Trust Guideline for the Management of Patients with confirmed or suspected Tuberculosis (TB)

Document Control:

For Use In:	All clinical areas within Norfolk and Norwich University Hospital (NNUH)		
	All Personnel who work within the Trust		
Search Keywords	Tuberculosis, TB		
Document Author:	Infection Prevention and Control Nurse Microbiology Consultant, Microbiology Specialist Registrar		
Document Owner:	Infection Prevention and Control Team		
Approved By:	Hospital Infection Control Committee (HICC)		
Ratified By:	Clinical Safety and Effectiveness Sub-Board		
Approval Date:	January 2023	**Date to be reviewed by:** This document remains current after this date but will be under review	November 2025
Implementation Date:	January 2023		
Reference Number:	627		

Version History:

Version	Date	Author	Reason/Change
V4.3	January 2021	IP&C	Communication Cascade for Suspected/Confirmed Tuberculosis-Outpatients flowchart removed Summary of minimum requirements for the isolation of patients with suspected or confirmed TB table removed
V5	January 2023	IP&C and Microbiology	Definitions extended Reviewed and changed as required

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
None	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:

Decontamination group
Department of Respiratory Medicine TB liaison Group
Health and Safety
Hospital Infection Control Committee Members
Serco Estates Dept
Matrons and Senior Nurses
Microbiology
Respiratory
Sterile Services (CSSD)
Ward Sisters and Charge Nurses
Workplace Health and Wellbeing

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospital; please refer to local Trust's procedural documents for further guidance, as noted in Section 4.

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Management of infectious tuberculosis

