e-TB Nurses of Aus

Inside this issue:

State Contact details.....2

STOP PRESS: BCG SUPPLY.....2

Upcoming Conferences.....3

Job Vacancies..... 3

Our NZ colleagues.....4

Achievements.....4

Staff Member profile.....4

Randomised Trial Rifampicin vs Isoniazid.....5

Training Resource.....5

History: what does it teach us.....6

Protocols.....6

Research 7

Question Box 7

HCWs with TB and smoking..... 8

Joint Partnership working well.....8

Development of a culturally sensitive tool to assist non-English speaking women in making informed health choices about xrays in pregnancy.....9

Case study 1- Victoria TB Control..... 11

Conference Report..... 12

Case Study 2 - NSW..... 14

Newsletter No. 3 - 2012

This newsletter nearly didn't happen! As I didn't have much information to circulate as of 30 July, it was looking like a brief email was about to replace the newsletter! However, I have been showered with some very interesting articles this week and we now have a very full edition. Thank you to all the regular and first-time contributors who have submitted some fantastic articles. I am sure there is more out there – so please don't be shy, send in your submissions. If you wish to have some help getting information together, please do not hesitate to contact Annmaree or myself.

Exciting news from Amanda Christensen, NSW State Coordinator this week related to the dates for the NSW Ministry of Health TB Conference for Nurses. Please put the 1 & 2 November in your diaries and await further information in a few weeks.

From the Queensland perspective, the Queensland Tuberculosis Control Centre, Brisbane is currently in a state of flux as we await the outcome of a plan by Queensland Health to devolve our TB services to the 17 Health and Hospital Services (districts). After 62 years of managing and controlling TB through a model which has proven to have excellent outcomes, (Brisbane centre of expertise and in partnership with 4 Regional TB Control Units), it is indeed a very worrying and stressful time for us and our patients as it is unknown if QTBCC will be able to continue to deliver services after 30 September 2012. We can only wish for a workable solution for decentralizing TB services whilst maintaining critical clinical supervision and monitoring of all aspects of TB management and control in Queensland. Sincere thanks to everyone for the well-wishes and support as we wait in hope for a favorable outcome.

That's All for now. Enjoy

Annmaree Nichols (co-editor) and Carmel Cochrane (Editor)

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State TB Services Internet sites:

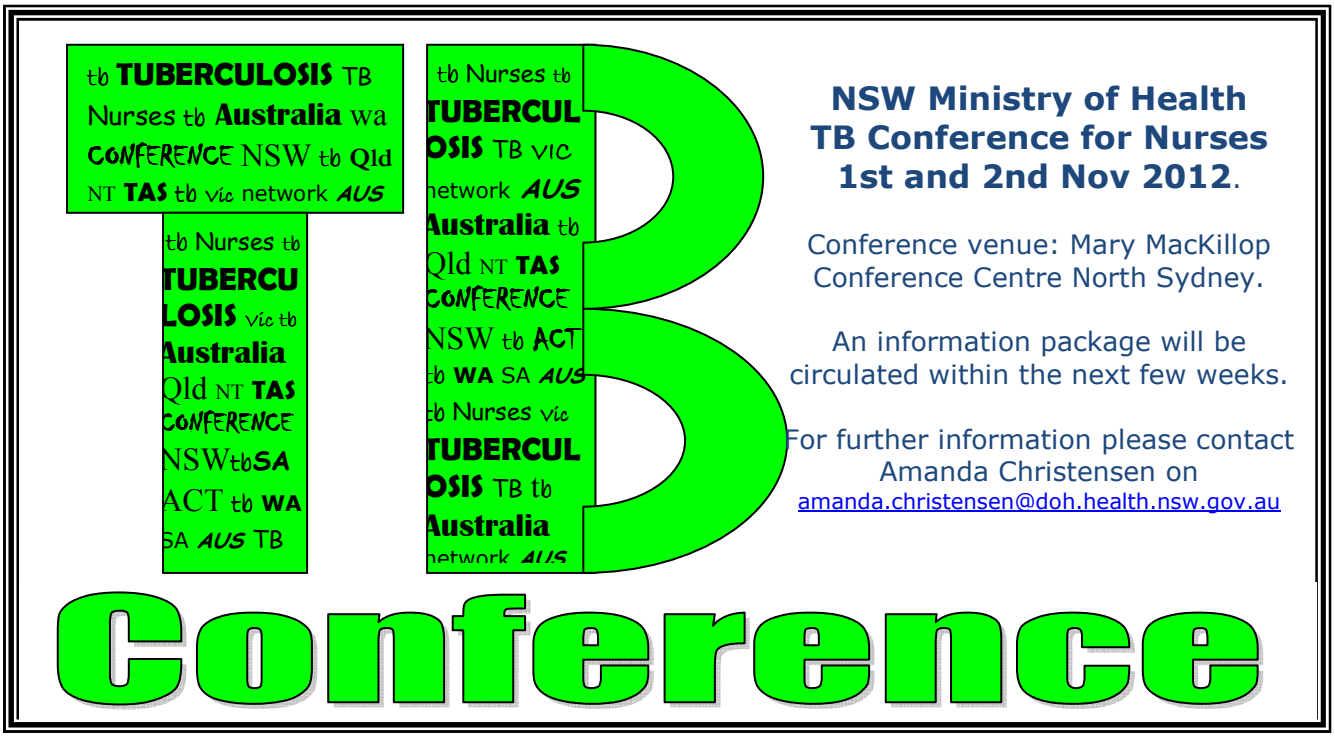
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ACT:	http://www.health.act.gov.au/c/health?a=da&did=10009573&pid=1207892937
SA:	http://www.rah.sa.gov.au/thoracic/about/
WA:	http://www.health.wa.gov.au/services/detail.cfm?Unit_ID=519
NSW:	http://www.health.nsw.gov.au/publichealth/infectious/tb/index.asp
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/

STOP PRESS:
BCG VACCINE IS *EXPECTED* IN AUSTRALIA SOON

The supply of the Statens Serum Institut (SSI) BCG Vaccine has been approved under section 19A approval of the Therapeutic Goods Administration. **The product is expected to be available by the week beginning 6 August.**

Further updates will be circulated as they become available.

