

1.1.C.8 Staff Tuberculosis Testing and Exposure Control Plan

I Policy Index:



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Office of Primary Responsibility: DOC Administration

I Policy:

The Department of Corrections (DOC) shall establish guidelines and procedures for the management/control of exposure and reduction of risk of tuberculosis (TB) in its facilities through ongoing testing of inmates and 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.

Tuberculosis disease (active TB):

A bacterial infection usually affecting the lungs and possibly other sites, caused by Mycobacterium tuberculosis. Only TB of the larynx and lungs is considered infectious. TB is spread from one person to another when the TB bacteria are put into the air by the infected person. This can occur when the infected person coughs, sneezes, speaks or sings. People nearby may breathe in these bacteria and become infected.

Significant Direct Contact:

Contact is defined as the duration of time a staff member spends in proximity with inmates housed in a DOC facility. Significant contact is contact between staff and offenders housed in a DOC facility that meets or exceeds twelve (12) hours within a continuous twelve month period.

III Procedure:

1. TB Tests for New Staff:

- A. All new staff members whose assigned job duties require significant direct contact with inmates housed in a DOC facility are **required** to have an initial tuberculin skin test (TB test) administered by DOC Health Service within 2 weeks of hire (ACA 4-4386) to rule out initial infection of TB.

1. New hire staff members will receive a two-step TB test, unless they have medical documentation showing the negative results of a provider administered TB test within the last calendar year.
 - a. The first TB test will be read forty-eight (48) to seventy-two (72) hours after administration 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 administration by Health Service staff.
- B. All new hire staff members will be asked if they have a family history of TB or have previously been diagnosed with TB.
- C. All new hire staff members will be instructed on the procedure to report possible exposure to TB to their supervisors.
- D. Staff not required to be tested for TB whose level of contact with inmates later meets the definition of significant direct contact, are required to contact Health Services to arrange for a TB test. Supervisors are responsible for ensuring staff compliance with the requirements set forth within this policy.

2. Annual TB Testing:

- A. Staff **required** to receive TB testing will be tested at least annually. Bureau of Human Resources (BHR) staff will notify staff of their annual TB test requirement (ACA 4-4386). Generally, notification will be sent during the month of the staff member's anniversary hire date. Health Service staff will notify BHR of the staff member's compliance with the testing. BHR will maintain a record of staff testing results and compliance, which shall be made available to the DOC upon request. The frequency of TB testing will be determined by Health Services and based on the Center for Disease Control recommendations and standards.
- 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. Staff is responsible for completing required TB testing and submitting the completed form to BHR staff for retention.
- D. All staff members demonstrating signs and symptoms of TB (Latent TB), are required to receive an annual chest x-ray, unless written documentation is received from their primary physician indicating otherwise.
- E. Staff members are allowed a one (1) month "grace period" from their anniversary month of hire to complete the required TB test and/or Employee Tuberculin Screening or chest x-ray.
- F. If any staff member exceeds thirteen (13) months from the date of his/her last TB test, they may be required to take the two-step test.
- G. Any DOC staff member who is **not required** by policy to receive an annual TB test (does not have significant direct contact with inmates housed in a DOC facility,) may request to receive a TB test by contacting the Bureau of Human Resources (BHR) representative and/or their supervisor. All provisions and requirements set forth in Sections 4- 5 of this policy apply to those staff who voluntarily elect to receive a TB test.

3. Staff Exposure to Tuberculosis:

- A. When a staff member has reason to believe they have been or may have been exposed to an offender with active TB, either in the community or in a DOC facility, the staff member will immediately complete an *Incident Report* and directly contact their supervisor to inform them of the possible exposure. Tuberculin Skin Testing will be provided/offered to the staff member through DOC Health Services.
 - 1. The staff member will be tested a second time ten to twelve (10-12) weeks following the exposure/suspected exposure, as recommended by Health Services and/or the Centers for Disease Control (CDC).
- B. If exposure is confirmed through a positive TB test, Health Services will notify the staff member immediately. Containment procedures and isolation will be initiated. "Isolation" means the separation of ill persons who have a communicable disease from those who are healthy, and the restriction of their movement to stop the spread of that disease or illness. Health Service staff will offer counseling to staff member.
- C. Staff who complete TB testing following exposure to an offender with active TB who test positive for TB will complete a *Report of Accident, Incident or Unsafe Condition* (See *Attachment 2*) and a *Major Incident Report* (See *Attachment 3*), which will be submitted to their supervisor and Risk Management. All confirmed exposures shall be reported 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 may administer TB tests to DOC staff identified for the required TB testing.
 - 1. Staff assigned to a facility housing inmates may receive TB tests from DOH staff (Health Services staff) assigned to the facility.
 - 2. Staff members assigned to community corrections (parole and Juvenile Corrections Services), may receive TB tests from local Community Health Care Centers, or DOH staff when permissible.
- B. TB testing will be administered at no cost to the staff member, unless the staff member chooses to receive TB testing through a source other than a Community Health Care Center or DOH staff.
 - 1. Staff may chose to receive TB testing through another source (i.e. private doctor, military); however, the staff member may be held responsible for all expenses associated with the testing.
 - 2. Staff completing TB testing through another source must provide Health Services with documentation of the required test(s) and results of the testing.

