

HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department of Public Safety
Prisons

SECTION: Infection Control

POLICY # IC-6

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SUBJECT: Tuberculosis Control Plan

EFFECTIVE DATE: September 2016

SUPERCEDES DATE: March 2011

To provide guidelines for the prevention and the treatment of tuberculosis (TB) in the N.C. Department of Public Safety.

POLICY

The N. C. Department of Public Safety will abide by this Tuberculosis Control Plan.

Authority:

- A. Administrative Code 10ANCAC41A.025 "Control Measures- Tuberculosis" and 10ANCAC41A.0206 "Infection Control HealthCare Settings".
- B. NC Tuberculosis Control Manual 10th edition April 2007 available at <http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html>
- C. NC DPS Safety, Occupational & Environmental Health Policy E-6 "Occupational Exposure to TB" effective 1/1/12.
- D. "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (MTB) in Health Care Settings," 2005, CDC, MMWR, December 30, 2005. Vol. 54. RR 17 "Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC" July 7, 2006, Vol. 55 No. RR-9; "Recommendations for Use of an Isoniazid-Rifapentine Regimen with Direct Observation to Treat Latent Mycobacterium tuberculosis Infection," CDC, MMWR December 9, 2011. Vol. 60. RR 1650.
- E. Each Prison facility will designate a nurse who will be responsible for monitoring infection control.

PROCEDURE

I. RISK ASSESSMENT

Early identification and successful treatment of persons with TB disease remains the most effective means of preventing disease transmission. Inmates who are likely to have infectious TB should be identified and begin treatment before they are released into the general population. Screening programs in the correctional setting also allow for the detection of substantial numbers of persons with latent TB infection (LTBI) who are at risk for TB disease and would likely benefit from a course of treatment.

- A. Each facility must perform a risk assessment annually in order to determine their risk for TB transmission within the facility (see attachment).
- B. A facility's risk assessment can be defined as minimal or nonminimal.
- C. Inmates in minimal TB risk facilities require an evaluation at entry for symptoms of TB.
- D. Evaluation for Suspected Tuberculosis
Diagnostic evaluation for suspected tuberculosis shall include:
 1. Medical history
 2. Physical examination
 3. Evaluation of TB skin test result
 4. Scheduling of chest X-ray within 7 days of positive skin test results
 5. Evaluation of all lab results to include specimen for AFB smear and culture.
- E. Confirmed active *Mycobacterium tuberculosis* cases
 1. Evaluate immune system (HIV testing is recommended)

