ANNUAL TB RISK ASSESSMENT

Name of Hospital: MANGUM REGIONAL MEDICAL CENTER

TB Risk Assessment for Calendar Year: 2025

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Appendix B. Tuberculosis (TB) risk assessment worksheet

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

Scoring √ or Y = Yes X or N = No NA = Not Applicable

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.	Community rate: **18.4/100,000** State rate: **1.9** National rate: **3.0 (3.1/2024)** Facility rate**: 0.49** Department 1 (ED) rate: **0.59** Department 2 rate **0.0** Department 3 rate **0.0**
Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?	**Yes**
If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	**Year** **No. patients** **Suspected Confirmed** 1 year ago **0** **1** 2 years ago **0** **0** 5 years ago **0** **0**
If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes**
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?	**No**

2. Risk Classification

Inpatient settings	
How many inpatient beds are in your inpatient setting?	**18**
How many patients with TB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	**Previous year: 0** **5 years ago: 0**
Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.)	**Low risk**
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes**
Outpatient settings	

How many TB patients are evaluated at your outpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	**Previous year: 0** **5 years ago: 0**
Is your health-care setting a TB clinic? (If yes, a classification of at least medium risk is recommended.)	**No**
Does evidence exist that a high incidence of TB disease has been observed in the community that the health-care setting serves?	**No**
Does evidence exist of person-to-person transmission of *M. tuberculosis* in the health-care setting? (Use information from case reports. Determine if any tuberculin skin test [TST] or blood assay for *M. tuberculosis* [BAMT] conversions have occurred among health-care workers [HCWs]).	**No**
Does evidence exist that ongoing or unresolved health-care–associated transmission has occurred in the health-care setting (based on case reports)?	**No**
Is there a high incidence of immunocompromised patients or HCWs in the health-care setting?	**No**
Have patients with drug-resistant TB disease been encountered in your health-care setting within the previous 5 years?	**No**
When was the first time a risk classification was done for your health-care setting?	**March 2021**
Considering the items above, would your health-care setting need a higher risk classification?	**No**
Depending on the number of TB patients evaluated in 1 year, what is the risk classification for your outpatient setting? (See Appendix C)	**Low risk**
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes**
Nontraditional facility-based settings – N/A	
How many TB patients are encountered at your setting in 1 year?	Previous year 5 years ago
Does evidence exist that a high incidence of TB disease has been observed in the community that the setting serves?	Yes No
Does evidence exist of person-to-person transmission of *M. tuberculosis* in the setting?	Yes No
Have any recent TST or BAMT conversions occurred among staff or clients?	Yes No
Is there a high incidence of immunocompromised patients or HCWs in the setting?	Yes No
Have patients with drug-resistant TB disease been encountered in your health-care setting within the previous 5 years?	Yes No Yes
When was the first time a risk classification was done for your setting?	
Considering the items above, would your setting require a higher risk classification?	Yes No
Does your setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Depending on the number of patients with TB disease who are encountered in a nontraditional setting in 1 year, what is the risk classification for your setting? (See Appendix C)	o Low risk o Medium risk o Potential ongoing transmission

3. Screening of HCWs for *M. tuberculosis* Infection

Does the health-care setting have a TB screening program for HCWs?	**Yes**
If yes, which HCWs are included in the TB screening program? (Check all that apply.) √ **Physicians** √**Mid-level practitioners (nurse practitioners [NP] and physician's assistants [PA])** √**Nurses** √**Administrators/Administrative/Business Office Staff** √**Laboratory workers** √**Respiratory therapists** √**Physical/Occupational, Speech therapists** √**Contract staff** √**Janitorial staff** √**Maintenance or engineering staff** √ **Dietary staff** √**Receptionists** √**All staff**	
Is baseline skin testing performed with two-step TST for HCWs?	**Yes**
Is baseline testing performed with QFT or other BAMT for HCWs?	**No**
How frequently are HCWs tested for *M. tuberculosis* infection?	**Upon hire and at exposure**
Are the *M. tuberculosis* infection test records maintained for HCWs?	**Yes**
Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records?	**1. Infection Preventionist (IP) Office; in a locked cabinet in a locked room.** **2. IP/RN**
If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years? † **The Hospital does not have a serial TB screening program based on OSDH and CDC recommendations. All new hires are screened and tested for TB upon hire.** **1 year ago: 0** **4 years ago: Data unobtainable** **2 years ago: 0** **5 years ago: Data unobtainable** **3 years ago: 0**	
Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)	**No change**
Do any areas of the health-care setting (e.g., waiting rooms or clinics) or any group of HCWs (e.g., lab workers, emergency department staff, respiratory therapists, and HCWs who attend bronchoscopies) have a test conversion rate for *M. tuberculosis* infection that exceeds the health-care setting's annual average?	**No**
For HCWs who have positive test results for *M. tuberculosis* infection and who leave employment at the health setting, are efforts made to communicate test results and recommend follow-up of latent TB infection (LTBI) treatment with the local health department or their primary physician?	**Yes**

