Reference Number: UHW 237 Version Number: 2	Date of Next Review: 24/09/2027 Previous Trust/LHB Reference Number: T/44

INFECTION PREVENTION AND CONTROL PROCEDURE FOR THE MANAGEMENT OF PATIENTS KNOWN OR SUSPECTED TO HAVE *MYCOBACTERIUM TUBERCULOSIS* (TB) IN HOSPITAL

Introduction and Aim

To provide appropriate advice to staff for the prevention and management of tuberculosis at all UHB hospitals based on current NICE guidance.

Objectives

- To describe the actions required on the admission of a patient known or suspected to have Tuberculosis.
- To describe the actions required when a case develops in a UHB hospital.
- To provide advice on the action required during an infectious incident or outbreak situation caused by Tuberculosis (see also the UHB Infection Control Procedure for Infectious Incidents and Outbreaks).
- To provide advice on the communications necessary whenever a cluster of cases of Tuberculosis develops amongst patients and/or staff.
- To provide advice on the actions required when admitting a patient from HMP Cardiff with suspected or confirmed Tuberculosis.

Scope

Cardiff And Vale University Health Board accepts its responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to tuberculosis in patients, staff and other persons working at or using its premises.

In order to prevent the possible spread of tuberculosis amongst patients and staff it is recognised that the UHB requires a procedural document to ensure effective management of infection. This is especially necessary in the case of an infectious incident/outbreak, as detailed in the UHB Infection Control Procedure for Infectious Incidents and Outbreaks.

This procedure applies to all staff in all locations including those with honorary contracts and students on placement at Cardiff and Vale UHB.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has been completed, and this found there to be no impact.*
Documents to read alongside this Procedure	C&V UHB Infectious Incidents & Outbreak Procedure C&V UHB Hand Hygiene Procedure NIPCM - Public Health Wales (NHS. Wales) C&V UHB Decontamination Procedure
Approved by	*Infection Prevention and Control Group*

Accountable Executive or Clinical Board Director	*Director of Nursing*
Author(s)	*Clinical Nurse Specialist in Infection Prevention & Control, Microbiologist ST7, TB Clinical Nurse Specialist, Infectious Diseases Consultant*

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2	*24/09/2024*	*27/09/2024*	Supersedes previous UHB version reference number UHB 237 Amendments: - Inclusion of recommendations following HMP Cardiff TB outbreak 2018. - location of infectious diseases ward, - Updated members of the integrated TB service, - Updated guidance and references, - Updated list of high-risk countries for MDRTB on “IP&C measures in in-patients” flowchart.
1	*2013*		

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1. SUMMARY

1.1 All forms of TB are Notifiable - clinicians must report all suspected cases to the TB Clinical Nurse Specialist (TB CNS 02920335125) (4.1) who will notify the Consultant in Communicable Disease Control / Consultant in Health Protection Tel 0300 0030032.

1.2 Unless there is a clear clinical or socioeconomic need, such as homelessness, people with TB at any site of disease should not routinely be admitted to hospital for diagnostic tests or care.

1.3 The Infection Prevention and Control Department (IPCD) should also be notified of any suspected or diagnosed case within a Health Board hospital.

1.4 In cases of suspected or confirmed Pulmonary (including laryngeal) tuberculosis a risk assessment for MDR/XDR TB must be completed (Appendix 5)

1.5 All patients with suspected or confirmed Pulmonary Tuberculosis to be transferred to the negative pressure room, until patient has been established on appropriate antimicrobial treatment, and always if patient has Multiple Drug Resistant or Extensively drug resistant Pulmonary (including laryngeal) Tuberculosis (MDR-TB or XDR-TB) (5.3).

1.6 FFP3 masks and eye protection need to be used when entering this room. (Please note fit testing is required before FFP3 masks are used. Please ensure that staff are trained by the Health and Safety team or an appropriate Fit tester within the UHB in the use of these masks.)

1.7 Patients with non-pulmonary (or laryngeal) tuberculosis may be nursed in an open bay on the infectious disease ward (5.6).

1.8 Patients with smear positive pulmonary disease can be considered non-infectious after two weeks of treatment in cases of drug-susceptible tuberculosis. If patients have continued respiratory symptoms, including a cough, fluid repellent face masks and eye protection must be worn by staff in line with transmission-based precautions once the infectious period is over.

1.9 Assessment of staff contacts of patients with smear positive pulmonary tuberculosis will be carried out by the TB Nurse Specialist in-conjunction with the IPC Department, local Public Health Officers (CCDC) and occupational health.

1.10 Any staff member diagnosed with Pulmonary TB should remain off work for a minimum of 2 weeks and until deemed non-infectious as advised by the TB Nurse (7.7).

2. INTRODUCTION

2.1 TB is a curable infectious disease caused by a type of bacterium called mycobacterium tuberculosis, it is spread by droplets containing the bacterium being coughed out by someone with infectious TB, and then being inhaled by people (NG33, 2019)

2.2 In 2006, The National Institute for Health and Clinical Excellence (NICE) developed guidelines for TB, 'Clinical diagnosis and management of tuberculosis, and measures for its prevention and control'. This guidance was updated in 2016, and again in 2019.

2.3 Overall numbers, rates and geographical distribution UK & Wales:
In the UK in 2021, a total of 4,795 cases of tuberculosis (TB) were reported, a rate of 7.1 cases per 100,000 population. Between the peak number of cases of TB in 2011 to 2021 a 46.2% reduction in cases of TB has been observed. However, a small increase in cases of TB and rate was observed in 2019, following the largest decrease to date in both cases of TB and rate. This occurred at the same time as the Coronavirus (COVID-19) pandemic. The most likely explanation for this large decrease is reduced numbers of cases presenting for diagnosis in the early stages of the pandemic. The increase in 2021 compared with 2020 is therefore not unexpected and is more in line with previous years.

Most cases of TB in the UK were in England with 4,425 cases of TB in 2023. As in previous years, London accounted for the highest number of cases of TB in the UK in 2021 (1,569/4,795 = 33%) and the highest rate of disease (17.4 per 100,000) (report of cases of TB to enhanced TB surveillance systems: UK 2000 to 2021 – Report UK HSA – ETS UK 2000 to 2021).