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2. Report to local health department and DPS Infection Control Coordinator.
- F. Precautions for Suspected or Confirmed *Mycobacterium Tuberculosis* Cases:
Inmates with suspected or confirmed infectious *Mycobacterium tuberculosis* shall be:
1. Evaluated promptly and tuberculosis precautions shall be followed during diagnostic evaluation period.
 2. Placed in a separate area away from other inmates
 3. Given a surgical mask to wear continuously until placed in an AII room.
 4. Provided education to include use of tissues and covering of mouth and nose during coughing or sneezing.
 5. Transferred to the appropriate treatment facility per DPS policy.
 6. Instructed regarding the tuberculosis precautions until inmate is determined to be non-infectious.
- G. Inpatient treatment for tuberculosis:
1. In suspected or confirmed cases of *Mycobacterium tuberculosis* respiratory isolation shall be implemented immediately at receiving facility.
 2. All DPS AII rooms will be designed to have negative pressure.
 3. To maintain negative pressure, doors to isolation room shall remain closed at all times except when patient or personnel must enter or exit room.
 4. Negative pressure shall be monitored and documented daily by the infection control person or their designee.
 5. Air should be exhausted to the outside and not recirculated to the general ventilation.
 6. When outside air ventilation can not be implemented, HEPA filtration shall be installed in the exhaust duct leading from the room to the general ventilation system.
 7. Any facility that admits and treats infectious tuberculosis patients shall have at least one tuberculosis AII room.
 8. All staff required to work with infectious tuberculosis patients shall be fit tested and trained in the use of N-95 approved respirators. This shall include staff working in medical areas that receive suspected tuberculosis patients as well as officers required to monitor suspected tuberculosis cases. Documentation of employee training on the use of the approved respirator will be retained in the employee's personnel records. Facilities in which respiratory protection is used are required by OSHA to develop, implement and maintain a respiratory protection program.
 9. Cleaning of isolation rooms will be done in accordance to Infection Control Policy AD VII-4.
- H. Discontinuation of Tuberculosis Isolation:
1. Patients who have been diagnosed or are suspected to have *Mycobacterium tuberculosis* may have isolation discontinued:
 - a. After diagnosis of tuberculosis disease has been ruled out.
 - b. After patient is determined to be non-infectious and use of airborne precautions, including respiratory isolation are no longer necessary when patient has:
 - three consecutive daily negative sputum specimens at least 8 hours apart
 - been compliant on tuberculosis medications to which the organism is judged to be susceptible,
 - evidence of clinical improvement on the therapy
 2. Continued isolation throughout the hospitalization should be strongly considered for patients who have MDR (multiple drug resistant) TB because of the tendency for treatment failure or relapse.
- I. Counseling, Screening and Evaluation
1. Due to the high risk of transmission of tuberculosis infection, all employees with direct inmate contact will be screened upon being hired and annually for tuberculosis. Any staff person possibly exposed to infectious

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tuberculosis shall be referred to the local health department, if indicated after tuberculosis testing is completed.

2. Any employee who has signs and symptoms of infectious tuberculosis shall not be allowed to return to the workplace until the employee is on therapy and determination has been made that the employee is non-infectious. The employee must provide documentation of treatment from their physician or health department prior to returning to work.
3. Employees who are receiving preventive therapy treatment for tuberculosis shall not be restricted from work assignment. Employees who cannot take or complete a full course of preventive therapy shall not be excluded from the workplace.

J. Coordination with the Public Health Department

1. As soon as patient is suspected of having active tuberculosis disease, the case will be reported to the Public Health Department
2. Sputum smears and cultures positive for *Mycobacterium tuberculosis* and drug susceptibility results will be reported to the health department as soon as they are available

II. HEALTH LAW VIOLATORS

Males sentenced to prison for tuberculosis treatment as a health-law-violator will be admitted and treated at Central Prison Healthcare Complex (CPHC) if they need isolation. After isolation they will be housed at Hoke Correctional Institution. Males seventeen years old and younger sentenced for tuberculosis treatment as a health-law-violator will be admitted and treated at Central Prison (CPHC) until sputum smear and cultures are negative, then they will be transferred to Western Youth Institution to complete treatment. Females sentenced for tuberculosis treatment as a health-law-violator will be admitted and treated at North Carolina Correctional Institution for Women (NCCIW). This policy shall not prevent the transfer of these inmates to another medical facility if their medical condition requires a higher level of care. A person imprisoned for failure to obtain treatment for tuberculosis shall not be released prior to the completion of the person's term of imprisonment unless and until a determination has been made by the District Court that release of the person would not create a danger to the public health. This determination shall be made only after the medical consultant of the confinement facility and the State Health Director, in consultation with the local Health director of the person's county of residence, have made recommendations to the Court.

The process is:

- A. When the person's tuberculosis treatment regimen is near completion (within 30 days), the person's attending physician in the incarcerating facility will send written notification to the local health director, with copies to the State Health Director, DHHS Director of TB Control and the Director of Health Services, and request the local health director to petition the District Court to release the person.
- B. It is then the responsibility of the local health director in the person's county of residence, after consultation with the person's attending physician at the incarcerating facility and the State Health Director, to petition the District Court to release the person.

III. TREATMENT FACILITIES

Special precautions must be taken whenever an inmate is suspected of having tuberculosis.

