What about the requirement to test for TB for all existing and new employees with follow up after initial testing?

As matter of policy, the function of Ask OSAP is to provide basic resource information pertaining to a specific topic. Ask OSAP does not render opinions, or comment upon enforcement proceedings.

In 2015, the US Department of Labor – Occupational Safety & Health Administration (OSHA) updated its instructions for conducting inspections and issuing citations related to worker exposures to tuberculosis in healthcare settings. A copy of that news release can be accessed at this link: https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=28254 [1]

OSHA does have a document which provides general enforcement policies and procedures to be followed when conducting inspections and issuing citations related to occupational exposure to tuberculosis (TB). 2 OSHA's Directive CPL 02-02-078 - Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis can be accessed at this link: https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-02-078.pdf [2]

This directive states in part:

XII. Inspection Scheduling and Scope.

A. For purposes of this Instruction, "healthcare setting" is defined as "any setting in which healthcare is delivered and workers might share air space with persons with TB disease or

come in contact with clinical TB specimens."

B. In workplaces containing healthcare settings, Area Offices shall conduct inspections related to occupational exposure to TB in the following circumstances:

1. In response to any valid employee complaint regarding TB exposure or in response to any valid referral regarding TB exposure from a government agency or safety and health professional.

NOTE: Complaints received from state and local government employees who are outside federal jurisdiction in federal enforcement states must be referred to the appropriate agency by the Area Office.

2. In response to TB-related employee fatalities or catastrophes.

3. As part of all health inspections in facilities where the incidence of TB infection among patients/clients in the relevant facility or healthcare setting is greater than the incidence of TB among individuals in the most local general population for which the health department has information.

C. The following are examples of healthcare settings that may be inspected in accordance with this Instruction. Various types of healthcare settings might be present in a single facility.

1. Inpatient settings may include: Patient rooms, emergency departments, intensive care units, surgical suites, laboratories,laboratory procedure areas, bronchoscopy suites, sputum inductionor inhalation/respiratory therapy rooms, autopsy suites, and embalming rooms.

2. Outpatient settings may include: TB treatment facilities, medical offices, ambulatory-care settings, dialysis units, and dental-care settings.

3. Nontraditional facility-based settings may include: Emergency medical service (EMS) facilities, medical settings in correctional facilities (e.g., prisons, jails, and detention centers), long-term care settings (e.g., hospices and skilled nursing facilities), drug treatment centers, and homeless shelters.

D. Home Healthcare: TB inspections of employers with employees who work in home healthcare settings should be limited to employer program evaluations and off-site employee interviews. [2]

And,

XVI. Violations.

If an employer does not comply with the requirements of the OSH Act or applicable OSHA standards, the Area Director should consider appropriate citations or notices. Although citations are to be classified on a case-by-case basis, the violations described below will often be classified as serious because occupational exposure to TB hazards can result in a substantial probability of death or serious physical harm.

A. General Duty Clause:

Section 5(a)(1) of the OSH Act provides, "Each employer . . . shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." And 29 CFR 1960.8(a) similarly provides: "The head of each [federal] agency shall furnish to each employee employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm."

The 2005 CDC Guidelines can be used to show industry recognition of the hazards associated with occupational exposure to TB. The Guidelines also contain widely accepted standards of

practice employers can follow in carrying out their responsibilities under the OSH Act.

1. Because OSHA's standards do not completely address the hazards associated with occupational exposure to TB, employers may have obligations under the General Duty Clause (Section 5(a)(1)) or 29 CFR 1960.8(a) to take further measures to protect workers from those hazards. In appropriate cases, the Area Director, in consultation with the Regional Office of the Solicitor and the OSHA Regional and National Offices, should consider issuing a 5(a)(1) citation, or a notice under 1960.8(a), to an employer that has employees working in healthcare settings who have been exposed to the following, without adequate protection. within the prior 6 months:

a) The exhaled air of an individual with suspected or confirmed pulmonary TB disease; or NOTE: A suspected case is one in which healthcare providers are considering a diagnosis of TB. The CDC has identified the symptoms of TB to include: coughing for 3 weeks or longer, coughing up blood, hoarseness, unexplained weight loss, loss of appetite, fatigue, night sweats, fever, and chest pain. The CDC has also noted that whether providers suspect TB may depend on the geographic area and the population being served. See 2005 CDC Guidelines, p. 16. The following populations may be at higher risk for exposure to and infection with TB: close contacts of individuals with pulmonary TB disease; foreign-born persons; residents and employees of congregate settings such as correctional facilities, long term-care facilities and homeless shelters; and medically underserved and low income populations. See 2005 CDC Guidelines, pp. 4-5.

b) Cough-inducing or aerosol-generating procedures performed on an individual with suspected or confirmed TB disease that have the potential to generate infectious airborne droplet nuclei.