2.4 In 2021, 90 cases of TB were reported to the ETS in Wales (2.8 cases per 100,000). This represents a 50% decrease in the number of cases reported in 2000 (179) (UK HSA, ETS UK, 2000 to 2021).

2.5 All forms of tuberculosis are notifiable; clinicians must report all suspected cases to the TB Nurse Specialist (02920335125) who will notify the Consultant in Communicable Disease Control/ Consultant in Health Protection (Tel 0300 0030032). Failure to

notify in some circumstances could lead to action for medical negligence. This ensures appropriate advice is given, close contacts are identified to be screened, and epidemiological data is collected (4.1).

3. Roles and Responsibilities

3.1 The Infection Prevention and Control Group are responsible for the approval of the Infection Prevention and Control Procedure for the Management of Patients known or suspected to have Mycobacterium Tuberculosis in UHB hospitals.

3.2 Individual directorates will be responsible for the implementation of the procedure document in clinical areas.

3.3 Distribution of the procedure will be through the UHB SharePoint.

3.4 The Integrated TB service roles and contact details are shown in appendix 3.

4. NOTIFICATION OF TUBERCULOSIS

4.1 All forms of TB are notifiable - clinicians must report all suspected cases to the TB CNS (02920335125) who will notify the Consultant in Communicable Disease Control/ Consultant in Health Protection (Tel 0300 0030032).

4.2 The TB nurse specialist in Cardiff and Vale UHB will then ensure the patient is officially notified on the national TB Surveillance System (NTBS). This is used to monitor tuberculosis control and includes treatment outcome monitoring. Failure to notify in some circumstances could lead to action for medical negligence.

4.3 The Infection Prevention and Control Department (IPCD) must also be informed. This will ensure that the appropriate infection control procedures are implemented at ward level.

4.4 The TB nurse specialist will be available to give advice and education to both the patient and staff, they will also ensure close household contacts are identified that may need TB screening.

4.5 An assessment of staff close contacts will be made by the TB CNS in-conjunction with IPCD, the Occupational Health Department (OHD) and local Public Health Officers.

4.6 The ward manager/nurse-in-charge will be given a letter and ward staff contact list to complete (Appendix 1a and 1b), which is then sent to occupational health department.

5. CONTROL MEASURES

5.1.1 The method of isolation/precautions used for patients with tuberculosis depends on the type of disease diagnosed (see appendix 4).

5.1.2 All suspected/confirmed cases of TB must undergo a risk assessment for MDR-TB or XDR-TB (See appendix 5)

5.1.3 Unless there is a clear clinical or socioeconomic need, such as homelessness, people with TB at any site of disease should not routinely be admitted to hospital for diagnostic tests or care.

5.1.4 If admitted to hospital with suspected pulmonary TB, patient to be nursed in a negative pressure room (A7, UHW), until confirmed otherwise. If confirmed TB is not pulmonary/laryngeal TB, then patient can be nursed in a side room on the infectious diseases ward (Heulwen, UHW).

5.2 SUSPECTED OR CONFIRMED OPEN (SPUTUM SMEAR AFB POSITIVE) PULMONARY DISEASE

5.2.1 Patients admitted with suspected open pulmonary disease require isolation in a negative pressure room (A7, UHW). (as section 5.1.4).

5.2.2 Health care workers caring for patients with suspected open pulmonary disease, must wear an FFP3 face mask, for which they have been appropriately fit tested, and eye protection as part of their personal protective equipment as per transmission-based precautions and the IP&C Manual.

5.2.3 The door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise, for which this should be clearly documented in the patient notes and risk assessed. Appropriate signage should be placed on the door to the room

indicating that transmission-based precautions are required, including appropriate personal protective equipment (PPE).

5.2.4 Smear positive patients without risk factors for MDR-TB (Appendix 5) should be cared for in a single room, until:

- They have completed two weeks of standard treatment regimen or
- They are discharged from hospital.

5.2.5 Patients with smear-positive pulmonary TB should be discouraged from leaving their negative pressure single room unless necessary, if they do leave then they must wear a surgical mask whenever they leave their single room.

5.2.6 If a patient on a general ward is diagnosed as having smear positive tuberculosis after having been there for several days, the IPC department should be contacted to make an initial assessment of risk to other patients. If required a further risk assessment will be made jointly by the IPCD, TB CNS, TB Consultant and CCDC (TB Incident Team), this is to determine patient TB exposure risk and if patient TB screening is required. If patient contacts require TB screening this will be organised and completed by the TB Clinical Nurse Specialist.

5.2.7 Assessment of staff contacts of patients with smear positive pulmonary tuberculosis will be carried out by the TB Nurse Specialist in-conjunction with the IPC Department, local Public Health Officers (CCDC) and Occupational Health team.

5.2.8 Any visitors to a child with TB in hospital should be screened as part of contact tracing and kept separate from other patients until they have been excluded as a source of infection. The TB CNS can arrange this screening.

5.2.9 Housekeepers cleaning the room are not at particular risk but are required to wear appropriate PPE as per transmission-based precautions, on entering the room, and should have had their BCG status established. Normal housekeeping procedures should be carried out, including enhanced terminal cleaning and curtain change on discharge of the patient, as well as Hydrogen Peroxide Vapour (HPV) disinfection for rooms of patients with MDR/XDR TB.

5.2.10 Crockery and cutlery can be treated as for any other patient and no extra precautions are required for linen etc. Infected

material and other clinical waste should be disposed of into an infected "clinical waste" bag.

5.3 MULTIPLE DRUG-RESISTANT PULMONARY TUBERCULOSIS (MDR-TB)

5.3.1 Patients with suspected or confirmed smear positive multiple drug resistant Pulmonary (including laryngeal) tuberculosis (MDR-TB) must be transferred to a negative pressure room on Ward A7 at UHW, or ITU (If level 3 care is required).

5.3.2 Staff and visitors entering the room of a confirmed or suspected case of MDR-TB must wear a specialised FFP3 mask (see appendix 4). Staff need to be fit tested to wear these masks (Health & Safety requirement).

