Public – To be published on the Trust external website

Title: Tuberculosis

Ref: IPC-0001-016-v4.1

Status: Approved
Document type: Procedure

Contents

1 Introduction

Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs, but it can affect any part of the body, including the tummy (abdomen), glands, bones and nervous system.

TB is caused by the bacterium Mycobacterium tuberculosis and in humans can be either active TB or latent TB. The active form of TB the patient will present with symptoms and evidence of an on-going disease process. In latent TB the patient will be asymptomatic but can go on to develop active TB.

Transmission of TB occurs during a period of prolonged contact with an infectious case and is a potentially serious condition, but it can be cured if it's treated with the right antibiotics.

The symptoms of TB vary depending on which part of the body is affected. TB disease usually develops slowly, and it may take several weeks before an individual notices they are unwell. Symptoms might not begin until months or even years after they were initially infected. Sometimes the infection does not always cause symptoms, this is known as latent TB. If they have symptoms then this is called active TB.

Typical symptoms of TB include:

- a persistent cough that lasts more than 3 weeks and usually brings up phlegm, which maybe blood stained
- weight loss
- night sweats
- high temperature
- tiredness and fatigue
- loss of appetite
- swellings in the neck

This procedure is required to ensure that patients who are suspected or diagnosed with TB are cared for safely and effectively and that the correct safety mechanisms are in place to protect staff and other service users whilst under the care of Tees, Esk and Wear Valleys NHS Foundation Trust.

2 Our Journey To change (OJTC)

This procedure reflects the Trust's strategic direction of travel, Our Journey to Change, by supporting its values and goals:

To co-create a great experience for our patients, carers and families, so you will experience:

- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

To co-create a great experience for our colleagues, so you will be:

- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

To be a great partner, so we will:

- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

Living our values is integral to the care we deliver. We will show respect to patients and their families, by actively listening to their concerns and acting upon them. We will ensure we are always compassionate, kind and supportive. We will be open and honest in our conversations, always receptive (listening) to how much information a person may want, and in what kind of format.

This guideline also supports the Trust's strategic goals. It is important that we work closely with the person and/or their families, so that the experience can be as good as it possibly can be, working to ensure the person has as much choice and control as possible. We will work closely with our Trust colleagues, so they feel supported in working with the person and their family.

Finally, we will ensure we work in close partnership with the other agencies involved with the person, such as their GP, the voluntary and charity sector and secondary health services, to ensure seamless and compassionate care.

3 Purpose

Following this procedure will help the Trust to:-

- Ensure the appropriate relevant action and management of patients with Tuberculosis (TB), takes place as required within TEWV in-patient facilities.

4 Who this procedure applies to

- This procedure applies to all trust staff.
- The Infection Prevention and Control Team (IPCT) provide education, training and support to all trust staff to ensure trust wide engagement with all clinical teams informing this procedure.
- This procedure aligns with Trust values as we listen to staff and respect their views. We ensure any staff member who has difficulties with the measures detailed in this procedure can discuss their needs so that standards are maintained while individual differences are recognised and supported

5 Related documents

The Infection Prevention and Control Policy IPC-0001 must read and understood and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

Hand hygiene

Infectious diseases

Decontamination of equipment

National infection prevention and control manual for England

6 What is Tuberculosis and how is it spread?

Tuberculosis (TB) is an infection disease caused by the organism Mycobacterium Tuberculosis.

TB is most commonly spread by airborne droplets which are expelled from an infected person's lungs especially when they cough or sneeze.

Close prolonged exposure over a period of time is thought necessary for person to person spread.

TB usually affects the lungs (pulmonary TB) but can affect other parts of the body (non-pulmonary TB) such as lymph nodes, bones, including spine, genitourinary tract, and brain and meninges.

Once a person has acquired the infection, there are three courses of action:

- The infection may heal spontaneously.
- Over weeks or months active disease may develop.
- It may not spread beyond a small area of the lung as the immune system creates a barrier around the bacteria, called 'latent TB'. This may reactivate later

in life or when other events weaken the individual's immunity.

