DORSET GUIDELINES FOR THE MANAGEMENT OF SUSPECTED / DIAGNOSED PULMONARY TUBERCULOSIS FOR HOMELESS AND DRUG AND ALCOHOL SERVICES

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TO BE REVIEWED EVERY 3 YEARS OR SOONER IN LIGHT OF NEW EVIDENCE

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SERVICE STATEMENT

TB services in Dorset co-ordinate all aspects of patient care for those suspected of, or diagnosed as having Tuberculosis (TB), as well as assisting in prevention and control activities throughout the county.

These guidelines are designed to be available and utilised by medical and non-medical personnel concerned in the care and well being of homeless and vulnerable individuals. The guidelines aim to provide sufficient information for a suspected or known tuberculosis patient to be referred to the appropriate service, diagnosed, managed, housed and followed-up.

The guidelines aim to provide an equitable service across Dorset for homeless and vulnerable persons. Although the majority of homeless services available are based around the Bournemouth area and these guidelines reflect that, it is hoped that they can be adapted to local areas to suit local resources.

Although the term ‘homelessness’ can be interpreted to describe many differing states of accommodation and dwelling, it is hoped that the guidelines can be adapted to suit the individual and agency concerned.

Persons accessing Drug and Alcohol Services are also at increased risk of having been exposed to and developing active TB.

Prompt referral and follow up of someone with potential TB signs and symptoms will help ensure that treatment is more effective and the public health consequences to others is reduced.
1.0 Background

1.1 Over the past few years, rates of tuberculosis among the UK born population remain low but have not reduced. This may reflect the changing epidemiology of tuberculosis in this population, with more cases occurring in high risk groups, such as the homeless and problem drug users (HPA, 2008).

1.2 ‘Homeless’ can be defined as persons who do not have customary and regular access to a conventional dwelling or residence (Rossi et al, 1987).

National figures have shown an increase in homeless applications and acceptances. The Office of the Deputy Prime Minister (ODPM) states that 120,860 homeless applications were accepted in 2004/05, with 101,070 living in temporary accommodation. Within Dorset, data for Bournemouth shows that in 2005/6, 263 homelessness applications were received with 95 accepted as homeless.

The count carried out for rough sleepers in Bournemouth in October 2006 - ‘people sleeping or bedded down in the open air, people in buildings or other places not designated for habitation, but not people in hostels, night shelters or squats’, although a ‘snapshot’ of what many think is in reality a larger problem, identified a total of five persons, which is a significant decline from the 44 recorded in 1997 (Bournemouth Borough Council, 2007). Weymouth and Portland recorded a count of 7 rough sleepers in July 2005 (ODPM).

1.3 Nearly one in fifty homeless people in London have previously been found to be infected with Tuberculosis (TB) (Crisis, 1997). Compared to the general population, people in hostels and Bed & Breakfast accommodation are twice as likely to have a chronic chest and breathing problems, and rough sleepers three times more likely to have a chronic chest condition and/or breathing problems (Crisis, 2003).

1.4 TB in the homeless is an important public health issue (Department of Health, 2004). The Department of Health’s Action Plan for Stopping TB in England (2004) calls for screening, diagnosis, treatment, and follow up of the homeless to be carefully managed and coordinated throughout the statutory and voluntary agencies caring for them. Dorset has so far had a low number of TB notifications amongst homeless individuals, but guidelines are required to ensure the safe management of the Index case (individual diagnosed with TB) and those caring for the patient and potential contacts (British Thoracic Society, 2000).

1.5 Treatment outcomes will be optimal if TB patients have a reliable source of food and shelter throughout the course of treatment (Morbidity and Mortality Weekly Report, 1992).
1.6 These guidelines are aimed at all persons involved in the care and management of homeless persons or those accessing drug and alcohol services and aims to provide comprehensive guidance in the assessment, screening, referral and safe management of an individual with TB.

1.7 Comprehensive guidance concerning the hospital in-patient management of persons with TB and those with suspected or confirmed Multi Drug Resistance TB (MDRTB) is contained within the Dorset-wide Policy for Suspected/Diagnosed TB.