5.3.3 The patient should remain in negative pressure isolation, until:

- Non-resistance is confirmed (either by direct culture or NAAT)
- In cases of confirmed MDR/XDR- pulmonary TB – 3x consecutive weekly negative smears (And preferably a negative sputum culture)

5.3.4 Decisions to deescalate from negative pressure isolation should always be made in conjunction with a TB clinician.

5.3.5 Before the decision is made to discharge a patient with suspected or known MDR TB from hospital, secure arrangements for the supervision and administration of all anti-TB therapy should have been agreed with the patient, carers and TB Nurse Specialist.

5.3.6 The decision to discharge a patient with suspected or known MDR TB should be discussed and planned with the TB clinician and TB Nurse Specialists.

5.3.7 Crockery and cutlery can be treated as for any other patient and no extra precautions are required for linen etc. Infected material and other clinical waste should be disposed of into an infected "clinical waste" bag.

5.3.8 Housekeepers cleaning the room are required to wear appropriate PPE as per transmission-based precautions, on entering the room, and should have had their BCG status established. Normal housekeeping procedures should be carried out, including enhanced terminal cleaning using an appropriate

Chlorine releasing agent and curtain change on discharge of the patient, as well as Hydrogen Peroxide Vapour (HPV) disinfection for rooms of patients with MDR/XDR TB.

5.4 PATIENTS WITH POLICE OR PRISON ESCORT

5.4.1 If TB is suspected on admission, Police and /or Prison escort staff (PPES) should be informed so they can reassess the risk of handcuffing. Record this conversation in the patient hospital notes.

5.4.2 Any PPES escorting a patient with pulmonary TB inside a cubicle, should be explicitly informed of the risk of TB exposure. This is equal or greater than household contacts, and greater than healthcare staff. This should be recorded in the patient hospital notes, and PPES should inform escort staff and record if on bed-watch log.

5.4.3 If after a risk assessment, PPES need to remain in the cubicle, they should be provided with appropriate FFP3 face masks and fit testing, appropriate to the situation.

5.5 CONFIRMED (SPUTUM AFB SMEAR NEGATIVE) PULMONARY DISEASE

5.5.1 The patient is to be nursed in a side room, as there may be immunocompromised patients on the ward (section 5.1.4).

5.6 NON-PULMONARY TUBERCULOSIS

5.6.1 The patient is to be nursed in a side room, as there may be immunocompromised patients on the ward (section 5.1.4).

5.7 INFANTS BORN TO MOTHERS WITH INFECTIOUS TUBERCULOSIS

5.7.1 Infants born to mothers who have infectious TB should receive chemoprophylaxis for six weeks and then be Mantoux tested. If further Mantoux and IGRA blood test are negative, prophylactic treatment can be stopped, and BCG vaccine can be given.

5.7.2 Specialist advice should be sought from the TB CNS and TB Lead for Paediatrics before starting treatment. These will arrange the TB testing and TB preventative treatment.

5.8 PATIENTS with TB ADMITTED TO A SETTING WHERE CARE IS PROVIDED FOR PEOPLE WHO ARE IMMUNOCOMPROMISED

5.8.1 Patients with TB should not be admitted to a setting where care is provided for people who are immunocompromised (e.g. Velindre Hospital, haematology wards, and solid organ transplant wards).

5.8.2 Patients with Pulmonary TB may be admitted to the infectious disease ward (which may contain HIV+ patients) but only to an appropriate isolation room.

5.8.3 When patients are moving to accommodation (inpatient or home) with people who are immunocompromised, including those who are HIV-positive, patients should stay in respiratory isolation until:

- The patient has had at least two weeks of appropriate multiple drug therapy.

And

- Is both tolerant and adherent to prescribed regime.

And either

- The patient has had at least three negative microscopic smears on separate occasions over a 14 day period,

Or

- Any cough has resolved completely.

6. TRANSFER OF PATIENTS

6.1 As with all Infection Control matters, the Nurse-in-charge of the ward has the responsibility to ensure that the necessary information regarding an infectious patient is passed on to a senior member of the receiving ward/department, prior to transfer.

6.2 WITHIN THE HOSPITAL

6.2.1 Patients with AFB smear negative pulmonary and non-pulmonary tuberculosis are to be isolated in a side room. When transfers of this type take place, the receiving ward must be informed of the patient's current status prior to transfer.

6.2.2 Patients who have AFB smear positive pulmonary tuberculosis must be nursed in a negative pressure room and should only be discharged from this room to another ward in the hospital when the consultant-in-charge of the patient is satisfied that they are no longer infectious.

6.2.3 Immediate clinical need may occasionally necessitate patient movement outside the negative pressure room. If this is necessary, then patients should wear a surgical mask during transfer. Further advice is available from the IPCD.

6.3 VISITS TO OTHER DEPARTMENTS AND SURGICAL OPERATIONS

6.3.1 Visits of smear-negative pulmonary tuberculosis cases, with clinical suspicion of pulmonary tuberculosis, to other departments should be kept to a minimum. When there is a need arrangements must be made with the senior staff of the department concerned prior to transfer. Patients should be seen at the end of the working session and should spend the minimum time in the department.

6.3.2 Patients with smear-positive pulmonary tuberculosis must not visit other departments unless there is an overriding clinical need. If they do need to visit another department, the patient should wear a surgical mask when outside the isolation room if tolerated and be seen at the end of the working session and should spend the minimum time in the department.

6.4 TRANSFERS TO OTHER HOSPITALS

6.4.1 No transfer should take place unless all parties have agreed these arrangements. The receiving ward must be informed of the current status of the patient.

6.4.2 For smear-negative or non-pulmonary tuberculosis transfer can take place much more readily; but the receiving ward must be notified of the patient's status prior to transfer.

6.5 AMBULANCE TRANSPORTATION

6.5.1 The ambulance service must be notified prior to transfer of any patient with suspected or confirmed open pulmonary tuberculosis. Further information for the ambulance service can be obtained from the Consultant in Communicable Disease Control/ Consultant in Health Protection (Tel 0300 0030032).