6.1 Multi-Drug Resistant Tuberculosis and Extensively-Drug resistant TB

Multidrug-resistant tuberculosis (MDR-TB) is when the TB bacteria fail to respond to a combination of two of the four main antibiotics (first line anti-TB drugs), rifampicin and isoniazid.

Extensively drug-resistant tuberculosis (XDR-TB) is a form of TB that is resistant to at least four of the main anti-TB drugs (rifampicin, isoniazid, fluoroquinolones and second-line injectable agents).

Patients usually acquire drug resistant disease either because of spread of a drug resistant strain from another person or because of ineffective or incomplete treatment.

- Currently at a low level in the UK.
- Thought to be more common in patients with a previous history of TB, those with bilateral pulmonary TB or HIV infection
- Patients diagnosed with MDRTB must be managed in negative pressure isolation rooms and precautions for patients must be discussed with Infection, Prevention and Control, Consultant respiratory physician, Consultant in Infectious diseases, TB Multidisciplinary Team (MDT)/Nursing service (where available) and UKHSA CHP (Consultant in Health Protection) on an individual basis.

Patients with active MDRTB or XDR-TB cannot be nursed in TEWV facilities – Doctor in charge to liaise with Acute services chest physician and arrange transfer to an appropriate acute hospital.

7 Diagnosis of TB

- Active TB may be suspected from clinical presentation, e.g. a chest x-ray, by organisms and on microscopy of sputum or other clinical specimens or from the histological appearance of the specimen.
- Sputum smear examination is important to identify infectious pulmonary cases. Microbiology testing will provide initial information to confirm if tuberculosis is present in the sputum sample – this is known as smear positive TB.
- Further confirmation diagnosis requires a positive culture of the organism and this may take several weeks.
- A positive skin reaction to Tuberculoprotein (Tuberculin or Mantoux test) indicates previous exposure to infection and may be used as an adjunct in diagnosis. A gene probe may be used to give a result in days.

All active cases **must** be referred to a consultant respiratory physician for appropriate management.

8 Management of patients with TB

- Suspected or confirmed patients with TB will be managed on the clinical decision of the Physician in charge and nursed in health care premises using an individual plan of care based on a risk assessment.
- **Patients with active MDRTB or XDR-TB cannot be nursed in TEWV facilities –** Doctor in charge to liaise with Acute services chest physician and arrange transfer to an appropriate acute hospital.

8.1 Obtaining sputum cultures

Suspected patients with TB who require respiratory samples to be sent will need if possible 3 deep cough samples, preferably including 1 early morning sample to be sent for TB microscopy and culture.

Obtaining deep cough / induced sputum is an **Aerosol Generating Procedure (AGP)** and should only be undertaken by staff fit tested to wear FFP3 respirators and in a room which appropriately engineered and ventilated (ideally a negative pressure room). If this is not possible an alternative location must be sourced (National infection prevention and control manual for England, 2022)

Required:

- A universal specimen container
- Apron, gloves, visor and FFP3 respirator
- A 5ml sample of sputum (not saliva) should be obtained, avoiding external contamination of the container.
- Secure the lid safely.
- Ensure that the correct details are entered on the request form.
- Staff should not be present in the room while the patient is producing a sputum specimen.
- Ensure that the specimen is placed in the appropriate plastic bag, with the request form in the separate compartment.
- Check with your local lab if danger of infection labels is required
- Specimens should be transported in a rigid container to the laboratory promptly. Leaking specimens will be rejected.
- Deal with spills in line with the Trust decontamination procedure

Follow the Royal Marsden Manual online procedure for specific specimen taking guidelines:

- Sputum sampling - Royal Marsden Manual (rmmonline.co.uk)

Safe labelling of specimens

- Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location eg. ward name.
- The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.

- Ensure the laboratory request form is also signed by the clinician who has requested the specimen.
- The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.
- Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as 'high risk' (high risk stickers can be ordered via cardea).
- Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

Transportation of laboratory specimens

- All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.
- Specimen transport containers must not be left unattended in a patient access area.
- Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.
- Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.
- Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen
- Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

8.2 Smear positive pulmonary TB in-patient

- Patients with smear positive pulmonary disease – sufficient TB bacilli to be seen on direct sputum examination **must** be regarded as infectious and require isolation in a single room with the door closed.
- Single room with en-suite facilities is required.
- Patient should not leave the room, please contact IPC for further advice.