- A. CPHC will provide treatment to male inmates.
- B. When sputum smears and cultures are negative for AFB, the male inmates seventeen years old and younger shall be transferred to Western Youth Institution to complete treatment.

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- C. The NCCIW will be the treatment facility for tuberculosis in females.
- D. Other prison facilities may be designated to receive and treat tuberculosis patients if determined to be properly equipped and staffed to do so. If the designated treatment facility does not have AII rooms that meet the requirements of CDC Guidelines (MMWR/Vol. 39/No. RR-17/ 30/05), then inmates with suspected tuberculosis may be admitted to an outside hospital (preferred provider) for respiratory isolation and treatment until the inmate is determined to be non-infectious.

IV. TENTATIVE DIAGNOSIS

- A. When an inmate is suspected of having infectious tuberculosis, the inmate shall be transferred hours as soon as possible to CPHC, NCCIW or a community hospital as designated by the chief medical officer at the receiving facility.
 - 1. CPHC can accept adult male inmates in medium, close or maximum custody and male inmates under seventeen years old regardless of custody level (919) 743-1514.
 - 2. NCCIW can accept all female inmates. (919) 733-4340.
- B. Transporting Suspected/Active TB cases
 - 1. Transport of an inmate with a diagnosis of suspected infectious pulmonary tuberculosis will be by an enclosed automobile. The inmate shall be instructed to wear a surgical mask and given tissues with instructions to cover mouth and nose when coughing or sneezing. Windows should be open to allow ventilation.
 - 2. An approved N-95 respirator must be worn by the transporting officer (s).
 - 3. Inmates transferred to the appropriate treatment facilities with suspected pulmonary tuberculosis shall have AFB isolation precautions initiated immediately upon admittance to the receiving facility.
- C. Upon admittance to the receiving facility, suspected pulmonary tuberculosis inmates shall be placed on AFB isolation precautions immediately. The following should be conducted: history, physical examination, a Mantoux skin test, a chest x-ray and appropriate bacteriologic and/or histological examinations to make a confirmed diagnosis. The receiving facility shall notify the DPS Infection Control Coordinator of any necessary investigation of contacts. The DPS Infection Control Coordinator will notify the transferring facility and/or other facilities where the inmate was recently housed.
- D. Sputum for acid-fast bacilli (AFB) smear and culture is the primary method used to confirm a diagnosis of active tuberculosis. The North Carolina State Health Laboratory will be used for sputum bacteriologic examination for AFB and Mycobacterium. State Laboratory approved sputum containers and laboratory requisitions may be purchased from the mail room supervisor, State Laboratory Mail Room, (919) 733-7656.
- E. Sputum collected for AFB smear and culture should be three early mornings, coughed up specimens, collected on three consecutive days. Each specimen must be placed in the inner plastic container, labeled with the inmate's name and number, placed inside the second container with the completed labels request. The second container is then placed inside the largest outside container. Seal all three containers securely. The outside container is pre-addressed and may be sent thorough the U.S. Mail to the N.C. State Health Laboratory.
- F. A tentative diagnosis of tuberculosis is usually made when an AFB smear(s) is positive from an inmate with chest x-ray and symptoms compatible with tuberculosis and for whom drug treatment is ordered. These inmates and their contacts must be investigated and handled as for disease due to Mycobacterium tuberculosis.

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G. The medical officer at CPHC and the NCCIW will ensure treatment of the inmate. The Infection Control Nurse at these units will complete the required public health reports and forward them to the Health Department in the county where the institution is located.

V. TUBERCULOSIS SKIN TESTING (See CP Guideline 4)

The North Carolina Department of Public Safety (DPS) shall use 0.1cc of 5TU Purified Protein Derivative (PPD) when performing skin testing for tuberculosis.

