Sarawak General Hospital TB Infection Control Policy

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Incidence of tuberculosis (TB) remains high in Sarawak. Therefore, Health Care Worker (HCW) is constantly at risk of exposure to TB.

As suggested by recently published “Guideline on Prevention and Management of Tuberculosis for Health Care Worker in Ministry of Health Malaysia 2012”, a written TB Infection Control (IC) policy is needed to strengthen the effort of preventing HCW from expose to TB.

This policy applies to all individuals in the employ of the Sarawak General Hospital and it is specifically aimed at staff who are likely to come into contact with patients who have known or suspected tuberculosis.
2. PURPOSE OF POLICY

To ensure that staff care for patients with Tuberculosis (TB) safely. It provides operational guidance on administrative, engineering, environmental control measures as well as the use of personal protective equipments.

This guideline also provides operational guidance of HCW TB Screening.
3. DEFINITION:

3.1 A **Suspect TB patient** is a person in whom a diagnosis of Infectious TB disease is being considered, whether or not antituberculosis treatment has been started.

3.2 **Infectious TB patient:**

   3.2.1 A person with smear positive PTB, on treatment for less than 2 weeks.
   3.2.2 A suspected TB patient not on treatment.
   3.2.3 A person who has relapse PTB who first sputum culture result is not yet available.
   3.2.4 A person with TB on inadequate/inappropriate antiTB.
   3.2.4 Any MDRTB patient, including previously treated MDRTB patient or suspected having MDRTB.

3.3 High TB Risk Area:

   3.3.1 Isolation ward/Room
   3.3.2 All Inpatient wards
   3.3.2 Treatment Room
   3.3.3 HIV patient management facilities.
   3.3.4 ICU/HCU/CCU
   3.3.5 All Endoscopy rooms, including bronchoscopy, ENT endoscopy, GI endoscopy.
   3.3.6 Operation theater
   3.3.7 Emergency Department
   3.3.8 Laboratory
   3.3.9 Outpatient Department
   3.3.10 Radiology Department

3.4 Inpatient TB Isolation room:

   3.4.1 Isolation room with negative pressure: All rooms at “Ward Pengasingan Penyakit Berjangkit” and 1 room at female medical ward.

   3.4.2 Single room at respective ward.

3.5 mm
4.1 SGH Tuberculosis Infection Control Subcommittee

4.1.1 Members

1. Hospital Director (Chairman)
2. Respiratory physician (Co-Chairman)
3. Public Health/Occupational Health Unit (OHU)-secretariat
4. HOD Pharmacy Department.
5. HOD Radiologist
6. HOD ICU and matron
7. HOD Emergency Department.
8. HOD Paediatric Department
9. HOD Surgery Directorate
10. Hospital Matron
11. Microbiologist
12. Hospital Engineer
13. Tuberculosis Infection Control Nurse
14. Medical Isolation Ward Sister

4.1.2 Responsibility

1. Responsible to development, monitoring and review of the TB Infection Control Program (TBIC-P) at SGH.
2. Responsible for the implementation, monitoring and review of HCW TB Screening.

4.2 SGH TB IC Task Force (TBIC-TF)

4.2.1 Member:

1. TB Infection Control Nurse (Sister Saidah)
2. OHU (Dr Chew)
3. Microbiologist (Ms Annabel)
4. Hospital Support Service (Mr Fairuz)
5. Staff Clinic (Dr Nicole)

