Policy 6.3  Active Surveillance for Tuberculosis in Health Care Workers

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<tbody>
<tr>
<td>Reference Number</td>
<td>WA Tuberculosis Control Program Policy 6.3</td>
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<tr>
<td>Policy Statement</td>
<td>This document addresses the assessment for TB risk of students and employees in health-related work.</td>
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<tr>
<td>Areas Covered</td>
<td>Pre-employment screening protocol for students and employees in health-related work. Hospital based infection control measures for TB patients.</td>
</tr>
<tr>
<td>Policy sponsor</td>
<td>Medical Director, WA TB Control Program</td>
</tr>
<tr>
<td>Issued</td>
<td>02 September 2011</td>
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<tr>
<td>Review Date</td>
<td>06 July 2016</td>
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Related WA TB Control Program Policies

1.1  Diagnosis of tuberculosis – Laboratory
1.2  Diagnosis of tuberculosis – Clinical
2.1  Medical treatment of tuberculosis (adults)
2.2  Case management of tuberculosis
3.1  Diagnosis of latent tuberculosis infection
3.2  Treatment of latent tuberculosis infection
4.1  Tuberculosis (active and latent) in children
4.2  Management of tuberculosis in prisoners and immigration detainees
4.3  Tuberculosis (active and latent) in pregnant women
4.4  Tuberculosis and HIV
5.1  BCG Vaccination
6.1  Contact tracing for tuberculosis
6.2  Active surveillance for tuberculosis in recent migrants
6.3  **Active surveillance for tuberculosis in health care workers**
6.4  Active surveillance for tuberculosis prior to anti-TNF alpha treatment
7.1  Notification of tuberculosis and enhanced surveillance data
8.1  Diagnosis and management of Hansen’s disease
9.1  Management of confidential information for the WA Tuberculosis Control Program
9.2  Client record management policy for the WA Tuberculosis Control Program
9.3  Fees and charges associated with tuberculosis and leprosy treatment

Document Control

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<td>01 Sept 2011</td>
<td>Policy and Operational Directive</td>
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<td>24 Nov 2011</td>
<td>WHO website added for country TB incidence</td>
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<tr>
<td>1.2</td>
<td>07 July 2103</td>
<td>Revisions post Osborne Park Hospital review</td>
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<td>25 Sept 2014</td>
<td>TB country profile weblink edited. OD updated</td>
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Policy 6.3  Active Surveillance for Tuberculosis in Health Care Workers

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Definitions

| ACC       | Anita Clayton Centre, (Centre for the WA TB Control Program). |
| HCW       | Health Care Worker. In this document, HCW refers to anyone who is an employee or student in health-related work |
| LTBI      | Latent Tuberculosis Infection |
| TST       | Tuberculin skin test |
| NTAC      | National Tuberculosis Advisory Committee |
| PT        | Preventive Treatment |
| QIFN      | QuantiFERON-TB Gold In-Tube assay |

1.0 Introduction

Tuberculosis (TB) is uncommon in Australia and rare in health care workers (HCWs). However, even in a low incidence setting, occasional exposure of HCWs is inevitable and there is reliable evidence demonstrating the increased risk of acquiring TB infection and disease among some HCWs (Stuart et al 2001 and Menzies et al 2007). In addition, the increasing numbers of HCWs being recruited from countries with high TB incidence means that there is an increased risk that these workers will have been infected with TB before arrival and may subsequently develop active disease. Among HCWs notified with TB, the proportion born overseas increased from 50% (10 of 20 cases) in 2001 to 92.9% (26 of 28 cases) in 2007 (National Tuberculosis Advisory Committee (NTAC), 2009).

This document addresses the assessment for TB risk of students and employees in health-related work and recommends minimum precautions that health care facilities (both public and private) in Western Australia should undertake to minimise the risk of TB transmission within the health care system.