7. HEALTH CARE PERSONNEL

7.1 Pre-employment

7.1.1 Employees new to the NHS who will be working with patients or clinical specimens should not start work until they have completed a TB screen or health check, or documentary evidence is provided of such screening in the last 12 months.

7.1.2 Employees new to the NHS who will have contact with patients should not start work if they have signs & symptoms of TB.

7.1.3 Health checks for employees new to the NHS who will have contact with patients or clinical materials should include:

- Assessment of personal or family history of TB
- Symptoms and signs enquiry/questionnaire
- Documented evidence of TB testing and/or BCG scar check by an Occupational Health professional, not relying on the applicant's personal assessment
- Mantoux result within the last 5 years if available.

7.2 TB SCREENING & BCG VACCINATION

7.2.1 New employees from the UK or countries with low TB incidence:

7.2.2 Offer a Mantoux test to new NHS employees who will be in contact with

- Patients or clinical materials if the employees:
- Are not new entrants from high-incidence countries and
- Have not had BCG vaccination (for example they are without scar, other documentation or reliable history)

7.2.3 If Mantoux test is negative, refer to the Green Book for BCG immunisation guidance. An individual risk assessment for HIV infection needs to be made before BCG vaccination is given.

7.2.4 If the Mantoux test is positive, offer an Interferon-gamma test and inform the TB Service. If interferon gamma positive, the person should be referred to the TB service for clinical assessment for diagnosis and possible treatment of latent infection or active disease. Clinical assessment by TB service should be completed before starting work.

7.3 NEW EMPLOYEES FROM COUNTRIES OF HIGH TB INCIDENCE OR HAVE HAD CONTACT WITH PATIENTS IN SETTINGS WITH A HIGH TB PREVALENCE:

7.3.1 Should have an interferon-gamma test.

7.3.2 If negative, offer BCG vaccination as 7.2.2. & 7.2.3.

7.3.3 If positive the person should be referred to the TB service for clinical assessment for diagnosis and possible treatment of latent infection or active disease. Clinical assessment by TB service should be completed before starting work.

7.3.4 If a prospective or current healthcare worker who is Mantoux negative (less than 6mm), declines BCG vaccination, the risks should be explained, and the oral explanation supplemented by written advice. If the person still declines BCG vaccination, he or she should not work where there is a risk of exposure to TB.

7.4 HEALTHCARE WORKERS WHO ARE IMMUNOCOMPROMISED:

7.4.1 Healthcare workers who are immunocompromised should be screened in the same way as other people who are immunocompromised:

7.4.2 For people who are severely immunocompromised, such as people with HIV, if CD4 counts less than 200cells/mm^3, or after solid organ or allogeneic stem cell transplant, offer an interferon-gamma test and a concurrent Mantoux test. If either test is positive refer to the TB service, who will:

- Perform a clinical assessment to exclude active TB and
- Consider treating latent TB infection

7.4.3 For other people who are immunosuppressed, individuals with HIV and CD4 counts of 200=500 cells/mm^3 offer an interferon-gamma test alone or with a concurrent Mantoux test. If either test is positive refer to the TB service, who will:

- Perform a clinical assessment to exclude active TB and
- Consider treating latent TB infection

7.5 CLINICAL STUDENTS, AGENCY AND LOCUM STAFF:

7.5.1 Those that have contact with patients or clinical materials should be screened for TB to the same standard as new employees in healthcare environments as recommended before.

7.5.2 Documentary evidence of screening to this standard should be sought from locum agencies and contractors who carry out their own screening.

7.6 STAFF CLOSE CONTACT SCREENING

7.6.1 Reminders of symptoms of TB, and the need for prompt reporting of such symptoms, should be included with annual reminders about occupational health for staff who:

- Are in regular contact with patients with TB or clinical materials, *or*
- Have worked in a high-risk clinical setting for four weeks or longer.

7.6.2 **Assessment of staff contacts of patients who have smear positive pulmonary tuberculosis (open TB):**

An assessment of staff close contacts will be made by the TB CNS in -conjunction with IPCD, the Occupational Health Department (OHD) and local Public Health Officers.

The ward manager/nurse-in-charge will be given a letter and ward staff close-contact list to complete (Appendix 1a and 1b), which is then sent on to occupational health department.

7.6.3 Close contacts are defined as members of staff who carry out:

- Have more than 8 hours of contact with the patient
- Mouth-to-mouth resuscitation
- Prolonged care of a high dependency patient
- Repeated chest physiotherapy

7.6.4 One-off reminders should be given to these identified staff after a TB Incident on their ward.

7.6.5 Casual contacts (not identified on list) should only be assessed if they are unusually susceptible (immunosuppressed) or have no history of BCG vaccination.

7.6.6 **Assessment of staff contacts of patients who have smear negative pulmonary or non-pulmonary tuberculosis (open TB):**

- In these cases no action is necessary.

7.7 Staff who are or become positive for pulmonary TB in their place of work

7.7.1 An assessment of staff close contacts, including patients, staff and community contacts will be made by the TB CNS in -conjunction with the IPCD, the Occupational Health Department (OHD) and the incident management team.

7.7.2 Any staff member diagnosed with Pulmonary TB should remain off work for a minimum of 2 weeks and until deemed non-infectious (usually following 2 weeks of TB treatment). This will be on the advice of the TB Team.

7.7.3 The Health and safety department must be informed if a member of staff has contracted TB through a work-related exposure, as this will need to be reported to the Health and safety Executive.

8. RESOURCES

8.1 The necessary resources for the management, training, risk assessments, monitoring and auditing for tuberculosis are already in place and the implementation of this procedure will not entail additional expenditure.

9. TRAINING

9.1 Mandatory Infection and Prevention and Control training updated every two years.

9.2 Further departmental based training is available by contacting the TB Clinical Nurse Specialists.

10. IMPLEMENTATION

10.1 The document will be available on the UHB intranet site and the Infection Prevention and Control clinical portal site. Individual directorates will be responsible for the implementation of the procedure document in clinical areas.

