

TUBERCULOSIS AND MULTI DRUG RESISTANT TUBERCULOSIS POLICY

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DOCUMENT CONTROL

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1. INTRODUCTION

- 1.1 Tuberculosis (TB) is a disease caused by the bacterium *Mycobacterium tuberculosis*. It can affect any part of the body, but is most commonly found in the lungs (pulmonary TB) and lymph glands. If an individual becomes infected, the disease develops slowly and it may take months for the symptoms to appear. In some cases the infection remains dormant for years and may only become active in later life.
- 1.2 TB can usually only be spread by someone who has infectious pulmonary TB. It can be transmitted by the respiratory route while the infected person is speaking, sneezing or coughing but is not highly contagious. Prolonged close contact with a person with infectious pulmonary TB is usually necessary for the infection to be passed on and those most at risk of catching TB are people who have had prolonged exposure to the infected person, such as household contacts
- 1.3 Non-respiratory TB in other parts of the body is unlikely to spread from person to person, and is not considered to be infectious. However, isolation in a single room may be required during aerosol generating procedures such as wound irrigation. The Infection Prevention and Control Team must be contacted for advice.

2. PURPOSE & SCOPE

The aim of this policy is to detail the infection control management for a patient with suspected or confirmed pulmonary TB. The policy is based on the National Institute for Clinical Excellence 2016 guidelines *Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control; NICE guidelines [NICE guidelines [NG33] Published date: January 2016 and can be accessed via <https://www.nice.org.uk/guidance/ng33>*

- 2.1 The procedural document applies to all clinical staff including Temporary, Locum, Bank, Agency and Contracted staff

3. DUTIES AND RESPONSIBILITIES

3.1 The Trust Board, via the Chief Executive is responsible for:-

- ensuring there are effective and adequately resourced arrangements for the detection & management of TB within the Trust;
- identifying a board level lead for Infection Prevention and Control;
- ensuring that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2015);

3.2 Director for Infection Prevention and Control is responsible for:-

- overseeing the local control of and the implementation of the Tuberculosis and Multi Drug Resistant Tuberculosis Policy.

3.3 Infection Prevention and Control Assurance Group is responsible for:-

- ensuring that procedures for the implementation of the Tuberculosis and Multi Drug Resistant Tuberculosis Policy are continually reviewed and improved within the Trust.

3.4 Assessing Clinician is responsible for:-

- risk assessing patients presenting with symptoms of active TB for MDRTB;
- arranging appropriate investigations;
- referral to respiratory specialist for advice and treatment;
- notification of all suspected TB cases to Consultant in Communicable Disease Control/ Public Health England, Devon Cornwall and Somerset Health Protection Team.

3.5 Treating Clinician is responsible for:-

- arrangement of any further diagnostic testing required after gaining consent from the patient;
- ongoing treatment and follow up for active TB;
- notification of all suspected TB cases to Consultant in Communicable Disease Control/Public Health England, Devon Cornwall and Somerset Health Protection Team if not already completed by assessing clinician.

3.6 Respiratory Specialist Nurse (contact through local Acute Trust) is responsible for:-

- carrying out any necessary contact tracing of family (in liaison with Public Health England, Devon Cornwall and Somerset Health Protection Team) or exposed patients and arranging appropriate follow up;
- supervision of treatment of patient in the community once discharged from hospital;
- education of the patient with regard to the medication, including timings and duration of the course.

3.7 Infection Prevention and Control Team is responsible for:-

- education and training as and when needed in the Infection Prevention and Control management of hospitalised TB patients;
- monitoring of isolation practice of patients isolated with suspected or confirmed infectious TB;
- patient education on TB and the isolation process;
- provide appropriate training for use of Personal Protective Equipment, (PPE) including 'fit testing' for use of FFP3 masks.

3.8 Ward Manager/Matron or Deputy is responsible for:-

- ensuring Infection Prevention and Control precautions are carried out as detailed in this policy;

- identifying the names of any staff close contacts prior to the instigation of infection prevention and control precautions and forwarding to Well at Work Team;
- ensuring FFP3 particulate filter respirator masks are available and all staff have been 'fit tested' (training provided via Infection Prevention and Control Team);
- ensuring that staff are aware of the policy;
- ensuring that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers;
- ensuring individual staff and team's training needs are met through appraisal and in line with the Trust Training Matrix. Training information should be passed to the Learning and Development Department who will update the individual staff member's Learning Zone record.