2.0 Pre-employment assessment

2.1  Rationale

a) HCWs may be exposed to TB in the course of their work. Baseline assessment of TB status is useful in the post-exposure assessment.

b) HCWs may have latent TB (LTBI), especially if they come from, or have worked in, high incidence countries, and are therefore at increased risk of developing active TB while working. This group should be considered for preventive therapy

c) HCWs may have active tuberculosis.
2.2 Risk assessment

All employees of health facilities, or students undertaking tertiary education that involves clinical work, should be assessed for risk of TB prior to starting clinical work. This assessment determines which TB tests are required and what action should be taken if the tests are positive.

A suggested proforma for risk assessment is included (Appendix A). The recommended procedure for using this assessment to determine the tests required and action to be taken is summarised in an included algorithm (Appendix B). A Fact Sheet explaining the reason for testing and the nature of TB risk for HCWs is also included (Appendix C), and this can be provided to all new employees at the time of TB screening.

Risk assessment involves three components:

i. History indicating risk of prior TB infection:
   - Country of birth has a high TB incidence (rate > 50 / 10^5, for tuberculosis country profiles see [http://www.who.int/tb/country/data/profiles/en/](http://www.who.int/tb/country/data/profiles/en/)).
   - Residence and/or work in a high incidence country for more than 6 months;
   - Past history of TB; and
   - Past history of contact with TB (work or personal).

HCWs who have any of the above in their history are considered to have high risk for LTBI, and referred to as Group 2 in Appendix B. HCWs who have none of these have a low risk for LTBI and are referred to as Group 1 in Appendix B.

ii. Predicted probability of future occupational exposure:
    The probability of future TB exposure should be categorised according to an employee’s likely contact with TB (see Table 1). Note that this does not refer to the risk of latent TB infection in any particular individual (assessed in part (i) above), or the risk of transmission of TB when contact tracing is undertaken (discussed in Policy 6.1 Contact Tracing), but rather an assessment of the likelihood of exposure to TB from patients in particular HCW roles. High & medium probability groups are distinguished, because the HCW in the high probability group should also be considered for routine follow up screening in addition to pre-employment screening (see section 5.0 below).
Table 1: Predicted probability of future occupational exposure

<table>
<thead>
<tr>
<th>High probability</th>
<th>Medium probability</th>
<th>Low probability</th>
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| Staff in the following roles, and thereby may have regular or higher risk contact with patients that have TB:  
  - TB clinics,  
  - Microbiology laboratories dealing with TB specimens,  
  - Bronchoscopy or sputum induction,  
  - Post-mortem examinations,  
  - Lung function testing. | Staff with regular contact with patients that are not in a high probability category. | Staff who do not usually have contact with patients (e.g. clerical, administrative, non-microbiological laboratory staff) |

iii. **Other useful information:**
- Previous Mantoux test results;
- Previous BCG vaccination;
- Medical history and medications that may compromise immune response; and
- Residency status and, if temporary, expected duration of stay in Australia.

### 3.0 Screening Test

If written documentation of a prior TB test (Mantoux or Quantiferon) is available, TB tests do not need to be repeated i.e. results from a prior employer are transferable to all subsequent workplaces. There is no time limit on this.

Screening tests for TB are indicated in the following health care workers:

- Persons assessed as low risk of prior TB exposure (Group 1 in Appendix B) **but predicted probability for future exposure to TB is high or medium.**

- **All persons assessed at high risk of prior TB exposure** (Group 2 in Appendix B) regardless of future occupational exposure

Individuals who are likely to have minimal or no contact with patients (low probability), and do not have any history indicating likely TB exposure, are **not** required to have any test.
There should be no financial impediment to HCWs undertaking TB screening or any necessary treatment. Institutions should consider providing these free of charge to employees and students.

The result of the test should be given in written form to the employee or student. A record of the pre-assessment and results of tests should be kept by each institution.

**Which screening test for LTBI should be used?**

The tests available for screening for latent TB infection (LTBI) in health care workers are the Mantoux or tuberculin skin test (TST) and the QuantiFERON TB-Gold In-Tube assay (QIFN). The National TB Advisory Committee (NTAC) recommends that TST be used as the primary test for LTBI, and that Interferon Gamma Release Assays, such as QIFN, be used only as supplementary tests in specified circumstances (NTAC 2009).