Communication Cascade for Suspected or Confirmed Tuberculosis In-Patients

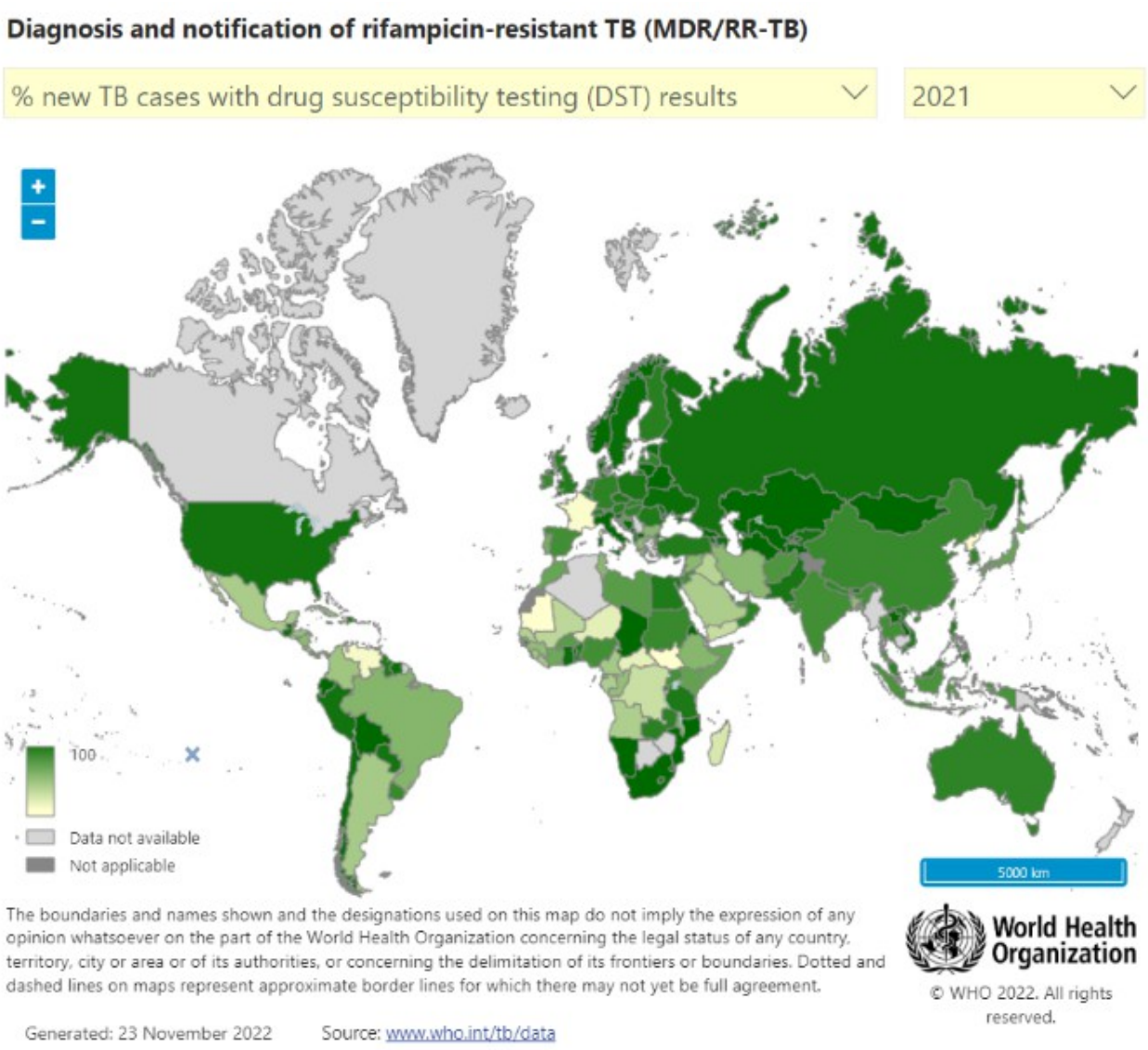
1. Introduction

1.1. Rationale

These guidelines relate to Mycobacterium Tuberculosis (MTB).

Bacteria of the MTB complex (Mycobacterium tuberculosis, Mycobacterium africanum, Mycobacterium bovis, Mycobacterium canettii, Mycobacterium caprae, Mycobacterium microti, Mycobacterium pinnipedii and Mycobacterium orygis) are acquired through inhalation of infected droplets. Immunocompromised patients are more susceptible to acquiring the disease. Treatment of TB should be managed in the patient's home whenever possible.

While the disease affects mainly the lungs, extra – pulmonary cases of TB can present, more commonly in: children, immigrants or visitors from countries with high prevalence of TB and the immunocompromised (e.g. patients with Human Immunodeficiency Virus (HIV)).



Global map of MDR/XDR T.B accessed 24/11/2022

Person-to-person transmission of TB occurs via inhalation of droplet nuclei (airborne particles 1 to 5 microns in diameter) that can be generated when persons who have pulmonary or laryngeal TB cough, sneeze, shout or sing.

Skin sensitivity to tuberculoprotein (Tuberculin, Heaf, and Mantoux test) develops (positive) after exposure to tubercle bacilli or following vaccination. The test result may provide evidence of previous infection and assist diagnosis of latent TB infection. However the Mantoux test does not have a place in the diagnosis of active disease.

Interferon-gamma testing should be considered for people whose Mantoux testing shows positive results, or in people for whom Mantoux testing may be less reliable, for example BCG-vaccinated people or those who are immunosuppressed.

Extrapulmonary TB

Patients with isolated extrapulmonary tuberculosis are not considered to be contagious. However, such patients require careful evaluation for presence of

concurrent pulmonary or laryngeal TB. Concurrent pulmonary TB is common in patients with pleural or pericardial TB.

Immunocompromised patients with extrapulmonary TB should be presumed to have pulmonary TB even if chest radiography is normal until proven otherwise: negative sputum samples for microscopy, culture and PCR.

Patients with extrapulmonary TB should be isolated in a single room until a doctor has reviewed for the presence of concurrent pulmonary or laryngeal TB. It should be documented in the patient care record when it is safe to leave the single room.

1.2. Objective

The objective of the clinical guideline is to improve patients care in compliance with national guidance, to prevent cross infection within the Trust, to promote understanding about the transmission of TB, i.e., health education and to protect patients, visitors and members of staff from acquiring pulmonary TB.