A. Reception/Intake Screening/Testing

All reception/admission facilities of the DPS shall skin test all incoming inmates unless the staff can verify written documentation of a past positive TB. Acceptable documentation of a past positive TB shall demonstrate appropriate evaluation, including chest x-ray, bacteriologic examination for a pulmonary suspect and consideration for prophylaxis. Lack of appropriate documented evaluation will require repeating the skin test and appropriate follow-up. Intake TB screening/testing will be completed and evaluated using the following policy:

1. Administer an intermediate strength mantoux skin test (5TU) unless the inmate gives a history of a past positive skin test.
2. Place inmates who give history of a past positive TB skin test on **medical hold**. Verify and obtain documentation of previous skin test result. Past positive history may be verified by phone then followed up by written documentation.
3. If past history cannot be verified **within three (3) working days of request for records**, the inmate shall have the TB test repeated and follow up shall be done according to policy based on the results of the test, i.e., evaluate HIV status according to policy; for positive results, symptom screening, CXR, and consideration for INH preventive treatment. **When symptom screening and CXR are negative, the inmate may be removed from medical hold and cleared for transfer. Patients experiencing TB symptoms (specifically patients with a productive cough) or suspicious CXR reports, will be maintained on the medical hold list and not cleared for transfer until evaluation for possible TB disease is completed according to policy** (exception: decision to transfer to an inpatient facility with isolation capability).

Physicians from the Centers for Disease Control in Atlanta concur that there have been no problems repeating the TB skin test on patients with history of a past positive result. Systemic allergic reactions have not been documented and intense localized reactions can be treated with steroids either topically or orally.

4. Staff in diagnostic facilities will continue the assessment for preventive therapy even though the inmate is cleared for transfer and removed from medical hold. If the inmate transfers out of the processing center prior to completion of evaluation for preventive treatment, **the transferring facility** will clearly document in a clinical encounter the need for the receiving facility to complete the assessment for preventive treatment. At the end of the encounter, they shall schedule a record review for "Nurse" the next business day after transfer. This appointment shall be noted on the exit summary.
Health care staff in the receiving facility shall routinely review the exit summary and appointment schedule for incomplete preventive therapy assessment and shall complete the assessment within two weeks of arrival at that facility.
5. All TB skin tests and results shall be documented in millimeters on the ~~DC-928 "Immunization Record/TB Skin Test" form in the inmate's health record and the OPUS MS03/MS10~~ **PPD** screens within twenty-four (24) hours of reading.

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6. Facilities that receive patients without millimeter documentation of the TB test or whose TB screening has not followed the above guidelines shall promptly skin test the inmate and perform the necessary diagnostic evaluations. The incident shall also be reported to the Director of Nursing by completion of "Medical Incident Report" (DC-798).
 7. Diagnostic center staff shall use the following procedure for symptom screening inmates with a documented past positive skin test:
 - a. Inmates who have a past positive TB reaction and a documented negative chest x-ray should have a repeat x-ray only when symptoms for TB disease are present.
 - b. Interview the inmate to determine if any of the following symptoms exist: productive cough, recent weight loss, anorexia, unexplained fever, night sweats, and shortness of breath or chest pain.
 - c. If there are any symptoms of acute disease present, inmate should be isolated, and transferred as soon as possible to CPHC or NCCIW as appropriate.
 - d. If there is no documentation of prior treatment for TB infection or disease, preventive is recommended once active disease is ruled out.
- B. Interpreting TB skin test reactions
1. For inmates with a TB reaction 5 mm or greater, the skin test is **POSITIVE**, if any of the following criteria exist:
 - a. Close contact of known TB case
 - b. Individual with HIV infection
 - c. Individuals with fibrotic changes on chest x-ray consistent with prior TB.
 - d. Those suspected of having TB disease based on clinical and/or chest x-ray evidence
 - e. Individuals with organ transplant and other immunosuppressed patients.
 2. A documented TB skin test within ninety-days prior to the annual screening date may be exempt from skin testing.
 3. Inmates/employees are at increased risk for contracting tuberculosis; therefore, TB reactions 10 mm or greater are considered **POSITIVE** except those listed in item above.
 4. Upon completion of the prescribed course of preventive therapy, screen annually for signs and symptoms of active disease.
 5. Any one with TB result 0 thru 9 mm and who are asymptomatic, repeat skin test annually.
 6. Refer to policy CP-4.
- C. Refusals of Skin Testing

