

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: PREVENTING TRANSMISSION OF POLICY 9.09
MYCOBACTERIUM TUBERCULOSIS IN THE WORKPLACE

Authority: Chapter 70.28 RCW *Control of tuberculosis*
WAC 246-101-101 *Notifiable conditions and the health care provider*

Reference: DOH 343-123 *Outpatient/Nontraditional Facility-Based TB Risk Assessment*
CDC MMWR *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*

PURPOSE

This policy requires Residential Habilitation Centers (RHCs) operated by the Developmental Disabilities Administration (DDA) to:

- A. Protect people residing or working in environments that place them at a reasonably anticipated risk of exposure to the airborne pathogen, *M. tuberculosis* (*Mycobacterium tuberculosis*), from occupational exposure to this organism.
- B. Establish measures that help detect, prevent, and control the risk of *M. tuberculosis* transmission.
- C. Ensure effective prescreening, post-exposure follow-up, treatment or referral for treatment, and reporting of communicable airborne diseases.

SCOPE

This policy applies to all DDA clients, employees, contract professional staff, student interns, and volunteers who reside or work at an RHC and who interact on a consistent basis with clients residing in the facility. This includes state employees who have a work station at an RHC. DDA employees who are not assigned to a work station at an RHC are exempt.

DEFINITIONS

Airborne pathogen is a disease-causing microorganism that is transmitted or spread through the air.

Conversion is a change in tuberculin skin test (TST) results from negative to positive. A conversion within a two-year period is usually interpreted as new *M. tuberculosis* infection, which carries an increased risk for progression to active disease. A booster reaction may be misinterpreted as a new infection.

Exposure to Tuberculosis means physical contact or time spent with a person with infectious tuberculosis (TB).

Immunosuppressed means a condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed people are at greatly increased risk for developing active TB after they have been infected with *M. tuberculosis*.

Infection means the condition in which an organism capable of causing disease (e.g., *M. tuberculosis*) enters the body and elicits a response from the host's immune defenses. TB infection may or may not lead to clinical disease.

Infectious means capable of transmitting infection. When persons who have clinically active pulmonary or laryngeal TB disease cough or sneeze, they can expel droplets containing *M. tuberculosis* into the air. A person whose sputum smear is positive for acid-fast bacilli (AFB) is probably infectious.

Mycobacterium tuberculosis (*M. tuberculosis*) is a rod-shaped, AFB, microscopic organism that may cause an infection in humans, generally in the lungs, and is usually transmitted by the inhalation of droplet nuclei in the air.

TB Blood Test is an interferon-gamma release assay to diagnose latent TB infections. Several versions are available.

Transmission is the spread of an infectious agent from one person to another. The likelihood of transmission is directly related to the duration and intensity of exposure.

Tuberculin Skin Test (TST) is a diagnostic aid for finding *M. tuberculosis* infection. A small dose of tuberculin is injected just beneath the surface of the skin, and the area is examined for induration by palpation 48-72 hours after injection.

Tuberculosis (TB) is an airborne communicable disease caused by *M. tuberculosis* or the tubercle bacillus.

Two-Step Tuberculin Skin Test or Two-Step TST is a diagnostic aid for finding *M. tuberculosis* infection. One to three weeks after the first TST result is read, a repeat TST is performed.

POLICY

- A. DDA clients, employees, student interns, and volunteers who reasonably anticipate occupational exposure to the airborne pathogen, *M. tuberculosis*, must be given all necessary training and protection to reduce the likelihood of exposure to, transmission of, and possible infection with *M. tuberculosis*.
- B. People with suspected or diagnosed infectious tuberculosis (TB) must be transferred to an appropriate treatment facility and must not return to finish treatment at an RHC until medically safe to do so.

PROCEDURES

- A. Assignment of Responsibility
 - 1. Each RHC must assign a person, typically the Infection Control Nurse, responsible for the TB infection control program.
 - 2. Any person assigned to the TB infection control program must have training in infection control and occupational health, and have authority to implement and enforce TB infection control policies.
- B. Risk Assessment
 - 1. Each RHC must develop and implement a written TB infection control plan based on a TB risk assessment.
 - 2. The plan must meet the requirements for the risk group as referenced in Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR), *Tuberculosis (TB) Risk Assessment Worksheet* (Appendix B).
- C. Detection of Active TB in Clients
 - 1. To identify people with latent or active TB infection an RHC must begin a Two-Step Tuberculin Skin Test within 3 days of a client's admission.
 - 2. The RHC must test each client annually using the Tuberculin Skin Test.
 - 3. Each RHC's TB infection control plan must include protocols for identifying, evaluating, referring, and transferring any person who may have or develop latent or active TB infection.

