e-TB Nurses of Aus

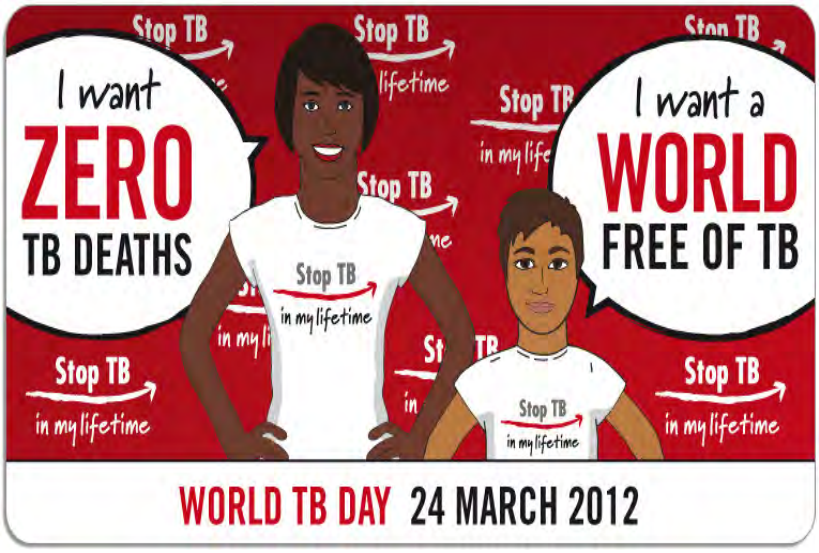
Newsletter No. 1 - 2012

What's in this edition:

Welcome back to the e-TB Nurses of Aus Newsletter – the first of hopefully many exciting editions to come in 2012. Thank you to all who responded to the feedback request regarding the newsletter. The responses were indeed very encouraging and provided renewed energy to keep this communication tool going as a means to providing news, education and networking opportunities. See pages 4 and 5 for the comments from your national colleagues. I'm not sure about doing a Sports Section, but I'm sure I could manage it in one of the editions - I just have to send out the reporter to get the full story and action shots!

Included in this newsletter evaluations and the feedback, was the very generous offer from Annmaree Nicholls to be a co-editor – obviously I didn't let that chance go by! Therefore to help to make our jobs a little easier, to keep this communication tool going and to reduce the number of photographs and stories of the editors to fill the gaps, we would dearly love to receive your articles, case presentations, snippets, photos, reports, questions, job vacancies etc that you would like to share with the rest of the TB nurses across Australia!

http://www.stoptb.org/events/world_tb_day/2012/



Don't forget World TB Day 24 March

What are you and your colleagues doing for World TB day?

Don't forget to let us know for the next edition

Without further adieu, we hope you enjoy the first newsletter for 2012 and don't forget to tell us what you think.

Carmel Cochrane (Editor) & Annmaree Nicholls (Co-editor

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State TB Services Internet sites:

VIC: http://www.health.vic.gov.au/ideas/bluebook

ACT: http://www.health.act.gov.au/c/health?a=da&did=10009573&pid=1207892937

SA: http://www.rah.sa.gov.au/thoracic/about/

WA: http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=519

NSW: http://www.health.nsw.gov.au/publichealth/infectious/tb/index.asp

NT: http://www.health.nt.gov.au/Centre_for_Disease_Control/Tuberculosis_and_Leprosy/index.aspx

TAS: http://www.dhhs.tas.gov.au

QLD: http://www.health.qld.gov.au/qtbcc/

Job Vacancies:

Watch this space for Lismore

Protocols / Policies:

- National TB Screening Policy for the Protection of Health Care Workers draft
  - was endorsed in principle at NTAC meeting in Aug 2011 as a living document and now sits at CDNA level for sign-off
  - will provide guidance for the review of statewide policies to ensure alignment with the national policy /guidelines.
- IGRA statement endorsed by NTAC (not yet on website)

