☐ADMINISTRATE POLICY & PROCEDURE (APP)	☐ INSTITUTIONAL POLICY & PROCEDURE (IPP) ☐ INTERDEPARTMENTAL ☐ INTERNAL	
TITLE		**POLICY NUMBER/V#**
Reportable Diseases - TB and Pulmonary Tuberculosis		MMC – IPC– 06 (01)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	**01/09/2025**	**01/08/2028**
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N/A		**08**
APPLIES TO	**RESPONSIBILITY**	
ALL STAFF	**Infection Control Department , Physicians**	

1. PURPOSE

To promote consistent reporting practices of Ministry of Health [MOH] reportable conditions and communicable diseases. Establish responsibilities and guidelines for the reporting of Tuberculosis during treatment and after treatment phases. Evaluate risks of transmission of Tuberculosis. Assist the Ministry of Health in determining morbidity of Tuberculosis in the community. Intervene rapidly when appropriate to prevent outbreaks. To describe methods for the prevention of exposure and transmission of active pulmonary tuberculosis and principles to follow for management of tuberculosis and patient with suspected or proven pulmonary tuberculosis.

2. DEFINITION

2.1 TB: (Tuberculosis): is a disease produced by infection with Mycobacterium Tuberculosis, or rarely by Mycobacterium bovis, it's a communicable disease that needs to be reported to MOH within 24 hours, during therapy and after completion of treatment.

2.2 AFB: Acid-Fast Bacilli

2.3 MDR: Multi Drug Resistant

2.4 N95 masks: "N" means 'Not resistant to oil',"95" refers to 95% filter efficiency. They offer protection by filtering the air before it enters the respiratory tract.

2.5 PPD: Purified Protein Derivative

3. RESPONSIBILITY

3.1 Infection Control Department & Physicians

4. POLICY

TB notification and reporting to MOH

4.1 All reportable communicable TB cases must be reported to the Ministry of Health, within 24 hours of a report of a positive smear, by the Infection Control Department.

4.2 Use MOH TB program FAX number 6878050 / 6876923 Tel: 6874058 / 6876923

4.3 When we have a positive case (pulmonary or not) we will send it by fax and send the original to MOH TB program Jeddah kilo-7 Makah Almukkaramah road.

4.4 All cases treated in outpatient services must be reported to the MOH on monthly basis in order to monitor the compliance and morbidity of this particular disease.

4.5 All cases completed treatment course must be reported to the MOH in order to close the case file in the MOH either by successful therapy or not.

4.6 TB-Management

4.6.1 All suspected or confirmed cases of open pulmonary or laryngeal tuberculosis which attend the clinic for clinical consultation must be immediately reported to the infection control department.

4.6.2 All patients suspected to have had open pulmonary or laryngeal tuberculosis must be isolated as cases until proven otherwise.

4.6.3 TB control measures are intended for all patients with potentially transmissible laryngeal or pulmonary tuberculosis.

4.6.4 Patients with suspected active pulmonary or laryngeal tuberculosis presenting or referred to any out-patient clinic or any department in the hospital including out-patient radiology, pharmacy, laboratory, should put on a surgical face mask, and minimize sitting in the waiting areas. Staff in out-patient departments and clinics should be notified about the possible risk for tuberculosis.

4.6.5 Patients must be placed in a negative pressure room and apply airborne precaution.

4.6.6 It is the responsibility of the treating physician and his/her team to explain to the patient and the family the rationale behind isolating airborne diseased patients.

4.6.7 Staff members who get exposed to such a case must report to the infection control department.

4.6.8 Purified protein derivative (PPD) skin test used for the evaluation of exposure to M. tuberculosis.

4.6.9 All staff exposed to open pulmonary TB case will be screened using PPD test.

4.6.10 Healthcare workers with newly positive PPD reading without documentation of treatment for latent TB infection (LTBI) or TB disease should receive one chest radiograph result to exclude TB disease.

4.6.11 All staff members should have a pre-employment screening for latent TP

4.6.11.1 Staff member with negative PPD will be re-tested on annual basis upon each contract renewal.

4.6.11.2 Staff member with positive PPD should have a CXR and will be given a course of chemoprophylaxis treatment for latent TB, if not previously given and if his/her CXR is normal, PPD should not be repeated afterwards.

5. PROCEDURE

5.1 Infection Control will be notified of all positive acid fast bacilli [AFB] smears from microbiology lab during the ICP's daily rounds to the laboratory from, phoenix, Nursing Units or Physicians.

5.2 Infection Control will forward the TB physical assessment sheet to the involved physician to complete and send back to the Infection Control Department.

5.3 Infection Control will attach the physical assessment sheet, the laboratory results and the demographic data and fax to the MOH attention and The MOH will conduct follow-up.