4. TB Infection-Control Program

Does the health-care setting have a written TB infection-control plan?	**Yes**

Who is responsible for the infection-control program?	**IP**
When was the TB infection-control plan first written?	**May 2021**
When was the TB infection-control plan last reviewed or updated?	**June 2024**
Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of *M. tuberculosis*)?	**No**
Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?	**Yes**
If yes, which groups are represented on the infection-control committee? (Check all that apply.) √ **Physicians** √ **Nurses** √ **Pharmacists** √ **Laboratory personnel** √ **Administrator** √ **Quality/Risk control (QC)** √ **Others: Dietary, EVS, Plant-Ops, Respiratory Therapists, Radiology Techs**	
If no, what committee is responsible for infection control in the setting?	**N/A**

5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name:	**Meghan Smith RN, IP**

Based on a review of the medical records, what is the average number of days for the following:

- Presentation of patient until collection of specimen
- Specimen collection until receipt by laboratory
- Receipt of specimen by laboratory until smear results are provided to health-care provider
- Diagnosis until initiation of standard antituberculosis treatment
- Receipt of specimen by laboratory until culture results are provided to health-care provider
- Receipt of specimen by laboratory until drug-susceptibility results are provided to health-care provider
- Receipt of drug-susceptibility results until adjustment of antituberculosis treatment, if indicated
- Admission of patient to hospital until placement in airborne infection isolation (AII):
  -Patient referred to Hospital outpatient wound care for wounds that started as a rash in September 2025. After visit in September, patient did not follow up with PCP. Was seen for first clinic visit on 12/3/25. Sent to outpatient wound care that same day. Upon evaluation the patient's condition was deemed too complicated for an outpatient visit. Patient transferred to ED to be evaluated.
  -Upon assessment patient was SIRS positive: WBC 20.1; Temp 100.1; HR 113. Sepsis protocol ordered. Blood cultures and urinalysis ordered.
  -CT ordered by APRN. Results: "1. Multiple bibasilar pulmonary nodules, with areas of air bronchograms and consolidation, are most likely due to pneumonia or metastatic disease. Recommend clinical correlation and CT of the chest with contrast to further evaluate. 2. Cholelithiasis. 3. Mildly enlarged inguinal lymph nodes are most likely reactive."
  -Patient reported a 20 lb weight loss. No respiratory symptoms reported. Patient is an everyday smoker.
  -No chest x-ray ordered. Patient transferred out for oncology and higher level of care.
  -On 12/8/26 receiving Hospital IP (D. Dahl) notified Mangum IP that patient had potentially active TB. TB status unknown to Mangum Hospital staff. prior to
  -Greer County Health Department notified by D. Dahl. No recommendations made for staff in house due to limited exposure time.
  -Actions by IPs (MS/AS): Baseline TST on ED nurse performed upon recommendation of the Greer County Health Department. Baseline TST results: 0 mm induration. **Follow-up TST:** 0mm induration.
  Baseline TST performed on medical provider. Test results: 0 mm induration. **Follow-up TST:** pending.

Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?	**Review of medical records, monitoring TB testing, lab and culture results, direct observation of staff practices related to infection control (e.g., PPE, engineering/administrative/ elimination controls).**
What mechanisms are in place to correct lapses in infection control?	**Just-in-time education.** **Procedure review and adjustments if needed.** **In-services.**
Based on measurement in routine QC exercises, is the infection-control plan being properly implemented?	**Yes**
Is ongoing training and education regarding TB infection-control practices provided for HCWs?	**Yes**

6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

Which of the following tests are either conducted in-house at your health-care setting's laboratory or sent out to a reference laboratory?	In-house	Sent out
Acid-fast bacilli (AFB) smears		**x**
Culture using liquid media (e.g., Bactec and MB-BacT)		**x**
Culture using solid media		**x**
Drug-susceptibility testing		**x**
Nucleic acid amplification (NAA) testing		**x**

What is the usual transport time for specimens to reach the laboratory for the following tests?