11. FURTHER INFORMATION

11.1 Guidance on the management of Tuberculosis was published by NICE in 2019. This guidance is still current and has been used in the preparation of this procedure which also considers local circumstances within the UHB.

11.2 National Infection Prevention & Control manual (updated May 2025) has been used in the preparation of this procedure which also considers local circumstances within the UHB.

12. AUDIT

12.1 Audit of compliance with the procedural document will be carried out by the Infection Prevention and Control Department as part of their procedure audit programme.

13. REVIEW

13.1 This procedure will be reviewed every three years or sooner if the national guidelines are updated.

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14. WHTM 07-01 Safe Management of Healthcare Waste, NHS Wales Shared Services Partnership – Facilities Services, 2013: https://nwssp.nhs.wales/ourservices/specialist-estates-services/specialist-estates-services-documents/whtms-library/whtm-07-01-safe-management-of-healthcare-waste-pdf/

Appendix 1a

TB CONTROL SERVICE & OCCUPATIONAL HEALTH SERVICE
CARDIFF AND VALE UNIVERSITY HEALTH BOARD

List of Staff Contacts (all disciplines) of:

NAME OF PATIENT: _____

WARD, HOSPITAL: _____ DATES OF ADMISSION: _____

To be completed and returned to Occupational Health Department within seven days. If no contacts are identified, ward manager to sign below.

SURNAME	FORENAME	DOB	STAFF GRADE	STAFF ADDRESS	For Occupational Health Use			
					BCG Date	Mx/IGF Date & Result	CXR Date & Result	Inform & advice

NO CLOSE CONTACTS IDENTIFIED. Signed _____ Ward Manager

Appendix 1b

TB Nurse Specialists
TB Control Service
Primary Care Service Centre - 1st Floor
Cardiff Royal Infirmary
Glossop Road
Cardiff, CF24 0SZ *Telephone 02920 335121*

University Hospital of Wales and University Hospital of Llandough

Ymddiriedolaeth CIG Ysbyty Athrofael Cymru ac Ysbyty Llandochau

Llandough Hospital
Ysbyty Llandochau
Penlan Road,
Penarth,
Vale of Glamorgan
CF64 2XX
Tel 029 20711711

Heol Penlan, Penarth,
Bro Morgannwg
CF64 2XX
Ffon 029 20711711

Confidential

Date:

Dear Sister/Charge Nurse – Ward:

Re:

Ward: **From:** **To:**

The person named above has been diagnosed as suffering from smear positive (open) pulmonary tuberculosis. In order to assist with the screening and monitoring of staff that have cared for this patient, would you please complete a list of the names of all staff working on the ward/unit that were in close regular contact on the attached form.

A CLOSE REGULAR CONTACT IS DEFINED AS ANY STAFF MEMBER INVOLVED IN:-

1. PROVIDING PERSONAL CARE FOR A HIGH DEPENDENCY PATIENT
2. ADMINISTERING ACTIVE AND RECURRENT CHEST PHYSIOTHERAPY
3. PERFORMING MOUTH-TO-MOUTH RESUSCITATION

The completed form should be returned to the Occupation Health Department of you trust.
Most staff will only require a reminder of TB signs and symptoms from the Occupational health department.

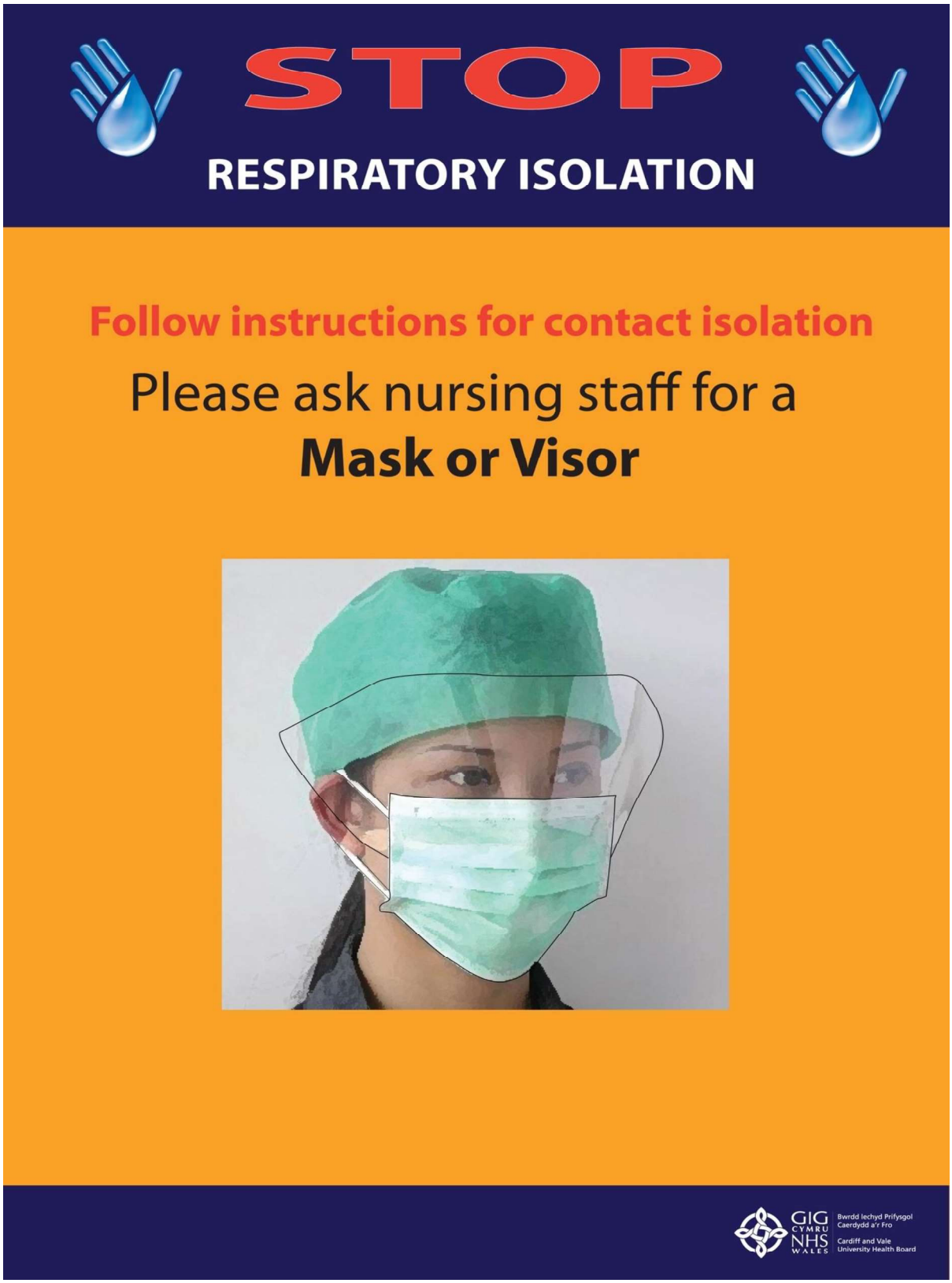
All other staff in contact with this patient may be reassured that they are not at risk. Staff who are unsure if they are protected against TB should contact the Occupational Health Department for further advice.
If you require any further detail regarding this matter, please contact me on the above telephone number.