1.3. Scope

These guidelines give guidance on the procedures to be followed when an inpatient is confirmed to have or is highly suspected of having **infectious TB**. Some patients will be considered to be particularly infectious. The consequences of transmission of infection with MTB may cause more severe problems if the individual affected is immunocompromised, including HIV positive, or if the MTB microorganism is drug resistant; greater care should be taken to reduce the risk of transmission of infection in these circumstances.

This document does not address issues of diagnosis and/or treatment of TB.

This document does **not** refer to atypical species of Mycobacteria or non-tuberculous mycobacteria (NTM).

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
AFB	Acid fast bacilli
AFB isolated	microscopy examination of sputum or other samples for acid-fast bacilli will be followed by mycobacterial culture. All mycobacterium spp isolated will be sent to the reference laboratory for identification and molecular/drug susceptibility testing.
AGP	Aerosol Generating Procedure
Bacteriologically confirmed TB case	When a biological specimen is positive by culture, i.e. report stating MTB complex isolated, or by molecular methods i.e. TB Polymerase Chain Reaction (TB-PCR) positive. These may be either smear positive or negative. All such cases should already have been referred to the TB management team. The time to complete species identification from culture positive result (AAFB isolated) varies from one to two weeks. This result should be considered culture positive until otherwise reported.

BAL	Bronchoscopy and Bronchoalveolar Lavage
BTS	British Thoracic Society
CCDC	Consultant in Communicable Disease Control
Clinically diagnosed TB case	When the diagnosis is not bacteriologically confirmed but based on clinical criteria suggestive of active TB and the patient may have started antituberculous treatment. This definition includes cases diagnosed on the basis of X-ray abnormalities or suggestive histology and extra pulmonary cases without laboratory confirmation. Clinically diagnosed cases subsequently found to be bacteriologically positive (before or after starting treatment) should be reclassified as bacteriologically confirmed.
Close contacts	are people who have had prolonged, frequent or intense contact with a person with infectious TB. For example, these could include 'household contacts' – those who share a bedroom, kitchen, bathroom or sitting room with the index case. Close contacts may also include boyfriends or girlfriends and frequent visitors to the home of the index case. Depending in the circumstances, occasionally co-workers are classed as 'close contacts although they are more usually classed as 'social contacts'. If an infectious or potentially infectious patient has been nursed in an open bay before the diagnosis of infectious tuberculosis is suspected, a list of patient contacts should be made.
COSHH	Control of Substances Hazardous to Health
DIPC	Director of Infection Prevention and Control
DR TB	Drug Resistant Tuberculosis. TB caused by M. tuberculosis strains resistant to one or more antituberculous drugs.
Drug Sensitive TB	Where there is no resistance to the 1st line anti-tuberculous drugs tested.
FFP3	Filtering Face Piece
HICC	Hospital Infection Control Committee
HIV	Human Immunodeficiency Virus
ICD	Infection Control Doctor
IP&CT	Infection Prevention and Control Team
MDR TB	Multi Drug Resistant Tuberculosis. TB caused by M. tuberculosis strains that are resistant to at least rifampicin and isoniazid and possibly additional antituberculous agents.
Monoresistant TB	TB caused by M. tuberculosis strains resistant to a single antituberculous agent.
MTB	Mycobacterium Tuberculosis
Negative Pressure Room	Defined as an isolation room that maintains negative pressure compared to the outside environment, thus not allowing the respiratory droplets from infectious TB patients to exit the room. Within the respiratory department there are 2 negative pressure isolation rooms on Hethel ward at NNUH.
NTM	Non- Tuberculous Mycobacterium