AFB smears	**< 24 hrs**
Culture using liquid media (e.g., Bactec, MB-BacT)	**< 24 hrs**
Culture using solid media	**< 24 hrs**
Drug-susceptibility testing	**< 24 hrs**
Other (specify)	**N/A**
NAA testing	**< 24 hrs**

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends?	**No** **_____** **Same as during weekdays; no changes for weekends.**

7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

Environmental control	Description
x AII rooms	**Rm 13**
o Local exhaust ventilation (enclosing devices and exterior devices)	**N/A**
o General ventilation (e.g., **single-pass system**, recirculation system.)	**Single Pass**
o Air-cleaning methods (e.g., high-efficiency particulate air [HEPA] filtration and ultraviolet germicidal irradiation [UVGI])	**N/A**

What are the actual air changes per hour (ACH) and design for various rooms in the setting?
Room: 13 ACH: 14.20 Design: Negative Pressure/Single-pass validation

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply) **N/A**
o Laboratory hoods
o Booths for sputum induction
o Tents or hoods for enclosing patient or procedure

What general ventilation systems are used in your health-care setting? (Check all that apply) **x Single-pass system** o Variable air volume (VAV) o Constant air volume (CAV) o Recirculation system o Other_____
What air-cleaning methods are used in your health-care setting? (Check all that apply) HEPA filtration **x Fixed room-air recirculation systems** o Portable room-air recirculation systems UVGI o Duct irradiation o Upper-air irradiation o Portable room-air cleaners

How many AII rooms are in the health-care setting?	**1 AII (2 additional negative-pressure rooms: OR 2 and Room 12 with single-pass ventilation system)**

What ventilation methods are used for AII rooms? (Check all that apply) Primary (general ventilation): **x Single-pass heating, ventilating, and air conditioning (HVAC)** o Recirculating HVAC systems Secondary (methods to increase equivalent ACH): **N/A** o Fixed room recirculating units o HEPA filtration o UVGI o Other (specify) _____

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?	**No**
Are environmental controls regularly checked and maintained with results recorded in maintenance logs?	**Yes**
Are AII rooms checked daily for negative pressure when in use?	**Yes**
Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?	**Yes**
Are these results readily available?	**Yes**
What procedures are in place if the AII room pressure is not negative?	**Per Plant Ops Director to evaluate and develop plan of action.**
Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?	**Yes**

8. Respiratory-Protection Program

Does your health-care setting have a written respiratory-protection program?	**Yes**

Which HCWs are included in the respiratory protection program? (Check all that apply) √ **Physicians** √ **Mid-level practitioners (NPs and PAs)** √ **Nurses** √ **Administrators** √ **Laboratory personnel** √ **Contract staff** √ **Janitorial staff** √ **Maintenance or engineering staff**

√ **Dietary staff** √ **Physical/Occupational/Speech Therapists Staff** √ **Ancillary staff (e.g., office staff)** √ **All staff**	
Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients). Manufacturer / Model / Specific application **3M / Aura 1870+ / Routine Contact** **3M / 8210 + / Routine Contact**	
Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?	**Yes**
Does your health-care setting provide initial fit testing for HCWs? If yes, when is it conducted _____	**Yes** **Upon Hire**
Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted?	**Yes** **Annually & as needed for physical changes in staff**
What method of fit testing is used? **Qualitative fit testing by trained and qualified personnel**.	
Is qualitative fit testing used?	**Yes**
Is quantitative fit testing used?	**No**

9. Reassessment of TB risk

How frequently is the TB risk assessment conducted or updated in the health-care setting?	**Annually or as needed**
When was the last TB risk assessment conducted?	**March 2025**
What problems were identified during the previous TB risk assessment? 1) Need for increased awareness and consideration for recognition of signs and symptoms and risk factors (e.g., travel history, exposure to TB, latent TB, etc.) associated with potential/actual TB infection patient.	
What actions were taken to address the problems identified during the previous TB risk assessment? 1) IP (MS) posted signage in the ED for TB symptoms designed to increase clinical staff awareness to remain alert for the potential for a TB infected patient. 2) IP (MS) sent out education on TB screening, signs and symptoms to the providers, nurses, and RT staff. 3) Additional education/presentation to be provided by Corporate IP staff on March 11, 2026: TB Education for Health Care Staff.	
Did the risk classification need to be revised as a result of the last TB risk assessment?	**No**

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.

† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).