The preferred test of the WA Tuberculosis Control Program is the TST. However, this policy recommends that either test can be used to screen for LTBI in HCWs. The choice of which test is used should be made by the institution conducting the screening. The advantages and disadvantages of the two tests are summarised below.

### 3.1 Tuberculin skin test (Mantoux test)

**Advantages:**
- Cutoffs for a positive result and conversion are well supported by research data; and
- Longitudinal data is available to validate the predictive value of results.

**Disadvantages:**
- Reduced specificity: cross reactions may occur, giving false positive results in subjects who have had prior BCG vaccination or who have had exposure to environmental mycobacteria;
- Requires 2 visits. Compliance with return visit to obtain the result is usually about 60%;
- Reduced sensitivity: co-morbidity or medication may render a subject anergic resulting in false negative results;
- Requires skilled practitioners that regularly administer and read the test;
- Booster effect: pre-employment TST can boost the result causing false positive conversion.

### 3.2 QuantiFERON-TB Gold Assay

**Advantages:**
- Convenience - a blood sample for QIFN testing can be taken at the same time as other blood sampling. This substantially improves compliance;
• Improved specificity: the test is minimally affected by previous BCG or sensitisation to non-tuberculous mycobacteria (Pai & O’Brien, 2008). This is especially useful in low incidence populations (Group 1 in Appendix B);
• Less inter-reader variability than with the TST (Pai & O’Brien, 2008);
• No boosting effect from previous QIFN testing (Mazurek et al, 2005); and
• Results are recorded and easily retrieved from a results database such as iSoft.

Disadvantages:
• Lack of evidence supporting its use for HCW screening and follow up;
• Lack of longitudinal studies that inform us how the test performs over time, especially conversion from negative to positive;
• The problem of indeterminate tests has yet to be resolved (Mazurek et al, 2005);
• Uncertainty about the significance of threshold results (positive or negative results that are near the cutoff) and the phenomenon of “flip-flopping” (threshold results that change from positive to negative or vice-versa between two tests) (Mazurek et al, 2010); and
• Time limitations: blood samples need to be collected and processed within a limited time frame. This can be a problem for samples collected outside the metropolitan area.

3.3 Provision of TST for Health Care Workers

The Anita Clayton Centre (ACC, Centre for the TB Control Program) does not routinely provide pre-employment screening tests for HCWs or tertiary students. In certain circumstances the ACC can provide this screening, but this is only by prior arrangement with the TB Nurse Manager.

The ACC is available to train practitioners in the provision of TST testing. This training can be arranged through the TB Nurse Manager. Alternatively TST is available through some private pathology providers, or Regional Public Health Units.

General considerations:

• Informed consent must be obtained from the HCW.
• A record of the TST (including date of the test and the reading) must be kept, with a copy given to the HCW.
• Tuberculin skin testing should only be undertaken by appropriately trained health care providers.

Management of abnormal results

The procedure for management of abnormal screening results, including what further tests are indicated (e.g. chest x-ray) and whether preventive therapy is recommended, is summarised in the attached algorithm (Appendix B).
HCWs with a positive TST test, or a positive or indeterminate QIFN, require a chest x-ray and medical evaluation by, or in conjunction with, a medical practitioner experienced in TB management. The Western Australian TB Control Program, based at the Anita Clayton Centre, is available for management or advice. Alternative practitioners for medical evaluation are Infectious Disease Physicians, Respiratory Physicians or Public Health Physicians with expertise in TB.

4.0 Post exposure follow-up

When a hospital inpatient, other health setting resident or health care worker is diagnosed with active TB, follow up of other staff and patients that have had contact, or exposure, to the index case may be necessary. This is done according to routine contact tracing principles, which are detailed in the WA Tuberculosis Control Program Policy 6.1 Contact Tracing. While specific details relevant to contact tracing in a health setting are given here, this section of this policy must be read in conjunction with Policy 6.1 Contact Tracing.