5.4 If no positive TB cases occur during one [1] calendar month then the Infection Control Practitioner will fax a letter - letterhead that there were no cases the previous month. Do this on the 1st of each month. Records are kept in the Infection Control Department for a period of one [1] year.

5.5 All outpatients on antituberculous treatment will be reported to the IC department to check if been notified previously or not:

5.5.1 If yes, then an update on the case will be reported to the MOH on each visit to the outpatient

5.5.2 If no, then a first time notification must take place with full report as previously mentioned then a follow up reporting will continue on each visit to the outpatient.

5.6 AFB results will be sent to MOH, after two weeks from staring of medication or whenever available when patient comes for follow up.

6. TB-Management:

6.1. Prevent Exposure:

6.1.1. Use airborne isolation

6.1.2. Use a negative air pressure room or a room with a minimum 6-12 air exchange per hour

6. 1.3. Close the door at all times.

6.1.4. Wear protective respiratory device when entering room. All clinic staff entering the room must wear an approved respirator [N95] mask.

6.2. Protection Before Procedure:

2.1. Prior to performing cough inducing procedure on patient [e.g., CT-guided Lung Biopsy]; the patient's chest x-ray should be assessed for tuberculosis.

2.2. Health care workers involved with procedure on patients with suspected or active tuberculosis shall wear [N95] mask at all times during the presence of the patient care area.

- Patient Care Equipment and Articles: See disinfection of medical equipment policy.

- Linen and Laundry, Drinking and Eating Utensils: No specific recommendations.

6.3 Terminal Cleaning: In non-negative air pressure rooms:

6.3.1. Housekeeping staff to use [N95] masks. Follow same procedure for cleaning negative pressure rooms except observe the time schedule for reuse of the room to allow adequate air changes. This requires 4 hours with the door closed.

6.3.2. In negative pressure rooms Housekeeping staff should use the [N95] mask.

6.4 Management of Personnel after Exposure to Tuberculosis:

6.4.1. Infection Control Practitioner and Unit Manager will compile a list of exposed persons to give family Medicine for post-exposure management.

6.4.2. PPD test as soon as possible after tuberculosis exposure once recognized and again 2-3 months later.

6.4.3. If the personnel are known to have reactive PPD test then he/she does not need to be retested but will have a review of symptoms. Personnel with evidence of new infection [converted PPD test] need to be evaluated for active tuberculosis.

6.4.4. The staff member who is tested positive should have a CXR and will be given course of chemoprophylaxis, if not previously given and if his/her CXR is normal, PPD should not be repeated afterwards. Staff Screening for Latent TB:

6.5 Pretest counseling

6.5.1. Counsel any employee or patient identified as needing a PPD test regarding: a. The indication(s) for testing.

6.5.2. The importance of early detection of TB infection.

6.5.3. The risks of TB infection and active disease. d. The importance of returning for reading the TST test within the specified time frame.

6.5.4. What a positive and negative test result could indicate.

6.5.5. How to care for the test site.

6.6. Pre-employment and Annual Screening

6.6.1 Question candidates regarding past positive test results prior to the actual planting of the TST.

6.6.2 Exclude persons who have had the following from testing:

6.6.2.1 Live vaccine administered within the past 3 weeks or on the same day as the TST because live-virus vaccines my cause a false negative reaction.

6.6.2.2. Current febrile illness.

6.6.2.3 Small pox vaccination within the past month.

6.6.2.4 Exclude those with a documented positive PPD.

6.7 Pre-employment Procedure:

6.7.1 All new hires undergo baseline (two steps PPD screen) see diagram below, if not done before.

6.7.2 The procedure is as follows:

6.7.2.1. The initial latent TB screening for staff should be done with the two steps methods as the TST should be repeated within 1-3 weeks for staff with a negative result.

6.7.2.2. If the second test result is positive, consider the person infected and evaluate with chest x-ray.

6.7.2. 3. If both steps are negative, consider the person uninfected and classify the TST as negative at baseline testing and to be repeated annually in staff health clinic.

6.8 Tuberculin Skin Testing: Administration and interpretation:

6.8.1. Administration: The skin test is administered intradermally using the Mantoux technique by injecting 1.0 ml containing 5 TU of purified protein derivative (PPD) solution. If a person is infected, a delayed-type hypersensitivity reaction is detectable 2 to 8 weeks after infection. The reading and interpretation of TST reactions should be conducted within 48 to 72 hours of administration by trained healthcare professionals.

6.8.2. Measurement: a. Measure the induration (hard bump) rather than the erythema. b. Palpate the area with the fingertips, measuring the diameter of induration Perpendicular to the long axis of the arm. c. Use a ballpoint pen to mark the edges of the induration. d. Use a tuberculin skin test ruler or a ruler with millimeter marks to measure the distance between the two points. e. Record the date and time of reading and the name of the person reading the TST. · The TST should not be performed on a person who has a documented history of either a positive TST result or treatment for TB disease. · TST results should only be read and interpreted by a trained healthcare professional.