Yours sincerely

Yvonne Hester

Yvonne Hester, Karen Baker & Martha Williams
Clinical Nurse Specialists in Tuberculosis

Appendix 2


STOP
RESPIRATORY ISOLATION
Follow instructions for contact isolation
Please ask nursing staff for a
Mask or Visor
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Appendix 3

Integrated Service for People with TB

Lead TB Clinician	Dr Simon Barry	Tel: 02920 715024
Infectious Diseases (ID) TB Clinicians	Dr Matthijs Backx Dr Bazga Ali Dr Owen Seddon Jonathan Underwood	Tel: 02920 742184
ID SpR		Bleep 5420
Paediatric Consultant (ID Interest)	Dr Jennifer Evans	Tel: 02920 742273
TB Clinical Nurse Specialists		
	Yvonne Hester (Lead)	Office 02920 335124
	Karen Baker	Office: 02920335125
	Martha Williams	Office: 02920335121
TB Office - Referrals & appointments		
	Office & Answerphone	02920 335121
Consultant Communicable Disease Control (CCDC)		
	Office	0300 0030032
Infection Prevention and Control Team		
IP+C Doctor	Gavin Forbes	02920 745896
	Rishi Dhillon	02920 745896
IP&C Head of Nursing	Yvonne Hyde	02920 746618
	IP&C Reception	02920 746703

Appendix 4

TUBERCULOSIS INFECTION CONTROL MEASURES IN IN -PATIENTS

Cardiff and Vale UHB – October 2011

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

Management of suspected TB cases
Most patients with suspected or proven TB do not need to be admitted. Discuss with SpR/ consultant respiratory or ID. Environmental mycobacteria are Not uncommon in those with chronic chest disease and are non-infectious

Consider TB
-high risk ethnic group
-cough > 3 weeks
-fever > 3 weeks
-night sweats
-weight loss

Radiological features of pulmonary TB
Upper zone patchy infiltrates and cavities (Lymphadenopathy and pleural effusion are features of TB, but in the absence of infiltrates/cavities are not usually AFB+ in s

CXR
With early review

Contact TB nurse specialist
For all patients discharged to Arrange review/FU

Pulmonary TB unlikely

Pulmonary TB likely

Assess need for admission

Segregate in side room.
3 sputa for AFB and TB culture

3 AFB neg

Infectious Disease ward (Heulwen, UHW), not with immunocompromised patients

High risk countries for MDRTB:

Angola	Indonesia	Republic of Moldova
Azerbaijan	Kazakhstan	Russian Federation
Bangladesh	Kyrgyzstan	
Belarus	Mongolia	Somalia
China	Mozambique	South Africa
Democratic People's Republic of Korea	Myanmar	Tajikistan
	Nepal	Ukraine
	Nigeria	Uzbekistan
	Pakistan	Viet Nam
Democratic Republic of the Congo	Papua New Guinea	Zambia
	Peru	Zimbabwe
India	Philippines	

MDR TB risk assessment
-From high-risk country
-previous TB therapy
-Contact with MDR TB case

Multiple Drug Resistance (MDR) Assessment. Defined as Rifampicin and Isoniazid resistance (may be resistance to other drugs as well.

Any of these

FFP3 face Mask & eye protection required for all care. Isolate in Negative pressure room,
Patient to wear surgical Mask for transfers.
Transmission-based precautions.

Smear +, MDR high risk

Contact Respiratory/ID SpR/Cons, Negative pressure room, FFP3 Masks / transmission-based precautions as per NICE Guidelines/ NIPCM

1 WHO Multidrug and extensively drug resistant TB 2023 report on global surveillance and response

2. NICE Tuberculosis Guidance 2019

Appendix 5

MDR/XDR TB risk assessment

For patients with clinically suspected/confirmed pulmonary TB a risk assessment for Multidrug resistant TB must be undertaken.

MDR TB should be suspected if any of the following risk factors are present;

- History of previous TB drug treatment, particularly if there was known to be poor adherence to that therapy
- Contact with known case of multidrug-resistant TB
- Birth or residence in a country in which the WHO reports a high proportion (>5%) of new TB cases are multidrug-resistant (See “WHO high MDR burden list” below)

In cases of suspected/confirmed pulmonary TB, where a risk factor for MDR-TB is identified;