Upcoming Conferences



RCNA Community and Primary Health Care Nursing Conference Perth 17–19 October 12



IUATLD: Driving Sustainability through Mutual Responsibility





Brisbane (Queensland Tuberculosis Control Centre):
CURRENTLY ON HOLD DUE TO CURRENT SITUATION

- Temporary full-time Clinical Nurse position exists from now until 31 Dec 2012
- Temporary part-time Clinical Nurse position exists from now until Mar 2013.

Phone Nursing Director for further information: 07 38963941

From the Land of the Long White Cloud

Hi Carmel
Thank you, for your very exciting email with your newsletters. I have circulated your email to all of the PHN's in our team who will be able to keep updated and possibly send you information in the future.

Kind regards
Jill Miller
Programme Supervisor, Communicable Disease Control, Auckland Regional Public Health Service, Private Bag 92 605, Symonds Street, Auckland, 1150
Website: www.arphs.govt.nz



New!

- Ann-Marie Baker: appointed as Acting Manager, Victorian TB Control Program (Jul-Dec 12)
- Catherine White: appointed Acting Clinical Nurse Consultant, Brisbane (May-Dec 2012)
- Melissa Carroll (PHN Victoria): successfully completed Master Public Health – International Health (Monash)
- Carmel Cochrane (ND, Brisbane): article published RCNA Connections June 2012 edition "Review of Clinical Placements of Nursing Students in a Public Health unit"

Staff Member Profile

By: Simone Bittmann and Melissa Carroll, PHNs Victorian TB Control Program

Introducing the Acting Manager for the Victorian TB Control Program:
Ann-Marie Baker

Ann-Marie replaces Lynne Brown as Manager of the Victorian TB Control Program until the end of December 2012. Her previous roles have included; nurse counsellor and educator at the Melbourne Sexual Health Centre, Public Health Nurse with the Department of Health / Human Services for 15 years, and more recently as Manager of the Department of Education and Early Childhood Development, Secondary School Nurses Program.

Ann-Marie has a passion for working in a variety of areas in public health and especially with culturally diverse groups and challenging families. Importantly, she has expressed her joy at being back with the team of TB nurses (as we are a great team to work with apparently!)

Ann-Marie is married with 1 child. She enjoys reading, traveling, cycling and new technology. Her preference is white wine ☺

Email: ann-marie.baker@health.vic.gov.au

A Randomised Trial of 4 Months Rifampin vs. 9 Months Isoniazid for Latent Tuberculosis Infection

By: Tessa Bird, RN Project Coordinator, Sydney

This "pragmatic" trial is one that simulates real life practice. The objective is to have results that are meaningful to routine clinical practice after the trial is over. TB clinics of 9 Sydney Hospitals are participating. The trial is comparing the efficacy of 4 months Rifampicin with 9 months Isoniazid. Through the continuing commitment of all clinic staff we have now recruited over 50% of our target. We also have Ethics approval to include children at 6 of the 9 sites and although we are yet to enrol our first child we hope to reach our target of 45 over the next 2 years.

SITE	Total randomised	Current treatment	Completed treatment
Canterbury	2	1	1
Concord	8	7	1
Liverpool	12	7	4
Parramatta Health	10	3	7
POWH	31	5	23
RPAH	30	10	18
St George	20	1	19
St Vincent's	7	0	5
Sydney	20	5	15
TOTAL	140	39	93

Training Resource

Injection Trainer: excellent training tool for intradermal technique purchased in May 2012. Currently in use at the Queensland Tuberculosis Control Centre and feedback provided to date has been excellent – however we are in the process of implementing a quality activity.



Multi-layered soft tissue pad for the practice of intradermal, subcutaneous, and intramuscular tissue injection techniques.

Skills

- Professional-to-patient communication
- Intradermal injection
- Subcutaneous injection
- Intramuscular injection
- Management of tissue

http://limbsandthings.com/au/products/injection-trainer/

History; what does it teach us?

By: Annmaree Nicholls, Area Tuberculosis Coordinator, Public Health Unit | Murrumbidgee and Southern NSW Local Health Districts

What are the responsibilities of the Tuberculosis nurse?
In 1919 Mary Van Zile the fielded supervisor (American Red Cross, New England Division) presented to the Nursing section of the National Tuberculosis Association, the preparation needed for TB nursing. Van Zile outlined that the TB nurse required a broad training to carry out four responsibilities: (1) provide care to the person with TB and his or her family, (2) provide sufficient support for the family to maintain a normal standard of living, (3) safeguard the community by teaching the patient, family and community about prevention, and (4) educate the public to support efforts to prevent the spread of TB. Van Zile also believed the nurse must have a community viewpoint not a personal one (King, 2011).