Polyresistant TB	TB caused by M. tuberculosis strains resistant to more than one antituberculous agent; the isolate may be resistant to either isoniazid or rifampicin but not both.
PPE	Personal Protective Equipment
Pre-XDR-TB	Pre-extensively drug-resistant TB. TB caused by M. tuberculosis strains resistant to isoniazid and rifampicin as well as a fluoroquinolone (levofloxacin or moxifloxacin) OR resistant to isoniazid, rifampicin, and at least one second-line injectable agent (amikacin, capreomycin, kanamycin).
Respiratory Precautions	This covers airborne or droplet transmission and depends on the infectivity and task being performed. This must be risk assessed and decision made with the respiratory physician and IP&CT. Respiratory precautions poster.
RR-TB	Rifampicin-resistant TB. TB caused by M. tuberculosis strains resistant to rifampicin. These strains may be susceptible or resistant to isoniazid (i.e. MDR-TB), or resistant to other first-line or second-line TB medicines. In these guidelines and elsewhere, MDR-TB and RR-TB cases are often grouped together as MDR/RR-TB and are eligible for treatment with MDR-TB regimens.
Hr-TB	Rifampicin-susceptible, isoniazid-resistant TB. TB caused by M. tuberculosis strains resistant to isoniazid and susceptible to rifampicin.
Smear	direct film from sputum or other samples, stained with auramine to look for Acid-Fast Bacilli (AFB) under microscopy.
Smear negative	AFB not seen on microscopy. This does not exclude TB but is important with regards to assessing infectivity. Further results will be available in the future.
Smear positive	AFB seen on microscopy. Further results will become available in the future.
Suspected TB	When clinical symptoms and/or signs are suggestive of the diagnosis of TB. Patients whose sputum is smear positive and they have signs suggestive of TB, are highly suspicious.
TB	Tuberculosis
TBMDT	TB Multi-Disciplinary Team
UKHSA	United Kingdom, Health Security Agency
WHWB	Workplace Health and Wellbeing
XDR TB	Extensively Drug Resistant Tuberculosis TB caused by M.tuberculosis strains resistant to isoniazid, rifampicin, a fluoroquinolone (levofloxacin or moxifloxacin), and at least one second-line injectable agent (amikacin, capreomycin, kanamycin) OR resistant to isoniazid, rifampicin, a fluoroquinolone, and either bedaquiline or linezolid
Xpert MTB/RIF (PCR)	Molecular test used to detect simultaneously M. tuberculosis complex and rifampicin resistance. In our laboratory we use this test on primary sputum and CSF samples for all new smear positive results. For patients with strong clinical suspicion of TB the laboratory should

	be notified in order to perform this test even on smear negative samples.

2. Responsibilities

Chief Executive - has overall responsibility for ensuring there are effective procedures and resources in place to enable the implementation of this guideline.

Director of Infection Prevention & Control (DIPC) has strategic responsibility within the Trust for the development and implementation of IP&C best practice.

Divisional Managers/Matrons/Ward Managers are responsible for ensuring they have a process in place to reassure the organisation that all staff are aware of and receive appropriate training, in line with IP&C, Health and Safety (H&S), and Workplace Health and Wellbeing (WHWB).

Infection prevention and Control Team (IP&CT) - The IP&CT have a responsibility to facilitate training and offer specialist advice and support to staff regarding the IP&C elements of this guideline.

Health & Safety (H&S) is responsible for overseeing the fit testing of the filtering face piece (FFP3) masks.

Microbiology department is responsible for reviewing this guidance and amending as required at the review date, or prior to this following new developments to reflect current best practice. They are responsible for rapidly processing specimens (Acid fast bacilli-AFB), reporting the results for any positive cases, informing the IP&CT, the patient's Consultant, the Consultant Respiratory Physician (TB lead) and liaising with the TB nurse specialist to notify UKHSA/HPT

TB consultant lead is responsible for informing the TB nurse specialist, liaising with the TB coordinator, notification via ETS database, informing IP&CT if patient contact tracing is required.

TB Multi-Disciplinary Team (TBMDT) are responsible for clinical management of all cases of TB and monitoring compliance with the TB policy.

Consultant/doctor is responsible for referring to the TB Clinical lead and assessing likelihood of MDR TB.

All Staff have a responsibility to ensure they follow the advice in this guideline and must ensure they attend appropriate training. Any deviations from these guidelines must be clearly documented including risk assessments made.