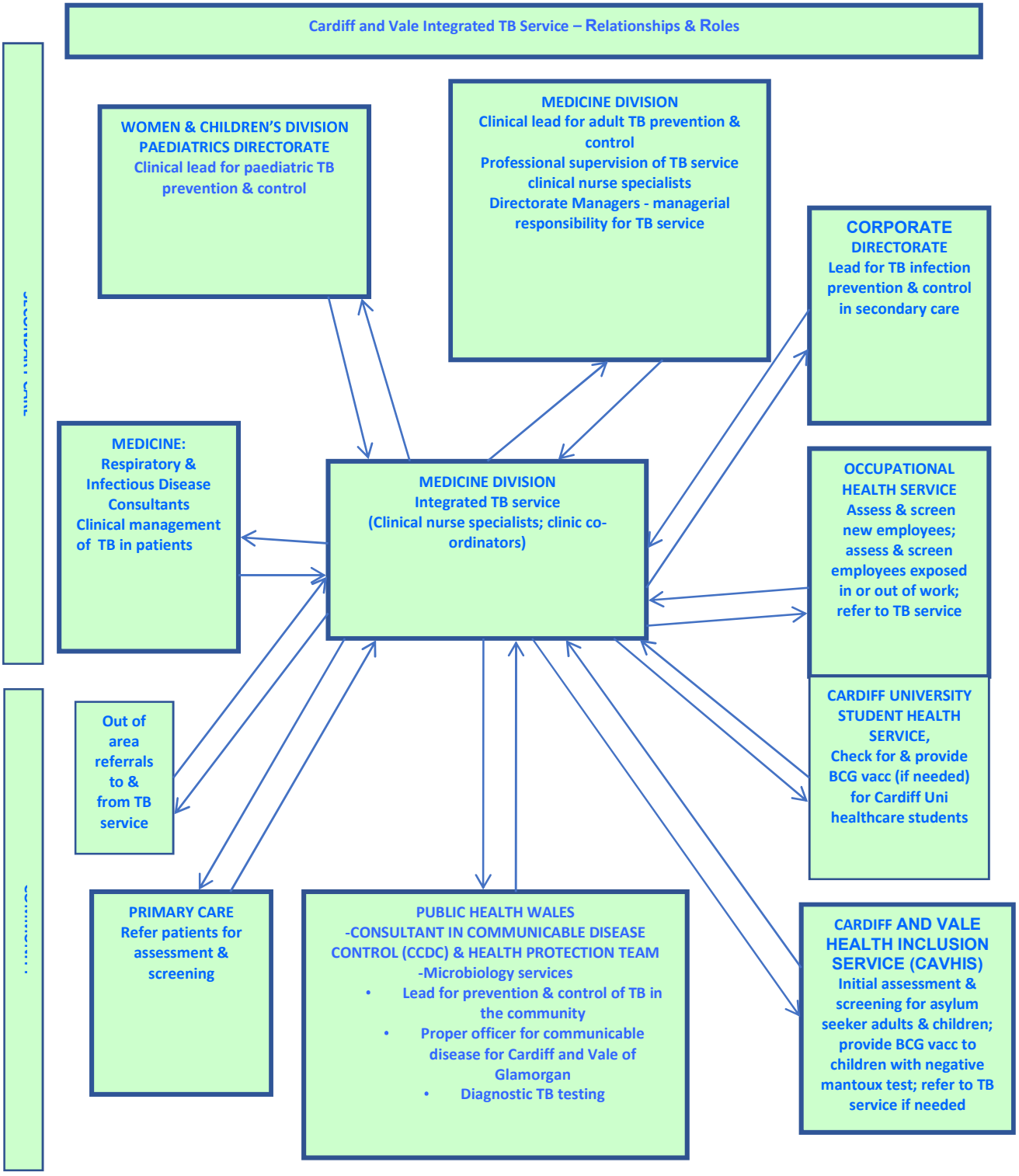
1. Start infection control measures as per 5.3.1
2. Discuss with TB lead or Infectious diseases team to arrange rapid diagnostic nucleic acid amplification tests for rifampicin resistance on primary samples.

WHO high MDR burden list 2021-2025

This list represents countries which currently have the largest burden in terms of case rates per capita and account 85% of the global burden of MDR TB.

Angola	Kyrgyzstan	Republic of Moldova
Azerbaijan	Mongolia	Russian Federation
Bangladesh	Mozambique	Somalia
Belarus	Myanmar	South Africa
China	Nepal	Tajikistan
DR Congo	Nigeria	Ukraine
DPR Korea	Pakistan	Uzbekistan
India	Papua New Guinea	Vietnam
Indonesia	Peru	Zambia
Kazakhstan	Philippines	Zimbabwe

Appendix 6


Cardiff and Vale Integrated TB Service – Relationships & Roles
WOMEN & CHILDREN'S DIVISION
PAEDIATRICS DIRECTORATE
Clinical lead for paediatric TB prevention & control
MEDICINE DIVISION
Clinical lead for adult TB prevention & control
Professional supervision of TB service clinical nurse specialists
Directorate Managers - managerial responsibility for TB service
CORPORATE DIRECTORATE
Lead for TB infection prevention & control in secondary care
MEDICINE:
Respiratory & Infectious Disease Consultants
Clinical management of TB in patients
MEDICINE DIVISION
Integrated TB service
(Clinical nurse specialists; clinic co-ordinators)
OCCUPATIONAL HEALTH SERVICE
Assess & screen new employees; assess & screen employees exposed in or out of work; refer to TB service
Out of area referrals to & from TB service
CARDIFF UNIVERSITY STUDENT HEALTH SERVICE,
Check for & provide BCG vacc (if needed) for Cardiff Uni healthcare students
PRIMARY CARE
Refer patients for assessment & screening
PUBLIC HEALTH WALES
-CONSULTANT IN COMMUNICABLE DISEASE CONTROL (CCDC) & HEALTH PROTECTION TEAM
-Microbiology services
• Lead for prevention & control of TB in the community
• Proper officer for communicable disease for Cardiff and Vale of Glamorgan
• Diagnostic TB testing
CARDIFF AND VALE HEALTH INCLUSION SERVICE (CAVHIS)
Initial assessment & screening for asylum seeker adults & children; provide BCG vacc to children with negative mantoux test; refer to TB service if needed

Appendix 7

Aerosol Generating Procedures

Aerosol generating procedures (AGPs) are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection).

The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- awake* bronchoscopy (including awake tracheal intubation)
- awake* ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning
- awake* upper gastro-intestinal endoscopy
- dental procedures (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
- induction of sputum
- respiratory tract suctioning**
- surgery or post-mortem procedures (like high-speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses.
- tracheostomy procedures (insertion or removal).