NOTE: Examples of cough-inducing or aerosol-generating procedures include aerosolized medication treatment, bronchoscopy, sputum induction, endotracheal intubation and extubation,suctioning procedures, dental procedures, endoscopic procedures, and autopsies. See 2005 CDC Guidelines, p. 40.

2. When conducting TB-related inspections, CSHOs should evaluate whether the employer has implemented appropriate abatement measures. An employer's failure to implement feasible abatement measures should be considered when evaluating whether to issue a 5(a)(1) citation or notice under 1960.8(a). Deficiencies found in any of the categories identified in paragraphs XVI.A.2(a)-(f) below, can result in a serious hazard that may be the basis for a citation under

5(a)(1) or a notice under 29 CFR 1960.8(a).

a) TB Infection Control Program.

The CDC recommends that employers develop written TB infection control plans that outline a protocol for the early identification of individuals with suspected or confirmed TB. The plan should be updated annually. The program should be supervised by appropriate personnel, e.g., a person or group with expertise in LTBI, TB disease, infection control, occupational health, environmental controls, and respiratory protection. See 2005 CDC Guidelines, pp. 8-9.

b) TB Risk Assessment

The CDC recommends that employers conduct initial and ongoing evaluations of the risk for TB transmission regardless of whether patients with suspected or confirmed TB disease are expected to be encountered in the setting. See 2005 CDC Guidelines, p. 9. The three TB screening risk classifications are low risk, medium risk, and potential ongoing transmission. See 2005 CDC Guidelines, p. 10.

The classification of low risk should apply to settings in which workers are not expected to encounter persons with TB or clinical specimens that might contain M. tuberculosis. The classification of medium risk should apply to settings in which workers will or will possibly be exposed to persons with TB disease or to clinical specimens that might contain M. tuberculosis. The "potential ongoing transmission" classification should apply temporarily to any setting where there is evidence suggestive of person-to-person (e.g., patient-to-patient, patient-to-worker, worker-to-patient, or worker-to-worker) transmission of M. tuberculosis during the preceding year. See 2005 CDC Guidelines, p. 10.

The types of administrative, environmental, and respiratory protection controls needed, and the need for medical surveillance, will depend on the risk classification assigned to the setting as a result of the risk assessment. Risk assessments also serve as on-going evaluation tools for TB infection control programs. See 2005 CDC Guidelines, pp. 9-10 and Appendix B – TB Risk Assessment Worksheet.

NOTE: If the facility has not completed a risk assessment, the Area Director should consider citing the employer for a failure to "identify and evaluate the respiratory hazard(s) in the workplace" (29 CFR 1910.134(d)(1)(iii)) or for a failure to "assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment" (29 CFR 1910.132(d)(1)). See also paragraphs XVI.B and XVI.C, below.

c) Medical Surveillance.

The 2005 CDC Guidelines recommend that TB screening programs cover workers who perform any of the following activities: a) entering patient or treatment rooms used for suspected or confirmed TB cases (whether or not a patient is present); b) participating in cough-inducing or aerosol generating procedures (e.g., bronchoscopy, sputum induction, and administration of aerosolized medication); c) participating in M. tuberculosis specimen processing (whether suspected or confirmed); or d) installing, maintaining, or replacing environmental controls in areas in which one encounters persons with TB disease. See 2005 CDC Guidelines, p. 4. The CDC has compiled a list of specific workers who might be included in a TB surveillance program (2005 CDC Guidelines, pp. 3-4).

Initial Exams. The CDC generally recommends that employers offer a baseline BAMT or TST to all new workers in healthcare settings (2005 CDC Guidelines, p. 28).