3.9 **Ward/Clinical staff are responsible for:-**

- adhering to the Infection Prevention and Control precautions detailed in this policy;
- ensuring communication of suspected or confirmed TB status of patient is transferred to another NHS body of healthcare facility;
- booking themselves onto initial and update mandatory training and for attending mandatory training, regardless of their grade, role or status, including permanent, temporary, full-time, part-time staff and locums, bank staff, volunteers, trainees and students.

3.10 **Learning and Development Team are responsible for:-**

- recording attendance at Training and will advise Operational Managers of non-attendance.

3.11 **Acute Trust Respiratory Nurse Specialists and Public Health England are responsible for:-**

- carrying out any necessary contact tracing of exposed staff and arranging appropriate follow up.

4. **EXPLANATIONS OF TERMS USED**

- 4.1 **Alcohol Acid Fast Bacilli** - Bacteria which having been stained with a dye to retain their colour in acid alcohol. Used as a technique for microscopic detection of *Mycobacterium* species.
- 4.2 **Active TB** - Infection with mycobacteria of the *M. tuberculosis complex* where mycobacteria are growing and causing symptoms and signs of disease. This is distinct from latent TB, where mycobacteria are present and may be dormant, but are not causing disease.
- 4.3 **Close Contacts** - May include boyfriend or girlfriend & frequent visitor to the house of the index cases, in addition to household contacts.
- 4.4 **Close Contact Staff** - Staff who have, prior to the instigation of infection control precautions, administered prolonged care of a high dependency patient

(equivalent to close household contact), repeated chest physiotherapy or mouth-to-mouth resuscitation. Surgical scrub and mortuary staff where a tuberculosis organ has been opened

- 4.5 **Contact Tracing** - The identification of contacts to find associated cases, to detect people with latent TB infection and to identify those not infected but for whom the screening process or BCG vaccination might be appropriate
- 4.6 **High Incidence Country** - Country with incidence equal to or greater than 40 cases per 100,000 population per year.
- 4.7 **Household Contact** - People sharing a bedroom, kitchen, bathroom or sitting room with the index case.
- 4.8 **Infectious TB** - Active sputum smear positive pulmonary tuberculosis i.e. with acid fast bacilli visible on direct microscopy. Active TB affecting other parts of the respiratory tract or oral cavity though rare is also considered infectious.
- 4.9 **Multi Drug Resistant TB (MDRTB)** - Tuberculosis resistant to Isoniazid and Rifampicin, with or without any other resistance.
- 4.10 **Negative pressure Room** - Isolation room where the air from the room is sucked out into dedicated ducting through a filter and into the outside air at a distance from all other air intakes. The level of pressure should be 10 Pascals below the ambient pressure.
- 4.11 **Non Respiratory TB** - Active TB affecting any part of the body other than the lungs, bronchi, pleura or thoracic lymph nodes.
- 4.12 **Particulate Filter Respirators (FFP3)** - Close fitting face mask which will, if worn correctly, protect the wearer from the inhalation of infectious airborne particles.
- 4.13 **Sputum Smear Positive (Smear positive alcohol acid fast bacilli (AFB) positive)** -Respiratory TB in which mycobacteria have been seen in a stained smear of sputum examined under a microscope. Confirmation of the diagnosis requires culture to differentiate the organism from atypical mycobacteria (those which are not in the *M. Tuberculosis* complex).

5. DIAGNOSIS AND TESTING

- 5.1 Symptoms of active pulmonary TB include persistent cough, haemoptysis, breathlessness, fatigue, weight loss, poor appetite and night sweats.
- 5.2 If TB is suspected, 3 consecutive sputum specimens (including one early morning sample) should be sent to the laboratory for culture and microscopy.
- 5.3 Microscopy for mycobacteria is normally done within 24hrs, except weekends. If urgent microscopy is required the laboratory should be telephoned to arrange this.
- 5.4 If mycobacteria are seen in a stained smear of sputum (Alcohol Acid fast bacilli, AAFB) the patient is said to be sputum smear positive and deemed to have

infectious TB. If AAFBs are not seen on any of the 3 specimens then the patient is deemed non infectious.

- 5.5 Confirmation of the diagnosis of TB requires a positive culture of the organism which may take several weeks.
- 5.6 A written consent for TB testing is not required (verbal and non verbal consent is adequate). However, an explanation of need and an information leaflet should still be given as a matter of good nursing practice. All healthcare notes should document this conversation fully.
- 5.7 Interpreters are available for any clients whose first language is not English.
- 5.8 For patients who lack capacity to consent, a best interest's assessment must be completed and a referral to the Trust Safeguarding team may be appropriate.

6. RISK ASSESSMENT FOR MULTI DRUG RESISTANT TB (MDRTB)

6.1 If pulmonary TB is suspected, a risk assessment should be carried out for Multi Drug Resistant TB, based on the factors below listed in order of relative risk.