1.8 TB can affect any age, racial group or social class, but certain groups are at an increased risk of developing disease once exposed such as:

- Immunocompromised patients (e.g. HIV infected individuals)
- Children and the elderly
- The homeless
- Alcohol /drug users
- Those with a family history of TB
- People belonging to ethnic groups from high incidence countries (WHO, 1996; Stellman, 2004; HPA, 2008; Storey et al, 2007).

1.9 TB can infect any part of the body, however, it is spread almost exclusively by people with active pulmonary disease (active TB infection in the lungs). TB is spread when someone with the active infection in their lungs with visible bacteria seen in their sputum (when viewed under a microscope), coughs and the infectious droplet bacterium becomes airborne and is breathed in by other people.

2.0 Does the patient have Pulmonary Tuberculosis (PTB)?

2.1 PTB should be suspected in any person who has a history of a cough lasting for more than three weeks associated with one or more of the following:

- Weight loss
- Loss of appetite
- Fever
- Night sweats
- Haemoptysis (blood in sputum)

2.2 Until PTB has been ruled out as a diagnosis, measures need to be taken to reduce the risk of potentially spreading TB to others.

Any homeless persons presenting with symptoms suggestive of PTB should be referred immediately to either their GP or to either East Dorset TB Service or Dorset County Hospital Respiratory clinic for screening.
3.0 What to do if you suspect PTB

3.1 It is essential that possible cases of PTB amongst the homeless or drug / alcohol users are identified quickly and referred urgently for the appropriate investigations and if necessary, commencement of treatment.

If the person has access to a medical practitioner or GP, then they should be referred straight to them. If there is no GP, or Doctor or Nurse available to see the person, then anybody can refer the patient direct to Dorset TB Services via the Fast Track Service (see 3.2).

If the individual is acutely unwell and is in need of immediate medical assistance and in particular, coughing up blood, arrange for them to be transferred to their nearest Accident and Emergency Department but inform the department that TB is suspected prior to transfer so suitable isolation measures can be taken. Advise the TB services that the person is coming.

3.2 FAST TRACK SERVICE

The fast track service is offered to the homeless and other vulnerable population groups. Referrals normally come from a medical practitioner or GP, but anybody is able to refer or indeed self-referral is accepted.

If the referral is from the East of the county, the referral should be made to the TB nurses based at Royal Bournemouth Hospital, and if the person is in the West of the county the referral should be made to the Respiratory Nurse Specialist at Dorset County Hospital.

East Dorset referrals to: TB Nurse Specialists (TBNS)

David Thomas / Miles Jarvis
Department of Thoracic Medicine
Royal Bournemouth Hospital
Phone: (01202) 704560 / 704570
Mobile: 07785290964 / 07919537102

OR

West Dorset referrals to: Respiratory Nurse Specialist

Respiratory Nurse Specialist
Department of Respiratory Medicine
Dorset County Hospital, Dorchester
Phone: (01305) 254238
Bleep Number: 351 Via Switchboard: (01305) 251150
Arrange transfer of patient for screening and assessment by TBNS/ Respiratory Nurse Specialist

This may involve calling an ambulance or taxi, follow the advice given by the TBNS / Respiratory Nurse Specialist

TB screening will include the following tests as appropriate:

- Past Medical History
- History of TB contact
- History of symptoms
- Chest X-Ray
- Sputum examination
- Skin test for TB sensitivity
- Blood tests

3.3 An arrangement is currently held with Chesthelp, (a Bournemouth based charity helping local people suffering from TB and other serious diseases of the chest) to reimburse any taxi fare costs incurred by statutory or voluntary organisations in Bournemouth for the transportation of a homeless or vulnerable person for TB screening.

This agreement is currently held with three homeless organisations in Bournemouth, St Paul's Nightshelter, YMCA and Alleyway Trust, but it is planned that it will be extended to cover all organisations caring for homeless or vulnerable persons. Follow advice from the TBNS on referral.

4.0 Hospitalisation

4.1 Patients to be admitted

4.1.1 If the patient needs to stay as a hospital in-patient the TBNS and managing Respiratory Consultant will continue to co-ordinate the screening for Tuberculosis and if TB is confirmed, instigate appropriate treatment.