D. Management and Isolation of Clients with Possible TB

1. For a client with suspected or diagnosed infectious TB, the RHC must transfer the client in accordance with their TB infection control plan.
2. Any person transporting or caring for the client must have appropriate respiratory protection.
 - a. Follow personal protective equipment procedures using available equipment until transfer has been completed.
 - b. Respiratory protection devices must meet recommended performance criteria as detailed in the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR), *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings* (12/30/05, Vol. 54/No. RR-17, p. 38-41).
3. If isolating a client with suspected or confirmed TB, the RHC must consult its local county health department to learn current isolation standards. The RHC must make a reasonable attempt to properly isolate the client until the RHC can transfer the client.
4. Cough-inducing procedures or sputum cultures for the diagnosis of TB must not be performed at an RHC.

E. Staff Education

1. All staff and volunteers must receive annual TB education appropriate to their work responsibilities and duties.
2. Training must include:
 - a. Management of TB in the facility;
 - b. TB pathogenesis;
 - c. Occupational risks of TB exposure; and
 - d. Practices that reduce the risk of *M. tuberculosis* transmission.

F. Screening, Staff Counseling, and Evaluation

1. The RHC must perform Two-Step Tuberculin Skin Tests (TSTs) on all new employees and volunteers.
2. A TB blood test may be substituted for the Two-Step TST if indicated by the Infection Control Nurse.

3. The RHC must administer the first part of the Two-Step TST within three working days of the employee or volunteer's start date.
4. If the RHC is a Low-Risk Healthcare Facility, annual retesting is optional.
5. If the RHC is not a Low-Risk Healthcare Facility, the RHC must perform annual, One-Step TSTs.
6. An employee or volunteer may be exempt from the initial testing if the employee provides proof that they have:
 - a. Tested negative for a Two-Step TST in the last 12 months;
 - b. Tested negative for a TST or TB Blood Test in the last 12 months and can provide sufficient risk information for the Infection Control Nurse to accept they are free from infection;
 - c. Tested positive with a TST result of 10 millimeters or greater; or
 - d. A waiver from the director of the TB Control Program at the Washington State Department of Health.
7. An employee or volunteer with a reaction to the TST of 5mm or greater must be evaluated by the Infection Control Nurse or qualified designee. The Infection Control Nurse, after consultation with the local Department of Health, may recommend individual testing or other follow up.
 - a. New employees may be directed by the infection control nurse to obtain additional testing, including blood testing, repeat TST, a chest x-ray, and a clearance from a qualified medical provider within 7 days, or not work until the x-ray and medical clearance documentation are provided.
 - b. Current employees with recent personal exposure or travel to areas of risk need to contact the Infection Control Nurse before returning to work. They may need clearance from a qualified medical provider before returning to work.
 - c. Employees or volunteers exposed to infectious TB during their course of duties may be directed by the infection control nurse to care by the facility.
8. Any person with pulmonary or laryngeal TB must not enter the RHC until they are noninfectious as described in the CDC MMWR, *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings* (12/30/05, Vol. 54/No. RR-17, p. 31).

9. A TST conversion on any employee must be documented on DSHS 03-133, Safety Incident/Near Miss Report, and the RHC's OSHA 300 log.
10. Counseling will be provided to individuals as indicated by the facility's infection control program. Counseling will include information about the increased risk to immunosuppressed persons.
11. Surveillance screening data, including TST conversions, must be collected as required under WAC 246-101-101.

G. Exposure Investigation and Evaluation of Conversions and Transmission

1. An Exposure investigation may be required by CDC MMWR, *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings* (12/30/05, Vol. 54/No. RR-17, pp. 32-36).
2. The Infection Control Nurse must consult with all available resources for investigations and follow up.

H. Liaison with Public Health Department

Each facility's TB infection control program must include a system for:

1. Reporting any active or suspected infectious TB case to the local public health department; and
2. Following the public health department's recommendations for treatment and isolation.

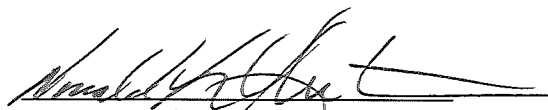
EXCEPTIONS

Any exception to this policy must have the prior written approval of the Deputy Assistant Secretary.

SUPERSESION

DDD Policy 9.09
Issued June 15, 2010

Approved:


Deputy Assistant Secretary
Developmental Disabilities Administration

Date: December 1, 2017