- History of prior TB drug treatment; prior TB treatment failure;
- Birth in a foreign country, particularly high incidence countries as defined by the HPA on its website. Go to www.PHE.org.uk and search for WHO country data TB;
- HIV infection;
- Contact with known case of drug-resistant TB;
- Residence in London;
- Age profile, with highest rates between ages 24 and 44;
- Male gender;

6.2 If the risk of MDRTB is thought to be significant urgent, diagnostic testing for Rifampicin resistance should be arranged.

6.3 The NICE 2016 guidelines recommend that MDRTB patients are cared for by physicians with substantial experience in drug resistant TB. Transfer to a hospital with a specialised Infectious Disease Unit or shared care should be considered.

6.4 Infection Control precautions for suspected or know MDRTB cases are detailed in Section 8

7. INFECTION CONTROL PRECAUTIONS FOR SUSPECTED OR CONFIRMED INFECTIOUS PULMONARY TB (MDRTB NOT SUSPECTED) as per <https://www.nice.org.uk/guidance/NG33/chapter/Recommendations#infection-control>

7.1 In addition to standard infection control precautions, the following isolation precautions must be put in place

Single Room - Adult patients with suspected or confirmed infectious TB must be admitted to a single room, preferably the negative pressure room which are available in most District General Hospitals.

If a negative pressure room cannot be made available or the patient's mental health needs outweigh their physical condition, then the patient should be admitted to a side room with own bathroom facilities vented to the outside air. The door must be kept closed.

Patient with suspected pulmonary or confirmed infectious TB should not be admitted to wards with immuno-compromised patients.

Isolation Notice - An Isolation notice should be clearly displayed on the door.

Patient education - The patient must receive education to ensure they cover their nose and mouth with a disposable tissue whenever they cough and sneeze and wear a surgical face mask if leaving their room. Tissues must be disposed of in a clinical waste bag. All patient education must be in a form that they can easily understand. Information should also be made available for family members.

Protective Clothing and Masks (PPE) - Particulate Filter FFP3 respirator masks are only required if performing aerosol generating procedures such as bronchoscopy, sputum induction or nebuliser treatment. Masks are **not** required for routine care. However, if the patient is requiring exceptionally prolonged care from an individual member of staff (e.g. specialising or complex daily wound dressing) the possible need to wear a mask should be discussed with the Infection Prevention and Control Team.

In line with the Isolation Policy, aprons should be worn when entering the room and gloves worn for direct patient contact.

Hand Hygiene - must be performed before and after direct contact with the patient, after glove removal and prior to leaving the room (see Somerset Partnership Hand Hygiene policy).

Equipment - Only essential equipment should be taken into the isolation room. Where possible disposable equipment or equipment dedicated for the use of the isolated patient should be used. If the use of common equipment is unavoidable it must be cleaned with detergent wipes or detergent and water before being used on another patient. Crockery and cutlery does **not** need to be dedicated for the use of the isolated patient, but must go through the dishwasher before being used for another patient.

Cleaning - The isolation room should be cleaned daily. Cleaning should not be undertaken when the patient is undergoing an aerosol generating procedure e.g. nebuliser treatment. Masks are **not** required.

Transfer to other departments/hospitals - If the patient is being transferred to another department or hospital (e.g. to visit the X-Ray department or ECT) the patient should wear a surgical mask. The receiving department and, where appropriate, the ambulance staff must be informed of the patient's TB status.

Linen - Used linen should be sealed in a pink alginate laundry bag and then placed in a laundry bag

Specimens - Sputum specimens sent to the laboratory must be in a sealed container, bagged and correctly labelled

Visitors - should be limited to those who have already been in close contact with the patient before the diagnosis (e.g. household members). Masks are not required.

7.2 Isolation precautions can usually be discontinued when:

- A diagnosis of infectious TB has been excluded by 3 consecutive smear negative sputum samples;

Or

- When a patient with confirmed infectious TB (sputum smear positive) has completed two weeks of compliant multi-drug therapy, providing there has been definite clinical improvement and response to treatment. This should be discussed with the Consultant Respiratory Physician.

7.3 Patients may be discharged on treatment into the community prior to the completion of 2 weeks therapy, under the supervision of the Respiratory Nurse Specialist. Contact should be restricted to those who have been exposed to the patient from immediately prior to the diagnosis of TB until 2 weeks of therapy have been completed.

7.4 Once isolation precautions have been discontinued or the patient discharged from hospital the room should be terminally cleaned and curtains changed.