Post-exposure follow up is not always necessary. Whether it is required depends on whether there has been ‘significant’ exposure, which in turn should be assessed on a case-by-case basis, but can be defined as:

‘Contact with an inpatient with pulmonary TB and sputum that is smear positive for acid fast bacilli (AFB), who has not been isolated or where a breach of TB isolation precautions has occurred’.

It is important to be certain of the sputum AFB smear result. Patients with pulmonary TB that is smear negative or who have extra-pulmonary TB only, do not routinely require post-exposure follow up, apart from other patients that have shared their room for more than 8 hours (this exception is detailed below).

Patients that have been isolated with uninterrupted respiratory droplet infection control throughout their admission do not routinely require post-exposure follow up, even when the sputum smear is positive.

Significant contact includes:

- Contact on a single occasion or cumulatively, ≥8 hours; and/or
- Contact involving a procedure that confers increased risk (e.g. sputum induction, bronchoscopy, post-mortem examination); and/or
- Contact where physical containment requirements in a microbiological laboratory are breached.

The above definitions broadly define the requirements for the necessity of contact tracing. However, there will be occasions when contact tracing is deemed necessary outside these requirements (e.g. sputum smear negative index case) and the decision to do this should be made by the responsible infection control officer in consultation with a physician with expertise in TB in the given institution and the Medical Director of the TB Control Program.
As described in detail in Policy 6.1 *Contact Tracing*, the extent and timing of screening tests when contact tracing is undertaken is critically dependant on whether contacts are identified as household ("close") or casual contacts. In general:

- Patients that have shared a room with an index case for more than 8 hours are considered close ("household") contacts. This applies to all index cases of pulmonary TB, whether smear positive or negative, but not extra-pulmonary TB.
- Patients that have contact with an index case (either patient or health care worker) in areas other than a shared room are classified as casual contacts, and are stratified according to the estimated time of contact.
- Health care workers that have contact with an index case (patient or another staff member) are considered casual contacts.
- All contacts of a health care worker with sputum smear positive TB are considered casual contacts.

As can be seen from these definitions, most contacts from a hospital based index case are considered "casual". Casual contacts generally only need one test after 8 – 12 weeks, in accordance with general principles as outline in Policy 6.1 (section 4.3.3).

To make the above principles and definitions clear, an algorithm for the broad process that should be followed is given in Appendix D. Post exposure follow up should also include:

1. Informing the contact in writing of the possible exposure as soon as possible. A standard template letter that can be used for this purpose is included at the end of this policy (Appendix E);
2. TB testing according to the test used for baseline testing. If a QIFN was done initially, a repeat QIFN should be done; if the baseline test was a TST or there is no baseline, a TST should be done; and
3. If the TB test is positive or converts (as compared to the baseline test), a chest x-ray should be done and the HCW should be referred to a medical practitioner experienced in TB management (as described above).

The responsibility for contact tracing of staff and patients from a health setting rests primarily with the hospital or other place in which it is to occur. It should, however, be conducted in consultation with the WA TB Control Program, and in particular screening should not be initiated until the index case details and the stratification of the contact list has been reviewed by the TB Control Program. Screening tests are generally done by the hospitals, but some responsibilities may be handed over to the TB Control Program e.g. follow up of patients that have been discharged, medical review of contacts with positive test results.

Some other issues to address in a health setting are:
- Clear and prompt communication with patients and health care workers, especially to alleviate anxiety or unfounded fear;
- Communication with senior Area Health executive or other responsible executive. This is recommended for all hospital based contact tracing;
- Addressing the possibility of publicity and media attention. It is not recommended that this be done pre-emptively. Any media enquires should be referred to the Medical Director of the TB Control Program through the Public Relations Department, NMHS;
- Ensuring the privacy and confidentiality of the index case.

