**Long-Term Care Tuberculosis (TB)**

***Risk Assessment***

**Facility name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Assessment date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Completed by/title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
|  **Part 1: Incidence of TB** | **Number**  | **Rate** |
| 1. Number of TB cases in your facility last year
 |  |  |
| 1. Number of TB Cases in your county or service region last year
 |  |  |
| 1. Number of TB Cases in the state last year
 |  |  |
| 1. Number of TB cases in the United States last year
 |  |  |
|  **Part II: Risk Classification (non-traditional settings)** | **Number**  | **Yes** | **No** | **N/A** |
| 1. How many TB patients are encountered at your setting in 1 year?
 |  |  |  |  |
|  a. Previous year |  |  |  |  |
|  b. Five (5) years  |  |  |  |  |
| 1. Does evidence exist that a high incidence of TB disease has been observed in the community that the facility serves?
 |  |  |  |  |
| 1. Does evidence exist of person-to-person transmission of *M.* *tuberculosis* in the setting?
 |  |  |  |  |
| 1. Have any recent TST/ BAMT conversions occurred among staff or residents?
 |  |  |  |  |
| 1. Is there a high incidence of immunocompromised staff or residents in the facility?
 |  |  |  |  |
| 1. Have any residents with drug-resistant TB been encountered in your facility in the last five (5) years? When? (List year) \_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |  |  |
| 1. Considering the items above, would your setting require a higher risk classification?
 |  |  |  |  |
| 1. Does your setting have a plan for the triage of patients with suspected or confirmed TB disease?
 |  |  |  |  |
| Depending on the number of patients with TB disease who are encountered in a nontraditional setting in 1 year, what is the risk classification for your setting?  **LOW RISK MEDIUM RISK** \_\_\_ No TB cases\_\_\_ < 200 beds: < 3TB residents with active TB per year \_\_\_\_ < 200 beds: > 3 residents with active TB per year\_\_\_ > 200 beds: < 6 TB residents with active TB per year \_\_\_\_ >200 beds: > 6 residents with active TB per year**POTENTIAL ONGOING TRANSMISSION**\_\_\_\_\_Evidence of ongoing M. tuberculosis transmission (Report to your local health department immediately) |
|  **Part III: Screening of HCPs for M. tuberculosis Infection** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does the healthcare setting have a TB screening program for HCPs?
 |  |  |  |  |
| If yes, which HCPs are included in the TB screening program? (Check all that apply)\_\_\_\_\_ Physicians \_\_\_\_\_ Mid-level practitioners (NP/PA) \_\_\_\_\_ Nurses \_\_\_\_\_ Administrators \_\_\_\_\_ Laboratory workers \_\_\_\_\_ Respiratory therapists \_\_\_\_\_ Janitorial staff \_\_\_\_\_ Volunteers \_\_\_\_\_ Receptionists \_\_\_\_\_ Maintenance/engineering \_\_\_\_\_ Physical therapists \_\_\_\_\_ Transportation staff \_\_\_\_\_ Contract staff \_\_\_\_\_ Dietary staff \_\_\_\_\_ Construction workers\_\_\_\_\_ Service workers \_\_\_\_\_ Trainees and students \_\_\_\_\_ Others (specify):   |
| **Part III: Screening of HCPs continued** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Is baseline skin testing performed with two-step TST for HCP?
 |  |  |  |  |
| 1. Is baseline testing performed with QFT or other BAMT for HCP?
 |  |  |  |  |
| 1. How frequently are HCWs tested for M. tuberculosis infection?

a. Annually |  |  |  |  |
|  b. When exposure occurs |  |  |  |  |
| 1. Are the *M. tuberculosis* infection test records maintained for HCPs?
 |  |  |  |  |
| 1. Where are the *M. tuberculosis* infection test records for HCPs maintained?
 |  |  |  |  |
| 1. Who maintains the records?
 |  |  |  |  |
| 1. If the facility has a serial TB screening program for HCPs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years?
* 1 year ago
* 2 years ago
* 3 years ago
* 4 years ago
* 5 years ago
 | **\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_** |  |  |  |
| 1. Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)

 \_\_\_\_\_ Increasing \_\_\_\_\_ Decreasing \_\_\_\_\_ No change  |  |  |  |  |
| 1. Do any areas of the facility (e.g., waiting rooms or units) or any group of HCP (e.g., lab workers, nursing unit staff, and respiratory therapists) have a test conversion rate for *M. tuberculosis* infection that exceeds the facility’s annual average?
* If yes, list :