- Actual culture 6 – 8 weeks for the result to be obtained from the pathology laboratory.
- Patients who are positive, are normally considered to be non-infectious after 14 consecutive days of continuous treatment with anti-tuberculosis therapy (antibiotics).
- The IPCT **must** be contacted before any decision is made to de-escalate isolation
- Transmission can occur after prolonged close contact, by inhalation of the airborne droplet nuclei produced from the sputum of infectious persons during coughing and sneezing.
- Due to Human Rights being restricted as isolation is required, please refer to Human Rights, Equality and Diversity Policy and explore ways to uphold patients Human Rights.

8.3 Personnel protective equipment (PPE)

- You **must** wear apron and gloves for all direct contact with sputum, body fluids and for handling specimens and disposed of.
- You **must** wash and dry your hands (IPC-0001-006 v3, Hand hygiene) before and after patient contact, before and after wearing apron and gloves and before leaving the patient's room.
- You **must** ask patients with smear positive TB who have a productive cough to wear a disposable surgical mask whenever they leave the room until they have had14 days consecutive treatment deemed non-infectious.
- Fluid resistant surgical masks (FRSM) **are not** required when performing routine care for a patient with TB, however if performing any aerosol generating procedures (AGP)this would indicate the use of a FFP3 respirator please seek individual patient advice from the IPC team.
- Wear a FRSM only for prolonged close contact e.g. 1:1 session with the infectious patient if the patient is unable to control coughs and is not compliant with covering his/her mouth.

8.4 Community IPC advice

- Specific precautions only indicated when patients are newly diagnosed.
- The patient will be advised they are infectious until they have received at least 14 consecutive days of continuous anti-tuberculosis therapy.
- Limit / minimise number of visits to clinics / outpatient settings.
- Contact IPC for further advice.

8.5 General measures

- Encourage the patient to cover their mouth and turn away from other people when coughing
- Encourage the patient to put tissues etc in the bin after each use and wash their hands.
- Dispose of sputum in a sealed container and dispose of in an orange clinical waste bag.
- Discuss with friends/relatives (including children) only those who have had contact prior to diagnosis will be allowed to visit.
- Document other patient contact exposure and discuss with clinician in charge of their care an appropriate way to inform the patients of their risk.
- Inform hotel services
- Clean patients room daily with chlorine releasing agent whilst deemed infectious and terminal clean on discharge or once the patient has received enough treatment to deem them no longer infectious.
- Wash all crockery using a dishwasher.

8.6 Non pulmonary TB

- Can affect any organ or tissue within the body.
- Is less common than pulmonary TB.
- Can be transmitted by direct contact with infected body tissue.
- Control measures include the application of standard infection prevention and control precautions when handling such tissue.
- Patients can be nursed in an open ward / home area.
- Contact IPC for further advice.

9 Notification of diagnosis of TB and contacts

TB is a compulsory notifiable disease under the Health Protection (Notification) Regulations 2010. It is a statutory responsibility for the clinician making or suspecting the diagnosis to report to the relevant UKHSA within 3 days of decision.

- Northeast Health Protection team: 0300 303 8596.
- Yorkshire and Humber Protection team: 0113 386 0300

All cases **must** be reported using a notification of communicable disease form:

https://www.gov.uk/government/publications/notifiable-diseases-form-for-registered-medical-practitioners

In the event a suspected or known case of TB within TEWV the following person(s) must be contacted in addition the IPCT:

Teesside:

- Refer to Respiratory Physician.
- TB Nursing Service James Cook University Hospital. Main switchboard: 01642 850850.
- TB Nursing service University Hospital of North Tees and Hartlepool Main switchboard 01642 617617.

Durham / Darlington

- Refer to Respiratory Physician.
- TB Nursing Service County Durham and Darlington Foundation Trust. UHND main switchboard: 0191 333 233.
- Contact Microbiologist.