5.0 Routine follow-up tests

Repeat TB test or chest x-ray is generally not recommended as a routine. However, routine testing is warranted in certain HCWs, specifically HCWs that:
- have ‘significant’ exposure (defined above under 4.0 Post-exposure follow up) more than once in a calendar year,
- are regularly in a role identified as “high probability” for future occupational exposure (see table 1, page 5).

If the baseline screening test was negative, these employees should be offered an annual test, using the same test that was done as the baseline test. If the test was positive, then annual chest x-ray can be considered. Any change in the test should prompt referral to the TB clinic or an appropriate alternative TB specialist for assessment.

6.0 Active TB

A HCW suspected of, or diagnosed with, active TB should be urgently referred (appointment within 1 week) to a TB physician at the Anita Clayton Centre, or a suitable alternative specialist, for assessment and treatment. If possible, arrangements should be made for the individual to submit 3 sputum samples collected on consecutive days for TB culture.

In addition:
- a) Informed consent must be obtained from the HCW before disclosure of details of the infection to the employer;
- b) The diagnosing practitioner is required, under the Health Act, to notify the Communicable Disease Control Directorate;
- c) The HCW is to be excluded from the workplace, if diagnosed with pulmonary TB, until cleared by the medical supervisor nominated by the institution in consultation with a medical practitioner experienced in TB management; and
- d) The HCW must complete a satisfactory course of treatment and follow up, with appropriate certification provided to the institution by the treating doctor.

7.0 BCG Vaccination

BCG vaccination is not recommended for HCWs in Western Australia.
8.0 Responsibilities

8.1 Health care facilities

Health care facilities should:

a) Periodically review the Tuberculosis Infection Control Policy for the facility and ensure that all HCWs are updated on current policy on a regular basis;

b) Have protocols to ensure the rapid detection, isolation and treatment of patients with infectious TB;

c) Manage patients with known or suspected TB as outpatients wherever possible;

d) Have isolation rooms for patients with known or suspected infectious TB that require inpatient management. These rooms should have appropriate engineering controls including negative pressure ventilation separated from general air conditioning, and exhausted to the outside of the building. The ventilation of the rooms should achieve at least six air changes per hour;

e) Promptly transfer inpatients with known or suspected TB to a facility with an appropriate isolation room, if inpatient management is required and isolation as described above is not available (the size or function of the facility may make the provision of such a room impractical). On rare occasions where immediate transfer is impractical, patients should at least be managed in a single room that is as isolated from other patients as possible;

f) Supply appropriate personal respiratory protection (e.g. a close-fitting, one micron filter mask; regular surgical masks are inadequate) to staff dealing with patients with, or suspected to have, infectious TB. Such patients should also be educated to cover their mouth or nose when coughing or sneezing;

g) Maintain microbiological laboratory protocols that ensure minimal risk of transmission of TB from potentially infectious specimens (National Tuberculosis Advisory Committee, 2006);

h) Educate staff about TB appropriate to their work category. It should be emphasised that the most effective way to control TB is early detection and commencement of treatment; and

i) Exclude HCWs who are HIV positive or otherwise immuno-compromised from work in an environment with known or suspected infectious TB patients.

8.2 Health Care Worker (HCW)

The HCW should:

a) Comply with this policy and ensure maintenance of adequate infection control standards in the workplace; and

Present promptly for medical assessment at the onset of any signs or symptoms suspicious of TB.
8.3 Western Australian TB Control Program

The Western Australian TB Control Program should:
   a) Provide specific advice to the health care facility about pre-employment screening, post-exposure contact tracing and maintenance of infection control infrastructure and policy;
   b) Provide training as required in TB infection control and HCW TB risk management. This includes training in TST if this is the screening test chosen by the institution; and
   c) Provide a consultative service for review of HCWs with positive tests for LTBI or suspicion or evidence of active TB.