4.2.2 Responsibility

1. Implementation of TB IC program.
2. Training, education, testing and evaluation of HCW on TB IC measures.
3. Review of HCW Contact screening/periodic screening
### 4.2.3 TB Infection Control Programme (TBIC-P):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
<th>Target site/audience</th>
<th>Implementer</th>
</tr>
</thead>
<tbody>
<tr>
<td>New staff Briefing</td>
<td>3 monthly</td>
<td>New staff.</td>
<td>TB Infection Control Task Force</td>
</tr>
<tr>
<td>TB Infection Control CPC</td>
<td>Yearly</td>
<td>All</td>
<td>Chairman of TB IC/HOD Respiratory Medicine</td>
</tr>
<tr>
<td>TB Infection Control Policy and measures at SGH: talk</td>
<td>6 monthly</td>
<td>All staff</td>
<td>TB Infection Control Task Force</td>
</tr>
<tr>
<td>N95 masks Fitting Test</td>
<td>3 monthly</td>
<td>All high TB risk Area’s staff Including support staff, nurses and doctors.</td>
<td>1. TB IC Nurse 2. Medical Isolation ward Sister and team.</td>
</tr>
<tr>
<td>Smoke Test and Inspection</td>
<td>3 monthly</td>
<td>All TB Isolation room</td>
<td>TB IC Task Force</td>
</tr>
<tr>
<td>TB IC Subcommittee Meeting</td>
<td>6 monthly</td>
<td>All TB IC Subcommittee Members</td>
<td>All TB IC Subcommittee Members</td>
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</table>
5. NOTIFICATION

5.1 All forms of tuberculosis are notifiable to the Respiratori Clinic once diagnosis is suspected, or confirmed by appropriate investigation, or when anti-TB treatment started.

5.2 This must be done initially by phone (Respiratory Clinic) within ONE working day, followed by the official notification form.

5.3 Routine notification to Kuching District TB Control Programme (Kuching TBCP) should still be done, independent on notification to Respiratory Clinic.

5.3 Notification of outbreak should also be done as above using Borang notifikasi WEHU L1/L2, PL206 & TBIS 10A1.
6. ADMISSION POLICY

6.1 Suspected TB patient at Emergency Department

6.1.1 All suspected TB patient should be directed to decon room.
6.1.2 Decision of admission/discharge/transfer should be expedite if possible.
6.1.3 Medical Officer should has high index of suspicion of Infectious TB cases.

6.2 Admission of patient

6.2.1 Active TB should be managed as outpatient unless indicated for admission due to medical/logistics issues.

6.2.1 Suspected TB whom do not required admission should be refer to ATAS clinic with detail referral letter and imaging performed. A record of patient’s particular need to be keep by Emergency Department.

6.2.2 Medical isolation ward is the primary ward for admission for all suspected PTB patient after authorization by physician in-charge of medical isolation ward.

6.2.3 If no bed is available at medical isolation ward, then case to be admitted to female medical ward negative pressure isolation rooms (2 rooms).

6.2.4 If option 6.2.2 and 6.2.3 are not available, admit patient to single room at medical ward.

6.2.5 For discipline other then medical, admit patient to respective ward’s single room.

6.2.6 Patient refer from other medical facility should have been clear of PTB if possible.

6.2.7 All MDRTB patient, including suspected/Previously treated/on treatment MUST be admitted to negative pressure isolation room.

6.2.8 All HIV patient should be admit to isolation room until infectious TB is excluded.
6.2.9: Management of in patient TB should follow directive “TATACARA PENGENDALIAN KEMASUKAN KES TB DI HOSPITAL” issued (JKNSWK/K/TBCP/5B/Jld.1(9) 2012)
7.1 all staff attending Infectious TB patient MUST use N95 mask.

7.2 Extrapulmonary TB patient is consider non-infectious and therefore do not need N95 mask during usual care expect then performing aerosol generating procedure or wound irrigation.

7.3 All infectious TB patients have to use surgical surgical mask at all time.

7.4 Patient should be discouraged to move outside of isolation room.

7.5 Carer should be limit to one, if needed.

7.6 Visitor should be discouraged, and limit to 2 at one time.

7.7 All carer and visitor to use surgical mask.

7.8 All Visitor of MDRTB patient MUST use N95 mask.

7.9 Sputum collection and induction should be done at Sputum Collection Room located at Female Medical Ward.

7.10 Sputum AFB report should be available in less than 24H including weekend and public holiday.

7.11 Chest physiotherapy/bronchoscopy should not be done until smear turned negative or requested by consultant for life saving indication.

7.12 If possible, postpone further invasive procedure (especially if cough inducing procedure) until 2 weeks of antiTB treatment.