Forthcoming Conferences

- Woolcock Research Institute, TB advanced clinical training and research days, 4 & 5 May 2012, Glebe Sydney. Program to be confirmed.
- 6th Conference of the Union Europe Region: London, UK; 4 -6 July 2012
- TB Conference, Netherlands April 2012 – awaiting date
- RCNA National Conference: Corporate & Clinical Governance; Cairns Qld; 23-26 May 2012
- 5th Passionate About Practice Nursing Conference, Brisbane Qld: late Aug 12 - awaiting date
- RCNA Community & Primary Health Care Nursing Conference, Perth WA; 17-19 Oct 2012
- NSW TB Nurses Conference – late 2012- date to be confirmed

Tuberculosis Control Program, Victoria

By Lynne Brown & Melissa Carroll

The Victorian Tuberculosis Control Program saw a 17% reduction in cases in 2011 (n=360) when compared with 2010 (n=436). Of note, Q4 numbers were 107 in 2011 compared with 112 in Q3. The Q4 figures were a 22% decrease on the same quarter in 2010 (n=138).

89% of cases were born overseas in 2011 and the largest number of cases identified were from India (n=93 or 27%). Pulmonary disease accounted for 56% of cases (n=205) in 2011 compared with 51% of cases in 2010. The number of new cases accounted for 95.3% of the total number and 3.9% were relapse.

The ratio of female to male in 2011 = 1:1.3. Age ranges from 1 year to 93 years, with a median age of 31 years. Of concern; 17 children aged less than 15 years diagnosed in 2011 compared with 6 in 2010.

There were 19 Healthcare workers identified through surveillance which accounted for 5.3% of cases. A further 6 cases identified as having worked in the healthcare industry >12 months prior to their TB diagnosis.

The program saw 6 MDRTB cases in 2011, one more than in 2010 (n=5).

Newsletter Evaluations

Thank you to those who provided feedback from the request in the November 2011 edition. Please see the following responses and the final outcome:

"Carmel this is a great initiative (however an enormous amount of extra work for you). Congratulations!
1. A great tool for communication between interstate TB Units and the nurses involved with TB control in other States.
2. It's giving status to TB nurses Australia wide as a highly specialised group.
3. Promotes research and education within our speciality by giving a platform for TB nurses to publish different articles.
4. Great to be able to put a "face" to a name rather than just talking on the phone.
5. Also an opportunity for all TB nurses to see how others in this area conduct their day to day business".

"For someone relatively new to TB, I think this is a great resource. It gives an overview of the other services and clinicians in Australia - which is awesome. I also really like how it highlights education and conferences - great inspiration for staff"!

"I find the e-newsletter a very informative and interesting read. I appreciate reading what is going on elsewhere as well as closer to home. In this edition, I found the article on the ulcers particularly interesting - I had heard of Bairnsdale and Daintree ulcers, but never knew what they were. Now I do - thank you. I look forward to next edition"

"Only thing missing is the sports page"!

"Very interesting newsletter"

"The short answer is I think this is a fantastic initiative which is worthwhile continuing - I think it will grow in popularity and value. Photographs of staff are particularly helpful as it gives us a face to a name".

I know that all of us in Melbourne have really enjoyed getting the newsletter and hearing about how everyone else works and reading the interesting profiles. I realise that it is a lot of work to put together and I would encourage all TB nurses to get behind the newsletter so we can keep it going without you having to stress too much to get content.

I love the newsletter and I think it is and will be invaluable to TB nurses as a structure for years to come. I agree with Lynne it is a lot of work for one and I hope more staff get behind it to support you, as busy as we all our it is for us and we need to work together. Remember we are all in this together. I have had some preliminary talks with ACU last week, who have a team of students travelling to India to do clinical placement in a TB/ Leprosy sanatorium next year. They are after some per trip lectures. This is a great opportunity to highlight TB nursing …and would assist with succession planning, getting student nurses interested in TB work. I wonder how many clinics have students visit?? I will let you know what happens. Thank you Carmel on behalf of all TB Nurses for the work you do.

I think the newsletter is a great idea and I apologise for no input from SA I guess it is one of those thing you think yes must do it and then it slips into the back ground. It is a great means of hearing what is happening and I promise to mend my ways in the New Year.

Just to let you know you have done a really great job with the newsletter. It is very informative and brings all TB services together as we read more about the other states TB services. I would like more education- like the report on M. Ulcerans as NTMs are very interesting, even though our main role is TB. Also would like a section on upcoming workshops, seminars etc related to TB if possible. Keep up the good work.