8. INFECTION CONTROL PRECAUTIONS FOR SUSPECTED OR CONFIRMED MDRTB

8.1 In addition to standard infection control precautions, the following isolation precautions must be put in place.

Single Room - Patients with known or suspected MDRTB (based on risk assessment) **must** be admitted to a lobbied negative pressure room, with continuous pressure monitoring. The doors must be kept closed and patient must not visit communal areas of the ward. These are available in most District General Hospitals so immediate transfer should be arranged.

Isolation Notice - An Isolation notice should be clearly displayed on the door, which should include requirement to wear a particulate filter FFP3 respirator mask prior to entry to the room.

Patient Education - As per drug sensitive TB.

Protective Clothing and Masks (PPE) - Particulate Filter FFP3 respirator masks **must** be worn during contact with suspected or known MDRTB patients. Aprons and gloves should be worn as per Isolation Policy

Hand Hygiene - As per drug sensitive TB.

Equipment - As per drug sensitive TB.

Transfer to Other Departments - Wherever possible any transfer within Somerset Partnership should be avoided. If transfer to another department is unavoidable the patient must wear a surgical mask and the receiving department informed. If the patient is transferred to another NHS body or healthcare facility the receiving department and, where appropriate, ambulance staff must be informed of the patient's current TB status.

Linen - As per drug sensitive TB.

Specimens - As per drug sensitive TB.

Visitors - must be limited to those who have already been in close contact with the patient before the diagnosis (e.g. household members). Particulate Filter FFP3 masks must be worn for patient contact.

Staff - caring for the patient must be kept to a reasonable minimum without compromising patient care.

Cleaning - The isolation room should be cleaned daily. Particulate Filter FFP3 respirator masks must be worn by cleaning staff.

- 8.2 Patients with MDRTB are likely to have a prolonged period of infectivity even after starting treatment. Precautions must only be discontinued after consultation with the Consultant Respiratory Physician, Microbiologist and Infection Control team.
- 8.3 The decision to discharge a patient with suspected or known MDRTB should be discussed with the Respiratory Nurse Specialist, Microbiologist, local TB service and Consultant in Communicable Disease Control (CCDC). Before the decision is made to discharge a patient secure arrangements for the supervision and administration of all anti drug TB therapy should have been agreed with patient and carers.
- 8.4 Once the patient has been discharged from hospital the room should be deep cleaned and curtains changed. Masks are not required for deep cleaning.

9. DECEASED PATIENTS

- 9.1 Last Offices - A body bag must be used and TB status entered on the Confirmation of Death Form (please also see Infection Control and The Deceased patient policy).
- 9.2 Ensure that patients' religious and cultural beliefs are taken into consideration, whilst maintaining the infection control processes
- 9.3 **Post Mortem** If a post mortem is required on a patient with suspected or known TB, and an incision into the lungs will be made, all persons present during the post mortem should wear an particulate filter FFP3 respirator mask.

10. CHILDREN AND TB

- 10.1 The child must be admitted to a single room or negative pressure room (see 7.1) depending on priority of mental health and physical health needs. Infection Control precautions should be followed as detailed in section 7.

- 10.2 If MDRTB is suspected the child **must** be admitted to the negative pressure available in most District General Hospitals and immediate transfer should be arranged. Doors and windows must be kept closed. Infection Control precautions, as detailed in Section 8 should be followed.
- 10.3 Children with TB may well have a close family contact with active disease that is infectious. Visitors must be kept to a minimum. All close family members must be referred for screening as soon as possible. Until deemed to be non-infectious visitors must be kept separate from other patients, must come and go directly to the room when visiting and must not use the communal areas.
- 10.4 Isolation precautions can be discontinued once it has been confirmed that both the child and visiting family members are non infectious.

11. SUSPECTED AND CONFIRMED NON MDRTB CASES IN THE COMMUNITY

- 11.1 Infection Prevention and Control precautions as detailed in section 7 should be observed especially in regard to patient education, PPE, equipment and hand washing for both domiciliary and outpatient appointments.
- 11.2 All patients with suspected or confirmed pulmonary TB should be separated from immuno-compromised patients in Out Patient Departments until they are shown to be sputum smear negative or when a patient with confirmed infectious TB (sputum smear positive) has completed two weeks of compliant multi-drug therapy, providing there has been definite clinical improvement and response to treatment. This should be discussed with the Consultant Respiratory Physician.
- 11.3 All patients with suspected or confirmed pulmonary TB should not attend Day Hospital/Centres until they are shown to be sputum smear negative or when a patient with confirmed infectious TB (sputum smear positive) has completed two weeks of compliant multi-drug therapy, providing there has been definite clinical improvement and response to treatment. This should be discussed with the Consultant Respiratory Physician.