7.13 Nebulization of Infectious TB patient should be done at least in a single room.

7.14 AntiTB treatment should be initiated as soon as possible, once active TB is suspected. Further investigation still can be perform after initiation of antiTB treatment.
8. DE-ISOLATION POLICY

8.1 De-isolation of infectious TB patient can be done once all the following criterias are fulfilled.
   1. two weeks of appropriate drug therapy
   2. tolerance of the prescribed treatment
   2. ability and agreement to adhere to the prescribed treatment
   3. Signs of clinical improvement for example remaining afebrile for a week.

8.2 Decision of de-isolation should be made by physician in-charged.

8.3 All suspected PTB with subsequent negative sputum AFB X3 can be transfer out from isolation room, unless other indication of isolation exist.
9.1 Comply with JKNS directive (JKNSWK/K/TBCP/5B/Jld.1(9) 2012)

9. DISCHARGE FROM HOSPITAL POLICY
10. HEALTH CARE WORKERS AND TB

10.1 All hospital staff comply with TB screening outlined in “Guidelines on prevention and management of tuberculosis for health care workers in ministry of health Malaysia 2012”. This include:
1. Pre-employment screening for new staff,
2. Periodic annual screening for existing staff and
3. Pre-retirement/Pre-transfer screening.

10.2 All category of personels working at SGH need to undergone TB screening. This includes part-time, full-time, temporary, and contract staff and student/trainee.(need to inform JKNS)

10.3 All HCW TB screening to be done at staff clinic, to be assisted by respiratory clinic staff.

10.4 HCW should NOT perform TB screening on their own.
10.5 All cxr if done, need to be reported by SGH radiology department. **Preemployment CXR is a MUST**

10.5 Flow of HCW TB Screening process:

1. Staff needing TB Screening identified
2. Report to OHU
3. Screening carry out at Staff Clinic with the help of Respiratory Clinic
CARTA ALIR PROSES SARINGAN TIBI PRA-PENEMPATAN BAGI ANGGOTA BARU DILANTIK

Anggota baru dilantik dan pertama kali melapor diri serta tidak pernah melakukan ujian saringan TiBi perlu menjalani ujian saringan 2 minggu selepas melapor diri

<15 mm
Ujian Mantoux

SARINGAN TAMAT

>15 mm

tidak normal

Normal

X-Ray Dada

SARINGAN TAMAT

ANGGOTA MELAPOR DIRI DI TEMPAT YANG DITETAPKAN

Rujuk kepada Pakar Perubatan / pakar perubatan respiratori/ pakar perubatan keluarga/ Pakar Kesihatan Pekerjaan

CARTA ALIR PROSES PROSES SARINGAN TIBI BERKALA (PERIODIC)

Kenalpasti anggota kumpulan berisiko tinggi dan bertugas di tempat berisiko tinggi

<15 mm
Ujian Mantoux

SARINGAN TAMAT

Digalakkan untuk jalani X-ray Dada setiap 2 tahun

>15 mm

normal

X-Ray Dada
tidak normal

Digalakkan untuk jalani X-ray Dada setiap 2 tahun dan nasihat berjumpa pakar perubatan/ pakar perubatan respiratori jika ada simptom pada bila-bila masa

Rujuk kepada Pakar Perubatan / pakar perubatan respiratori/ pakar perubatan keluarga
Reference Document:
2. Tatacara perlaksanaan pekeliling ketua pengarah kesihatan Bil.9/2012:Process saringan TiBi bagi anggota kementerian kesihatan.
10.5 All request for TB contact screening should be directed to OHU. Do not initiate TB screening without informing OHU.
10.6 Flowchart for contact screening:

**Algorithm 5: Investigations For Contact Tracing in Adults**

- **PTB Close Contact***
  - **Symptomatic**
    - Evaluate for active TB
    - CXR
    - Sputum AFB
    - Mantoux test (optional)
    - Diagnosis confirmed – treat
    - Diagnosis inconclusive – refer specialist
  - **Asymptomatic**
    - Mantoux test
    - ≥10 mm
    - Chest x-ray
    - Abnormal – evaluate for active TB
    - Normal – manage as latent TB infection
    - <10 mm
    - Discharge with advice**

*Immunocompetent close contacts
**To seek medical advice if patient has symptoms suggestive of TB such as fever, cough etc. for more than two weeks.

(Reference document: 3rd Malaysian TB CPG 2012)