5. Positive TB Test Results:

- A. If a staff member tests positive for TB, the results will be recorded by Health Services staff and BHR staff will be notified,

- B. Staff who test positive for TB, who have not completed the recommended treatment, will be referred to their primary care provider by Health Service. BHR staff will be notified by Health Services staff that the staff member is required to provide documentation of treatment.
- C. All staff members with a new positive TB test result are required to complete the [Employee Tuberculin Screening](#) and receive a medical exam, including a chest x-ray from their primary care provider, unless the staff member's primary care provider 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.
- D. Health Service staff will complete the following when a staff has a new positive test for TB:
1. Provide the staff member with TB education information from the CDC.
 2. Provide the staff member with a copy of the TB form and contact information for the Correctional Health Director.
 3. Advise the staff member to follow-up with their primary care provider. Urgent follow-up for those with symptoms, within 30 days for those with no symptoms.
 4. Inform BHR staff of the documentation requirements for the staff member.

Note: Health Services staff 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 5 years.
2. Persons evaluated for tumor necrosis 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. Hodgkin's disease
12. Diabetes
13. Close contacts (defined as confirmed exposure to an infectious TB case in the last 12 months. The TB source case name must be reported.

E. Symptoms of TB disease include:

- A bad cough that lasts 3 weeks or longer
- Pain in the chest
- Coughing up blood or sputum
- Weakness or fatigue
- Weight loss
- No appetite
- Fever
- Sweating at night

1. It is the staff member's responsibility to complete any recommended treatment, procedures and follow-up care, as prescribed by their primary care provider, and to provide copies of any required documentation to Health Service staff and/or BHR staff.
 2. Staff who have 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 all recommended treatment to Health Services.
 - a. Documentation will include confirmation the staff member was evaluated by a licensed medical professional and whether the staff member is, or is not, infectious with TB, including a description of the rationale supporting the conclusion.
 3. Health Service staff will annually confirm the staff member has not had symptoms consistent with TB through the [Employee Tuberculin Screening](#) form, chest x-ray or other approved screening methods. Health Service staff will notify the BHR if there are changes in the staff member's condition which necessitates they be excluded from work activities within a DOC facility. Symptomatic staff will be required to receive a thorough medical evaluation prior to resuming work activities within a DOC facility or being granted access to a DOC facility.
 4. Staff health records are considered confidential and will be protected from unauthorized release in accordance with state and federal law.
- F. Staff having symptoms consistent with active TB are excluded from working in or on facility grounds where offenders are present, or having direct contact with offenders or staff until a medical practitioner certifies the staff person is free from infectious TB.
- G. Staff are required to complete all prescribed treatment regimen for TB and submit a physician's statement indicating he/she is not infectious to Health Services staff before being eligible to resume work activities within a DOC facility or being granted access to a DOC facility.
- H. Staff with a documented history of positive TB skin tests, who have completed TB preventive therapy and had a medical practitioner certify they have no symptoms of active TB, are not generally required to complete further testing unless there are changes in their condition.
- I. Costs for required counseling, testing, treatment and/or medical care incurred as a result of occupational exposure to TB may be paid by the DOC and/or the state health insurance plan.
- J. Costs associated with counseling, testing, treatment and/or medical care incurred by a staff member as a result of a non-work related exposure (not occupational exposure) to TB, or a pre-existing condition, will not be paid by the DOC. This includes new staff hires whose initial TB test shows a positive result.
- K. Staff who fail to complete the required testing procedures, fail to comply with the prescribed treatment regimen or refuse to provide medical information as requested and required, will not be allowed access to DOC facilities housing offenders.
- L. Because of the extreme health concerns posed by TB, non-compliance by staff with testing, treatment and prevention protocols/procedures, as ordered/required pursuant to this policy and/or the DOC, may result in disciplinary action, including and up to termination of employment.

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 that 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.

