

1.1.C.8 Tuberculosis Exposure Control Plan

I Policy Index:



Date Signed: 10/23/2013
Distribution: Public
Replaces Policy: 4E.16
Supersedes Policy Dated: 01/24/2013
Affected Units: All Units
Effective Date: 10/23/2013
Scheduled Revision Date: November 2014
Revision Number: 12
Office of Primary Responsibility: DOC Administration

I Policy:

The Department of Corrections (DOC) requires all staff members to have a Tuberculosis (TB) test administered upon hire and every year thereafter, or as deemed necessary by Health Service staff.

II Definitions:

Staff Member:

For the purposes of this policy, a staff member is any person employed by the DOC, full or part time, including an individual under contract assigned to the DOC, an employee of another State agency assigned to the DOC, authorized volunteers and student interns.

Whole Blood Assay Test:

A process where blood is drawn to test for TB.

III Procedure:

1. TB Tests for New Staff:

- A. New staff members are **required** to have a tuberculin skin test (TB test) administered by DOC Health Service staff within the first week of employment.
1. New staff members will receive a two-step TB test unless they have documentation showing the results of a TB test which was administered within the last calendar year.
 - a. The first TB test will be read forty-eight (48) to seventy-two (72) hours after placement by Health Service staff.
 - b. The second TB test will take place one to three (1-3) weeks after the first test and will be read forty-eight (48) to seventy-two (72) hours after placement by Health Service staff.
 2. Under special circumstances, other TB testing accommodations may be allowed at the request of the staff member by the Chief Executive Officer of the institution/unit. This may include:
 - a. Whole blood assay test.

- B. All employees will be asked if they have any history of TB in their family or a history of TB themselves.
- C. All new employees will be instructed on the procedure to report exposures or possible exposure to TB to their supervisors (See [Attachment 2](#)).

2. Annual TB Testing:

- A. All staff members are required to have a TB test administered annually on their anniversary date of hire. Bureau of Human Resources (BHR) staff will assist Health Service staff in monitoring when staff are due for their annual TB test.
- B. Any staff member with a history of TB (including a past positive TB test) is required to contact Health Services annually to complete the [Employee Tuberculin Screening](#) (See [Attachment 1](#)).
- C. DOC Health Services personnel should review the annual [Employee Tuberculin Screening](#) after the staff member has completed and submitted the form to the respective BHR office for retention.
- D. All staff members who have demonstrated signs and symptoms of TB will be required to receive an annual chest x-ray, unless written documentation is received from their primary physician indicating otherwise.
- E. All staff members will be allowed a one (1) month "grace period" from their anniversary date of hire to complete the required TB test and/or [Employee Tuberculin Screening](#) and/or chest x-ray.
- F. If any staff member exceeds thirteen (13) months from the date of his/her last TB test, they will be required to take the two-step test.
- G. Designated DOC supervisors and/or BHR staff are responsible for ensuring annual testing records are maintained for all DOC staff.

3. Staff Exposure to Tuberculosis:

- A. When a staff member is exposed to an active case of TB, or suspected of possibly being exposed to an active case of TB, Tuberculin Skin Testing will be provided/offered to the staff member immediately by DOC Health Services staff and again ten to twelve (10-12) weeks following the exposure/suspected exposure.
- B. The staff member will complete a [Report of Accident, Incident or Unsafe Condition](#) (See [Attachment 2](#)) and a [Major Incident Report](#) (See [Attachment 3](#)) and report the exposure/suspected exposure to the Secretary of Corrections in accordance with DOC policy 1.1.A.3 [Reporting Information to DOC Administration](#).

4. Administering TB Tests:

- A. DOC Health Services staff will administer TB tests to DOC staff members.
 - 1. Institutional staff will have their tests administered by DOH staff at their respective institutions.
 - 2. Field staff (those assigned to community corrections) will have their tests administered at their local community health service office.

- B. TB testing will be administered at no cost to the staff member, unless the staff member chooses to have TB testing completed through another source.
 - 1. Staff may chose to have TB testing completed through another source (private doctor); however, this is typically at the staff member's expense.
 - 2. Staff completing TB testing through another source must provide Health Services with documentation of the required test(s) and the results.

5. Positive TB Test Results:

- A. If a staff member tests positive for TB, the results will be recorded and consultation coordinated by their respective BHR office.
- B. Staff who have tested positive for TB in the past and who have not completed the recommended treatment must contact DOC Health Services to complete the annual [Employee Tuberculin Screening](#).
- C. All staff member's with a new positive TB test result are required to complete the [Employee Tuberculin Screening](#) and a chest x-ray, unless the staff member's primary physician provides written documentation to Health Services stating the staff member does not have TB and can confirm the staff member has had a chest x-ray completed.