4.1.2 If Multi-Drug Resistant TB (MDRTB, see section 8.0) is suspected advice should be sought from the relevant microbiologist as soon as possible with regard to the processing of samples and availability of PCR testing (specialist test extracting DNA of mycobacterium to determine presence of TB bacteria and potential Rifampicin resistance).
4.1.3 As an in-patient, infection control and isolation measures will be undertaken as per hospital and ‘Dorset Policy for suspected/diagnosed TB’.

4.1.4 If TB is diagnosed, prior to the patient’s discharge, arrangements for suitable accommodation will need to be in place, requiring planning between the social work department, homeless organisations, drug and alcohol teams, GP and medical team.

4.1.5 Arrangements for Directly Observed Treatment (DOT) must be in place prior to discharge. Please refer to section 7.0 for full explanation and implementation of DOT.

4.1.5 If TB is not found; the resulting diagnosis will be treated and managed accordingly. The patient will be discharged to the care of GP and followed up by the medical team as appropriate.

4.2 Patients not warranting admission

4.2.1 If the patient does not medically need hospital admission, suitable accommodation is still required whilst undergoing investigations. The patient needs a single room in appropriate lodgings (see isolation in temporary lodgings, section 5.0) until TB has been disproved. Discharging the patient to find his or her own lodgings or to sleep rough is not acceptable. It carries the potential to lose the patient to further follow up, worsen their illness and potentially spread TB to others.

4.2.2 Arrangements will need to be made between the TBNS/ Respiratory Nurse Specialist, Social Services and homeless services to secure a single occupancy room in appropriate lodgings to minimise household and social contact with others. During this time the client will continue the screening for TB and if necessary will be commenced on anti TB treatment.

4.2.3 If infectious TB is confirmed, after 2 weeks of compliant TB treatment with an improvement in symptoms the individual is no longer infectious. This decision will be made with guidance from the TBNS / Respiratory Nurse Specialist, managing Respiratory Consultant and Consultant Microbiologist. (See section 7.0 for explanation of TB treatment)

5.0 Isolation in temporary lodgings –

5.1 If TB is strongly suspected, yet the individual does not medically warrant Hospital admission, whilst it is safe (and best practice) for the individual to be temporarily housed, the following precautions are recommended until TB is disproved or the person has adhered to 2 weeks TB treatment:
The person must be housed in single room accommodation with doors and windows closed (this prevents bacteria being blown around).

The person must cough and sneeze into tissues and dispose appropriately into a lidded bin with a plastic bag liner.

All meals are to be taken in their room. Crockery and cutlery can be used by others following normal dishwashing, it is not necessary for the individual to use separate crockery or cutlery.

No special requirements are needed regarding laundering of linen etc. Continue to follow local hygiene policy.

The person is free to leave their room at any time but must be encouraged to wear an appropriately supplied mask when in company of others.

Staff and visitor contact must be kept to a minimum, and those that are known to be immunocompromised should avoid any contact.

5.2 In these circumstances the shelter/lodgings will be guided on an individual case-by-case basis throughout the period of isolation by the TBNS / Respiratory Nurse Specialist. Appropriate teaching and support will be provided to help facilitate the management of the patient.

6.0 Ongoing Care of those with Confirmed PTB

6.1 After the period of isolation, either as an in-patient in hospital or in lodgings has been discontinued, the person will still require guaranteed lodgings, high protein diet, supervision of medication (see section 7.0) and follow up for the duration of their treatment, usually six months.

6.2 The homeless or drug / alcohol using person with confirmed TB may not view their health as their highest priority or concern. Other concerns such as shelter, supplies and safety are likely to be of greater priority. As a result, the early involvement of social and key workers can assist in addressing these and other issues promoting a greater chance of completion of TB treatment (MMWR, 1992; Storey et al, 2007).

6.3 Maintaining contact with homeless persons being investigated, screened or treated for TB is notoriously problematic. The postal address is often a shelter, and individuals may prove unreliable in providing updates of movements, supply of medicines, side effects,
and future appointments. They may also be known by different names by different agencies.