It's a great networking opportunity

Newsletter Evaluations (continued)

I think the newsletter is great and certainly a worthwhile link to others working in the same area around Australia. I have forwarded it to our Respiratory Consultant here who was very impressed so please don't give up the great work you do on it.

We in the ACT love the newsletter. We often think about contributing but feel that our own TB data /stories are perhaps not worthy enough.... but guess what - they probably are... so please keep going.....

Thank-you for the Newsletter and for all the hard work that goes into it. It certainly fills a need on the TB Scene for Nurses.

I found the newsletter great and & an asset to see what is happening around TB Clinics in Australia. I was absolutely thrilled when I saw the 1st newsletter. It gives us that great networking with others in OZ and also keeps us updated with what is happening. It is like an enpowerment and I get the great feeling that we all speak the same language (TB) and can understand the issues facing us - which does not happen when you talk to others in health and management.

I feel that it is worthwhile and would like to keep it going. Maybe have a newsletter twice a year instead of quarterly. I am currently snowed under and so have been keeping a low profile but interest is very much still there. I would certainly like to get involved next year.

Would be a bit easier for you if it was published two or three times a year instead of 4? It has been a great read, especially the most recent November 2011 edition. It's such a good way of keeping in touch with what other states are doing. I hope you will keep it going.

I have enjoyed reading the newsletter & thank you for all your hard work to bring it to us. I like reading about what others are doing around Aust. It's like a mini-conference that you can get ideas from & re-ignite your enthusiasm for the important TB work we are doing. I especially like seeing photos attached to the stories so that I can put a face to the names of people I deal with from time to time.

Improvements? *Perhaps a call for volunteers to report back on the conferences you have listed. Not many of us get the chance to go to some of the overseas conferences. It would be nice to get a brief note about some of the good presentations or trends being presented.*

Continue? *I would like to see the newsletter continue. I think that distribution could be improved though. Even if it is just a link to an online website that has the newsletter posted. Unfortunately I lose track of when they are published & don't think to look for it. Luckily someone has forwarded on the last couple.*

Other comments?

- *Perhaps some brief progress notes from those doing the research stuff listed.*
- *Maybe some feedback would be helpful to the researchers.*
- *Do the researchers have a blog page that econversations can be held to stimulate ideas & enthusiasm.*

Outcome:

- **Due to popular demand, the e-TB Newsletter will continue.**
- **Annmaree Nicholls kindly offered to be co-editor and I gratefully welcome her assistance.**
- **Suggestion to have a Case Study section and more education**
- **We need your assistance with the input – so please send us your articles**
- **If there are any of your colleagues who wish to be on the newsletter circulation list, please email me with address/s.**

Visiting Papua New Guinea "Land of the Unexpected"

By Kerry McGrath (Public Health Nurse, Victoria)

I had expressed an interest in visiting PNG for five years. My wish became reality after a friend, who had been before, was keen to return. We flew first to the highlands attending the Goroka Show: a photographer's dream, with an amazing diversity of cultural groups distinguished by their costumes, music, and dance. We then flew to Tufi, a sleepy coastal town in Oro Province, to the north east of the mainland. Tufi boasts a Council office, a Medical Centre, one policeman, a Primary school, but no Secondary school, although there are plans afoot to build one with Australian Aid. Tufi boasts some of the best diving in PNG, and is surrounded by spectacular fiords. There are no roads connecting Tufi: as in most of PNG, transport is limited to walking, canoe, or plane. The closest major town and hospital is at Popendetta, which is 30 minutes flying time.

Goroka Show – Highlands

We visited the Tufi Medical Centre to deliver donated spectacles. There we met two health care workers, one a midwife: they generously showed us around. There was no running water or electricity. Torches are employed during delivery and other procedures. Refrigeration is available at the Dive Resort, and this is where vaccines are stored. The water supply appeared to be clean: according to the HCW's, diarrhoea was not a problem amongst the children. Patients supply their own linen and towels; beds are provided in the in-patient ward, but without any mattress. During our visit, there were two patients in the ward: one of whom had been transported from her remote village by Dive resort boat. My travel companion, a midwife from the Northern Territory who has practiced in remote areas, was impressed with the knowledge of the local midwife. She saw some similarities with conditions experienced in remote Australian bush communities. Tufi Medical Centre displayed two TB Posters: one emphasizing that TB is not contracted by sorcery, the other focusing on TB transmission. Both HCWs were aware of DOTS Program and had supplies of fixed dose combination medication, as well as Streptomycin for defaulters. In Port Moresby, we met Sian White, Project Co-ordinator, TB DOTS Program World Vision ACSM (Advocacy Communication and Social Mobilisation). Sian's program has developed a Community Support Volunteer Training Manual complete with posters, flip chart, flyers, stickers and educational comic books. Once again we noted that the emphasis on TB disease not being as a result of sorcery.