Note: Health Services is **required** to notify the SD State Health Department TB Control if one of the following risk factors is present:

- 1. Foreign-born persons who entered the U.S. within the last 15 years.
 - 2. Persons evaluated for tumor necosis factor-alpha therapy.
 - 3. Immunosuppressive therapies (i.e. high dose therapies)
 - 4. Radiographic evidence of prior TB
 - 5. HIV infection
 - 6. Renal dialysis
 - 7. Silicosis
 - 8. Organ transplant
 - 9. Head and neck cancers
 - 10. Leukemia
 - 11. Hodgkins disease
- D. If the staff member demonstrates signs and symptoms of TB, the staff member will be required to receive a chest x-ray within 7-days, unless written documentation is received from their primary physician.
 - 1. It is the staff member's responsibility to ensure the required chest x-ray is completed.
 - 2. The cost of the annual chest x-ray will be paid for by the DOC and/or the cost of the medical appointment to determine if a chest x-ray is required.
 - 3. Staff who has completed the recommended treatment must provide a copy of their blue card issued by the Department of Health or a copy of their medical records showing they have completed recommended treatment to DOC Health Services.
 - 4. Health Services will annually confirm the staff member has not had symptoms consistent with TB through the [Employee Tuberculin Screening](#) form or a chest x-ray.

5. The respective BHR office will retain a copy of all required documentation in the staff member's file.
- E. Staff with a positive TB test result and an affirmative chest x-ray will not be allowed to work. In this event, the Secretary of Corrections will be notified.
- F. Employees that have tested positive for TB will not be tested again by the DOC unless otherwise recommended by a physician or SD State Health Department TB Control .
- G. Costs for required counseling, testing, treatment and/or medical care incurred as a result of a work related exposure to TB by a DOC staff member will be paid by the DOC.
- H. Costs for counseling, testing, treatment and/or medical care incurred as a result of a non-work related exposure to TB by a DOC staff member will not be paid for by the DOC.

IV Related Directives:

DOC policy 1.1.A.3 -- [Reporting Information to DOC Administration](#)

V Revision Log:

March 2002: **Revised** section B under Positive Test Results **Deleted** references to Sioux Valley Hospital. **Revised** Custer section on Attachment 1.

December 2003: **Revised** the policy statement. **Rearranged** policy sections and some information within the policy sections. **Changed** South Dakota Department of Health infection control to South Dakota Department of Health Tuberculosis Control Program TB Treatment Regulations.

August 2004: **Revised** the wording on annual TB testing to allow for a one (1) month grace period.

January 2006: **Revised** the definition of employee. **Added** reference to DOH policy Y-B-01.

Clarified that if a TB test is done through a non-state source the results of the test must also be provided.

January 2007: **Revised** the policy statement. **Changed** the definition of Employee to Direct Care Employee. **Added** a definition for offender.

December 2007: No changes made.

November 2008: **Revised** formatting of policy and attachment in accordance with DOC policy 1.1.A.2. **Added** definition of other employee and whole blood assay test. **Added** statement regarding documentation of TB test must be within past year and TB test must be completed within first month of employment of ss (A1), **deleted** new in reference to other employees in ss (B1, B1b and B1c) and **added** ss (B1a and B3a) of TB Tests for New Employees). **Added** new ss (A, B, B1, B2 and C), **revised** ss (D) to include other employees and TB Test Declination, **revised** ss (E) to include all employees vs direct care employees and **added** Employee Tuberculin Screening and chest x-ray per this policy, **replaced** direct care employee with any in ss (F), **deleted** former ss (D and E) regarding other employee having their annual TB tests and **revised** bullets for entire Annual TB Testing. **Added** prior approval of the CEO in ss (B of Administering TB Tests. **Deleted** former Attachment 2 regarding procedures for positive PPD Test, **replaced** chest X-ray with Employee Tuberculin Screen and **added** reference to green card in ss (B), **added** ss (C), **added** statement regarding cost of medical appointment in ss (C2), **deleted** green card in ss (C3) and **added** reference to the Employee Tuberculin Screening in ss (C4) of Positive TB Test Results. **Added** phrase regarding testing positive in the past and **replaced** chest x-ray with annual screening in ss (B), **revised** wording in ss (B) and **added** Note regarding reporting positive TB tests to DOH, **added** ss (C and D), **deleted** each year in ss (C1), **deleted** blue card in ss (C3) and **added** statement regarding screening or chest x-ray if indicated by screening in ss (C4) of Positive TB Test Results. **Deleted** reference to SD DOH Tuberculosis Control Program TB Treatment Regulations throughout policy. **Revised** wording and formatting throughout policy. **Added** new Attachment 2 and **deleted** former Attachment 2 from policy. **Revised** numbering of attachments throughout policy.