6.4 The TBNS / Respiratory Nurse Specialist will conduct an assessment on the likelihood of adherence to therapy and, if appropriate, a treatment agreement between the patient, Respiratory Consultant, TBNS / Respiratory Nurse Specialist, GP and the hostel staff will be undertaken. Details about personal activities, friends and favoured gathering places should be discussed along with a physical description of the patient to assist co-workers in patient identification. It is essential that a rapport between the patient, health care team and agencies be established and maintained at the earliest opportunity.

6.5 The TB Service will continue to monitor the patient throughout their treatment, promoting adherence and managing potential side effects. The patient will also be followed up by their Respiratory Consultant and will be supported by their GP.

6.6 Periodically, the person may have to attend hospital for further outpatient appointments, repeat chest x-rays and blood tests. Assistance may be required to ensure attendance in the form of reminders and physical assistance in transportation. Follow advice given by TBNS / Respiratory Nurse Specialist.

6.7 The TBNS / Respiratory Nurse Specialist will offer continued support, education and information for any voluntary or statutory organisation involved in caring for the individual.

7.0 TB Treatment and the use of Directly Observed Treatment (DOT)

7.1 The minimum duration of treatment for PTB is six months. A combination of four different antibiotics is used for the first two months followed by two antibiotics for the remaining four months (NICE, 2006). These drugs might be prescribed to be taken daily or a larger dose taken three times a week. The number/amount of tablets/antibiotics will be dependant on the individual's weight. Other medicines may also be offered to help assist in overcoming potential side effects.

7.2 The person will be advised of potential side effects, must notably urine and bodily fluids will be discoloured orange/red due to a dye in the medication.

7.3 It is important that the TB treatment is taken as prescribed and for the correct duration of time. Due to the potential side effects and the risks associated with treatment non-compliance, all patients need to be carefully monitored throughout their treatment. If treatment is taken randomly or haphazardly then there is a risk of drug resistance developing.
7.3 The homeless and drug/alcohol users are at risk of non-compliance due to a variety of factors: loss of medication due to theft or exposure to the elements, erratic movements, addiction or existing medical/mental health conditions.

7.4 To ensure a greater compliance, Directly Observed Treatment (DOT) is required. DOT means that a supervisor actually watches the patient swallowing the tablets and reports non-compliance back to the TBNS/Respiratory Nurse Specialist. This ensures that the patient takes the right drugs, in the right doses, at the right intervals. DOT does not need to be by a TBNS, other staff can be trained to supervise DOT should the need arise.

8.0 Multi-Drug Resistant TB (MDRTB)

8.1 MDRTB is defined as a resistance to both Rifampicin and Isoniazid, the most important drugs used to treat TB. Additional resistance to other first and second line drugs, such as Pyrazinamide, Ethambutol and Streptomycin may further complicate management. MDRTB is not known to be more virulent or more infectious than other forms of TB, but the consequences of acquiring disease are much more serious owing to the complexities of its treatment management.

8.2 MDRTB is difficult to treat, often requiring a combination of several drugs for a much longer period of time. The patient may remain infectious for longer until the appropriate medicine starts to work, and has the potential to pass on the resistant properties of the infection to others.

8.3 The homeless and drug/alcohol users have an increased risk of MDRTB due to

- risk of previous contact with MDRTB
- risk of HIV infection
- poor compliance with previous or current treatment
- possible periods of imprisonment

(MMWR, 1992; NICE, 2006; Storey et al, 2007)

8.4 The likelihood of MDRTB will be assessed by TBNS/Respiratory Nurse Specialist on referral and if strongly suspected the person will be admitted to ‘negative pressure’ isolation facilities at Poole General Hospital or Dorset County Hospital.

8.5 In the event of confirmed MDRTB the patient will remain in ‘negative pressure’ isolation for the duration of hospitalisation and only discharged once no longer infectious and on direct guidance of TBNS/Respiratory Nurse Specialist, Respiratory Consultant, Consultant Microbiologist and Consultant in Communicable Disease Control
(CCDC). Any hostel/shelter staff involved in caring for the patient on discharge will be advised accordingly.