Inmates may not refuse TB skin testing during admission processing, during the annual screening program or after being identified as a close contact of an active case of tuberculosis. The North Carolina Communicable Disease Rules (10A NCAC 41A.026CC) mandate that close contacts of an active case of tuberculosis have a skin test and all inmates have a skin test for tuberculosis upon admission and annually thereafter unless there is a documented past positive TB skin test recorded in millimeters. Tuberculosis is a life-threatening disease that is transmitted through the air from one person to another. The Communicable Disease Rules are based on the threat to public health due to the increase in the incidence of tuberculosis and because tuberculosis occurs three times more often in correctional facilities than in the general population. The DPS policy shall be to comply with the Communicable Disease Rules. If an inmate refuses TB skin testing during admission processing or during the annual screening program, the following procedure shall be followed:

1. The inmate may be placed in medical isolation until TB skin testing has been completed and evaluated.

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2. The unit medical staff shall verify and document that TB skin testing is indicated and that there is no record of a past-positive skin test or disease treatment.
 3. The inmate will be referred to the unit physician to determine if there are any medical contraindications for skin testing the inmate. The inmate will be skin tested unless there is documented medical reason(s) by the physician for omitting the TB skin test. The inmate's verbal history of a previous positive skin test without supporting documentation is not a medical reason to omit TB skin testing.
 4. The unit medical staff shall counsel the inmate and make an effort to obtain the inmate's compliance.
 5. If the inmate still refuses, the medical staff shall then enlist the assistance of the unit custody staff. The inmate shall be given a direct order to submit to TB skin testing. If the inmate still refuses, staff shall explain to the inmate that force will be used to administer the TB skin test. In all cases the Chief of Health Services/designee shall be notified prior to using force to administer a TB skin test.
 6. Upon the inmate's continued refusal, custody staff shall restrain and hold the inmate so the TB skin tests can be administered. A licensed nurse will administer a TB skin test to the inmate. Only the degree of force reasonable to perform TB skin testing is to be applied.

In the above situations the inmate's consent shall be sought in all cases. Complete and thorough documentation of all counseling and screening efforts is required.

D. Contraindication to Repeat Skin Testing

An inmate's verbal history of a previous "positive" skin test is not a contraindication to repeat skin testing. A repeat skin test shall be given in the following situations:

1. Physician's order
2. During admission processing when no written documentation of millimeter readings exist
3. Previous test done by multiple-puncture "Tine" method
4. Close contact to a sputum positive case
5. Symptomatic patient
6. Annual skin testing in the prison

Known or proven tuberculin positive inmates need not be tested again.

E. Contact Investigation

1. For complete guidelines on structuring a contact investigation see the Guidelines for the Investigation of Contacts of Persons with Infectious TB. MMWR 2005.54 (no.RR-14). The goals of a contact investigation are rapid identification of individuals who are high priority contacts to known or suspected case of pulmonary, laryngeal or pleural TB; timely initiation of appropriate treatment for those determined to be recently infected or exposed with a significant risk for progression to disease; and identification and treatment of additional individuals found to have suspected TB disease in order to prevent further spread of disease.
2. Prioritization of contacts is based on the characteristics of the case, the individual risk factors of the contacts, and the environment in which the exposure occurred in determining the infectiousness of a case evaluate in the following manner. Case characteristics include:
 - a. High priority case/suspects have pulmonary, laryngeal, or pleural TB with a positive smear and/or cavitory disease on chest x-ray.