November 2015: **Added** “The DOC shall establish guidelines for the management/control and reduction of risk of TB in its facilities through ongoing testing of offenders and staff” in the Policy Statement. **Added** definition of TB. **Added** definition of “Significant Direct Contact” **Added** “whose normal job duties require significant direct contact with offenders housed in a DOC facility” and **Deleted** “contact within the first week of employment” and **Replaced** with “at no cost to them within 2 weeks of hire and before having direct contact with DOC offenders” in Section 1 A. **Added** “medical” “negative” and “provider administered” in Section 1 A. 1. **Added** D. in Section 1. **Deleted** 3. in 1. A. **Added** “will receive the test at least annually, usually on or about their anniversary date of hire” and **Added** “documenting staff compliance and notifying staff of their annual test requirements” and **Added** “The frequency of TB testing will be determined by Health Services and/or CDC recommendations and standards” and **Added** “Health Service staff will notify BHR of the staff member’s compliance with the testing. BHR will maintain a record of staff testing results/compliance which shall be made available to the DOC upon request” in Section 2 A. **Added** “through contact with an offender” and **Added** “either in a DOC facility or through contact with an offender in the community” and **Added** “will immediately contact their supervisor” and **Added** “or as recommended by HS staff and the CDC” in Section 3 A. **Added** B. to Section 3. **Deleted** “exposure/suspected exposure” and **Replaced** with “confirmed exposure” in Section 3 C. **Added** “not approved or authorized by the DOC” in Section 4 B. **Deleted** “in the past” in Section 5 B. **Added** “medical exam” in Section 5 C. and D. **Added** list of symptoms in Section 5 D. **Added** “DOC Health Service staff will notify the BHR if there are changes in the staff member’s condition which necessitates they be excluded from work activities within a DOC facility” in Section 5 D. 4. **Added** 6. to Section 5 D. **Added** “DOC Health Services does not provide treatment to staff members” in Section 5 E. **Deleted** “positive test result and an affirmative check e-ray will not be allowed to work” **Added** new G. and H. and **Deleted** “staff 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” in Section 5. **Added** J and K. to Section 5.

June 2016: **Added** G. to Section 2.

Denny Kaemingk (original signature on file)

Denny Kaemingk, Secretary of Corrections

06/20/2016

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: _____

Birthdate: ____/____/____ Employee Number: _____ Sex: Male Female

Race/Ethnicity: White, not Hispanic Asian or Pacific Islander
 Black, not Hispanic American Indian or Alaska Native
 Hispanic Other race, specify: _____

Were you born in the U.S.? *(Persons from outlying U. S. areas such as Puerto Rico, Guam, and the Virgin Islands should check no.)*
 Yes No If no, country of birth: _____
 Year entered the U.S.: _____ or Don't know year

Have you ever received BCG vaccine? *(BCG vaccine is not a PPD Tuberculin Skin Test.)*
 No Don't know Yes If yes, year received vaccine: _____

Have you ever had TB disease? Yes No Don't know
 Have you ever been exposed to a person with infectious TB disease? Yes No Don't know

Date employed (month/year): ____/____ Facility: _____
 Job title: _____ Full-time Part-time Contract

Work location since last form filled out: *(Check only one.)*
 Work 75% or more of the time at one location. Specify: _____
 Work at multiple locations

Last documented PPD date: ____/____/____ Last PPD result: ____ mm Circle: Positive or Negative

Symptom evaluation: *(Answer yes or no.)*
 Persistent cough? Yes No
 Unexplained weight loss? Yes No
 Fever? Yes No
 Night Sweats? Yes No

Employee signature: _____ Date: _____

PLEASE DO NOT WRITE BELOW

Step	Brand/Lot #	Date Given	Given By	Date Read	Read By	Result (mm)
1						
2						

Referred for follow-up evaluation? Yes No

If yes, where: Employee health unit Local health department
 Personal physician Other, specify: _____

Interviewer 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	Title		DOB
<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent		Work Phone	Home Phone
Person Involved in the Accident or Incident			
Name	Address		DOB
Business 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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Page 2 of 2

The image displays two side-by-side screenshots of a 'MAJOR INCIDENT REPORT' form. The left screenshot, labeled 'Page 1 of 2', shows the top portion of the form. It includes a header with the South Dakota Department of Corrections logo and policy information. Below this, there are fields for 'TO:' (Secretary of Corrections, Mary Wilson) and 'FROM:'. A section for 'NAME OF OFFENDER(S):' has four columns for 'LAST NAME', 'FIRST NAME', 'DOB', and 'Crime or Application'. Other fields include 'TYPE OF INCIDENT:', 'DATE OF INCIDENT:', 'TIME OF INCIDENT:', and 'LOCATION OF INCIDENT:'. A large 'NARRATIVE SUMMARY:' field is present, with a note: '(Provide how the incident occurred, how the incident was discovered and all details of the incident in chronological order)'. The right screenshot, labeled 'Page 2 of 2', shows the bottom portion of the form. It starts with 'WHO WAS INVOLVED?' (Include the names of all staff involved in the incident) and 'HOW WAS ESTABLISHED POLICY AND PROCEDURES FOLLOWED?'. A 'RESPONSE:' section asks if law enforcement, media, and others were contacted, with sub-questions for 'Media Contacted', 'Law Enforcement Contacted', and 'Others Contacted?'. Each sub-question has 'Yes/No' radio buttons and a 'Date/Time Contacted' field. The final section is 'CORRECTIVE ACTION:' (Briefly state any corrective action or disciplinary action that has been taken or will be taken as a result of this incident).