8.6 For full management guidelines of suspected or confirmed MDRTB refer to the ‘Dorset Policy for Management of Suspected/Diagnosed Tuberculosis’.

9.0 TB Contact Tracing

9.1 Early case finding and effective treatment of persons with active TB are the most effective measures in preventing the spread of TB. A risk assessment for the extent of contact tracing will be undertaken by the TBNS / Respiratory Nurse Specialist for every case of PTB.

9.2 Those most at risk of receiving exposure of TB from an infectious source are those that have close, prolonged contact. Usually these are partners or ‘household’ contacts.

9.3 Contact screening within the homeless drug / alcohol use population usually focuses on a taking a past medical history, chest x-ray and possibly some sputum tests. A blood test may occasionally also be undertaken.

9.4 All relevant contacts of the PTB case will be offered screening, including those with occupational contact where appropriate. Those who are identified as contacts of a PTB case are not infectious themselves (unless they incidentally have active pulmonary tuberculosis).
POSSIBLE SIGNS AND SYMPTOMS OF ACTIVE TB:
Cough lasting more than 3 weeks AND one or more of the following:
Haemoptysis (blood in sputum)
Weight loss
Loss of appetite
Night sweats
Fever
Consider – History of TB/previous contact with TB
Leaflets

TB & Homelessness
Guidance for homelessness sector staff
Tuberculosis (TB) is an airborne infectious disease that spreads through prolonged contact. TB rates in the UK are on the increase and homeless people are particularly vulnerable to the disease. Not all forms of TB are infectious, only respiratory TB can be passed on from one individual to another.

**Think TB!**

If people with TB are detected early the disease is easier to treat and further spread is limited. Look out for the following symptoms:

- A cough which seems to get worse over a period of two to three weeks
- Persistent fever
- Heavy sweating at night
- Loss of appetite
- Unexplained weight loss
- General & unusual sense of tiredness and being unwell
- Coughing up blood – seek urgent medical advice

A person with 3 or more of these symptoms should seek medical advice. Anyone coughing up blood should seek medical attention urgently.

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**Referral pathway**

- **Client presents with 3 or more symptoms** or **Coughing up blood?**
  - **NO**
  - **YES**

- **Does the person have a GP?**
  - **NO**
  - **YES**

- **Either**
  - **GP**
  - **A & E**

- **Is there a specialist health care team for homeless people (e.g. PMS) in your area?**
  - **YES**
  - **NO**

- **Specialist homeless health care teams**
  - Infection control advisors
  - TB nurses
  - Communicable diseases nurses

- **Local hospital Respiratory / Infectious Disease unit or TB clinic**
  - Chest / Infectious disease clinic nurses

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If you need more information about your local services contact your local PCT or Health Protection Unit. Their details can be found at the back of the leaflet.
Client advocacy
Vulnerable clients may need support in accessing health services and should, when possible, be accompanied by a member of staff who can speak for and support them. If you cannot go with the client phone ahead to let the relevant service know that they are coming and explain any difficulties the client may have. Make sure you keep a record of all communications with medical staff, as this may be important for any follow-up activity.

Medical staff may need to know:
- The address of the patient's hostel, bed and breakfast hotel or pitch (if sleeping rough).
- The address of day centres he or she visits.
- Details of others who may need to be tested for TB if the person is infectious (usually limited to close contacts).
- The name of his or her GP, outreach worker, hostel or day centre key worker, social worker, or friends - someone through whom contact can be made.
- Information on the medical history of the patient - particularly about medication, treatment or investigation the patient is undergoing.

Supporting treatment
If a client is diagnosed with TB they will be placed on a drug treatment lasting at least 6 months. TB can be completely cured provided that the medication is taken regularly and for the entire course.

Getting clients to take a full course of TB treatment is the most challenging obstacle to TB control.

You may support TB control through:
- Motivating and supporting those who are taking TB treatment to complete the full course. The Department of Health strongly advises that support is provided to TB patients to remind them to take their medication and that they are observed to be swallowing it. This is called Directly Observed Therapy (DOT).
- Supporting clients to keep their follow up appointments.
- Helping to get in touch with people who have been in close contact with an infectious patient.
- Helping the health services to locate people who have stopped attending before their treatment has been completed.
- Support TB screening by reassuring clients and motivating people to get checked.
- Liaising with local TB services to organise screening of high risk groups.
- Contribute to local TB policies and working groups.