  |  |  |  |  |
| 1. For HCPs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?
 |  |  |  |  |
|  **IV: TB Infection Control Program** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does the facility have a written TB infection control plan?
 |  |  |  |  |
| 1. Who is responsible for the infection control program?
 |  |  |  |  |
| 1. When was the TB infection control plan first written?
 |  |  |  |  |
| 1. When was the TB infection control plan last reviewed or updated?
 |  |  |  |  |
| 1. Does the written infection control plan need to be updated based on the timing of the previous update *(i.e., >1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of M. tuberculosis)?*
 |  |  |  |  |
| **IV: TB Infection Control Program**  | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does the facility have an infection control committee (or another committee, e.g. QAPI, with infection control responsibilities)?
 |  |  |  |  |
| If yes, which groups are represented on the infection control committee? (Check all that apply.)\_\_\_\_\_ Physicians \_\_\_\_\_ Risk assessment \_\_\_\_\_ Nurses \_\_\_\_\_ Epidemiologists \_\_\_\_\_ Engineers \_\_\_\_\_ Quality control \_\_\_\_\_ Pharmacists \_\_\_\_\_ Administrator \_\_\_\_\_ Others (specify)\_\_\_\_\_ Health/safety staff \_\_\_\_\_ Laboratory workers  |  |  |  |  |
| If no, what committee is responsible for infection control? |  |  |  |  |
| **V. Implementation of TB Infection Control Plan Based on Review by Infection Control Committee** | **Comments** | **Yes** | **No** | **N/A** |
| Has a person been designated to be responsible for implementing an infection control plan in your facility?* If yes, list the name:
 |  |  |  |  |
| What mechanisms are in place to correct lapses in infection control? |
| List ongoing training and education regarding TB infection control practices provided for HCP? |
| **VI. Environmental Controls** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does the facility have an Airborne Infection Isolation (AII) Room(s)?
 |  |  |  |  |
| If NO, continue to **VII:** **Respiratory Protection Program** |  |  |  |  |
| If YES, please complete ***Appendix A*** |  |  |  |  |
| **VII. Respiratory Protection Program** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does your facility have a written respiratory protection program?
 |  |  |  |  |
|  If NO, continue to **VIII:** **Reassessment of TB Risk** |  |  |  |  |
|  If YES, please complete ***Appendix B*** |  |  |  |  |
| **VIII. Reassessment of TB risk** |
| 1. How frequently is the TB risk assessment conducted or updated in the facility?
 |
| 1. When was the last TB risk assessment conducted?
 |
| 1. What problems were identified during the previous TB risk assessment?
 |
| 1. What actions were taken to address the problems identified during the previous TB risk assessment?
 |
| 1. Did the risk classification need to be revised as a result of the last TB risk assessment?
 |

**References**

**North Carolina TB Manual**

[**http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html**](http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html)

**CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings, 2005**

[**https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s\_cid=rr5417a1\_e**](https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e)

**Appendix A: Environmental Controls**

***Complete only if the facility has an Airborne Infection Isolation (AII) Room***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VI. Environmental Controls** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Airborne Infection Isolation (AII) Room(s) |  |  |  |  |
| 1. List room(s):
 |
| 1. Are AII rooms checked daily for negative pressure when in use?
 |  |  |  |  |
| 1. Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?
* Smoke tubes
* Visual checks
 |  |  |  |  |
| 1. Are these results readily available?
* If yes where?
 |  |  |  |  |
| 1. Are environmental controls regularly checked and maintained with results recorded in maintenance logs?
 |  |  |  |  |
| 1. Do AII Rooms meet the recommended pressure differential od 0.01-inch water column negative to surrounding structures?
 |  |  |  |  |
| 1. What air cleaning methods are used in your facility? (Check all that apply)

**HEPA filtration**\_\_\_\_ Fixed room air recirculation systems\_\_\_\_ Portable room air recirculation systems**UVGI**\_\_\_\_ Duct irradiation\_\_\_\_ Upper air irradiation\_\_\_\_ Portable room air cleaners |
| 1. What ventilation methods are used for AII rooms? (Check all that apply)

**Primary (general ventilation)**\_\_\_\_ Single pass heating, ventilating and air conditioning (HVAC)\_\_\_\_ Recirculating HVAC systems**Secondary (methods to increase equivalent ACH)**\_\_\_\_ Fixed room recirculating units\_\_\_\_ HEPA filtration\_\_\_\_ UVGI\_\_\_\_ Other (specify): |
| 1. Does your facility employ, have access to, or collaborate with an environmental engineer (e.g., Professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) or consultation on design specifications, installation, maintenance, and evaluation of environmental controls?
 |  |  |  |  |

**Appendix B: Respiratory Protection Program**

***Complete only if the facility has Respiratory Protection Program***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VII. Respiratory Protection Program** | **Comments** | **Yes** | **No** | **N/A** |
| 1. Does your facility have a written respiratory protection program?  |  |  |  |  |
| 1. Which HCP are included in the respiratory protection program? (Check all that apply)

\_\_\_\_ Physicians \_\_\_\_ Mid-level practitioners (NP and PA)\_\_\_\_ Nurses \_\_\_\_ Contract staff\_\_\_\_ Construction or renovation staff\_\_\_\_ Service personnel\_\_\_\_ Laboratory personnel \_\_\_\_ Janitorial staff\_\_\_\_ Administrator \_\_\_\_ Maintenance or engineering staff\_\_\_\_ Transportation staff\_\_\_\_ Dietary staff\_\_\_\_ Students\_\_\_\_ Others (specify):  |  |  |
| 1. Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).
* Manufacturer
* Model #
* Specific application
 |  |  |  |  |
| 1. Is annual respiratory protection training for HCP performed by a person with advanced training in respiratory protection?
 |  |  |  |  |
| 1. Does your facility provide initial fit testing for HCWs?
* If yes, when is it conducted?
 |  |  |  |  |
| 1. Does your facility provide periodic fit testing for HCWs?
* If yes, when and how frequently is it conducted?
 |  |  |  |  |
| 1. What method of fit testing is used?
* Describe:
 |
| 1. Is qualitative fit testing used?
 |  |  |  |  |
| 1. Is quantitative fit testing used?
 |  |  |  |  |