At the time Van Zile presented her paper (1919) the cause of TB have been discovered by Robert Koch in 1982 but there was still no known cure for the disease (Bates, 1992). It was well known however that certain conditions contributed to the contagious nature of the disease. Namely poverty, environment, poor sanitation and crowed living conditions. Public health strategies of the day to prevent spread, especially among children included the development of open air schools and summer camps. The aim; to promote healthy living strategies children could learn and then take back to the family (King, 2011).

The significance of TB in the early part of the 20th century is highlighted in a review conducted of the Index to Public Health Nursing Magazine, 1909-1952, which identified 74 articles on TB published between 1909 and 1920. TB nurses could see the effects on the health of the children and set out to collect data to support the need for the summer camps that were to follow. They weighed and recorded children's general health parameters and presented their results to organisations such as the Lion's Club, Y.M.C.A and the Y.W.C.A. Working collaboratively with these groups they developed the strategies to meet the needs of the children and community as well as the needs of the individuals with TB (King, 2011).

The camps were established and attended with children rewarded for meeting certain health goals. Hand washing featured, a simple but effective strategy we still strive to achieve in 2012. Ribbon rewards were given for weight gain and competition to gain weight and win ribbons was great. The summer camps were designed to provide an environment away from the confines of cities that was both wholesome and educational. To keep the children engaged as health crusaders upon return to their homes and communities health clubs were established again through the partnerships of the Y.M.C.A and Y.W.C.A (King 2011).

The work the nurses did in the clinic and the camps reflect the breadth and scope of the public health TB nurse as described by Van Zile in 1919 and I believe the responsibilities remain unchanged for 2012. TB nurses need to have a community focus while looking after an individual. They need to be responsive to needs of the TB patient and the family, collect accurate data to assist program development and provide education to the patient, family and community. What does history teach us? For all that changes nothing does.

References:
Bates,B. (1992). Bargaining for life: A social history of Tuberculosis, 1876-1938. Philadelphia: University of Pennsylvania press.

King, M,G. (2011). Four responsibilities of the Tuberculosis Nurse, Circa 1919. Public Health Nursing Vol 28 no 5, pp469-472

Van Zile, M, (1919). Preparation of the Public health nurse for tuberculosis nursing. The Public Health Nurse, 11(10), 780-782



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
  - will provide guidance for the review of statewide policies to ensure alignment with the national policy /guidelines.
- IGRA statement endorsed by NTAC

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. Nichols
Assessment of nurse-led TB-related assessment clinics	Carmel Cochrane, Brisbane	A. Nichols
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 be developed	C. Cochrane ?Others
TB models of Care across Australia: a descriptive analysis	Annemaree Nichols	?Others interested
DOTs Programs: nurses understanding of DOTs, delivery of DOTs	Annemaree Nichols	C. Cochrane ?Others



Who am I?



- I am a Clinical Nurse from Qld TB Control Centre
- A Kiwi who loves a chat – other staff have requested the purchase of ear plugs
- I love fooling around – hence the beautiful purple flowers in my hair
- I am usually very happy and a pleasure to have in the team
- The only time I'm not happy is when my RDO is cancelled due to my raucous rowdy behaviour
- I have been known to eat a block of chocolate and maccas for breakfast
- I am a great team player and always willing to help out
- I have recently undertaken some professional development courses in leadership and enjoyed them immensely

Who am I?

I am Joanne Crisp

Snippet for Interest only

By: Carmel Cochrane
Nursing Director, Queensland Tuberculosis Control Centre

Helping Smokers Quit-

Lets get Serious!

World No Tobacco Day
May 31



Perhaps the message is getting out there.

From a total 117 health care workers diagnosed with TB in Queensland from 2002-current:

- 18 (15.3%) only reported smoking at the time of their TB diagnosis (pack size was not always recorded by RNs/ MOs)
  - 11 males and 7 females ranging in age from 18 - 65 yrs (average age 44.7)
  - 5 (27.7%) Australian-born
  - 2 doctors, 10 nurses/carers, 2 wardspersons, 1 radiographer, 1 cleaner, 1 traditional therapist and 1 family support worker
- 13 never smoked
- 78 (66.6%) reported not smoking at the time of their TB diagnosis: 2 stated past smoking but 76 did not state or were not asked if *ever* smoked
- 8 were not recorded by RNs/ MOs

Report from Gladstone, Queensland



Pictured outside Nhulundu Health Service following a recent clinic are Marie Hall, Clinical Nurse Child Health Gladstone and Joy Pappagallo, CNC Infection Control

Joint Partnership Working Well

The initial 6 month evaluation of Joint Partnership between Queensland Health – Gladstone Health Service and Nhulundu Wooribah Indigenous Health Organisation Inc. for the provision of a TB Screening and Vaccination Service has proven to be beneficial to the Gladstone Community. An increase in attendance of 25% has been a great initial outcome of the Clinic relocation. The Tuberculosis (TB) Screening and Vaccination Service was moved from the Gladstone Community Health Centre located adjacent to the hospital to Nhulundu Health Service after signing of the Joint Partnership Agreement in May 2011. The first Joint Partnership Clinic was held at Nhulundu Health Service in August 2011. The Clinics are staffed by Queensland Health staff deemed competent by the Queensland TB Control Centre to provide the screening and vaccination service. Nhulundu Health Service promotes availability of the service and provides a family friendly and multi culturally inclusive environment for the second monthly drop in clinics. Overall the 6 monthly evaluation of the Service Agreement was positive with some minor improvements identified including additional education to be provided to the staff of Nhulundu Health Service and provision of a roster of Queensland Health staff rostered to attend the Clinics during 2012.

