the delegate of the Chief Executive, if appropriate. Eligibility is based on completion of the assessment package hosted by the Health Protection Branch (HPB), and endorsement by the designated supervisor. Upon issuing the identification card, the individual's name will be added to the CTO register, maintained by the HPB.



Where the treating medical officer/s are not designated contact tracing officers, but have expertise in TB medicine, they must consult with the case management team within a TBCU to determine the infectivity of a TB case and assist as required with contact tracing.

While performing the interview as part of contact tracing, the CTO must:

- review the case to determine infectiousness
- assess environmental and behavioural factors that may modify the likelihood of transmission
- promptly identify persons who have had significant close or prolonged contact with the person diagnosed with, or under suspicion of having TB
- obtain a list of close household and close other contacts and invite them for screening within seven days of diagnosis or as soon as practical after this. Where deviations from these timelines are made, the reasons should be clearly documented
- complete a Nursing interview with the patient diagnosed with active TB form, enter data into the TBCU's database and attach to the patient file of the index case, and
- attend to 'concentric screening' according to a risk assessment where large numbers of contacts are involved.

The case management nurse must then discuss findings of the interview and contact tracing with a senior TBCU clinician to plan the screening management. The senior TBCU clinician is to determine if extended screening is deemed necessary.

3.3.13 Contact Screening

TBCUs are responsible for the management of contact screening for individuals residing within the TBCU's region. Where contact screening involves a health care facility, the relevant infection control service will be required to work closely with the TBCU to determine who has been in contact with the index case and ensure appropriate follow-up.

Where a contact resides in a different region, the originating TBCU will forward information to the relevant TBCU who will undertake screening and provide test results and or screening outcomes back to the originating TBCU. Where a TBCU does not have resources to manage a large screening processes, the TBCU should immediately notify the HHS executive to seek the required resources.

CDB will facilitate interjurisdictional referral where contact screening is required for persons in other State or Territory jurisdictions or countries. Sufficient case and contact data to inform appropriate contact management must be provided to the CDB to inform the relevant notification.

The case management team must determine (and communicate to the CDB) if secondary transmission has been identified through identification of clusters or reviewing epidemiological data.

TBCUs are responsible for ensuring appropriate post-screening follow-up and treatment occurs.

The case management nurse must ensure that accurate, up-to-date electronic records are kept of identified contacts and their individual screening outcomes. Such records must be made readily available, if requested, to the CDB.

Where available, the Tuberculosis and Related Diseases Information System (TARDIS) is to be used to record contact screening activities.

3.3.14 Non-Attendance of Contact Screening

In the instances where the risk of transmission of TB is high and contacts fail to present for their screening appointment TBCU business processes must include a minimum of two additional invitations to encourage the contact to attend a screening. If the contact continues to fail to attend, a senior TBCU clinician (nursing or medical) must be consulted and a record of all attempts and outcomes documented. TBCUs must ensure that the contact tracing activities, including follow up for non-attendance are conducted in a culturally and linguistically appropriate manner.

3.3.15 Airline Contact Tracing

Generally, contact tracing among airline passengers is only necessary if the index case was, or thought to be smear positive at the time of the flight, and where the total flight time (inclusive of all time in the aircraft, during flight and on tarmac) was eight hours or greater.

Screening must be offered to passengers and airline staff who were seated in the same row and two rows before and two rows after (inclusive) of the index case and to airline staff as nominated by the relevant airline. Refer to the Communicable Diseases Network Australia *National Guidelines for the Public Health Management of TB* for additional information.

3.3.16 Bacille Calmette-Guerin Vaccination and Tuberculin Skin Testing

Tuberculin Skin Testing (TST) and administration of Bacille Calmette-Guerin (BCG) vaccine must only be undertaken by appropriately trained staff with the relevant authority to administer a schedule 4 drug as per the *Health (Drugs & Poisons) Regulation 1996*. Successful completion of theoretical training and subsequent successful assessment of clinical competency as detailed below is a requirement for registered nurses/ midwives to administer BCG or TST.

Currently clinical competency assessment provided by Queensland Health is restricted primarily to nurses working in, or intending to work in, Queensland TBCUs but may include other registered nurses/ midwives that support the TB control program, as determined by their respective TBCU.

A BCG and TST e-learning theoretical training package has been developed by the CDB and is comprised of online learning modules and mini-examinations. Successful completion of the online theoretical component is required prior to the health care worker completing the relevant practical component, (administration of BCG or TST) as arranged with a TBCU.