Am I at risk?
There is no evidence to suggest that homeless sector workers working with TB patients are more at risk of TB. Nevertheless, awareness of symptoms and treatment regimens are crucial to ensure that TB cases are detected early.

You should be aware of symptoms, treatment and what to do if you suspect that you, a client or other members of staff have TB. If you have not had a BCG vaccination you should consider a vaccination and discuss this with your GP. If you are especially susceptible to infection, for example if you have an illness or have to take medicines that reduce your immunity, then you may need to take further precaution.

Need to know more?
Further information, training materials and contacts are available on:
- Homeless Link: www.homeless.org.uk/index
- HPA website - www.hpa.org.uk/infections/topics_az/tb/menu.htm
- NHS Direct - www.nhsdirect.nhs.uk/ or call on 0845 4647
- TB Alert – charitable organization: www.tbalert.org or ring 0845 456 0995 (office hours)

Your local Health Protection Agency

Your local Primary Care Trust (PCT)

To find your local health protection unit go to: www.hpa.org.uk/tb前进/ 进一步的主页.htm

To find your local PCT go to: www.nhs.uk/ England/AuthoritiesTrusts/Pct/Default.aspx

Your local TB nurse can be contacted at:
What is TB and how could I catch it?

TB is the short name for an infectious disease called tuberculosis. You can get TB by prolonged and close contact with someone who has TB in his or her lungs. They can pass the germs to other people when they cough. Not all forms of TB are infectious: only lung TB may be (but not always) passed on from one individual to another. People who misuse drugs or alcohol are more at risk of catching TB. TB rates in the UK are on the increase, and individuals with a substance misuse problem are around 10 times more likely to get the disease compared to the general population.

Is my cough TB?

It could be a normal cough, or it could be from smoking, another infection or TB. If your cough lasts for more than three weeks, ask to see a nurse or doctor.

What are the symptoms of TB?

If you have a persistent cough and/or at least two symptoms below, you may have TB. You should ask to see a nurse or doctor urgently.

- Persistent fever
- Heavy sweating at night
- Loss of appetite
- Loss of weight for no reason
- Unusual sense of tiredness and being unwell
- Coughing up blood
- Recent contact with someone who has TB.

People with TB don’t all have a cough. TB can occur anywhere in the body not just the lungs. If you are worried about your health ask to see a nurse or doctor.
I think I have a cough and two or more symptoms. Do I have TB or not?

- This does not mean that you necessarily have TB. The symptoms could be due to another infection, smoking or drug withdrawal. Coming off drugs can cause symptoms similar to those stated previously.
- But it is important that you get your symptoms checked out, especially if your cough has lasted more than three weeks.

Please note: Just because you have had the vaccination for TB (BCG) does not mean that you cannot get TB!

How can TB be diagnosed?

- A doctor or nurse will arrange for you to have some tests. This may involve testing your phlegm and having a chest x-ray.
- You may be referred to a specialist TB or chest clinic for these investigations, or they may be arranged by your GP.

Will I have to go to hospital?

- If you have a secure place to live and you are well enough, you can stay at home.
- If you have TB in the lungs and are coughing up phlegm, it usually takes a couple of weeks of treatment before you stop being at risk of being able to pass your infection on to others. If you do not have a place to stay and are at risk of infecting others, you may be kept in a separate room in hospital for these two weeks.

In hospital:
- If you are on opiate substitution treatment, staff in the hospital will ensure that this treatment will be continued while you are in hospital.
- When you are discharged home, you will be asked to attend a hospital clinic regularly so that your progress can be monitored. Your TB treatment will be supplied free of charge by the TB / chest clinic.

Can TB be cured?