The development of a culturally sensitive tool to assist non-English speaking women in making informed health choices about x-rays in pregnancy

By: Deborah Baverstock
Nursing Unit Manager, Parramatta Chest Clinic

Abstract: Australia accepts 13,500 refugees, 2,999.00 migrants and others on Humanitarian programs annually. With large numbers coming from countries where communicable diseases are highly prevalent and health services limited, there is a challenge for health care providers (HCP) addressing specific health needs and cultural barriers to health care. Barriers faced by migrants when accessing health care include a lack of English proficiency, low literacy levels, a lack of skilled interpreters for new communities and relevant cross-cultural skills deficit among HCP. This project focused on pregnant women from culturally and linguistically diverse (CALD) populations, exploring 'like' resources in the desired target languages with the view to develop a multilingual visual resource about client awareness re: x-rays in pregnancy.

Relevance to work: The poster provides culturally sensitive health care advice to pregnant women, aiming to provide better health outcomes, increased knowledge and understanding of issues around radiation exposure while pregnant and empowers CALD women in decision-making through their involvement in their own health care. The final outcome was to develop a culturally sensitive tool to assist non-English speaking women in making informed health choices about x-rays in pregnancy.

Aim: To research 'like' resources addressing x-rays in and to develop a culturally sensitive multilingual tool to assist non-English speaking women in making informed health choices about x-rays in pregnancy.
Nature of the Problem X-rays are an integral component of diagnosis and are conducted upon the client's first visit to this unit. Communicating with clients is difficult when the client's native language is unknown until presentation. A major obstacle for staff was to determine eligibility for x-ray in women of child bearing age.

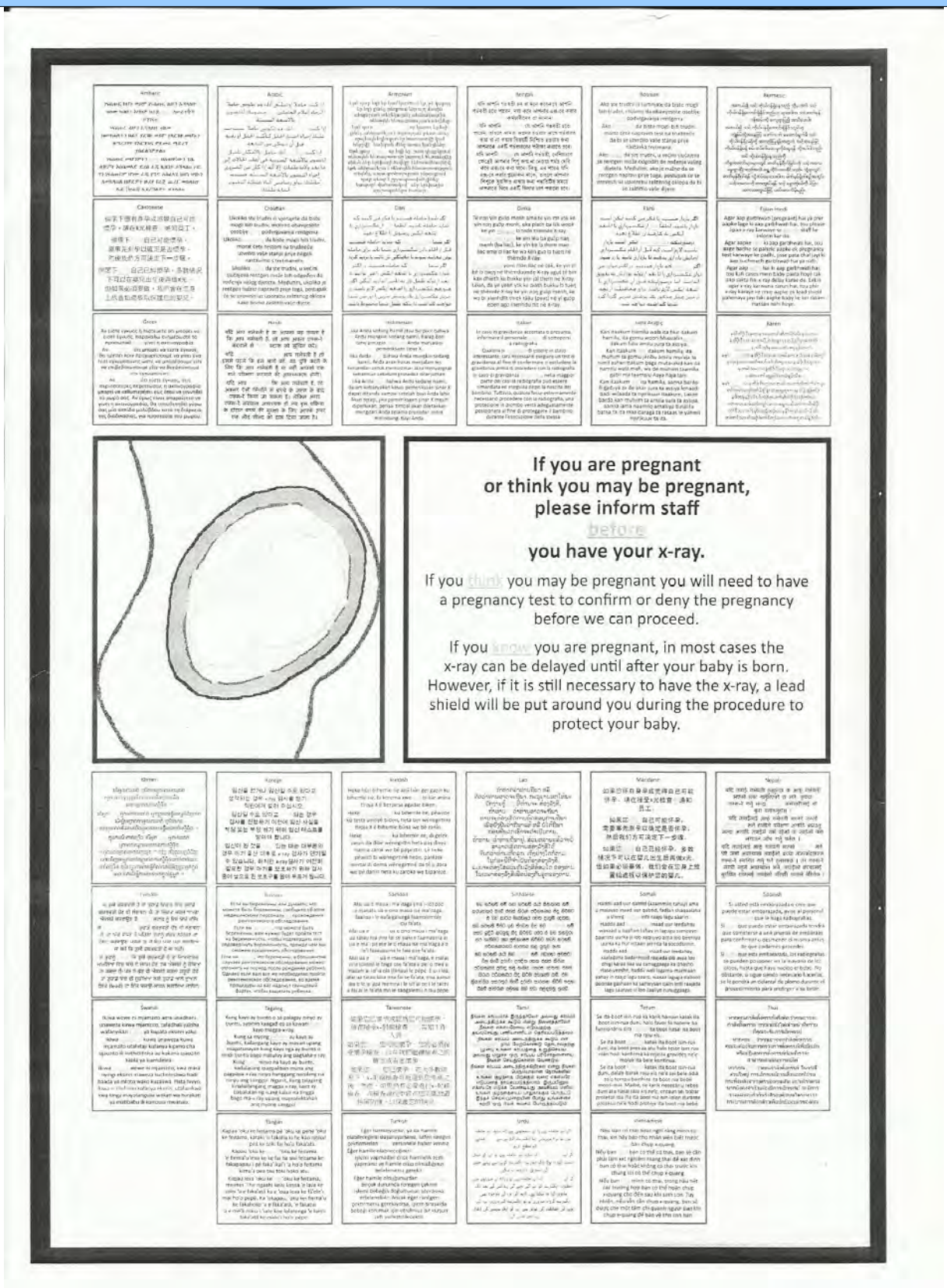
Extent of the problem Identifying the need to provide multilingual information to women about the use of x-rays in pregnancy, PCC undertook research on what resources were currently available to CALD populations about this topic and found very few resources available. While consulting with service partners such as AGFA it was noted that even high end producers of x-ray film and equipment had little or no multicultural resources available for consumers. Existing written resources, even translated ones, may be of little benefit as they do not address the broad spectrum of languages represented by the diverse CALD populations within WSLHD.