Once competent, the HCW must undergo reassessment at defined periods, as determined by the relevant TBCU in partnership with the HHSs, to remain clinically competent to perform TSTs and/or BCGs. Leading TB clinicians may need to assess each other for competency.

All TBCUs must have a current vaccine management protocol (VMP) endorsed by the relevant Public Health Unit. HHSs will have in place a process to determine that all staff involved in vaccine management demonstrate appropriate competency as outlined in the VMP.

3.3.17 Laboratory diagnosis

TB is notifiable upon detection of *Mycobacterium tuberculosis* (*M. tuberculosis*) complex DNA by nucleic acid amplification (NAA) technology, isolation of *M. tuberculosis* complex by culture or by clinical criteria outlined elsewhere.

(http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd_tb.htm).

BCG strain *M. bovis* is an exception to this requirement whereas other members of the *M. tuberculosis* complex are notifiable. The finding of acid-fast bacilli from a clinical sample is also notifiable, but in itself does not distinguish TB from non-tuberculous mycobacteria.

It is essential that all efforts are made to establish a microbiological diagnosis. This confirms that the illness is due to TB and provides an organism for drug susceptibility testing. This is essential for ensuring a correct antimicrobial treatment regimen and enables genetic typing to assist in epidemiological investigations and public health control of TB transmission.

The Queensland Mycobacterium Reference Laboratory (Pathology Queensland) is the reference laboratory for all HHSs and receives all referred MTB isolates from Queensland based private pathology providers.

New smear positive respiratory samples will be automatically tested with the GeneXpert MTB/RIF assay which is a NAA test which detects both the presence of *M. tuberculosis* and the presence of rifampicin resistance. This test can be clinician requested for AFB smear negative samples where the clinical suspicion of TB +/- drug resistance to rifampicin is high. GeneXpert or alternative NAA detection can be performed on non-respiratory samples depending on the nature of the sample – such testing should be discussed with the laboratory (07 36460032).

3.3.18 Workers and students in health care facilities risk assessment

Hospital and Health Services (HHSs) and Health Support Qld (HSQ) must ensure that all workers in health care facilities, including contractors, students and volunteers, whose role may pose a risk of acquisition and/or transmission of TB are assessed and screened appropriately using the Queensland Health TB risk assessment form.

The risk assessment form identifies those workers who require further assessment and medical testing for the presence of latent or active TB. Those who are from or have travelled to [high risk TB countries](#) for three months or longer (cumulative) are at the greatest risk for developing TB.

The risk assessment form must be completed prior to commencement of work or clinical placement with further screening, if required, to occur soon after. HHSs must have an arrangement in place with tertiary institutions to ensure that before accepting a student for a clinical placement, the student has undergone this risk assessment.

It is the responsibility of each HHS to securely and retrievably store records of risk assessments and referrals for Queensland Health employees.

BCG vaccination is not routinely recommended for any health care workers or students on clinical placement.

For further guidance and tools to support assessment of risk of TB for workers in health care facilities refer to the Queensland Department of Health tuberculosis website

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/tuberculosis/screening/healthcare-workers-students>

For definitions of Contractors, students and volunteers please refer to the HSD Protocol: Vaccine preventable disease screening for Contractors, students and volunteers

https://www.health.qld.gov.au/data/assets/pdf_file/0021/155415/gh-hsdptl-047-1.pdf



For definitions of workers please see HR policy B1 Recruitment and selection
https://www.health.qld.gov.au/_data/assets/pdf_file/0034/635893/gh-pol-212.pdf

4. Supporting and related documents

Authorising Health Service Directive

- Health Service Directive – Tuberculosis Control

Legislation

- *Financial Accountability Act 2009*
- *Health (Drugs & Poisons) Regulation 1996*
- *Hospital and Health Boards Act 2011*
- *National Health Securities Act 2007*
- *Public Health Act 2005 and Public Health Regulation 2018*
- *Right to Information Act 2009*
- *Work Health and Safety Act 2011*
- *Queensland State Archives Health Sector (Clinical Records) Retention and Disposal Schedule*

[Queensland Health Guidelines](https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/tuberculosis/guidance/guidelines) (<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/diseases/tuberculosis/guidance/guidelines>)

- Treatment of TB in adults and children
- Management of latent tuberculosis in adults
- Management of latent tuberculosis in children up to 16 years
- Treatment of tuberculosis in patients with HIV co-infection
- Treatment of tuberculosis in pregnant women and newborn infants
- Treatment of tuberculosis in renal disease
- Management of contacts of multi-drug resistant tuberculosis

[National Tuberculosis Advisory Committee guidelines and position statements](http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-ntac-pubs.htm)