TB DOTS – Poster (Sorcery)

PNG certainly faces health challenges: delivering health information to the most linguistically diverse country in the world where 800 languages are spoken. The national language is English and Pigeon English. Life expectancy is 61 years. 13% of the population live in urban areas. The remainder live in rural communities, in traditional villages, where they are dependent on subsistence farming, currently challenged by climate change. Mining too changes the ecology of the land and river systems. Most of the people have no access to electricity, running water. Even in Port Moresby, the water is turned off between 9pm to 7am; and firewood was being sold on the streets for fuel.

Law and Order is another challenge impacting upon health: particularly in Port Moresby, Mount Hagen and Lae. The geography of PNG present challenges too. PNG is an expensive travel destination with tours often not conducted professionally. The ex-pat community are constantly concerned about safety. We experienced no difficulty with regard to our safety, although, we were always accompanied by a local 'minder.' Unfortunately, PNG gets so much bad press here that most people say it would be the last place they would like to visit.
Despite the issues, I hope to return.

Staff Member Profile

Introducing Cindy Rugsten, RN BN DTM AFTM RCPS(Glasg)
Clinical Nurse, Queensland Tuberculosis Control Centre, Brisbane

How long have you worked for the TB Program?
I am a new migrant to Australia. I moved here with my family in July 2011 after working for 20 years in east Africa. In August 2011 I started working at the Queensland TB Control Centre.

What were you doing before coming to the TB Program?
I am a Canadian nurse qualified in Travel Medicine. My last nine years of work included the assessment and care of both in and out patients in a very busy 24 hour private walk-in clinic in Kampala, Uganda. Infectious diseases dominated our case load and many of our patients were HIV and/or TB positive. I was as well a clinical advisor to both nurses and doctors on issues of vaccination and travel medicine. TB screening and LTBI treatment were aspects of my work at the US Embassy Health Unit in Kampala where I was employed part-time for four years.

In my garden in Kampala, Uganda

For eight years prior to the above, I worked in Primary Health Care in some of the most resource challenged environments in the world: South Sudan, Somalia, and rural Kenya. I worked on the guinea worm control program, the onchocerciasis control program, and mass measles and polio vaccination campaigns coordinated by UNICEF. For 20 years I have been either implementing or supervising aspects of the WHO Expanded Program of Immunization.

What are your hobbies and/or interests?
I don't have hobbies. I love reading newspapers and medical journals. I spend what spare time I have with my kids and look forward to taking camping trips into the Australian bush.

Several years ago, one of our Queensland colleagues who shall remain nameless, was dutifully explaining the Tuberculin Skin test procedure to an anxious male client seated awaiting the test. Whilst the nurse was drawing up the Tuberculin, the explanation was being given……."Just a little prick under your foreskin……."

On hearing this, his pallor changed drastically to a shade of stony white, he instantly developed bilateral exopthalamus, his eyes became watery and he nervously crossed his legs whilst he re-positioned himself in the chair. He appeared very much relieved when his left forearm was swabbed!. The nurse was oblivious to her explanation until others in the room who overheard the comments burst into laughter! True story!