Planning and implementing solutions Unable to source any appropriate signage locally or interstate we determined that there were no existing resources depicting either the desired message or the targeted audience available to us. Government and non-Government organisations, Cancer Care Services and Chest Clinics locally and Interstate were consulted. The outcomes of this qualitative research in addition to local consultation with staff resulted in identifying the need for us to develop this resource, mindful of the message needed to be conveyed and the languages (other than English) needed to be translated. A multilingual visual resource was deemed the most suitable type of resource to effectively communicate our key message to the multilingual communities who frequent our service. CALD planning meetings were conducted; target languages were identified as representative of the clinics core client demographics. Interpreter Services and Multicultural Health Network were then brought in as project partners. Translations were made and rechecked, poster graphics produced and printers sought. Finally the desired resource had been produced

Outcomes and Evaluation Qualitative research and information from other services resulted in the development of a poster in 43 different languages. Due to the high rates of illiteracy in target communities, experience and feedback from other local health districts (LHDs), shareholders and service partners involved, the project team see the poster as an effective method of disseminating information to CALD communities. Existing resources were of little benefit, not addressing the broad spectrum of languages represented by CALD populations within Western Sydney LHD. The poster has already improved our practice by providing non-English speaking clients culturally appropriate information/education at point of service, informs women from non-English speaking clients that x-rays during pregnancy (especially in the first trimester) is not recommended here, targets a wider demographic group than other 'like' resources, is translated into both the common and marginal languages represented by the Clinic's demographic profile, reduces the need to withhold services until an interpreter can be provided, reduces the risk of radiation exposure to pregnant women and their unborn babies and reduces the risk of liability to the Local Health Network

Sustaining change After completion of the project, sustaining change is as simple as directing clients to the poster. No additional processes/structures need to be in place to ensure the improvements will be sustained.
Transferability and Future Scope The poster has had a positive response from HCP both locally and interstate. Over 52 posters have been distributed nationally and we have now gone into second print with orders for another 30. Future potential is great as we expect that this project will get more exposure and generate more orders as the poster is more widely distributed.

The development of a culturally sensitive tool to assist non-English speaking women in making informed health choices about x-rays in pregnancy (cont'd)



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Case Study 1

By: Peter Trevan
Public Health Nurse, Victorian TB Control Program

In June 2011 a notification was received from Geelong Hospital; a 34 y.o male had been admitted 3 days earlier with a 5 week history of productive cough fever, sweats, shortness of breath and 5 kg weight loss. The patient worked in management at a major local newspaper.

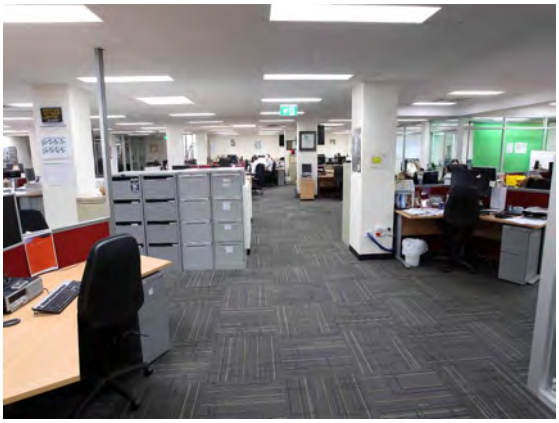
The chest X-Ray revealed RUL consolidation, sputum microscopy was smear positive for AFB. PCR was positive for M.tb complex and HRZE treatment was commenced. A fully sensitive isolate was identified in July 2011.

Family
The index case was married with 2 children; a 6 month old daughter and a 4 year old son. The 6 month old daughter was commenced on Isoniazid prophylaxis and baseline Tuberculin skin testing was performed on all family members, revealing negative results at this time.

Break of contact screening began in August;

- 4 yo converted to 15mm TST, had chest X-Ray changes and gastric aspirate, was commenced on HRZ, the specimen later cultured, and fingerprinted the same as the index case
- Wife converted to 17mm TST, Chest X-Ray normal but is 5 months pregnant so treatment for LTBI is deferred
- 6 month old daughter's TST remains negative
- Case's Father and two siblings (28 y.o /25 y.o) TST positive, referred for treatment

Workplace Screening



- Carried out workplace assessment and review of floor plan
- 64 staff members Tuberculin skin tested (screening extended to include total 88 persons)
- 23/88 (26.1%) test positive and referred for further follow–up screening (Chest Xray/ Specialist referral)

<u>Total contacts screened 107</u>

28 (26.1%) tested positive according to TST / Quantiferon TB Gold or both.
1 New case PTB (4 y.o)
25/28 (89.1%) Australian born
3 Overseas born (endemic countries)
12 BCG (11.1%)



Linking Case
The Index case revealed possible exposure to case in 2009. a 25 y.o music teacher with smear positive TB that resulted in 62 contacts / 6 conversions (9.6%) with 2 treated for active disease.