North Yorkshire

- Refer to Respiratory Physician.
- TB Nursing service North Yorkshire, Harrogate and District NHS Foundation Trust Tel: 01904 687100 or out of hours 01423 555734.

9.1 Surveillance of TB

It is essential to identify local epidemiological trends of the disease, outbreaks can be identified, preventative and treatment services can be planned and the effectiveness of interventions evaluated.

The Consultant Health Practitioner (Proper Officer) is responsible in liaison with Consultant Chest Physicians or Paediatrician and Consultant Microbiologists for the collection of data.

9.2 Clinical responsibility for the management and treatment of TB

- Initiation and supervision of treatment is the responsibility of the Consultant Respiratory Physician, who will liaise with the Consultant Psychiatrist, General Practitioner (GP) or other health care workers as appropriate.
- Continued management advise can be sought from the above health care professionals and through local TB Specialist Nursing Services/Multi-Disciplinary Teams (MDT).

9.3 Contact tracing

- Is an integral part of the routine management of patient with TB.
- This involves identifying all close contacts of the infected patient.
- Close contacts for example, are, people who share a house with someone who is infected (these people are most at risk of infection).
- BCG vaccination **may** be offered if staff are involved in contact investigations.

9.3.1 In Durham and Darlington

- Contact tracing is undertaken by the TB nursing service at County Durham and Darlington NHS Foundation Trust in collaboration with the CHP and TEWV.

9.3.2 In Teesside

- Contact tracing is undertaken by the TB Nursing Service in collaboration with the CHP and TEWV.

9.3.3 In North Yorkshire

- Contact tracing is undertaken by the North Yorkshire TB nursing service with the CHP and TEWV.

9.3.4 Staff

- Responsibility of the relevant Occupational Health Department

- When collating lists of staff contacts remember those staff who intermittently visit wards e.g. physiotherapists.
- Health care workers are considered as casual contacts, there are no extra risks to hotel service staff or nurses doing routine tasks.

9.3.5 Family and community contacts

- Contacts of the patient will be managed by the relevant TB nursing service and UKHSA

9.3.6 Hospitalised patient contacts

- Aimed at detecting infections caught from infectious patients while in health care premises.
- Risk of casual contact is negligible, but patients nursed in the same multi-bedded areas for up to and over 8 hours must be considered as close or intermediate contacts; may need follow up by the respiratory physician.
- Consultant Respiratory Physician, in liaison with the Infection Prevention and Control

Doctor and Consultant in charge, will assess each individual case and advise on what contact procedure are necessary for hospitalised patient contacts.

- An outbreak / incident control team **must** be convened depending on identified risks.
- Exposure to TB **must** be documented in the medical record of each patient identified as a contact.
- Patients **must** be observed during their stay for respiratory signs e.g. cough.
- On discharge, the patient **must** be advised to contact their GP if they suffer any respiratory illnesses lasting more than 48 hours within the next six months.
- A letter **must** be sent to the GP advising them that the patient has been in contact with TB.
- An appointment **must** be made with a Consultant Respiratory Physician if necessary.
- A list of staff involved with a positive TB patient **must** be sent to Occupational Health who will check the status of staff and follow-up will be arranged in accordance with TB NICE guidelines.

Staff who undertook mouth to mouth resuscitation on a smear positive infectious patient to be considered as a close contact.

9.4 Protection of healthcare workers

9.4.1 Pre-employment

- All staff in regular contact with patients or handling specimens **must** be checked for a BCG scar, assessment of personal or family history of TB and Mantoux result if available.
- If no evidence of BCG scar, a Mantoux test **must** be performed.
- If this is negative BCG vaccination **must** be offered.
- Refusal of the BCG vaccination **may** restrict where the staff member can work

- Staff refusing a Mantoux test **must** sign a disclaimer form.
- If a prospective healthcare worker who is Mantoux tuberculin skin test (or interferon-gamma test) negative, declines BCG vaccination, the risks should be explained and the oral explanation supplemented by written advice. He or she should usually not work where there is a risk of exposure to TB. The trust will need to consider each case individually, taking account of employment and health and safety obligations.