November 2009: **Replaced** on with reference to one month within ss (C) and **added** reference BOP emailing staff who have access to email of their annual TB test in ss (D) both within Annual TB Testing. **Added** hyperlinks.

November 2010: **Revised** formatting of Section I **Replaced** "regular volunteers" with "Level One Volunteers" in the definition of Direct Care Employee **Added** definition of Level One Volunteers. **Revised** Attachment 1 to include still an employee for TB testing.

January 2012: **Deleted** "Non-Public" and **Replaced** with "Public".

December 2012: **Added** A-D and **changed** previous A. to E. and **Deleted** B. "Also refer to DOH policies PB 01 and YB 01 for additional environmental procedures in Section 3. **Added** "direct care" to Section 4 B. 2 **Added** Attachment 3, 4, and 5.

October 2013: **Deleted** definition of "Direct Care Employee", "Other Employee" and "Level One Volunteer" and **Added** definition of "Staff member" **Added** "Health Service staff" to Section 1 A. 1. A. and b. **Deleted** B. and B. 1. a-c and B. 2. a-b and B. 3. a. **Renumbered** previous C. to B. and D. to C in Section 3. **Deleted** term "employee" and **Replaced** with "staff member" throughout policy. **Deleted** B. "All other employees, except those who signed a one time TB Test Declination are required to have a TB test administered annually on their anniversary date" in Section 2. **Renumbered** sections that followed. **Deleted** "assigned to the DOC will be responsible for completing" and **Replaced** with "should review" and **Added** "after the staff member has completed this" to Section 2 C. **Deleted** "month" and **Replaced** with "week" and **Deleted** "their anniversary date of hire" and **Replaced** with "any positive test results" in Section 2 D. **Deleted** "Parole and Juvenile Corrections Agents, supervisors" and **Replaced** with "Designated DOC supervisors" in Section 2 H. **Deleted** A. B. C and D. in Section 3 reference blood borne exposure **Renumbered** E. to A. in Section 3 **Added** B. to Section 3. **Added** "or suspected of possibly being exposed to an offender with an active case of TB" to Section 3 A. **Deleted** "Direct care employees" and **Replaced** with "Staff completing TB testing through another source" and **Deleted** "DOC" and **Replaced** with "Health Services" in Section 4 B. 2 **Deleted** "report all positive TB tests to the SD DOH. The DOH will issue the employee a green card" and **Replaced** with "The SD Health Department TB Control if one of the following risk factors is present" in Section 5 C **Added** 1-11 in Section 5 C. **Added** "within 7 days" in Section 5 D. **Deleted** "either covered by the Centers for Disease Control or" and **Replaced** with "will be paid by the DOC" in Section 5 G. **Deleted** Attachments 1, 3 and 4.

Denny Kaemingk (original signature on file)

Denny Kaemingk, Secretary of Corrections

10/23/2013

Date

Attachment 1: Employee Tuberculin Screening

This form is provided by South Dakota Department of Health.

South Dakota Department of Health Correctional Health Services EMPLOYEE TUBERCULIN SCREENING																											
NAME Last: _____		First: _____		Middle Init: _____																							
City: _____			State: _____		ZIP: _____																						
Birth date: ____/____/____		Employee Number: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female																							
Race/Ethnicity: <input type="checkbox"/> White, not Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black, not Hispanic <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Other race, specify: _____																											
Were you born in the U.S.? <i>(Persons from outlying U. S. areas such as Puerto Rico, Guam, and the Virgin Islands should check no.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, country of birth: _____ You entered the U.S.: _____ or <input type="checkbox"/> Don't know																											
Have you ever received BCG vaccine? <i>(BCG vaccine is not a PPD Tuberculin Skin Test.)</i> <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes If yes, year received vaccine: _____																											
Have you ever had TB disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Have you ever been exposed to a person with infectious TB disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know																											
Date employed (month/year): ____/____			Facility: _____																								
Job title: _____			<input type="checkbox"/> Full-time		<input type="checkbox"/> Part-time <input type="checkbox"/> Contract																						
Work location since last form filled out: <i>(Check only one.)</i> <input type="checkbox"/> Work 75% or more of the time at one location. Specify: _____ <input type="checkbox"/> Work at multiple locations																											
Last documented PPD date: ____/____/____			Last PPD result: ____ mm		Circle: Positive or Negative																						
Symptom evaluation: <i>(Answer yes or no.)</i> Persistent cough? Yes No Unexplained weight loss? Yes No Fever? Yes No Night sweat? Yes No Employee signature: _____ Date: _____																											
PLEASE DO NOT WRITE BELOW																											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Step</th> <th>Brand/Lot #</th> <th>Date Given</th> <th>Given By</th> <th>Date Read</th> <th>Read By</th> <th>Result (mm)</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>							Step	Brand/Lot #	Date Given	Given By	Date Read	Read By	Result (mm)	1							2						
Step	Brand/Lot #	Date Given	Given By	Date Read	Read By	Result (mm)																					
1																											
2																											
Referred for follow-up evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where: <input type="checkbox"/> Employee health unit <input type="checkbox"/> Local health department <input type="checkbox"/> Personal physician <input type="checkbox"/> Other, specify: _____																											
Instructing Signature: _____			Date: _____																								