Requested typing by the laboratory: MIRU typing match.

Report on "Healthcare leadership for challenging times: reducing cost through quality improvement and innovation

By: Carmel Cochrane, Nursing Director, Brisbane

The conference was held in Sydney by the Australian Healthcare & Hospitals Association on 14 & 15 May 12. I felt extremely privileged to have attended given the travel restrictions within Queensland Health occurring at the time. This is indeed timely as there have been even more restrictions and reductions in Queensland as a result of budget cuts. The overall message was that leadership is critical in quality improvement and innovation and that processes must be re-engineered to deliver improvements and to develop sustainable systems to support health care.

According to Jim Easton who presented "Creating the future of healthcare", we, as health care professionals and a generation of potential leaders have to lead the change. We are consuming more of the wealth of Australia on healthcare which is totally unsustainable. Managing quality and resources is an important ethical issue. Quality and cost must be linked to create a self improving industry. We must engage to mobilize people - people are not psychic so one of the drivers for change is effective communication. Think of innovation and start with the end in mind. A common language is also required for communication as well as a transparent measurement. We must measure quality care but it also needs to be transparent to the public. Health care data is now beginning to be made available to public e.g. mistakes in surgery, errors in medications, but is only the beginning. An additional quality measure is "are we doing what we said we would do and when"? However, safety is critical and our underpinning message is DO NO HARM.

As leadership is critical, we need to be continually improving ourselves as leaders. "Just a good enough performance" is not good enough for our colleagues and the community. We need to design and build system/s which cover the following quality aspects: Patient-centred care; Safety; Timely; Effective; Efficient; Equitable. Errors usually occur due to processes not in place or out of date. Helen Bevan, a clinician from the UK presented "Mobilizing and organizing for change". Intrinsic motivation with employees is about the emotional connection with staff. There is a risk that some staff view change as optional but we need leadership and role models to drive change. The following was suggested for how we build energy as a fuel for change:

- Creating deeper meaning for change process, building the commitment to change, connecting with values, creating hope and optimism for future, calling to action.
- Looking at energy in organizations (Steve Radcliffe)
- Intellectual, emotional, spiritual and physical
- Large scale change must be driven by passion
- If we want people to take action, we must connect through values & emotions
- Improving productivity in connecting goals and values - engage
- Once you have people engaged, you have to keep them engaged which is often very difficult and time-consuming. But the end result is all worth it.

In order to engage people, we need to put forward our own values when building commitment to change. We need to tell our own story, make it personal and authentic to create a sense of us. Harness passion and innovate with collaboration was another take home message. Today's successful leaders must be visible and need to rise to the challenge to influence, build and utilise the confidence, skills, wisdom and experience of their entire workforce in order to successfully meet the challenges ahead. This requires a more innovative approach from every leader in our system and especially those with financial expertise. Creating the culture for innovation is not always easy but according to Maher & Mugglestone 2010, the most frequently occurring themes on this topic are:

1. Relationships: general & teams- honour, trust & open environments where team-based work is norm
2. Risk taking - effective and purposeful. Encouragement to trying new things is the norm. Emotional support, balanced assessment of risk and learning from failure environment. Fail often but fail early.
3. Resources; time and financial resources, authority or autonomy to act- empowerment, get the messages or reports out there on twitter, blogs, websites, (NHS MOs are reaping rewards of this)
4. Knowledge; exposure to things outside health eg UK engaged Formula 1 Racing personnel to visit Operating theatres to offer comments on streamlining patient waiting and equipment processes. It was a huge success and has been used by several health facilities. Link with local industry and universities
5. Goals; call for innovation - what, not how; links with strategic plan; make the message meaningful to staff e.g. streamline processes as we will lose staff and reduce FTEs - get staff to come up with ideas.
6. Rewards - recognition of innovative effort; reward people as individuals; money doesn't cut it - but recognition or given time off or time to work on another idea/project will be more effective.
7. Tools: deliberate process, flexibility to adapt to varying situations, training and tools required.

The Institute of NHS in the United Kingdom has a very helpful on-line survey tool encompassing 29 questions to assess culture for innovation in organizations. It can be segmented by department or by profession and uses benchmarking data. Check website for this tool: www.institute.nhs.uk.

Change is all about the person leading the change to start with. It's about influencing people and the techniques that are used which are effective. We need to change the way we think and behave and we must have a commitment to a common purpose. There will always be the silent assassins who don't want change to work so trust is essential. The majority of people respond favorably to being trusted. Transformational leadership is a good model to use, change the culture to a Can Do and change the common language. The ideal is to change the sceptics to change champions.

According to Lynne Maher, feedback surveys do not necessarily represent the true picture. "What matters to patients" (Roberts, Cornwall, Brewrely &Teal 2010) is an excellent article related to obtaining the best feedback from patients. Ensure that both functional and relational feedback is used to obtain the most meaningful information. Consumer feedback can include patient journey feedback by gathering patient stories which can be recorded or filmed. It is a powerful message to staff to use patient stories at the beginning of meetings on their experience in their health system. It is useful to access the following website related to transforming the patient experience www.institute.nhs.uk/theguide. www.institute.nhs.uk/patient. We need our mistakes and failures in our faces as a reminder.