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- b. Medium priority cases/suspects have smear negative pulmonary, laryngeal, or pleural TB with AFB negative smear and/or non-cavitary chest x-ray that is consistent with TB.
 - c. Low priority cases/suspects are those wherein extra pulmonary disease has been ruled out.
3. Contact risk factors include
- a. High priority contacts include HIV+, household contacts; contacts living in congregate settings such as prisons and jails; contacts less than 5 years old; contacts exposed during medical procedures; and contacts with medical risk factors that increase the likelihood of progression to disease, e.g. silicosis, diabetes mellitus, a history of gastrectomy or jejunioileal bypass surgery.
 - b. Medium priority contacts include contacts 5 through 14 years of age.
 - c. Low priority contacts are those who are below the threshold for medium priority.
4. Environment in which the exposure occurred
- a. High priority contacts

Whenever an inmate or staff member is believed to have contagious tuberculosis (TB) disease all close contacts of that person must be identified and screened for TB infection or disease. Medical staff has a responsibility to carefully identify, evaluate, and supervise any contacts that have had a significant exposure to tuberculosis.

1. When an inmate is reasonably suspected of having active tuberculosis, the inmate shall be transferred to the appropriate treatment facility until TB is ruled out or is adequately treated and determined to be non-infectious. The facility nurse where the suspect case was discovered shall notify the Facility Nurse Manager, Superintendent, Regional Nursing Supervisor, and the DPS Infection Control Coordinator of such cases. The nursing staff at the facility where the suspect case has resided during the last three months shall immediately identify and compile a list of contacts.
2. When an infectious TB patient is identified in a prison or jail it can be difficult to determine a contacts priority level since it is often difficult to determine how much exposure may have occurred. Initiate investigation of high priority contacts to laryngeal, pulmonary and pleural TB within 7 days of notification. Evaluate medium priority contacts within 14 days of notification.
3. The facility nurse should consider the following factors in assessing TB transmission:
 - a. Infectiousness of the case: Is source case determined to be pulmonary disease as determined by chest x-ray? Was coughing present in source case? Was productive coughing present?
 - b. Infectious period: What was the frequency and duration of exposure to source case? What were the smear and culture results? Are cavities present on chest x-ray reports? Given the uncertainty in establishing the infectious period, a recommended start date of 3 months prior to report symptom onset or first positive sputum smear should be used.
 - c. Characteristics of the environment: What is the state of ventilation conditions of the housing area? What is the volume of common air space? What is the degree of recirculation of shared air?
4. The Infection Control Nurse at the treatment facility will notify the DPS Infection Control Coordinator of the chest x-ray report and sputum smear results as soon as they are available. If chest x-ray and sputum smears from the suspect case are negative then further investigation of contacts is not necessary. If sputum smears and chest x-ray from the suspect case indicate active TB, assessment of contacts will be necessary. The DPS Infection Control Coordinator will notify the Nurse Supervisor

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and Facility Nursing Staff of what action to take as soon as active TB has been ruled out or confirmed in the suspect case.

5. If contact assessment and investigation is determined necessary, the Facility Nurse may enlist the assistance of the TB Control Nurse from the local health department. The facility nurse shall keep the list of close contacts and forward a copy to the local health department TB Control Nurse and the ~~DOP~~ DPS Infection Control Coordinator. For more information about conducting contact investigations in a correctional facility refer to: Prevention and Control of Tb in Correctional Facilities: Recommendations from CDC MMWR 2006; 55 (No. RR-9) <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5501a1.htm>.
6. Inmates/ employees identified as contacts shall be assessed and treated as follows:
 - a. Administer a TB skin test to all close contacts. Skin testing can only be omitted in the following instances:
 1. Contacts having a skin test within the last 30 days.
 2. Contacts who have a documented past positive skin test.

- b. Inmates/employees with a documented negative chest x-ray and previous positive TB shall be screened for symptoms of active disease. If the patient is asymptomatic, conduct second screening in 60 days. If patient is still asymptomatic, no further treatment is necessary.