It is the responsibility of each employee to be aware of the procedural documents which relate to their department/area of practice.

3. Processes to be followed

3.1. Diagnostic Specimens

Sputum specimens or other respiratory specimens should be sent in sealed plastic bags and labelled 'biohazard' with a yellow biohazard/danger of infection label

To make the laboratory diagnosis of pulmonary TB, three fresh sputum specimens (with one early morning sample) normally taken at daily intervals, should be sent to the Microbiology Laboratory for staining for acid-fast bacilli (AFB) and culture. When there is strong clinical suspicion of TB the laboratory should be notified to perform PCR directly on sputum samples. These should whenever possible be sent prior to starting chemotherapy. In urgent cases three consecutive specimens may be sent, ideally within seven days of starting treatment. (NICE 2016).

Sputum specimens and other respiratory specimens should be sent in sealed plastic bags and labelled 'bio-hazard'. Procedure for the Labelling and Packaging of Specimens.

3.2. Initial assessment of patient infectivity

If no specimen result is available, all suspected cases are considered infectious until proven otherwise (after clinical assessment or by laboratory confirmation) and should be nursed in a negative pressure room with respiratory precautions. Patients then need to be categorised according to the following:

Non-infectious TB/lower infectivity: sputum negative by smear **and** culture in three consecutive samples taken on different days (at least three negative sputum microscopy specimens taken on different days).

Potentially Infectious Pulmonary Disease: sputum smear negative and culture results not known or positive. In this case, treatment may have already been started based on clinical suspicion until culture results are back (usually up to 6 weeks). The TB team should be contacted.

Infectious Pulmonary TB Disease: sputum smear positive, (i.e., AFB present on microscopy). In this case, the TB team needs to be contacted ASAP. A clinical should be performed for MDR TB by Consultant Respiratory Physician.

MDR TB Risk assessment

Multi Drug Resistant TB (MDR TB) has serious implications for the patient and the public, as there are limited numbers of alternatives with which to treat the patient. It usually arises from incomplete/inadequate treatment that is commonly due to the patient's non-compliance.

For people with clinically suspected TB, a TB specialist should request rapid diagnostic nucleic acid amplification tests for rifampicin resistance (PCR) on primary specimens if a risk assessment for multidrug- resistance identifies any of the following risk factors:

- History of previous TB drug treatment, particularly if there was known to be poor adherence to that treatment
- Contact with a known case of multidrug-resistant TB
- Birth or residence in a country in which the World Health Organization link reports that a high proportion (5% or more) of new TB cases are multidrugresistant.

Molecular tests for identification of MTB and Rifampicin resistance are strongly recommended if, following the risk assessment undertaken by the Consultant Respiratory Physician, the patient is regarded as a significant risk for MDR TB.

3.3. Infection prevention and control measures

3.3.1. Patient care and isolation for suspected/confirmed TB (deemed low risk for MDR TB)

For quick reference guide for the management of suspected/confirmed TB please refer to the Management of Tuberculosis-infectious flowchart.

The following recommendations are either based on NICE TB guidelines (2016) or as agreed by the local NNUH TB MDT.