Providing Clinical Placement Opportunities for Nursing Students in the TB / Public Health setting

Report by Carmel Cochrane, Nursing Director, Brisbane

In late 2010, whilst liaising with the universities in south-east Queensland regarding the recommended TB screening for their HCW students prior to clinical placements, I began to question the awareness of the role of the TB unit by the health and educational sectors in addition to the awareness of TB disease itself by HCWs given my interest in TB diagnosed in HCWs in Queensland. For some five years previously, the nursing unit had been "taking" 2 students only from one university campus and allowing them to "tag" along for two weeks with the clinical nurses depending on what was happening. There was no documentation of a program, expectations, objectives, outcomes and/or feedback – merely a form from the university with student names and dates advising the unit to expect two students. It was at this point, that I decided to seize the opportunity with both hands to offer student nurses a clinical TB & public health experience they would never forget and with the hope of several win-wins:

- Provide a clinical experience totally different from the hospital scenario
- Teach students as much as possible re TB and public health
- Increase awareness of our unit within the group of future HCWs
- Increase awareness of public health nursing with a view to providing employment opportunities in the future for employment thus assisting with succession planning

And thus the Clinical Placement Program at QTBCC for Nursing Students was born and developed for the 2011 3rd year students undertaking a Community Health subject. The following is a direct "cut & paste" from the QTBCC Australian Council of Healthcare Standards (ACHS) Accreditation document submission Oct 2011

Improvements:

- Contacted several universities to identify if there was a need for clinical placement opportunities in the public health/ community settings
- Provided Onsite university screening for students undertaking health related courses as pre-clinical placement testing
- Student and lecturer word of mouth together with the provision of onsite TB screening has increased our profile in the tertiary sector with students requesting to attend QTBCC for placements.

What did you change:

- Reviewed the adhoc approach by QTBCC to student placements 2005-2010
- Reviewed the hospital-based program and written guidelines
- Searched for public health/community setting placements information in Queensland - nil
- Reviewed Queensland Health written guidelines

Result / Outcome:

- Developed a full information package including:
  - QTBCC profile
  - Clinical information and resources for both clinical lecturer and student
  - Student learning objectives
  - Program template for period of placement
  - Specifically designed feedback form for student
  - Register to record student details and feedback
  - Role and responsibilities of QTBCC Clinical Nurse
- Forwarded information package with an offer of invitation to all universities SE Qld with a nursing faculty to consider placement opportunities at QTBCC
- Documented student learning opportunities during their placement to ensure all QTBCC nurses were aware of student's learning
- Developed documented procedure for QTBCC
- Increase from 2 students/year to 14 nursing students for clinical placements at QTBCC in 2011
- Resulted in extra workload to QTBCC nursing team but considered worthwhile. Procedures streamlined to improve efficiencies.
- 95% students enjoyed their placements and provided very positive feedback re the knowledge and professionalism of QTBCC clinical staff, the level of information and resources available to the students to meet their objectives; the great benefit to their learning needs and their role at QTBCC whilst on placement
- Screened approx 5000 HCW students each year since 2009 prior to their clinical placements – identified one TB case in 2011; 2 cases in 2010 and 3 cases in 2008. Several students with LTB

Conclusion: has been considered a win-win situation for both student and QTBCC

Surviving a change management process

Report by Carmel Cochrane, Nursing Director, Brisbane

The Queensland TB Control Program was established in 1950 with the model of the central unit in Brisbane afforded both statewide responsibility for the management and control of TB *and* the delivery of clinical services across south east Queensland. This model remains to this day with Queensland TB Control Centre (QTBCC) Brisbane providing clinical services in the south-east corner in addition to statewide advice, locum support and surveillance of TB and other mycobacterial diseases. The Regional TB Control units (RTCUs) are district based and are responsible to District Managers for the services they provide which includes TB and mycobacterial diseases services. Even though the RTCUs do not report directly to QTBCC, it is through the established rapport over the decades that the relationship is one of partnership and support.

Due to our long awaited project of a statewide TB database and associated electronic records system (currently expected to go-live Oct 2012), the nursing team has been in a state of flux due to 1x FTE nurse dedicated to the in-house project since August 2010. Unfortunately many go-live dates have come and gone and we still have a nurse off line until approx 6 months past the go- live date for the delivery of essential training. As only you, our public health practice nursing colleagues can appreciate there is just as much difficulty in recruiting nurses for TB services as there is for other nursing fields. It continues to be a major management challenge to maintain staffing levels in order to continue to deliver expert, quality and safe nursing services given the above project and in addition to supporting "normal" staff leave and professional development requests including secondments whilst remaining vigilant of the ever-increasing workload and the negative impact this can have on staff if there is a shortfall in the number of nursing hours and/or experienced TB nursing staff.