NOTE: A "TB skin test," or TST, means the intradermal injection (Mantoux Method) of PPD (a tuberculin antigen) with subsequent measurement of the indurations (hardened mass) by designated, trained personnel.

A two-step baseline TST should be used for new employees who have not had a documented negative TST result during the preceding 12 months (2005 CDC Guidelines, Box 1, p. 29). Alternatively, the BAMT can be used (2005 CDC Guidelines, p. 28). With the BAMT, only a single test is required to establish the baseline (2005 CDC Guidelines, p.29). TB tests should be offered at no cost, and at times and locations that are convenient for employees.

NOTE: A positive result to the second step (but not the first step) of a baseline two-step TST is probably caused by boosting, not by recent infection with M. tuberculosis. Such responses can result from remote infections with M. tuberculosis or previous Bacille Calmette-Guérin (BCG)

vaccination. Two-step testing minimizes the likelihood that boosting will lead to an unwarranted suspicion of M. tuberculosis transmission based on subsequent testing. See 2005 CDC Guidelines, p. 28. The BAMT may be preferable for testing employees who have previously been provided the BCG vaccine, as it is not expected to result in false positive results. See 2005 CDC Guidelines, p. 29.

NOTE: The reading and interpretation of TB skin tests should be performed by qualified individuals in the manner described in the 2005 CDC Guidelines (p. 46). Periodic Evaluations. CSHOs should determine whether TB testing has been conducted in accord with Appendix C of the 2005 CDC Guidelines for employees in low risk settings, medium risk settings, and settings with the potential for ongoing transmission. The employer's decisions concerning medical surveillance should be based on up-to-date risk assessments. See 2005 CDC Guidelines, p. 30.

Periodic Evaluations. CSHOs should determine whether TB testing has been conducted in accord with Appendix C of the 2005 CDC Guidelines for employees in low risk settings, medium risk settings, and settings with the potential for ongoing transmission. The employer's decisions concerning medical surveillance should be based on up-to-date risk assessments. See 2005 CDC Guidelines, p. 30.

In low risk settings, annual screening is not necessary; however, if an exposure to a person with, or specimen containing, TB occurs, the employer should provide screening and update the risk assessment in accord with the 2005 CDC Guidelines.

In medium risk settings, screening should be provided at least every year.

In settings where there is the potential for ongoing transmission, workers should be tested every 8 – 10 weeks until a determination is made that there is no more ongoing transmission. At that point, the setting should be reclassified as medium risk, and should remain at that classification (at a minimum) for at least one year.

Serial testing is not necessary if an employee has (1) a documented history of TB disease; (2) a documented positive test result; or (3) documented completion of treatment for LTBI or TB disease (2005 CDC Guidelines, p. 29). Persons with positive TST or BAMT results should receive one baseline chest radiograph to exclude a diagnosis of TB disease. Further chest

radiographs are not needed unless the patient has symptoms or signs of TB disease or unless ordered by a physician for a specific diagnostic examination. Instead of participating in serial skin testing, workers with positive TST results should receive a medical evaluation and a symptom screen. The frequency of this medical evaluation should be determined by the risk assessment for the setting. See 2005 CDC Guidelines, p. 80.

Staggered serial follow-up screening (e.g., not testing all employees in the same department in the same month) increases the chances that infection-control problems will be detected early (2005 CDC Guidelines, p. 30). [2]

Please note that there may be varying requirements in those states with State OSHA Programs. It is recommended that you contact OSHA in your state to find out if there are any different requirements. Further information about State OSHA Programs can be accessed at https://www.osha.gov/dcsp/osp/index.html

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Any further questions on this topic should be directed to your area OSHA office.

There may also be other requirements specific to your state. It is recommended that you contact your State Department of Health as that agency may also possibly have input on such requirements.

Resources

1) US Department of Labor – Occupational Safety & Health Administration. OSHA directive updates inspection procedures for protecting workers from tuberculosis in healthcare settings. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=28254
Accessed on April 28, 2016.

2) US Department of Labor – Occupational Safety & Health Administration. Directive CPL

02-02-078 Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis. https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-02-078.pdf Accessed on April 28, 2016.

3) US Department of Labor – Occupational Safety & Health Administration. Frequently Asked Questions about State Occupational Safety and Health Plans. https://www.osha.gov/dcsp/osp/index.html Accessed on April 28, 2016.

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