- For suspected/confirmed infectious pulmonary or laryngeal TB, patients should be nursed in a negative pressure isolation room, with respiratory precautions. This may involve prioritising their care above that of others.
- If MDR TB is suspected following risk assessment by **Consultant Respiratory Physician** or is confirmed, patients should be nursed in a negative pressure room with respiratory precautions and have specimens sent for rapid diagnostic tests, such as nucleic acid amplification tests. (See also 3.3.3 patient care and isolation for MDR TB)
- Patients should be given information about isolation and precautions. While you are in isolation leaflet.
- Explain to inpatients with suspected infectious or confirmed pulmonary or laryngeal TB that they will need to wear a surgical mask in the hospital whenever they leave their room for diagnostics and ask them not to wander into communal areas unmasked. The lead clinician is responsible for explaining this to the patient.
- Ask them to continue wearing it until they have had at least 2 weeks of treatment and are showing clinical improvement. This decision should be ultimately made by the TB MDT lead as per de-escalation of isolation
- Standard and respiratory infection control precautions apply (see Trust Policy for the Management of Isolation procedures).
- Do not admit people with suspected infectious or confirmed pulmonary TB into a ward containing people who are immunocompromised, such as transplant recipients, people with HIV and those on antitumour necrosis factor alpha or other biologics, unless they can be cared for in a negative pressure room on the same ward.
- Patients with suspected/confirmed pulmonary TB going to theatre should be put at the end of the list and recovered inside the theatre. Staff should wear appropriate PPE and a clinical clean, code 2, as per trust guidance, (Cleaning and disinfection guideline) should take place after.
- With regards to anaesthetic machines, the machines should be cleaned and maintained as per local policy.
- Minimise the number and duration of visits a person with TB makes to an outpatient department while they are still infectious. To minimise the risk of

infection, people with infectious TB should be seen at times or in places away from other people.

- Assess any visitors to a child with suspected active TB in hospital for symptoms of infectious TB and keep them separate from other people until they have been excluded as a source of infection.
- Marked crockery and separate washing up facilities are **unnecessary** and confirmed or suspected TB patients may use general ward library services.
- Disposal of infected material should be by incineration in clinical waste as per trust guideline Waste management policy.
- Fumigation of rooms that have housed patients with TB is **unnecessary**.
- Staff contact with infectious patients should be kept to a reasonable minimum without compromising patient care. Immunocompromised and HIV infected health care workers should not care for patients with infectious TB, nor should staff who do not have a history of TB immunisation and suffer from chronic lung disease. WHWB will undertake necessary investigations and testing for staff that have been in 'close contact' if required.
- Mantoux, interferon-gamma testing and BCG vaccine for staff are reviewed /undertaken at the commencement of employment by WHWB. Staff who are concerned about their compliance or about a contact with infectious cases of TB should contact WHWB to discuss. (Out of hours WHWB advice)
- Visitors should be limited to those who have already been in close contact with the patient prior to his/her diagnosis. All visitors will be advised to wear a mask when visiting.
- Additional precautions regarding contact may be required between patients with both HIV and TB and their visitors (including children). Advice should be given on a case-by-case basis in consultation with the physician in charge, IP&CT and health and safety.
- Linen from patients with infectious pulmonary or laryngeal TB or any linen soiled with blood or body fluids should be treated as **'infected'** and managed accordingly. Refer to Soiled Linen Bagging Procedure.
- No special precautions are required for used linen from TB patients not deemed to be infectious.
- Open abscesses should also be considered infectious.

3.3.2. De-escalation of isolation precautions

Consider deescalating isolation after 2 weeks of treatment, taking into account the risks and benefits, if:

- The patient is showing tolerance to the prescribed treatment.
- There is agreement (by patient) to adhere to treatment.
- There is resolution of cough.
- There is definite clinical improvement on treatment; for example, remaining afebrile for a week.

- There are not immunocompromised people, such as transplant recipients, people with HIV and those on antitumour necrosis factor alpha or other biologics, in the same ward.
- The person's initial smear grade was not high; for example, 2 or less.
- There is not extensive pulmonary involvement, including cavitation.
- There is no laryngeal TB.
- Patients should not be moved from an isolation room without the agreement of the designated respiratory physician and the TBMDT and documented in patient care record.
- Isolation rooms and appropriate PPE worn will be required for all extra-pulmonary TB patients if aerosol-generating procedures (AGP's) are performed e.g. abscess or wound irrigation.
- Patients whose sputum is smear negative, whose bronchial washings are smear positive, are not considered infectious and do not need isolation rooms unless:
    a) They become sputum smear positive after bronchoscopy (send 3 samples routinely after BAL).
    b) They are on a ward with immunocompromised patients.
    c) They are confirmed or suspected of having MDR TB, then they should be managed as highly/potentially infectious and should be isolated in a negative pressure room with respiratory precautions.