9.4.2 Employed

- Immunocompromised staff are advised **not to** have a BCG or work directly with patient with Pulmonary TB.
- Occupational Health Physician / Nurse responsible for assessing the risk of

immunocompromised staff and to decide whether exclusion from working in high-risk areas is appropriate.

- Recognise that staff with disabilities or long term health conditions would be impacted but due to health and safety this cannot be mitigated against, but the trust would work with the staff member to ensure they fully understand and a suitable alternative work environment would be sought.
- Staff **must** ensure that appropriate protective clothing / equipment (if required) is used to minimise the risk of spread to themselves and others.
- When a case of TB occurs in a health care worker in direct contact with patients, the Occupational Health Department, Infection Prevention and Control team, Consultant Respiratory Physician, Consultant Microbiologist / Infectious Disease Consultant and C/SHP will assess the risk to others and establish screening procedures if necessary.

It is very uncommon for health care workers to acquire TB from patients. Concerned staff **must** be reassured and reminded of the possible symptoms of TB and the importance of reporting such symptoms.

10 Terms and definitions

Term	Definition
CHP	• Consultant in Health Protection
MDRTB	• Multi Drug Resistant Tuberculosis. Resistant to two or more anti-TB drugs.
XDRTB	• Extensively resistant TB. Resistant to at least four of the main anti-TB drugs
UKHSA	• UK Health security agency
TB	• Infection caused by a bacterium Mycobacterium tuberculosis that can affect any part of the body, but most commonly affects the lungs or lymph nodes
IPCT	• Infection prevention and control team
AGP	• Aerosol generating procedures are medical procedures that can result in the release of potentially infected aerosols from the respiratory tract
FFP3	• Filtering face piece, tight fitting respirator
FSRM	• Fluid resistant surgical mask
PPE	• Personal protective equipment which is intended to be worn or held by a person at work and which protects the person against one or more risks to that person's health or safety, and any addition or accessory designed to meet that objective

11 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.
- Each team/ward manager will ensure that staff training needs are met in accordance with the Trust's training needs analysis
- Each healthcare professional is responsible for his or her own professional development and an individual's needs should be addressed through appraisal and training needs analysis

11.1 Training needs analysis

Although there is no specific training required to implement this specific Guideline, staff are expected to undertake appropriate training and education pertinent to their role. This training is identified as follows

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered MH/LD Nursing Staff (Inpatients): AMH, SIS, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Inpatients) Face to Face	1 day	Once Only (but can be accessed as required)
Registered MH/LD Nursing Staff (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Community) Face to Face	1 day	Once Only (but can be accessed as required)
Nursing Support Staff inc Nursing Associates (Inpatients): AMH, SIS, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Inpatients) Face to Face	1 day	Once Only (but can be accessed as required)
Nursing Support Staff inc Nursing Associates (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Community) Face to Face	1 day	Once Only (but can be accessed as required)
All clinical staff who undertake, document, report and respond to any interventions outlined as part of NEWS	NEWS2 Training Via ESR	1hr	Once Only (but can be accessed as required)
Mandatory for nominated staff who do not have access to an Emergency Response Bag and equipment	Cardiopulmonary Resuscitation (CPR) & AED Face to Face	2 hours	Annual
Mandatory for nominated clinical staff who have access to the Emergency Response Bag and would be expected to participate in its use	Basic Life Support (BLS) Face to Face	3.5 hours	Annual

Mandatory for all designated medical staff, ECT nursing staff and Physical Healthcare Practitioners	Immediate Life Support (ILS) Face to Face	5 hours	Annual

12 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	IPC Mandatory training	Ward managers / Modern Matron / Annually	IPCC
2	Hand hygiene competency	Ward managers / Modern Matron / annually	IPCC
3	IPC environment audit	IPCT / Modern matron / annually	IPCC

13 References

The Health and Safety at Work Act (1974) http://www.hse.gov.uk/legislation/hswa.htm

(COSHH): The Control of Substances Hazardous to Health Regulations (1999) http://www.hse.gov.uk/coshh/