Obtain chest x-ray for patients who have symptoms indicative of TB and complete the diagnostic evaluation including sputum bacteriology. Provide treatment as indicated.

Employees will be referred to the local health department for evaluation and treatment.

- c. For HIV- negative inmates with TST result 0 - 4 mm:
 1. Consult physician regarding possible preventive treatment if they have extremely high risk for developing TB. If treatment is to be given, obtain a chest x-ray (posterior-anterior view) within 7 days.
 2. Repeat TST in 8 weeks.
 - d. For inmates with TST result 5 mm or greater:
 1. Chest x-ray (posterior-anterior view) within 7 days of no S/S of active disease.
 2. If there is any unexplained productive cough and/or suspicious chest x-ray findings, isolate immediately and transfer to CPHC or NCCIW as indicated.
 3. If there is no indication of active disease from signs or symptoms, or chest x-ray examination, preventive treatment is recommended. If HIV positive and ~~not~~ on antiretroviral therapy, refer to infectious disease specialist.
 4. Persons for whom TB preventive therapy is recommended, but who refuse or are unable to complete a recommended course should be counseled to seek prompt medical attention if they develop signs or symptoms compatible with tuberculosis. Routine periodic chest x-rays should not be done in the absence of symptoms.
 - e. For inmates/ employees with previous TST 0-9 mm who have had a skin test within the preceding thirty days, repeat skin test in 60 days after exposure.
 - f. Documentation of TST testing should be recorded in HERO in the PPD section. Schedule a retest date in HERO in HERO; create an Alert showing that the inmate is a close contact to an active TB case. The provider will enter the diagnosis to the Health Problem section of HERO.

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- g. Employee test results will be documented and placed in the employee's medical records. The Department must ensure that employee records are kept confidential and not disclosed or reported without the employee's written consent. Medical records must be maintained for duration of employment plus thirty (30) years.

F. Sputum Collection

When sputum for AFB needs to be collected in an asymptomatic patient and AFB AII rooms are not available, provide inmate with instructions on proper collection procedure. Collect specimen outside in open air away from staff/inmates.

III. TUBERCULOSIS THERAPY (See HCPM policy CP-4)

A. Directly Observed Therapy

DPS staff shall ensure inmate compliance with preventive treatment or treatment of active disease by utilizing Directly Observed Therapy (DOT).

B. Release of inmates on tuberculosis therapy

1. When inmates who are on TB therapy for active disease are released into the community, the local HD should be informed so the inmate's DOT can be immediately assumed by the local HD.
2. When inmates on TB therapy are released into the community an effort will be made to ensure that at least one month's supply of treatment medications are given to the inmate.

C. Continuity of Care

1. When an inmate on TB chemotherapy (preventive INH or active disease treatment) is released, the unit nurse will complete Form DC-516 "Community TB Referral".
2. The original will be sent to the county Health Department where the inmate will reside, a copy will be given to the inmate upon release and a copy shall be scanned into HERO.
3. The very highest priority shall be given to notification of the Health Department when an inmate on active disease treatment (two or more first line drugs, INH, PZA, Ethambutol, Rifampin, Streptomycin) is released.
4. There will be continuing education concerning the reasons for therapy and **CLEAR** instructions to report to the local county Health Department within five days for both inmates receiving TB disease and LTBI treatment.

VII. IMMUNODEFICIENCY VIRUS (HIV) TESTING

A. The Health Services Section of the Division of Prisons recommends voluntary HIV testing of any person with a positive TB, persons with abnormal chest x-ray, other abnormal diagnostic test or symptoms suggestive of pulmonary or extra-pulmonary tuberculosis. HIV testing shall proceed as follows:

1. Signed consent and physician order, shall be obtained prior to testing for HIV
- B. When HIV antibody test results are received (positive or negative):
1. The case should be immediately evaluated with the physician to determine if any change in TB disease treatment is warranted. This evaluation should be documented in the inmate's health record.
 2. A full course of TB drug therapy, appropriate to the inmate's condition, should be completed in all HIV/AIDS related tuberculosis cases.