(<http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-ntac-pubs.htm>)

- The strategic plan for the control of tuberculosis in Australia (2011-2015).
- Essential components of a tuberculosis control programme within Australia
- The BCG vaccine: information and recommendations for use in Australia
- Management of tuberculosis risk in healthcare workers in Australia
- Position statement on interferon- γ release assays for the detection of latent tuberculosis infection
- National position statement for the management of latent tuberculosis infection
- Infection control guidelines for the management of patients with suspected or confirmed pulmonary tuberculosis in healthcare settings
- CDNA National Guidelines for the Public Health Management of TB
- Australian Immunisation Handbook



Other resources

- Health Protection Branch-Environmental Health Training Program
- Contact Tracing Officer – Application for Appointment
- Contact tracing guide for Contact Tracing officers
- Adverse Event Following Immunisation Reporting Form
- Form PHA s70 Notifiable Conditions Report Form (1) for Queensland clinicians (Clinical and Provisional diagnoses)
- Post notification information (Form 1)
- Post notification Form 2
- Torres and Cape Hospital and Health Service: Management of Papua New Guinea traditional inhabitants presenting to Queensland Health facilities within the Australian islands of the Torres Strait Protected Zone
- Torres and Cape Hospital and Health Service: Management of Papua New Guinea Nationals accessing healthcare within the Australian islands of the Torres Strait Protected Zone, presumed to have or diagnosed with tuberculosis.

5. Definition of Terms

Term	Definition / Explanation / Details
AFB	Acid Fast Bacilli
Authorised person	Means a person appointed as an authorised person under section 377 of the Public Health Act 2005
BCG	Bacille Calmette-Guerin
Case Management Team	Consists of the treating clinician, case manager nurse, case management medical officer, and others as required
Case Manager Nurse	A senior nurse with appropriate knowledge and expertise who supports and advocates for a patient during their treatment regimen
CDB	Communicable Diseases Branch
CNC	Clinical Nurse Consultant
CN	Clinical Nurse

Clinical and related areas	This category includes all healthcare workers who have contact with patients including: <ul style="list-style-type: none"> • medical practitioners • nursing staff • Indigenous Health Workers • allied health practitioners • dental staff (including assistants) • clinical pharmacy staff • maintenance personnel who service clinical equipment (including plumbers) • sterilising services staff • mortuary staff and technicians • specimen collection staff • operational staff in other categories who have contact with patients • cleaning staff and waste-management personnel • portage and patient assistance staff • security staff • laundry staff • home care workers • laboratory staff • ward catering staff • administration staff in patient care areas • religious service providers
Contact Screening	Testing of close contacts for latent TB infection, or active TB disease. This is performed as soon as possible after contact tracing has occurred
Contact Tracing	Determining, as per the <i>Public Health Act 2005</i> , who the TB index case's close contacts are, via a structured interview
CTO	A contact tracing officer appointed under the Public Health Act 2005 has the power to legally request information from an individual or a business.
DHA	Department of Home Affairs
DOT	Directly Observed Therapy
Enhanced Surveillance Data	Data contained within TB Post Notification Form 1 and the Outcome data contained in TB Post Notification Form 2.
Health Care Worker	Includes nursing, medical, paramedical and allied health professionals
Health Manifests	A manifest provided by DHA to manage refugees who require screening
Health Undertaking	An agreement that is made between the Australian Government and an immigrant/visa holder to ensure that visa holders with a history or an increased risk of tuberculosis do not develop active TB while in Australia
HHS	Hospital and Health Service
MDR-TB	Multi Drug-Resistant Tuberculosis
NAA	Nucleic Acid Amplification testing
NNDSS	National Notifiable Diseases Surveillance System



No out of pocket expenses	There will be no costs directly charged to the patient, however costs can be indirectly recovered from a third party (such as a health insurer), with the service provider arranging this, and ensuring that no costs are passed onto the patient.
RR	Rifampicin resistant
TB	Tuberculosis
TEAG	Tuberculosis Expert Advisory Group
TBCU	TB Control Unit
TST	Tuberculin Skin Test
XDR-TB	Extensively Drug-Resistant Tuberculosis

6. Approval and Implementation

Protocol Custodian

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Mr Michael Walsh

Director-General, Department of Health

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Version Control

Version	Date	Prepared by	Comments
1	01/07/2013	Communicable Diseases Unit	Three new documents
2	11/11/2015	Communicable Diseases Branch	Reviewed HSD – one single protocol.
3	30/11/2018	Communicable Diseases Branch	Reviewed HSD and Protocol