The Management of Health and Safety at Work Regulations (1999) The Management of Health and Safety at Work Regulations 1999

Public Health (infectious diseases) Regulations (1988) http://www.legislation.gov.uk/uksi/1988

County Durham and Darlington Local Health Protection Unit (2004) Policy for the Management of Tuberculosis

Joint Tuberculosis Committee of the British Thoracic Society (2000): Control and Prevention of Tuberculosis in the United Kingdom. Thorax 49:1193-1200 www.brit-thoracic.org.uk

The Interdepartmental Working Group on Tuberculosis (1998) The Prevention and Control of Transmission of 1. HIV related Tuberculosis. 2. Drug resistant including multiple drug resistant Tuberculosis, London Department of Health

National Institute for Health and Clinical Excellence (2016) Tuberculosis www.nice.org.uk/guidance/ng33 (updated September 2019)

National Institute for Health and Clinical Excellence (2017) Tuberculosis Quality Standards www.nice.org.uk/guidance/qs141 (published January 2017)

RCN (2019) A case management tool for TB prevention care and control in the UK.

NHS England (2022) National infection prevention and control manual for England. London NHS England.

Standards Unit, National Infection Service, PHE Bacteriology (2020) UK Standards for Microbiology Investigations. Investigation of specimens for Mycobacterium species. Issue no 7.3, 5.10.2020, pages 1 of 56.

Personal protective equipment (PPE) at work regulations from 6 April 2022 https://www.hse.gov.uk/ppe/ppe-regulations-2022.htm

Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers. (2007) London, Department of Health.

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

14 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	11 November 2022 v4 19 January 2023 v4.1
Next review date	11 November 2025
This document replaces	Tuberculosis IPC-0001-016 v4
This document was approved by	IPCC

This document was approved	11 November 2022 v4 19 January 2023 v4.1 (changes in principle)
This document was ratified by	IPCC v4.1 (actual amended document to be retrospectively approved)
This document was ratified	20 April 2023 (pending formal retrospective approval)
An equality analysis was completed on this policy on	21 November 2022
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
v4	11 Nov 2022	Changed into updated Trust format. Contact numbers checked and verified.	Approved
V4.1	19 Jan 2023	Minor changes only: Information regarding safe labelling and transportation of specimens added to section 8.1, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection. Links to specimen collection procedures within the Royal Marsden Online Manual added into section 8.1 Royal Marsden online added to references.	Agreed in principle at IPCC 19 Jan 2023, pending retrospective final approval at IPCC 20 April 2023

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Infection prevention and control
Title	Tuberculosis
Type	Procedure
Geographical area covered	Trust wide
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by trust staff.
Start date of Equality Analysis Screening	27/10/2022
End date of Equality Analysis Screening	21/11/2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Staff and patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and

	Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	
Describe any positive impacts	

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	NICE guidelines British Thoracic medicine guidelines National infection prevention and control manual for England
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and	

