



HEALTHCARE

Tuberculocidal Claims No Longer Reflect Disinfectant Efficacy

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Overview

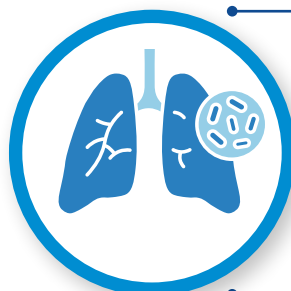
Despite advances in microbiology and updated infection prevention and control (IPC) guidance, many healthcare facilities still treat the tuberculocidal (TB) disinfectant kill claim as a default benchmark for surface disinfectant efficacy. However, *Mycobacterium tuberculosis* bacterium is an exclusively airborne pathogen that is not transmitted via surfaces, and US federal guidance has not required a TB claim for healthcare surface disinfectants for decades.

Current guidance from the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), and The Joint Commission (TJC) collectively supports a risk-based, organism-specific approach that prioritizes healthcare-associated pathogens of concern that are transmissible via surfaces, such as *Clostridioides difficile*. This commentary by Clorox Healthcare's Clinical and Scientific Affairs (CASA) team examines the historical origins of the TB claim benchmark, presents survey findings across 25 states, and makes the case that healthcare surface disinfectants should be selected based on relevant organisms and EPA-registered kill claims rather than a universal TB kill claim.



1939

Microbiologist Earle Spaulding created risk-based disinfection framework for disinfection and sterilization¹



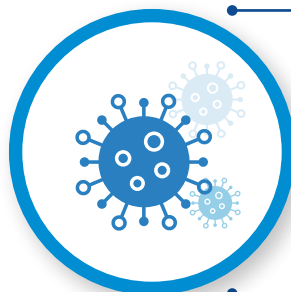
1972

Spaulding's framework was formalized and adopted, resulting in CDC guidance identifying the TB claim as a benchmark for disinfectant efficacy¹



1990s

OSHA encouraged the use of bleach or a disinfectant with a TB kill claim for cleaning blood or bodily fluids, reinforcing perception of the importance of having a TB kill claim



1997

OSHA clarified that EPA-registered disinfectants with HIV-1 and Hepatitis B kill claims were acceptable for blood and infectious material surface decontamination, effectively eliminating any TB claim requirement²



2023

CloroxPro surveyed healthcare coordinators and found no TB claim requirements at the state level among the 25 assessed states³



2024

CDC reinforced the risk-based selection of EPA-registered disinfectants with microbicidal activity against the most relevant pathogens for each healthcare facility, further reinforced by TJC alignment^{4,5,6}

Results

Across all 25 states examined, no evidence was found that hospital-grade disinfectants are required to carry a TB claim.³ Responses from state HAI coordinators consistently reflected three guiding principles:

- ▶ Disinfectants should be appropriate for the type of pathogen or microorganism
- ▶ Each facility must determine which disinfectant is appropriate
- ▶ Facilities should follow OSHA, CDC, and EPA guidance for cleaning and disinfecting

A review of federal guidance further confirms this finding. In 2024, the CDC refreshed its Core IPC Practices for Safe Healthcare Delivery in All Settings, directing facilities to “select EPA-registered disinfectants that have microbiocidal activity against the pathogens most likely to contaminate the patient-care environment.”⁴ That same year, TJC implemented a full rewrite of the IPC chapter for hospitals, aligning with CDC’s Core IPC Practices and emphasizing program governance, use of evidence-based guidelines, and competency.⁵ Neither TJC nor CDC guidelines impose a TB claim requirement for environmental surface disinfectants.

Conclusions

By functioning as an unintentional gatekeeper, the TB claim has historically excluded highly effective and innovative surface disinfectants that offer shorter contact times, improved material compatibility, and relevant pathogen efficacy.

Healthcare facilities, in compliance with OSHA, CDC, EPA, and TJC, should pivot to a risk-based and indicated-use approach to disinfectant selection, anchored in organism threat (e.g., *Clostridioides difficile*), product label directions, medical equipment Instructions-for-Use (IFU) and material compatibility, contact time, and operational fit.

The question should no longer be “Does this disinfectant have a TB claim?” but rather “Does this disinfectant address our current pathogen risks, fit our workflows and IFU requirements, and support compliant use?”

References:

1. Spaulding EH. Chemical disinfection and antisepsis in the hospital. J Hosp Res. 1972;9:5-31.
2. Occupational Safety and Health Administration. Standard interpretations: EPA-registered disinfectants for HIV/HBV. Published February 28, 1997. Accessed May 11, 2026.
<https://www.osha.gov/laws-regs/standardinterpretations/1997-02-28-1>
3. CloroxPro. Tuberculosis claim on a surface disinfectant. Published 2023. Accessed May 11, 2026.
<https://www.cloroxpro.com/resource-center/tuberculosis-claim-on-a-surface-disinfectant/>
4. Centers for Disease Control and Prevention. CDC’s core infection prevention and control practices for safe healthcare delivery in all settings. Updated April 12, 2024. Accessed May 11, 2026.
<https://www.cdc.gov/infection-control/hcp/core-practices/index.html>
5. The Joint Commission. R3 Report: new and revised requirements for infection prevention and control for critical access hospitals and hospitals. Published December 20, 2023. Accessed May 11, 2026.
<https://digitalassets.jointcommission.org/api/public/content/01f83448fbb54ba7b9225048834e7247?v=4e3fcb2>



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