Any queries regarding these recommendations should be directed to:

Western Australian TB Control Program
Anita Clayton Centre
Suite 1, 311 Wellington St
Perth WA 6000
Tel: (08) 9222 8500
Fax: (08) 9222 8501
9.0 Works Cited


Appendix A: Suggested Proforma for Assessment of Risk of TB in HCWs

Surname: __________________________________________
First name: ________________________________________
Date of Birth: _____________________________________
Address: _________________________________________
Telephone contact: _________________________________
Employee or student number: _______________________

What is the risk of TB infection?
1. Have you been treated for TB in the past? ________
2. Have you had contact, personally or at work with somebody that suffered from TB? ____________
3. Country of Birth? _____________________________
4. What countries have you lived or worked in for more than 6 months, other than your country of birth?
   ____________________________________________
   ____________________________________________
5. Are you Aboriginal or a Torres Strait Islander? ______

If “Y” to ANY of the above, then Group 2 (yellow) in algorithm (Appendix B)


What is the risk of TB contact from work?
What is the proposed area in which you will be working or studying in the health system?
   Specify: 1) position (e.g. doctor, RN, physio, student etc.): ___________________________
   2) speciality area (e.g. medical, surgical, paediatric etc.) __________________________

Other information
Have you had a Mantoux skin test before? ☐ No ☐ Yes Result: _______________________
Have you had BCG vaccination? ☐ No ☐ Yes When: __________________________
Do you have a medical history of immune deficiency, ☐ No ☐ Yes
   or take medicines that reduce immune response? ☐ No ☐ Yes
Are you a permanent resident / citizen of Australia? ☐ No ☐ Yes
Visa expiry date? ___________
### Office Use Only

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<th>Option 3</th>
<th>Option 4</th>
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<th>Option 7</th>
<th>Option 8</th>
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<td>Refer to TB specialist for assessment</td>
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<tr>
<td>Risk of Latent TB infection?</td>
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<td>☜ High</td>
<td>Group 1 (blue) in algorithm</td>
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<td>☜ Low</td>
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<td>Test for Latent TB Infection:</td>
<td>Date:</td>
<td></td>
<td>TST – result: __________ mm</td>
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<td>Chest x-ray done?</td>
<td>☐ No</td>
<td>☜ Yes</td>
<td>Result: _________________</td>
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<tr>
<td>Referred to TB specialist?</td>
<td>☐ No</td>
<td>☜ Yes</td>
<td>Where: _________________</td>
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Delivering a **Healthy WA**
Appendix B  
Algorithm for Management of TB risk in HCWs

All Health Care Workers & Tertiary Students in Health Care

↓

Risk assessment for TB infection *

↓

Is there high risk for LTBI?

**

NO (Group 1)

Aim – establish baseline TB status

↓

What is the probability of contact with TB? **

Low

Medium or High

↓

Is there written documentation of a prior LTBI screening test?

YES

LTBI screening test #

↓

Neg

Pos or Indeterminant

↓

Record risk assessment +/- test result

Refer to TB specialist for CXR & education

YES (Group 2)

Aim - diagnosis & treatment of active TB and LTBI (preventive therapy)

↓

CXR

(if not done in last 6 months)

↓

Is there written documentation of a prior LTBI screening test?

NO

↓

LTBI screening test #

↓

Neg

Pos or Indeterminant

↓

Record risk assessment & test result

Refer to TB specialist for consideration of preventive therapy

Notes:

* See text of "Tuberculosis & Health Care Workers" document and Appendix A

** See text of "Tuberculosis & Health Care Workers" document

LTBI Latent TB Infection

CXR Chest x-ray

# TST or Interferon Gamma Release Assay

Note: If past history of TB treatment, refer to TB clinic.
Appendix C  Pre-Employment Fact Sheet for Health Care Workers

Tuberculosis (TB) Screening

You have been asked to undergo screening for tuberculosis (TB) as part of your pre-employment assessment. This is a routine requirement of all personnel working in clinical areas. The following are answers to commonly asked questions for your information:

1. Why do we do screening?
   There are two reasons:
   a. To check for dormant (latent) TB infection and, if this is found, to offer you the opportunity to have preventive therapy to protect your future health.
   b. To act as a baseline, which helps in the interpretation of future screening that may be required because you come into contact with a patient with TB.