Attachment 2: Report of Accident, Incident, or Unsafe Condition

The **Report of Accident, Incident, or Unsafe Condition** form is located on Risk Management's website.

A copy of the **Report of Accident, Incident, or Unsafe Condition** may be printed as follows:

1. Click [here](#) to access the **Report of Accident, Incident, or Unsafe Condition** by:
 - a. Placing mouse on the word "here" above
 - b. Press and hold the "Ctrl" key on the keyboard
 - c. Click the left button of mouse.
2. Or go to <http://orm.sd.gov/documents/AccidentIncidentUnsafeConditionfill.pdf> to access the **Report of Accident, Incident, or Unsafe Condition**.

Risk Mgmt Non-State Vehicle Accident Report Report of Accident, Incident, or Unsafe Condition (Non-State-Automobile)			
Bureau of Administration Phone (605) 773-5879		Office of Risk Management Fax (605) 773-5880	
Department/Bureau	Agency/Division	Date of Accident	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
Type <input type="checkbox"/> Accident <input type="checkbox"/> Incident <input type="checkbox"/> Unsafe Condition		Location of Accident, Incident, or Unsafe Condition	
Employee Completing Report			
Name	DUB		
Title	<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent	Work Phone	Home Phone
Person Involved in the Accident or Incident			
Name	DUB		
Address	Home Phone	Occupation	
Business Address	Business Phone		
What was the person involved doing at the time of the accident or incident?			
Injury			
What was the nature and extent of the injury?			
Was first-aid administered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom?			
Describe the type of first-aid treatment given.			
Was medical treatment administered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, by whom?			
Name and address of medical facility			Did accident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No
Property Damage			
Owner (include address and phone)		Damage description (include estimated repair costs)	
Witnesses			
Name (include address and phone)		Name (include address and phone)	
Accident Description			
Legal			
Law Enforcement Contacted <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Law Enforcement agency			
Signature			
Employee Signature:		Date:	
Authorized Agency Signature:		Date:	
Make copy for your records and send original to: Office of Risk Management 1429 East Sioux Pierre, SD 57501 Note: This Report Does Not Constitute A Claim Against The State of South Dakota, Nor Does It Constitute A Notice of Injury Pursuant To SDCL ch 3-21			
Attach Additional Sheets For More Information			

Attachment 3: Major Incident Report

The **Major Incident Report** form is located on the state's WAN.

A copy may be printed using **Microsoft Word 97** as follows:

1. Click [here](#) to access the **Major Incident Report** by:
 - a. Placing mouse on the word "here" above
 - b. Press and hold the "Ctrl" key on the keyboard
 - c. Click the left button of mouse.
2. Or Select **File/New** from the Menu Bar / Select the **DOC** tab / Select **Major Incident Report**.

The gray areas indicate the information that is to be entered.

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The image displays two side-by-side screenshots of a 'MAJOR INCIDENT REPORT' form. The left screenshot shows the top portion of the form, including fields for 'TO:' (Secretary of Corrections, Mary Wilson), 'FROM:', 'NAME OF OFFENDER(S)', 'TYPE OF INCIDENT', 'DATE OF INCIDENT', 'TIME OF INCIDENT', and 'LOCATION OF INCIDENT'. The right screenshot shows the bottom portion of the form, including fields for 'WHO WAS INVOLVED?', 'HOW WAS CORRECTIVE POLICY AND PROCEDURES FOLLOWED?', and 'CORRECTIVE ACTION:'. Both screenshots show a header with the document title and policy reference information.