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3. The inmate must be informed of the HIV test result, given appropriate counseling, including required control measures for persons who are infected.
4. Inmates diagnosed with either Mycobacterium Tuberculosis (MTB) or another Mycobacterium and HIV infection should be reported as AIDS cases to the local Health Department. Copies of the DHHS 2124-Communicable Disease Report ~~Card~~ and the CDC AIDS Case Report shall be sent to the Health Department. File copies of CDC AIDS Case Report in the inmate's medical record.

C. For inmates co-infected with HIV and TB Infection:

1. Unless medically contraindicated, preventive treatment should be given to persons of any age with HIV and TB infection.
2. Review "TB and AIDS" pamphlet with the inmate. Document teaching effort in the inmate's health record.
3. Consult with Infections Disease Specialist as needed.

VIII. RELEASE OF MEDICAL RECORDS

All communicable disease information is strictly confidential and may be released only as allowed in the confidentiality law (G.S. 130A-143). Release of information is allowed under this policy when:

- A. The inmate has given written consent.
- B. The information is shared with other health care providers involved in providing direct care to the inmate in order to continue appropriate care for the inmate's condition (i.e., Health Departments).
- C. Release is necessary to protect the public health and is made as provided by the Public Health Commission in its rules regarding control measures for communicable diseases and conditions.
- D. An inmate who is on preventive or active pulmonary tuberculosis chemotherapy is released from DPS, the nurse shall complete form DC-516 "Community TB Referral" and send it to the county Health Department where the inmate will reside. A copy will be placed in his/her transition/aftercare package and scanned into HERO.



9/21/2016

Paula Y. Smith, MD, # Chief of Health Services

Date

SOR: Infection Control Coordinator

NC Administrative Codes 10ANCAC41A.025 "Control Measures- Tuberculosis" and 10ANCAC41A.0206 "Infection Control HealthCare Settings".

NC Tuberculosis Control Manual 10th edition April 2007 available at

<http://www.epi.state.nc.us/epi/gcdc/tb/manual.html>

NC DOC Safety, Occupational & Environmental Health Policy E-6 "Occupational Exposure to TB" effective 1/1/07.

"Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (MTB) in Health Care Settings" 2005, CDC, MMWR, December 30, 2005. Vol. 54. RR 17

"Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC" July 7, 2006, Vol. 55 No. RR-9.

HEALTH SERVICES POLICY & PROCEDURE MANUAL

**North Carolina Department of Public Safety
Prisons**

SECTION: Infection Control

POLICY # IC-6

PAGE 12 of 12

SUBJECT: Tuberculosis Control Plan

EFFECTIVE DATE: September 2016

SUPERCEDES DATE: March 2011

NC Department of Correction/ Division of Prisons
FACILITY RISK ASSESSMENT SHEET
To Completed Annually on December 31

Facility Name _____
(Do not use abbreviations)

Facility Number _____

Risk Assessment for Year ending December 31 _____ (year)

	Yes	No
A case of infectious TB has occurred in this facility in the last year		
A substantial number of inmates housed at this facility have risk factors of TB (i.e. HIV infection, injection drug users, recent immigration, diabetes mellitus, immune suppressive therapy, etc.)		
This facility houses immigrants (persons arriving in the United States within the previous 5 years).		
Employees at this facility are at risk for TB		

Circle One

NON MINIMAL RISK: Responded NO to all of the above questions

MINIMAL RISK: Responded YES to at least one question listed above

Signature of person completing Report _____ Date _____

Signature of Nursing Manager _____ Date _____

SOR: "Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC"
July 7, 2006, Vol. 55 No. RR-9.

File on Site

Must be available for examination to official state and department inspectors upon request.