3.3.3. Patient care and isolation for suspected/confirmed MDR TB

If people with **suspected or known infectious MDR TB** are admitted to hospital, admit them to a negative pressure room with respiratory precautions.

Consider earlier discharge for people with confirmed MDR TB, if there are suitable facilities for home isolation and the person will adhere to the care plan.

For people with confirmed MDR TB whose symptoms have improved and who are unable to produce sputum, discharge decisions should be taken by the multidisciplinary team and the health protection team.

Staff and visitors should wear filtering face piece (FFP3) masks during contact with a person with suspected or known MDR TB while the person is thought to be infectious.

Before deciding to discharge a patient with suspected or known MDR TB from hospital, agree with the patient and their carers secure arrangements for supervising and administering all antiTB therapy.

3.3.4. Aerosol generating procedures (AGP)

- In people who may have TB, **only** carry out AGP's e.g. sputum induction and abscess or wound manipulation in an appropriately engineered and ventilated area (ideally a negative pressure room).
- Other procedures, such as respiratory function tests, may also provoke coughing. These should not be performed unless it is essential, and then performed in a single room with enhanced mechanical ventilation and adherence to respiratory and standard precautions.
- Respirator (FFP3) masks should be worn by staff for all AGP (see section 3.3.5).

The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- Awake* bronchoscopy (including awake tracheal intubation)
- Awake* ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning
- Awake* upper gastro-intestinal endoscopy
- Dental procedures (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
- Induction of sputum
- Respiratory tract suctioning**
- Surgery or post-mortem procedures (like high speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses.
- Tracheostomy procedures (insertion or removal).

3.3.5. Cough hygiene/use of masks by patients

- Patients should be encouraged to cover both the nose and mouth with a tissue whenever they cough or sneeze, use paper tissues when expectorating and dispose of used tissues safely into a clinical waste bag, followed by hand hygiene.
- Explain to inpatients with suspected infectious or confirmed pulmonary or laryngeal TB that they will need to wear a surgical mask in the hospital whenever they leave their room for diagnostics and ask them not to wander into communal areas unmasked. The lead clinician is responsible for explaining this to the patient.
- Ask them to continue wearing it until they have had at least 2 weeks of treatment, are showing signs of clinical response and have been advised to do so by the TB lead. The decision to stop the mask wearing should be made by the TB team lead.

3.3.6. Recommendations for the use of FFP3 masks by health care workers

- An FFP3 mask, gloves and apron must be worn at all times when entering the room of all patients

who are known or suspected of having TB. The probability of this must be determined by the medical team as soon as possible.

- Staff must be fit tested prior to wearing FFP3 mask, with records of training held by the training department, including which brand. Staff must fit check the mask each time the mask is applied. **Wards and departments should have staff trained to fit test and further guidance may be sought from the H&S team.**
- All masks have a limited life span and are single use only. The manufacturers should supply you with this product specific information. Masks are no longer effective when **wet** and must be changed.
- FFP3 masks should be close fitting and filter particles of 1-5 microns, which must meet the European standard FFP3 EN149:2001). The valved mask is designed to minimise heat build-up and make breathing cooler. **Never** let a patient wear a valved mask, as the one-way valve allows the escape of exhaled unfiltered air.
- Manufacturers of masks should supply simple, easy to use, fit testing devices and procedures.

3.3.7. Recommendations for the use of masks by visitors

MDR TB (suspected or confirmed) Visitors should be advised to postpone visiting until risk of infection has ceased. If they insist on visiting, they should be shown how to put on an FFP3 mask and the risks explained to them.

3.4. Decontamination of Endoscopes

Patient-to-patient transmission of MTB (and environmental mycobacteria) via endoscopy has been well documented. After cleaning, endoscopes should be disinfected following the Trust's guidance.

All staff involved in the decontamination of endoscopes should have access to and wear appropriate PPE in line with standard precautions, including full face visors, disposable gloves, aprons and forearm protection.