An Australian website is now available: **Patient opinion - Be Heard** as patient and advocate groups are becoming stronger and more active across the world. Staff are definitely listening to active twitter sites set-up in UK healthcare related to patient's care. We could also be using twitter to look at patient comments as our patients provide information as a free gift. The community (our patients) also have skills and therefore health facilities could indeed be using patient focus groups to rewrite patient brochures and letters in a language that the public can understand. Relationships are also improved by using focus groups as they feel part of the decision making. Capture the experience by gathering patient stories (story board), interviews, still photography and film, then improve and measure the impact. We need to listen to our users, go with them and redesign the process. For patient focus groups, just a few patients are needed to work with you - not 100's. We need to know what patients want; do they want to talk to other patients with TB? MS patients in the UK talked to each other on a webpage and it was discovered that what mattered most to this group of debilitated patients was that they wanted all their appointments to be integrated and linked. Can we do the same for our TB patients?

For short stay patients, an experience questionnaire is beneficial e.g. mapping the patient journey through the service. See day surgery questionnaire on UK website. Queensland Tuberculosis Control Centre could gather this relational data as opposed to the current functional data e.g. patients feeling scared or anxious re their appointment, having to park car, obtain parking permit, NESB pts, cultural differences, who will call them in, where they will be seen. As the patient waiting area needs refurbishing, redesign the area with the input and assistance from patients. Patients want a good experience not a gold plated service.

Governing bodies and boards are there to provide the vision and ensure that safe, high quality seamless services are delivered with courtesy and respect. The boards need to have knowledge of all feedback and must ensure that equal weight is given to safety as all other agenda items. One of the most powerful messages that can be given by management is to ensure that the achievements are celebrated by all staff. Recognition of innovative effort needs to be rewarded as money isn't always what is wanted – rewarding the individual such as time off work or flexible work hours is another option if it is suitable to the workplace.

Things to do: I was prompted to question practices and to follow up upon my return:

- Publish data from TB unit - Safety data, treatment data, feedback re service,
- Has the average age of patients developing TB changed over the last 10-20 yrs since migration settlement has altered? Is this data part of annual report?
- Concentrate on improvements in safety, error rate and processes
- Feedback - consumer feedback, dial in, patient journey feedback
- Gather Patient stories – staff could record, film etc and use patient stories to start CME, Q&S, MTM
- Develop relational data questions as opposed to the current functional data feedback
- What are our acceptable levels of errors??
- Looking at Formula 1 - Can we do a whole system change with our medical and nursing appointments? Waste of clinical & admin resources due to Failed to Attends (FTAs).
- Knowledge; exposure to things outside health e.g. formula 1 with Farrari and OT process, linked in with local industry and universities
- Can we redesign flow and quality processes from the patient feedback perspective
- Goals; call for innovation - what, not how;
- Rewards - recognition of innovative effort
- The Institute for Innovation and Improvement in NSW has website with beneficial information.
- Be direct, respectful, have the difficult conversations as required
- Management team agenda to contain more reporting on quality and safety
- Show the process of engagement with TB patients
- Follow up language groups such as an elders of African groups

In anticipation that Queensland Tuberculosis Control Centre remains open as a TB unit given the current concerns, I remain passionate about leading the quality program for TB services in Queensland as best I can in making a difference for our patients and workforce.

Case Study 2

By: Flora Van Der Heide, Sydney LHD TB Coordinator, Redfern Health Centre

Case study of a 23 year old Vietnamese born female who came to Australia with a student visa in 2005. In 2008, she commenced nursing studies. She underwent a Tuberculin Skin Test (TST) on 21/05/08 with a reaction of 0mm. She had had a BCG as a child. On 28/05/08, she had a repeat TST (2-step test) which was also 0mmm. She travelled to Vietnam in Jan to Feb 2009 for Lunar New Year. In August 2009, she presented to her GP with lower respiratory tract infection and was prescribed a course of Amoxil.

CXR's (private via GP)

- Aug 2009 → extensive consolidation on L) side
- Oct 2009 → consolidation on the left
- Nov 2009 → extensive opacifiction around left hilum in L)LL associated with cavitation
- Dec 2009 → suggestive of TB

22/12/09 → sputum AFB smear negative with culture & sensitivities pending (PCR not requested)
3/1/10 → self presented to RPAH with 4 month history of worsening symptoms & failed antibiotics
→ symptoms of cough, green sputum, pleuritic chest pain, fevers, night sweats, 1-2kg weight loss
→ 5weeks pregnant
→ CXR consistent with active TB
→ admitted under general respiratory team
→ for respiratory isolation, further investigation
→ commenced standard 4 drug TB treatment
→ sputum AFB smear 3+ positive & PCR positive with culture & sensitivities pending
→ HIV negative
Social → completed 2nd year nursing
→ works casual part-time for agency as AIN
→ received phone call from GP during admission to inform of TB diagnosis on sputum culture
19/1/10 → discharged after tolerating 2 weeks of standard 4 drug therapy
→ for DOTS 3x/wk & care transferred to chest clinic doctor
→ *NOTE:* no follow-up CXR or sputum specimens were taken during admission
18/2/10 → sputum AFB smear 3+ positive & PCR positive with culture & sensitivities pending
23/2/10 → MDR-TB notification received
→ admitted to RPAH for respiratory isolation
→ all drugs stopped & expert panel teleconference planned
25/2/10 → sputum AFB smear 3+ positive with culture & sensitivities pending (PCR not done)
6/3/10 → sensitivities received from specimen dated 22/12/09