2. What is the risk you will get TB from your work?
   TB is uncommon in WA and TB is not a highly contagious disease, so the risk is very low. Usually patients with TB are appropriately isolated and/or on treatment so that the TB cannot be transmitted to you. Occasionally, when this is not the case, you may be asked to have further screening tests (see below), because you are identified as a contact of the patient with TB.

3. What screening tests are done?
   You will be asked to complete a simple, single page questionnaire that is designed to assess the risk that you have already had contact with TB. You may also be asked to have a tuberculin (Mantoux) skin test or Quantiferon Gold TB assay (blood test). These tests measure whether you have been infected with TB.

4. What if the test is positive?
   A positive test does not usually mean you have tuberculosis, but rather that you may have been infected in the past. A positive test indicating dormant infection means that there is no immediate risk to your health and you cannot pass the TB on to anyone else. If you have a positive test, arrangements will be made for you to have a chest x-ray (to make sure there is no active TB) and to see a TB specialist doctor who will discuss with you what the result means and what can be done about it.

5. What if you think you have active TB?
   TB usually affects the lungs and causes a cough lasting for more than 3 weeks, possibly together with phlegm production, low grade fever and weight loss. If you are worried you have active TB you should contact an Occupational Health officer in your place of employment or the TB clinic (see below) as soon as possible.

6. Contact:
   If you have queries regarding this advice, please feel free to contact the TB clinic:
   Anita Clayton Centre (previously called the Perth Chest Clinic)
   Hours of operation: Mon – Fri, 8:15 – 4:15pm
   T: (08) 9222 8500  E: ACCadmin@health.wa.gov.au
Appendix D  Procedure for TB Contact Tracing in a Health Care Setting

NB. This algorithm should be followed with reference to details given in the policy, section 4.0 Post Exposure Follow Up

TB case diagnosed - inpatient, resident or health care provider

Pulmonary TB  Extra-pulmonary TB only

No health care setting contact tracing required

Sputum AFB smear

positive

negative

Type of contact

Casual

Close ('Household')  Patient only

Inform all contacts ASAP: see Appendix E
General group-based information also useful

Screening test

After 8 - 12 weeks

ASAP

negative

positive

or test conversion

negative

retest after 8 - 12 weeks

negative

discharge

CXR and referral

CXR also required ASAP as screening for patients identified as close contacts

discharge
Appendix E  Template to inform HCW of occupational exposure to TB.

Dear

We have reason to believe you have been in contact with someone who has been diagnosed with tuberculosis (TB). This is an airborne infection which may be passed on from person to person by coughing, sneezing, etc. Although the risk of acquiring TB from occupational exposure is low we recommend you undergo routine screening.

We recommend you have a [insert screening test: Tuberculin Skin Test (Mantoux test) / Quantiferon GOLD TB Assay], which can be provided at the [insert location]. The test will be available to you free of charge. It is important that you have the test 8 weeks after exposure, rather than immediately, and therefore you will need to have your test done after the [insert date]

In Australia TB is an easily treatable disease. It is preferable to detect the infection early as often preventive treatment can be given to stop the development of the disease. Even if screening tests show that the exposure to TB has lead to infection in you, this does not result in you being infectious and you can not pass the bacteria onto other people.

It is normal practice to keep the name of the person with TB confidential. All information relating to your visit will also be confidential.

If you have already attended to this screening or do not want to undergo the tests, please complete the slip below and return it to [insert location].

Please bring this letter with you when you attend the clinic. If you have any queries please telephone the WA Tuberculosis Control Program on 9222 8500 and ask to speak to a Nurse. Further information can be found at http://www.health.wa.gov.au/acc/home.

Yours sincerely

_____________________________________________________________
Name…………………………………. Position………………………….

☐ I do not wish to undergo screening tests following my exposure to a TB patient.

☐ I have already undergone the screening tests following my exposure to the TB patient.

Signed………………………………..           Date…………..

Delivering a Healthy WA