3.5. Cleaning and disinfection of other equipment and the environment

For information relating to the decontamination of the environment and/or equipment, please refer to the Trust policy for Cleaning and Disinfection which is found in the IP&C Manual.

4. Related Documents

- Cleaning and disinfection guideline
- Drug-resistant TB: global situation

- Hand hygiene policy
- Isolation Procedures
- NHS England, (HTM 01-06) Management and decontamination of flexible endoscopes, page last updated 31/08/2021 NHS England » (HTM 01-06) Management and decontamination of flexible endoscopes, link accessed 24/11/2022
- NHS England and NHS Improvement, 2022, National infection prevention and control documents for England V2.3, Published 14/04/2022, last updated 28/11/2022 https://www.england.nhs.uk/publication/national-infection-prevention-and-control/ link accessed 24/11/2022
- Procedure for the Labelling and Packaging of Specimens
- Public Health England Guidance: Latent TB infection (LTBI): testing and treatment, Published 2015, last updated 14/05/2019 https://www.gov.uk/government/publications/latent-tb-infection-ltbi-testing-and-treatment, link accessed 24/11/2022
- Respiratory precautions poster
- Soiled Linen Bagging Procedure
- UKHSA, 2021, Tuberculosis (TB) action plan for England, 2021-26, TB Action Plan for England, 2021 to 2026 (publishing.service.gov.uk), link accessed 24/11/2022
- Waste management policy
- While you are in isolation leaflet
- World Health Organization (WHO) consolidated guidelines on tuberculosis. Module 3: Diagnosis - Rapid diagnostics for tuberculosis detection 2021 update WHO consolidated guidelines on tuberculosis: module 3: diagnosis: rapid diagnostics for tuberculosis detection, 2021 update , link accessed 24/11/2022
- World Health Organization (WHO) Consolidated Guidelines on Tuberculosis, Module 4: Treatment - Drug-Resistant Tuberculosis Treatment 2020. WHO consolidated guidelines on tuberculosis: module 4: treatment: drug-resistant tuberculosis treatment link accessed 24/11/2022

5. References

NHS England and NHS Improvement, published 2022, National infection prevention and control manual for England, V2.4 updated 10th January 2023 https://www.england.nhs.uk/wp-content/uploads/2022/04/PRN00123_National-infection-prevention-and-control-manual-for-England-version-2.4_100123.pdf link accessed 17/01/2023

Public Health England (PHE), 2016. Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings. Respiratory tract infection, guidance (PHE 2016), link accessed 24/11/2022

The National Institute for Health and Care Excellence (NICE Guidelines), Published 2016, last updated 12/09/2019 Overview | Tuberculosis | Guidance | NICE link accessed 24/11/2022

6. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Compliance with isolation for patients with confirmed or suspected Tuberculosis	Confirm at TB meeting document in minutes.	TB team	Respiratory clinical governance, HICC and IP&C Organisational Wide Learning if applicable.	Biennial
Compliance with the communication cascades	Minutes of weekly TB team meeting.	IP&CT/TB team	Respiratory clinical governance, HICC and IP&C Organisational Wide Learning if applicable.	Biennial

The audit results are to be discussed at relevant governance to review the results and recommendations for further action. Then sent HICC who will ensure that the actions and recommendations are suitable and sufficient.

7. Appendices

If there are no appendices, then state the following: There are no appendices for this document.

8. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	Clinical Support Services	**Department**	Infection Prevention & Control
Name of person completing form	Sarah Morter	**Date**	24th November 2022

Equality Area	**Potential Negative Impact**	**Impact Positive Impact**	**Which groups are affected**	**Full Impact Assessment Required YES/NO**
Race	None		N/A	No
Pregnancy & Maternity	None		N/A	No
Disability	None		N/A	No
Religion and beliefs	None		N/A	No
Sex	None		N/A	No
Gender reassignment	None		N/A	No
Sexual Orientation	None		N/A	No
Age	None		N/A	No
Marriage & Civil Partnership	None		N/A	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?		N/A		

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.