FLORIDA DEPARTMENT OF JUVENILE JUSTICE
DETENTION SERVICES
FACILITY MEDICAL POLICIES

Superintendent _____ Signature **Designated Health Authority** _____ Signature	**Effective Date:** November 1, 2016	**Revised Date:** July 5, 2018		**Procedure Number:** **8016** **Medical Services**
Subject: TUBERCULOSIS (TB) CONTROL AND SCREENING			**Reference:** 63M-2.004 F.A.C. Health Services Manual 3-6 Quality Improvement Standard 4.17	
Purpose:	The purpose of this policy is to address the routine screening of all youth for latent and active Tuberculosis (TB) as well as environmental controls in the case of a youth with active Tuberculosis.			

PROCEDURE:

A. All youth are required to be screened for TB and accurate documentation of results will be maintained by the facility.

B. There will be at least one verified Tuberculin Skin Test (TST) (formerly PPD) documented in the IHCR in accordance with the Center for Disease Control Guidelines.

C. Initial Symptom Screening Method (Tier I): Interview with Youth

a. The Department's Medical and Mental Health Screening form will be utilized for a youth's initial TB symptom screening. Emphasis should continue to be on thorough, standardized symptom screening upon each admission to a detention center and residential commitment program (including re-entry after temporary transfers or releases).
b. Youth with symptoms suggestive of active Tuberculosis would have one of more of the following findings on the entry screening:
    i. A cough productive of mucous for greater than 3 weeks; and
    ii. Any three (3) of the following symptoms:
        1. Fever greater than 101 degrees
        2. Significant weight loss without dieting
        3. Fatigue
        4. Night or early evening profuse sweating
c. Youth with these symptoms will not be placed in the general population until the 24hour screening process by licensed medical staff, contact with DHA/Designee or medically assessed by the facility DHA or designee.
d. If after a nursing assessment the clinical judgment suggests concern for active TB, or this evaluation cannot be accomplished immediately, then the youth must be immediately transported to the nearest hospital or local county health department for evaluation. It is advisable to contact the chosen facility prior to departure. While awaiting evaluation or transport, the youth shall be provided an infection control mask

and, if possible, placed in an isolated area or an outside in the open air (provided the youth can be accompanied).

e. If the facility DHA or designee are on-site and latent TB is suspected based on the subsequent medical evaluation the following should occur as clinically indicated: a Tuberculin Skin Test or QuantiFERON-TB Gold blood test (QFT-G), a chest x-ray and, if indicated, sputum examinations. If this extensive an evaluation is warranted, then the youth should be transported to the nearest hospital or local county health department. If is advisable to contact the chosen facility prior to departure.

f. For those youth known to be infected with TB, a chest x-ray will be part of the initial admission screening. Youth who have x-ray results suggestive of active TB will be isolated immediately and the facility will consult with the DHA or designee for further instructions. CDC Recommendations indicate that sputum-smear and culture examinations should be performed for these youth who are symptomatic and whose chest x-rays are consistent with TB disease regardless of their PPD/QFT-G results.

g. All youth with the following conditions are at increased risk for latent TB infection and the risk of progression from latent to active Tuberculosis disease. They will require further screening with a TST, a QFT-G or chest x-ray within 7 days of arrival to a detention center or residential commitment program.
    i. Recent Immigration
    ii. History of Tuberculosis
    iii. Recent close contact with a person with tuberculosis disease
    iv. Injection-drug use
    v. Diabetes Mellitus
    vi. Conditions requiring immunosuppressive therapy
    vii. Hematologic malignancy or lymphoma
    viii. Chronic renal failure
    ix. Medical conditions associated with substantial malnutrition
    x. A person with a history of gastrectomy or jejunoileal bypass

h. For youth refusing the TST/PPD test a chest x-ray shall be completed or reviewed if previously completed within the past 5 years along with risk screening. This information shall be explained in the Chronological Progress notes, documented on the Infectious and Communicable Disease Form (ICDF) as well as on the Comprehensive Physical Assessment(CPA).

Note: Do not place youth who have a strong index for active disease in any kind of confinement room unless that room has a negative pressure airflow system, verified to be effective.