The Mar 2010 evaluation and upgrade of the Nurse Manager role to Nursing Director and the "loss" of the experienced CNC (T. O'Brien) from clinical services to the project in August 2010 (anticipated 3-6 months) forced a review of nursing services and processes. Initially this appeared daunting as it identified many shortfalls in maintaining delivery of nursing services i.e. several person-specific and inadequately documented tasks and processes developed over years; increasing clinical & administrative workload; increasing staff burn-out and stress; time consuming tasks which prevented a "stop and re-focus time". However, after 2 years, I am elated to report that we as a team have survived an extremely challenging period and the many changes implemented have had a positive impact on the team and the TB services of which the following are just a few:

- Performance & Development (PAD) tool taken on by Nursing Director (ND) in the absence of permanent CNC and implemented immediately as an ongoing mandatory process for each nurse
- Informal and positive PAD discussions held to establish individual needs, identify specific interests in expanded roles and portfolios, wishlist for professional development opportunities, suggestions for improvements to nursing and/or TB services and feedback for nursing management. Research and professional development were strongly encouraged in addition to documenting any code of conduct issues. Culminated in a written commitment from ND to each nurse for the 12 months ahead.
- De-identified info from PAD discussions, collated and circulated within nursing team for communication tool: proposed changes & suggestions; professional development opportunities & portfolios; outcomes.
- PAD now a relaxed regular discussion at least every six months for each nurse
- Workplace culture changed to a positive, learning and supportive environment
- 3 x CNs gained the opportunity of upskilling and now competently trained to perform the CNC role allowing for succession planning and backfilling of staff leave
- CNC training program was documented and continues as a living document education tool
- TB Nurses training program was documented and endorsed for statewide use
- Several long-standing, traditional nursing procedures and processes were streamlined saving 1.5 FTE
- Active networking and recruitment drive to obtain full staff establishment to cover project and nurses' leave - successful but remains a continual challenge.
- Rostering reviewed and re-modelled: nursing team divided into teams with specific portfolios given to those interested in taking on expanded roles. More home visit and administrative time – nurses HAPPY
- The role of provision of external Education sessions has been gladly accepted by several CNs
- Improvements to data collection for nursing activities to allow more accurate Business Planning
- Improvements in the collection of patient data through improved accurate completion of information
- Opportunities for clinical placements for nursing students broadened with full documentation of process, feedback loop and preceptorship training for staff.
- Internal nursing staff survey done in July 2011 showed a 540% improvement in the satisfaction of teamwork, quality, leadership & management and communication issues documented in 2008.

Further challenges:

- The unknown outcome of the health reform and the impact for the QTBCC
- CNC role currently rotated between 3 CNs as T. O'Brien (CNC) has taken 12 mth leave from QTBCC
- To improve on the timely, accurate and complete collection of patient data and outcomes statewide
- To collect timely, accurate and complete activity data statewide
- Maintain adequate nursing staff hours in relation to workload

Responses from the November 2011 Question Box

From the last newsletter, Margot Thompson from Tasmania requested input:
A new Respiratory consultant commenced with us at the Royal Hobart Hospital and is responsible for overseeing the TB Service for Southern Tasmania. Our aim over the next few months is to change the structure of our 4 week clinic from purely Medical reviews to integrating Nursing Review clinics other than our active cases or those attending for their initial review. I would be really interested to hear from the states how their clinics run and how they have overcome any hiccups in regard to dispensing etc.

Response 1: Annmaree Nicholls
I work in rural NSW as the Area TB coordinator. I'm not employed in an acute care setting but attached to the Public Health Unit and my role is to coordinate the delivery of TB services for a rural area, in summary;

- Comprehensive TB diagnostic, treatment and management service for the region
- Coordinate & evaluate TB services
- Collect, collate, monitor, evaluate & report data
- Leadership & education
- Expert consultancy & resources
- PHU action

The area I cover extends from the NSW South Coast across the Great Dividing Range and the Snowy Mountains through the south-west slopes, Riverina and Murrumbidgee regions & Murray border areas. It covers an area of approximately 166,000 square kilometres. There are six main areas of population density at Albury, Deniliquin, Goulburn, Griffith, Queanbeyan and Wagga Wagga and the Area has many smaller rural towns. The area surrounds the Australian Capital Territory. The Southern border of the Area follows the NSW/Victorian border, while to the west and north the Area borders Greater Western Area Health Service and South-East Sydney/Illawarra Area Health Service. The Area is divided by the Great Dividing Range, which creates a natural barrier separating the coastal regions from the inland tablelands and western plains.
Medically we have private respiratory physicians, fly in respiratory physicians and interstate (ACT) respiratory and infectious disease physicians who service the region in relation to TB and TB/HIV co-infection.