*Awake including ‘conscious’ sedation (excluding anaesthetised patients with secured airway)

** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, which means that oral/pharyngeal suctioning is **NOT** an AGP.

Please note:

This information is taken from the Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) including COVID-19 for Health and Care Settings - WALES. FINAL version approved 16.02.2023 – PHW ARI Management Group (amended 05.04.2023), and as such is subject to change.

Equality & Health Impact Assessment for

Infection Prevention and Control procedure for the Management of Patients Known or Suspected to have *Mycobacterium Tuberculosis* (TB) in Hospital

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Infection Prevention and Control procedure for the Management of Patients Known or Suspected to have *Mycobacterium Tuberculosis* (TB) in Hospital. Reference number UHW 237, version number: 2
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Corporate Directorate, Ellen Davies Clinical Nurse Specialist in Infection Prevention and Control, Contact Telephone number: 02921 826389

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objectives of this procedure are to provide all staff working within Cardiff and Vale UHB with a comprehensive understanding of the management of patients with confirmed or suspected *Mycobacterium* Tuberculosis.
4.	Evidence and background information considered. For example • population data • staff and service user's data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	Cardiff and Vale University Health Board accepts its responsibility under the Health and Safety at Work Act 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to an infectious disease in patients, staff and other persons working at or using its premises. In order to prevent the possible spread of infection amongst patients and staff it is recognised that the UHB requires procedural documents to ensure effective management of infection. Please be advised that all the below lists and links are not an exhaustive list of the available evidence and information but provides an indicative summary of the evidence and information applicable to this policy. An internet search was conducted in November 2022 using the following search terms in combination "Mycobacterium Tuberculosis", "Multidrug Resistant TB", "Procedure", "Policy" and "Equality Impact", "Wales". The search revealed several equality impact assessments. Examples can be found by following the links below:

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		Tees, Ask & Wear Valleys NHS Trust, Tuberculosis procedure, November 2022: Tuberculosis-procedure.pdf (tewv.nhs.uk) York Teaching Hospital NHS Trust, Pulmonary Tuberculosis procedure, May 2011: yorkhospitals.nhs.uk/seecmsfile/?id=878 Calderdale and Huddersfield NHS Trust, Tuberculosis Policy, 2021: Section_S_-_TB_Policy_V8.pdf (cht.nhs.uk) University Hospital of Leicester NHS Trust, Tuberculosis Policy, 2016: Microsoft Word - Tuberculosis - Guidelines for the Management of Patients.doc (leicestershospitals.nhs.uk) World Health Organisation TB guidelines: recent update, 2021: TB guidelines (who.int) Public Health England Tuberculosis (TB): action plan for England Tuberculosis (TB): action plan for England - GOV.UK (www.gov.uk) Tuberculosis; NICE guideline [NG33]; Published: 13 January 2016 Last updated: 12 September 2019, Overview | Tuberculosis | Guidance | NICE GOV.UK, Tuberculosis (TB): diagnosis, screening, management and data; Published 1 June 2014, Last updated 5 September 2022 Tuberculosis (TB): diagnosis, screening, management and data - GOV.UK (www.gov.uk)

		TB Infection Control in Health Care Settings https://www.cdc.gov/tb/topic/infectioncontrol/TBhealthCareSettings.htm NICE Healthcare-associated infections: prevention and control in primary and community care, Clinical guideline [CG139], Published: 28 March 2012 Last updated: 15 February 2017; https://www.nice.org.uk/guidance/cg139 Reports of cases of TB to UK enhanced tuberculosis surveillance systems, 2000 to 2021, Last updated 15th December 2022, https://www.gov.uk/government/statistics/reports-of-cases-of-tb-to-uk-enhanced-tuberculosis-surveillance-systems-2000-to-2021 HMP Cardiff Tuberculosis Outbreak 2018, Report of the Outbreak Control Team, Released August 2020. Tuberculosis. Quality Standard. National Institute for Health and Care Excellence: Published 10th January 2017 [QS141]. https://www.nice.org.uk/guidance/qs141 Tuberculosis cases UK: 2000 to 2019. Public Health England (Online). https://www.gov.uk/government/statistics/reports-of-cases-of-tb-to-uk-enhanced-tuberculosis-surveillance-systems Review of the HMP Cardiff 2018 Mycobacterium Tuberculosis Outbreak report and inclusion of lessons learnt. Consultation with Microbiologist, TB nurses and Infectious disease Consultant.
5.	Who will be affected by the strategy/ policy/	This procedure applies to all staff in all locations, including those with honorary

	plan/ procedure/ service	contracts and students on placement within Cardiff and Vale University Health Board. Patients, visitors and UHB staff will benefit from compliance with the procedure in that the risk of transmission of infection will be reduced. The UHB will benefit organisationally and financially from reducing the impact and cost of the transmission of infection.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	No negative impact	N/A	N/A
6.2 Persons with a disability			

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	No negative impact	N/A	N/A
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
6.4 People who are married or who have a civil partner.	No negative impact	N/A	N/A
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	No negative impact	N/A	N/A
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	No negative impact	N/A	N/A
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	No negative impact	N/A	N/A
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Refer to where the mitigation is included in the document, as appropriate
vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	No negative impact	N/A	N/A
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No negative impact	N/A	N/A
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No negative impact	N/A	N/A

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Refer to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No negative impact		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Refer to where the mitigation is included in the document, as appropriate
alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Refer to where the mitigation is included in the document, as appropriate
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No negative impact	N/A	N/A
7.5 People in terms of social and community influences on their health:	No negative impact	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Refer to where the mitigation is included in the document, as appropriate
Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities			
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	No negative impact	N/A	N/A

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	These guidelines are to assist in the identification and management of all aspects of infection risk involving Mycobacterium Tuberculosis, to enable staff to minimise the risk of transmission and in doing so ensure their safety and well-being as well as those of patients.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	No negative impacts identified therefore no actions identified			
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The E&HIA process has not identified any evidence that different groups will be affected disproportionately or any evidence or concern that this procedure may discriminate against a particular population group. Procedure continues unchange as there are no significant nega impacts.			