YES. TB CAN BE COMPLETELY CURED IF YOU TAKE TABLETS REGULARLY FOR THE FULL LENGTH OF TREATMENT, WHICH IS AT LEAST 6 MONTHS

Treatment

- You may start treatment in a TB / chest clinic or at home. If you are diagnosed with TB that is infectious to others (not all TB cases are infectious), you may be admitted to hospital and treated till you are no longer infectious (usually 2 weeks). You will then be discharged home to continue with your course of treatment and regular clinic follow-up.
- If you stop taking the tablets, the disease could come back and be more difficult to treat because the TB bacteria could become resistant to the anti-TB drugs. You may become more infectious and pass on the disease to family and friends.

Directly Observed Therapy

You may be supervised while taking your medication, that is, someone will be responsible for watching you take it. This is to ensure that you are taking the treatment as prescribed to help you get better, prevent the spread of tuberculosis to others and to prevent you from developing TB that is resistant to your medication.

What happens if I continue drinking alcohol during my treatment for TB?

- The drugs used for treating TB can affect your liver; this can be made worse if you continue drinking heavily – your TB nurse, doctor or key worker will discuss this with you.
What if I am receiving treatment for my drug use?

- It is safe to take the two sets of treatment together, as long as the treatment is carefully monitored by a healthcare team. Substitute drugs, such as methadone, and TB medication affect each other. The effect is unpredictable; it could cause drug withdrawal or overdose. Your substitute medication dose may need to be changed. It is extremely important that you allow your healthcare team to monitor this closely, and report any symptoms immediately.
- It is important that you share any concerns you may have with your doctor / healthcare team – they are there to help you get better.

What happens if I am co-infected with Hepatitis B or C, or HIV?

- Your treatment will be monitored more closely because some side-effects are more likely. Please make sure that you keep all your hospital appointments.

Who can I go to for advice / who can I talk to?

You will have a TB nurse who will support you during treatment and make sure that you see specialist medical staff regularly. It is very important that you discuss your concerns and anxieties freely with your doctor and members of your healthcare team; they are there to help you get better.

Will my views be considered?

You will be consulted and your view will be taken into account before making any decisions about your care plan and future. It is very important that you talk to your healthcare team. If you think your treatment is not working properly discuss your concerns with your medical team as they may need to change your medication or make other changes to your care plan.

Am I infectious to other people?

You are only infectious if you have TB of the lungs and are not taking your medication regularly. After 2 weeks of treatment you will normally become non-infectious. You cannot pass on the infection to other people by sharing the kitchen, toilets, crockery, bed linen etc.

If you have TB of the lungs, it is possible that you have been infectious for some time before starting treatment. So it is very important that you tell the healthcare team who you have spent time with so that appropriate screening can be arranged for these people.

What if I don’t want my family or friends to know about this?

If you don’t want your family / friends to know about this, they will not be told. However, the TB nurse may need to discuss this with you further if you have infectious TB, since your family and friends may need to be checked for TB if you see them regularly.
Copies of other TB information leaflets and posters are available including foreign language versions and leaflets concerning contact tracing, BCG vaccination, latent TB, TB treatment and Multi-Drug Resistant TB from:

TB Alert:  
www.tbalert.org

or from:

The National Knowledge Service - TB Pilot:  
www.hpa.org.uk/tbknowledge/default.htm

Leaflets are downloadable from web site or available to order.

Further information regarding the BCG vaccine is also available from the Department of Health website:  
www.immunisation.nhs.uk
12. DORSET TB SERVICES CONTACT DETAILS

East Dorset TB Service:
David Thomas / Miles Jarvis
Royal Bournemouth Hospital
Castle Lane East,
Bournemouth
BH7 7DW
(01202) 704560/70
david.thomas@rbch.nhs.uk
miles.jarvis@rbch.nhs.uk

For West Dorset TB patients:
Respiratory Nurse Specialist
Dorset County Hospital
Williams Avenue
Dorchester
DT1 2JY
(01305) 254238

Dr Sue Bennett
Consultant in Communicable Disease Control
Dorset and Somerset Health Protection Unit
Victoria House
Princess Road
Ferndown
BH22 9JR
(01202) 851272

Sue Appleby
TB Lead
Dorset and Somerset Health Protection Unit
Victoria House
Princess Road
Ferndown
BH22 9JR
(01202) 851272
sue.appleby@ferndown.nhs.uk
13. OTHER ADVICE, INFORMATION AND SERVICES