involve people from different groups	

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

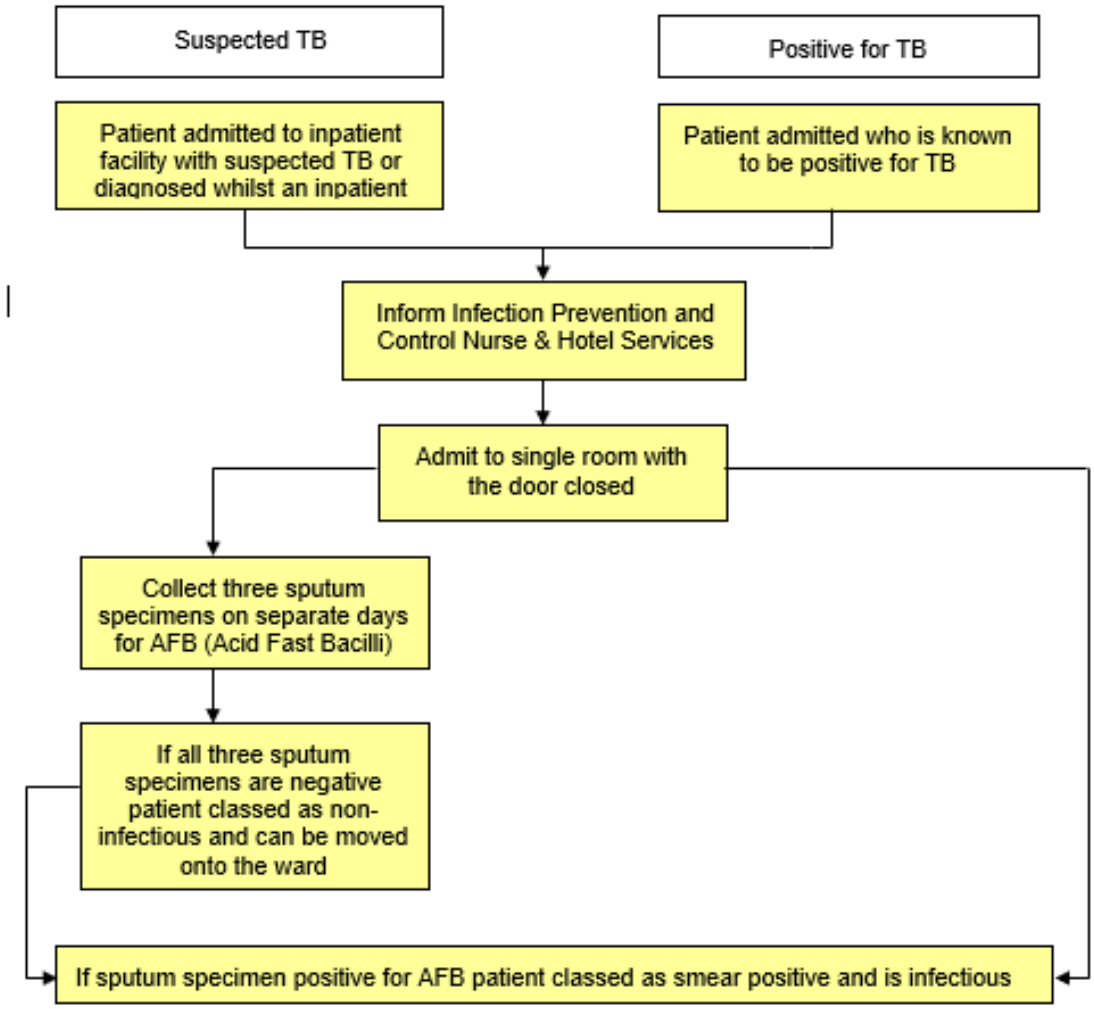
Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 - Approval checklist

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	N/A	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?		
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3 - Management of TB within TEWV flowchart



Healthcare workers caring for patient with TB must not use masks or gowns unless Multi Drug Resistant (MDR). TB is suspected or aerosol generating procedures are being performed eg suctioning, physio etc saline nebuliser for sputum induction. When such equipment is used the reason must be explained to the patient.

Smear-positive TB patient must be cared for in a single room until they have completed two weeks of treatment or they are discharged from hospital.

Patients with smear-positive TB with an active cough must be asked to wear surgical masks whenever they leave the room if their condition allows until they have had two weeks of treatment and deemed non-infectious.

Visitors must be restricted to those people who have already had contact with the patient prior to hospital admission.

Multi Drug Resistant TB

If the patient is known or suspected to have Multi Drug Resistant (MDR) TB, based on a risk assessment, they must be admitted to a negative pressure room at RVI/Newcastle Hospitals.

Staff and visitors must wear FFP3 masks during contact with a patient suspected or known MDR TB whilst the patient is considered infectious.

Appendix 4 – TB contacts

Trust:			
Name:	**Date admitted**:	**Consultant**:	**Admitted via A&E**:
Other departments visited by the patient:			

Please give details below of all staff, including housekeepers, physiotherapists etc who have been in contact with the patient on the ward and return the form to your relevant Occupational Health Department

Surname	**Forename**	**Maiden Name**	**Designation**	**Birth Date**	**For office use only**			**Remarks**
					CXR Date	**TT date / result**	**BCG date**	