The nurses do the interviewing and clinical work up of all patients from TBUs, contacts, to active cases (depending on how they are referred and identified) and then present the cases to the physicians either in person or by mail in the case of TBUs. The physician provides medical care but the nurses provide all follow up care including DOTs, pathology and monitoring such as eye testing etc. The nurses also attend all medical review with the physician. Medically the patient is reviewed monthly to two monthly clinically dependant. In the case of TBUs often the physicians never see the patient but reviews clinical history CXRs etc provided by the nurses. Only if there is a clear diagnosis of LTBI and the choice of IPT to be considered does the patient see a medical officer. In most cases the patient is counselled by nurses re choice for IPT, this is dependent on patient and experience of the nurse.

The nurses in the region are guided by the NSW Controlling TB manual and associated policies. Nurses under MOU agreement are able to request Lung CXR's and basic pathology as no provider number is required utilising practice guidelines. All nurses for who TB is part of their role (due to low disease incidence no nurses except me work fulltime in TB) are all clinical nurses specialist grade 1 or grade 2 (in NSW grade 1 is a personal grading, grade 2 is organisational) and all are employed in community health centres. I'm a clinical nurse consultant and take on more of the advanced clinical practice work.

We developed a TB service delivery plan, this outlines how the service will be provided and the responsibilities of all parties. This is endorsed by the CE and executive. It governs how TB services are provided in this rural region. Due to health reforms I'm in the process of rewriting this service delivery plan to reflect the changes from area health service to local health districts as they are now called.

Response 2: Flora Van Der Heide
I am a TB CNC and oversee 3 clinics at RPA, Canterbury & Concord Hospitals which all run very similar services:

- Tuberculin Skin Testing (TST) - all staff are accredited to give, read & interpret TST's. Those with abnormal TST's i.e. Latent TB Infection are sent for CXR & given an appt for medical review with the view to offering preventive Isoniazid.

- BCG vaccination - all staff are accredited to give BCG. Each clinic runs 1 per month on different weeks so that we can try to accommodate patients within the area & not have to send them to other clinics outside our area. On the whole this works well but there are the occasional problems.
- TB Health Undertakings (TBU) - the doctors at RPA review the file & films to triage everyone & ensure appropriate & timely follow up. Canterbury & Concord just book them in for CXR & medical review. In all 3 clinics, if there is an urgent referral for a patient that likely has active TB then urgent Nursing assessment is done i.e. symptom assessment, spontaneous sputum requested (RPA can also order induced sputum) & medical review at next clinic. Once the patients see the doctor the potential is for them to go on to have bronchoscopy if the sputum is neg on smear.
- DOTS - TB patients have a community TB medication chart completed by the doctors. This allows us to get 1 month worth of medication at a time. If we have someone being supervised elsewhere, we can ask for 3 months supply.

Response 3: Sue Devlin

The TB services model we use on the North Coast of NSW sounds similar to what you are proposing…..we have probably even taken it a step further in some regions with client review by the Doctor only initiated for initial prescriptions for active cases (even this will go when my NP scope of practice is endorsed) and if there are complications or complexities with the treatment.. Essentially TB Services on the NSW North Coast are nurse led, provided by nurses and provided in the community – often a home-based service. We practice patient-focused service to the highest degree; we are even investigating a way to take Xray services to the client as this is the last frontier of taking the service to the people, rather than the client to the clinic.

The geographic region the North Coast *Team TB* covers from Port Macquarie to the Queensland border on the eastern side of the Great Dividing Range. We have about 12 residents in the area diagnosed with TB each year, in recent years about half of those are Aboriginal. The North Coast TB service model is underpinned by culturally appropriate engagement with the Aboriginal community, as this is where the majority of our work is located. The other population group we work with a lot is recently arrived refugees, mostly from Africa. We treat quite a few people with latent TB infection, practicing with the motto "a decision to test (TST) is a decision to treat (if positive)". Most cases of TB are found by GPs or as inpatients in hospital. The TB cases *that Team TB* find are usually through contact tracing.