Adfam (Families, Drugs and Alcohol)
www.adfam.org.uk

Big Issue
51-53 Poole Hill
Bournemouth
BH2 5PW
(01202) 314261

Bournemouth Council Homelessness Advisors
(01202) 451467

Bournemouth Hospital
(01202) 303626

CADAS (Community Drug and Alcohol Service)
28 High West Street
Dorchester
Dorset
DT1 1UP
(01305) 265635

Citizens Advice Bureau
Bournemouth 01202 290967; advice line 08444 994105
Bridport 01308 456594
Dorchester 01305 262220
Gillingham 01747 822117
Poole 01202 680838
Salisbury 01722 327222
Weymouth 01305 782798
Online - www.adviceguide.org.uk

CRI – Bournemouth Street Services
(01202) 209460

Dorset County Hospital (Dorchester)
01305 251150

DDAAS (Dorset Drug & Alcohol Advisory Service)
01305 760799

Dorset Housing Aid Centre
0808 8000380
Essential Drug and Alcohol Services (EDAS)
2 West Hill Road
Bournemouth
Dorset
BH2 5PG
Support and advice (01202) 311600

Genesis (Counselling and Advice Services)
5 Belle Vue
Weymouth
Dorset DT4 8DR
(01305) 779706

HPA TB website: [www.hpa.org.uk/infections/topics_az/tb/menu.htm](http://www.hpa.org.uk/infections/topics_az/tb/menu.htm)

Housing Needs Team (for the Christchurch area)
Twynham Housing Association
Dolphin House,
Wick Lane,
Christchurch
(01202) 460460

National Missing Persons Helpline
0500 700 700 (open 24 hours)

National Knowledge Service - TB Pilot: [www.hpa.org.uk/tbknowledge/default.htm](http://www.hpa.org.uk/tbknowledge/default.htm)

The National Treatment Agency [www.nta.nhs.uk](http://www.nta.nhs.uk)

Poole Hospital
(01202) 665511

Purbeck Housing Trust
Wareham
01929 558400
Emergencies out of hours 01929 558455

Runaway Helpline - confidential helpline for young people up to the age of 17 0808 800 7070 (open 24 hours)

Salisbury (Odstock) Hospital
01722 336262

Samaritans
0845 790 9090

Shelter – Housing advice
0845 121864
Shelter - Helpline
0808 800 44 44 (open 8am-midnight 7 days)

Social Services Bournemouth
Out of Hours - Homelessness
(01202) 668123

St Paul’s Night Shelter
(01202) 587160

Talk, Don't Walk - provides support, advice and guidance to young people who have run away, or are thinking of running away
Helpline - 0800 085 2136

West Dorset Housing Partnership
22 High West St
Dorchester
01305 756045

West Dorset Housing Advice Centre
01305 251010
Out of office hours emergency phone line 01305 250365

Weymouth and Portland Housing Advice Centre
Ferry Terminal
Weymouth
01305 838400

Young Adults Drug and Alcohol Service (YADAS)
(for young people under the age of 19 years old)
2 West Hill Road Bournemouth BH2 5PG or
505 Ashley Road Poole BH14 OAD
(01202) 319191 or (01202) 741414

YMCA
56 Westover Rd
Bournemouth
BH1 2BS
(01202) 290451
Further information available regarding local council services and contact details are available by the following links:

Weymouth
http://www.weymouth.gov.uk/living/housing/home.asp?svid=814

Purbeck

West Dorset
http://www.dorsetforyou.com/index.jsp?articleid=393

Christchurch
http://www.dorsetforyou.com/index.jsp?articleid=330754

North Dorset
http://www.north-dorset.gov.uk/index/living/housing.htm

Poole

Bournemouth
http://www.bournemouth.gov.uk/Residents/housing/default.asp
14. REFERENCES and FURTHER READING


Homeless Link Tackling TB - An information pack for staff and volunteers working with homeless people
http://www.homeless.org.uk/policyandinfo/issues/health/tb/hleaflets/lbc%20TBinfopack%20FINAL.pdf


www.crisis.org.uk

www.homeless.org.uk