RESISTANT	SENSITIVE	
Ethambutol	Amikacin	Rifabutin
Isoniazid 0.1	Capreomycin	Rifampicin
Isoniazid 0.4	Ciprofloxacin	Streptomycin
Pyrazinamide	Ethionamide	

8/3/10 → significant concerns re cavity, no treatment for 2 weeks, progressing pregnancy
→ commenced challenge of daily MDR-TB treatment with

DRUG	DOSE / ROUTE	FREQUENCY
Rifampicin	600mg	Daily
Moxifloxacin	400mg	Daily
Amikacin	750mg IV	Daily

11/3/10 → expert panel teleconference convened
→ concerned that may have developed Rifampicin resistance as had effectively been on 1 drug
→ counselling re pregnancy +/- termination pending drugs to be used
→ treatment regime changed to

DRUG	DOSE / ROUTE	FREQUENCY
Rifampicin	600mg	Daily
Moxifloxacin	400mg	Daily
Amikacin	750mg IV	Daily
Clofazamine	100mg	Daily
Cycloserine	250mg mane & 500mg nocte	Daily
Pyridoxine	25mg	Daily

21/4/10 → sensitivities of Feb sputum shows new resistance to Rifampicin but sensitive to Ethambutol
→ repeat testing of original sputum show likely Ethambutol sensitivity all along

21/4/10 → treatment changed to

DRUG	DOSE / ROUTE	FREQUENCY
Ethambutol	1200mg	Daily
Moxifloxacin	400mg	Daily
Amikacin	750mg IV	Daily
Clofazamine	100mg	Daily
Cycloserine	250mg mane & 500mg nocte	Daily
Pyridoxine	25mg	Daily

4/6/10 → sputum smear negative conversion achieved
→ discharged on home isolation with following instructions:

- For home DOTS by community TB nurses (self medicate on week-ends)
- IV Amikacin given via Baxter pump & self administered
- PICC line dressing weekly by general community nurses
- Patient to ensure good ventilation at home
- Patient to wear mask when attending clinic appointments
- Visitors at home to wear masks
- Fiancé to wear mask at home & not share bed

24/8/10 → gave birth to a healthy baby boy
7/12/10 → plan to continue IV Amikacin until end Jan 2011 & oral tablets until Oct 2011
3/1/2011 → itchy PICC line dislodged overnight so Amikacin ceased & PICC removed
21/9/11 → ceased treatment

CONTACT SCREENING

- Close family & friends screened by TST +/- CXR as per usual contact screening policy
- Fiancé TST positive & given Rifampicin for preventive therapy as organism was initially sensitive
- TST screening only for baby → not for BCG
- University class screened by TST +/- CXR as per usual contact screening policy
- TST positive contacts recommended to have CXR follow-up for 5 years
- No workplace screening attended as patient on exams & then sick didn't work any significant shifts

ISSUES / CHALLENGES

- Insensitive ward staff: one nurse commented on the pregnancy "if I were you I'd get rid of it". This caused a great deal of anguish particularly due to the patients Christian beliefs. It was a long term point of discussion. Since she is a nursing student, we took this as a learning opportunity with regard to communication & the type of nurse she would like to be one day.
- Side effects: patient's skin become quite dark. This is not culturally appealing. Regular eye testing & audiology undertaken. Mentally the patient was quite fragile at times. She continually needed re-assuring. Patient would experience a heavy headed feeling for a few hours after taking her medication (not very conducive to looking after a newborn).
- Breastfeeding: patient was very keen to breastfeed baby. There was some simple online literature to support this from Queensland. We contacted the RPAH drug information who provided us with a comprehensive literature review on each drug used. He highly recommended that we speak with Mothersafe at Prince of Wales Hospital. As a result the patient was able to breastfeed her baby & very importantly experience the special bonding that comes with breastfeeding. The only off-putting thing for me was that every time the baby would reflux vomit, it was pink in colour due to the clofazamine. Luckily the baby's father encouraged the patient to ween after about 3 months – he works in a child care centre & was keen to bond with baby by bottle feeding.
- Support: patient was in Australia without her own family. She was unable to join any mothers groups due to demands of her treatment. The social isolation that followed made it very difficult for her to seek advice from anyone on anything. Basically we became her mothers group. We re-assured her on all to do with baby & his development, reminded her re his vaccinations before travelling to Vietnam to get married, advised on simple winter cold remedies for baby, were a shoulder to cry on….

LESSONS LEARNED

- No follow-up CXR or sputum specimens were taken to confirm adequate response to treatment during the first admission. In hind-sight the doctor she was under was a general respiratory physician that did not work in the chest clinic & I should have given some gentle reminders to ensure more sputum was done. I understand that they were avoiding CXR due to pregnancy but it shows that with an active case, perhaps the radiation risk benefit balance needs more consideration. Her re-admission was traumatic. We had teased her with freedom only to then separate her from her fiancé for 3 months.
- I can't emphasise enough the positive benefit to outcome that building a strong relationship with the patient can have. Open honesty without being too alarming can allow the patient to feel involved in the decision-making process & thus have a degree of control over their destiny. I always said to her that TB treatment was only a speed bump in her life. She is pregnant again & due in 8 weeks. Her permanent residency status is nearly complete. She plans to finish her final year of nursing in the near future. Life goes on.