12. SUSPECTED AND CONFIRMED MDRTB CASES IN THE COMMUNITY

- 12.1 Domiciliary visits are more appropriate until the criteria for non-infectiousness have been met. Advice should be sought from the Consultant Respiratory Physician.

13. CLIENTS WITH INFECTIVE PULMONARY TB WHO WISH TO TAKE THEIR OWN DISCHARGE

- 13.1 Infectious patients who wish to take their own discharge should be strongly advised against this. They should have the necessary arrangements for protecting their home contacts explained to them. If they do not agree to these arrangements, it should be explained to them that they might be compulsorily admitted to, and detained in, a secure room or ward under the powers of sections 37 and 38 of the Public Health Act. This Act, however, does not allow for the compulsory treatment of patients.

14. CONTACT TRACING

- 14.1 **Patients** - If a patient on an open ward is diagnosed as having open tuberculosis the risk of other patients being infected is likely to be small. Patients in a bay who have had over 8 hours contact with an infectious pulmonary TB case prior to the instigation of isolation precautions, will be contact traced and followed up by the Respiratory nurse Specialist. Confidentiality will be maintained, as the name of the patient with TB will not be used in any communication with the contacts.
- 14.2 **Staff** – Those staff involved in the care of a patient with open TB prior to the instigation of infection control precautions will be followed up in accordance with the current Occupational Health and Safety Department procedure. Definition of a close contact includes staff who have administered prolonged care of a high dependency patient (equivalent to close household contact), repeated chest physiotherapy or mouth-to-mouth resuscitation and surgical scrub and mortuary staff where a tuberculosis organ has been opened.
- 14.3 **Family Close Contacts** – family and close contacts will be followed up by the Respiratory Nurse Specialist in liaison with the Public Health England, Devon Cornwall and Somerset Health Protection Team

15. NOTIFICATION

- 15.1 All forms of tuberculosis are notifiable to the Consultant for Communicable Disease Control under the Public Health Control of Disease Act 2010. The clinician making or suspecting the diagnosis is responsible for notification. A decision to commence treatment indicates a level of suspicion that should trigger notification for all forms of tuberculosis. The notification should indicate the sputum smear status of the patient

16. FOOD TRANSMISSION

- 16.1 Transmission from food is possible although very rare in the UK. Tuberculosis may be found in unpasteurised dairy products from infected cows. The UK has a stringent testing regime for all dairy herds to stop infected products reaching the human food chain but other countries may not have similar safe guards in place.
- 16.2 Somerset Partnership does not provide unpasteurised dairy products for clients.

17. TRAINING REQUIREMENTS

- 17.1 The Trust will ensure that all necessary staff (qualified, unqualified, other clinical staff and bank staff) are appropriately trained in line with the organisation's training needs analysis.
- Trust Induction Training
 - Hand Washing Training
 - Infection Prevention and Control Training
 - Fit Testing - All staff who may need to wear FFP3 particulate respirator masks must have received Fit testing training. It is the responsibility of the member of staff's manager to ensure this has been carried out.

18. EQUALITY IMPACT ASSESSMENT

- 18.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

19. MONITORING COMPLIANCE AND EFFECTIVENESS

19.1 Monitoring arrangements for compliance and effectiveness

- Overall monitoring will be by the Infection Prevention and Control Assurance Group.

19.2 Responsibilities for conducting the monitoring

- The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas.

19.3 Methodology to be used for monitoring

- Incident reporting and monitoring

19.4 Frequency of monitoring

- The Infection Prevention and Control Assurance Group reports to the Clinical Governance Group every quarter.

19.5 Process for reviewing results and ensuring improvements in performance occur.

Surveillance results will be presented to the Infection Prevention and Control Assurance group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

20. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 20.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the **fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment

Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

20.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16: Notification of death of service user

20.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

Relevant National Requirements

- NG33 Tuberculosis : NICE guideline

21. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

21.1 References

British Thoracic Society (2000) Control and prevention of tuberculosis in the United Kingdom: Code of practice. Thorax; VOL 55:p887-90.

Department of Health (updated 2015) The Health and Social Care Act 2008, Code of Practice for health and social care on the prevention and control of infections and related guidance.

NICE guidelines [NG33] Published date: January 2016
<https://www.nice.org.uk/guidance/ng33>
 Public Health Act 1984, Section 37 and 38, HMSO

21.2 Cross reference to other procedural documents

Infection Prevention and Control Policy
 Cleaning of Equipment and Decontamination Policy
 Isolation Policy
 Learning Development and Mandatory Training Policy
 Risk Management policy and Procedure
 Staff Training Matrix
 Untoward Event Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.