The TB nurses lead every aspect of the service from case diagnosis →treatment →monitoring →contact tracing →treatment or monitoring of contacts→ surveillance

Team TB currently consists of 1 x Nurse Practitioner (officially 0.5 FTE for TB services) and 2 x Clinical Nurse Specialists (grade 2). The nurses work across the whole region, but in practical terms 1 x CNS case manages for the North half of the area (based at Lismore) and the other case manages in the south (based at Coffs Harbour). This means they can go to the edge of their area and back in a day.

DOT is provided by generalist community nurses. We approach DOT as a support service with monitoring for side effects rather than a compliance check. Doctors are assigned to provide TB services at the four major centres Tweed Heads, Lismore, Coffs Harbour and Port Macquarie. Most are VMO respiratory specialists, one is a Staff Specialist. We also utilise a few Paediatricians; VMOs or Staff Specialists. Medical involvement in client review is arranged prn, titrated to the workload e.g Coffs Harbour has a regular monthly clinic scheduled for with the respiratory physician at present due to the patient load (and Dr preference from a logistics perspective, it saves a lot of ad hoc phone calls to batch information exchange into a scheduled 30 minute time slot), but at the other centres Dr review are arranged prn. We don't have Medical-only reviews, all client reviews involve and are led by a nurse (usually the case manager) –the Doctor is involved for collaborative decision making and addressing what is beyond the nurse's scope of practice (e.g. prescribing).

The keys to this model working in our rural area with small case load spread across a large geographic area are

- Team approach: all the nursing team are familiar with the situation for each client on treatment and have access at their fingertips to information via electronic information systems
- Case management approach: the nurses have good systems for ensuring continuous medication supplies etc. Scripts are written at the commencement of treatment (for the duration of treatment) with dispensing done on a monthly basis. Nurse review occurs with putting the medication in the patients hands. Of course the patient is already having close monitoring through DOT.
- Culture of collaborative decision making with relevant involvement of health personnel e.g. radiologists and pharmacists are directly consulted by the nurses as often as the "TB doctors"
- Trust and rapport with the Doctors and other health personnel is paramount. Often this relationship has to be built by working closely together for a while. This is part of the rationale for the arrangement described above at Coffs Harbour (the new doctor and nurse are building their relationship).
- Communication

TB Research / Projects of Interest received to date

TOPIC	AUTHOR / LEAD	Collaboration
Quality-assurance review of data over a 3 year period using QuantiFERON TB-Gold test by the Victorian TB team as an adjunct for the diagnosis of latent TB infection in contacts	Karen Goebel, PHN Victoria	
Is there a need for TB screening of HCWs in low prevalence country	Carmel Cochrane, Brisbane	
Development of a national database for TB brochures/fact sheets and consents	Carmel Cochrane, Brisbane	A. Nicholls
Assessment of nurse-led TB-related assessment clinics	Carmel Cochrane, Brisbane	A. Nicholls
Outcomes of molecular epidemiological typing for Qld notified cases 2002- 2011	Carmel Cochrane, Brisbane	
Development of a standardized National TB Nursing Training Package	National working group to be developed	C. Cochrane ?Others interested
TB models of Care across Australia: a descriptive analysis	Annmaree Nicholls	?Others interested
DOTs Programs: nurses understanding of DOTs, delivery of DOTs	Annmaree Nicholls	C. Cochrane ?Others interested

Case Study for next edition

We are hoping that a few of you will provide a case study for our next newsletter as a learning tool for all. The suggested headings are:

Case Summary:

- *Brief history include sex, age,*
- *presentation including symptoms,*
- *how did referral to your service occur.*

Tests performed

- *Diagnosis - how was that made, clinical suspicion confirmed etc.*

Treatment commenced

Contact Tracing: *how was this handled?*

Issues/ Challenges: *List any issue or challenge and how you addressed them.*

Lessons learned: *Any pearls of wisdom you have.*

Questions: *Questions from the staff submitting the case;*
Ask the group if they have any questions

Nil for Feb 2012