

CITY OF TSHWANE METROPOLITAN MUNICIPALITY

OCCUPATIONAL HEALTH

MEDICAL SURVEILLANCE

PREVENTION OF TUBERCULOSIS IN HEALTH CARE WORKERS

POLICY

BACKGROUND

Transmission of M. tuberculosis from patients to Health Care Workers (HCWs) is a recognized risk that is increasing as tuberculosis increases because of the HIV pandemic.

AIM

The aim of this policy is the prevention of occupationally acquired TB among HCWs.

SCOPE

The policy will apply to all health care workers in close contact with patients.

HCWs at risk include Medical Practitioners, nurses (all levels), radiographers, administrative personnel, cleaners and any other person in close contact with patients.

An Infection Control Program will be maintained to protect HCWs against TB as far as possible, consisting of:

1. Provision of healthy and safe working procedures.
2. Provision of healthy and safe working environments.
3. Initial Health Evaluation (IHE) of Medical Practitioners, nurses (all levels) and Radiation workers including Chest X-ray and two sputum specimens.
4. Medical surveillance programme of Medical Practitioners, nurses in TB clinics and Radiation workers.
5. Information sessions concerning TB to all personnel working in clinics.

HCWs and Radiation workers who are immune compromised e.g. HIV positive, diabetes mellitus, chronic kidney and liver impairment and anyone on long term cortisone treatment should not work in a TB clinic due to increased susceptibility.

Should a HCW or Radiation worker be or become immune compromised it is in his/her interest (although not compulsory) to inform the General Manager who should relocate such workers to a safer post.

LEGAL FRAMEWORK

1. Constitution of RSA 1996 – Bill of Rights
2. OHSA, Act 85 of 1993
3. Hazardous Biological Agents Regulation
4. COIDA, Act 105 of 1993
5. Health Act of 2004

PROCEDURE TO BE FOLLOWED BY DEPARTMENT

1. According to the Risk Assessment done, supported by statistics, Medical Practitioners, nurses working in TB Clinics and Radiation Workers are significantly more exposed to the risk than other personnel and must therefore be on a Medical Surveillance Program.
2. All newly appointed Medical Practitioners, nurses and Radiation Workers must report on the first workday to the nearest CTMM TB clinic for chest X-rays and two sputum samples. (The Department: Health and Social Development, Health Care, carries the cost of these tests).
3. Occupational Health (OH) sends TB questionnaires to all Medical Practitioners, nurses in TB clinics and Radiation Workers. It must be completed quarterly and send to the relevant OH clinic for evaluation. See Annexure 1.
4. HCWs and Radiation Workers with suspicious signs and symptoms of TB or unexplained loss of weight of > 10% body mass should be referred for TB workout.
5. In case of exposure to MDR (Multi-drug resistant) TB of > than two hours, chest X-ray should be done after 8 weeks.
6. Should a HCW or Radiation Worker contract any form of tuberculosis it must be reported as an Occupational Disease in the prescribed manner by the relevant TB clinic or diagnosing physician to Occupational Health.

MEDICAL SURVEILLANCE PROGRAMME – TB QUESTIONNAIRE

SOCIAL DEVELOPMENT		HEALTH CARE		CLINIC:				JOB TITLE									
NAME:				PAY NR:				ID NUMBER									
DATE OF EMPLOYMENT:						DATE OF TERMINATION OF SERVICE:											
TB EXPOSURE HISTORY :		No of Years:				Months:				Continuous:		Intermittent:					
INITIAL HEALTH EVALUATION				CHEST X-RAY RESULT				SPUTUM ANALYSIS RESULT									
DATE:																	
Please complete the questionnaire in full. Please sign form every quarter																	
Do you have immune compromising condition(s)? YES / NO																	
Condition (s):																	
PERIODIC EVALUATION																	
Financial Year		20 - 20				20 -20				20 - 20							
Quarter		AUG		NOV		FEB		MAY		AUG		NOV		FEB		MAY	
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Coughing longer than 3 weeks																	
Night sweats																	
Poor appetite																	
Mass (kg)																	
Height (cm)																	
Employee Signature:																	
Date																	
ONP Signature																	
Date:																	
EXIT MEDICAL EVALUATION				CHEST X-RAY RESULT:				SPUTUM ANALYSIS RESULT:									
DATE:																	
Comments:																	