6.8.3. Interpretation of Tuberculin Skin Test Reactions:

6.8.3.1. A TST reaction of ≥5 mm of indurations is considered positive in: a. HIV-infected persons b. Recent contacts of infectious TB cases c. Persons with fibrotic changes on chest radiograph consistent with prior TB d. Organ transplant recipients e. Those who are immunosuppressed for other reasons

6.8.3.2. A TST reaction of ≥10 mm of induration is considered positive in: a. Health care workers and residents or employees of high-risk areas (prisons, jails, long term care facilities) b. Injection drug users c. Mycobacteriology laboratory personnel d. Children younger than 4 years of age e. Infants, children, or adolescents exposed to adults at high risk for TB disease

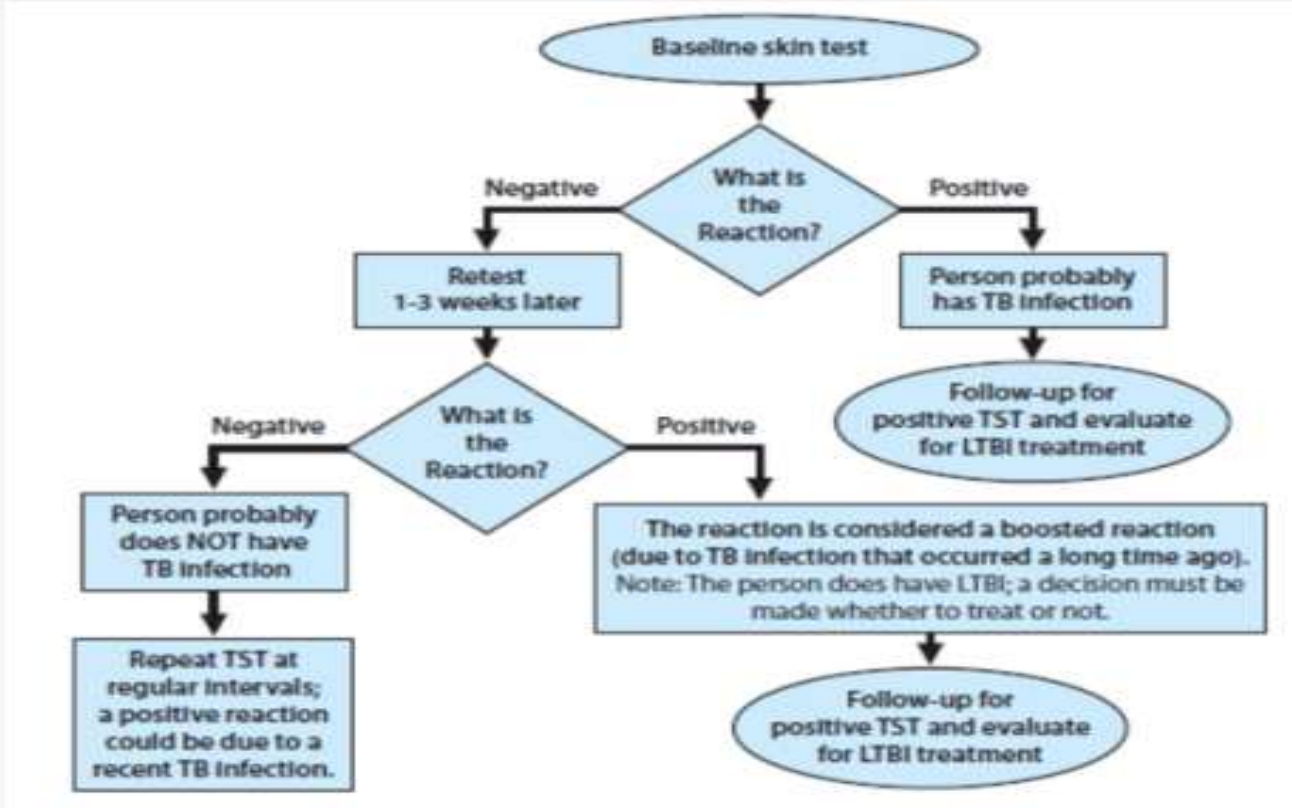
6.8.3.3. A tuberculin skin test reaction of ≥15 mm of induration is considered positive in persons with no risk factors for TB.

7. EQUIPMENT

N95 Masks

8. REFERENCES

Kingdom of Saudi Arabia, MOH Manual of Infectious Diseases 4th edition. GCC Infection prevention and control manual 3rd edition, 2018 CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings 2015



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