D. Verification of Prior TST Testing

a. If after screening there is a low index of suspicion for active TB disease, the facility will determine if a TST is warranted, based on existing records.

b. All youth should have on file in the DJJ Individual Health Care Record, one (1) verified TST skin test result within the past year, measured and documented in millimeters (unless skin testing is medically contraindicated). This documentation may come from prior records, including private health care practitioners, county health departments, or from prior TST administered in DJJ detention centers or residential commitment programs. If a county health department or private health care practitioner has a TST on file for a youth, a facsimile copy is acceptable and should be filed in the youth's Individual Health Care Record (IHCR), and recorded on the Infectious and Communicable Disease (ICD) form in the core health profile. The department is not responsible for repeating TST to meet outside provider admission requirements.

c. An appropriately documented and interpreted tuberculin skin test result from another DJJ facility's aggregate Tuberculosis Testing Log may be accepted by telephone from one licensed nurse to another licensed nurse and then recorded in the youth's Individual Health Care Record (on the Infectious and Communicable Disease Form), located in the Core Health Profile.

E. Administration and Interpretation of the Mantoux/Tuberculosis Skin Testing (TST) with Purified Protein Derivative (PPD)

a. If no record of a prior TST result within the past 12 months is located, or identified after a youth enters a detention center or residential commitment program, and the youth's juvenile probation officer (JPO) has made a reasonable attempt to obtain test results from outside providers, the tuberculin skin test will be administered.
b. All youth will who have received TST within the past 12 months (unless medically contraindicated) and whose skin test results/interpretations can be retrieved and included in the youth's Individual Health Care Record shall not receive a repeat/duplicative skin test, unless their respective medical conditions, history, or other findings by the practitioner suggest a need for the TST, as this could result in a false positive reading
c. Tuberculin skin testing using 0.1 ml of 5 tuberculin units of purified protein derivative will be utilized when testing for TB infection. Multiple-puncture tests (e.g. tine test) will not be used. Youth who have a documented history of a positive TST result, history of TB disease, or a reported history of a severe necrotic reaction to tuberculin will be exempt from a routine TST. Youth with a history of severe necrotic reactions and without a documented positive result with a millimeter reading will have a QFT-G blood test to substitute for the TST or chest x-rays, whichever is indicated by the practitioner.
d. The facility may use a Physician admission order for the administration of TST to youth admitted to the facility. The results of the skin test should be recorded on the departmental (ICD) form and on the CPA.
e. A trained and proficient, licensed health care professional (LPN, RN, ARNP, PA, Physician) will administer the TB skin test and interpret the reaction 48 hours after the injections by measuring the area of induration (e.g. palpable swelling) at the injection site. The diameter of the indurated area will be measured across the width of the forearm. Erythema (redness) of the skin should not be measured. All reactions, even those classified as negative, should be recorded in millimeters of induration, (e.g. 0 mm). The test results will then be documented on the Infectious and Communicable Disease form, the current CPA, and on the Medication Administration Record. If the TB log is used, it shall reflect only those youth who receive the testing while on site at the detention center.
f. A TST reaction of greater than 10mm induration is considered a positive result in youth of good general health. Groups that should be given high priority include:
    i. Adolescents exposed to adult high-risk categories,
    ii. Immigrants (<5 years) from high prevalence countries
    iii. Recent residents of a homeless shelter and other high-risk categories
g. However, an induration of greater than 5 mm is considered a positive result in the following persons:
    i. Persons infected with HIV
    ii. Youth or employees with fibrotic changes on a chest x-ray consistent with previous TB disease;

iii. Individuals who have had recent contacts with someone that has TB disease;
iv. Organ transplant recipients and individuals with other immunocompromising conditions (e.g. persons receiving greater than 15mg/day of prednisone for greater than one month
v. Anyone suspected of have TB disease.

h. For any youth that has a positive TST result and no symptoms suggestive of TB disease, the Physician or designee will be notified and an order obtained for a chest x-ray to be performed as soon as possible but no longer than 24 hours after the skin test is interpreted.
i. Persons who have symptoms suggestive of TB disease will immediately receive a medical evaluation and will be placed in an Airborne Infection Isolation Room until TB disease has been ruled out.
j. TST skin testing is not contraindicated for persons who have been vaccinated with BCG, and the PPD results of such a person will be used to support or exclude the diagnosis of tuberculosis infection. A diagnosis of tuberculosis infection and treatment for latent TB infection should be considered for any BCG vaccinated person who has a positive PPD reaction.
k. The TST is also not contraindicated for females who are pregnant or planning to get pregnant per the National Board of Obstetricians and Gynecology.

Two step testing is no longer required by the CDC, however, at the discretion of the practitioner, the QT-F testing may be indicated and administered for quantifying unclear results. *Note: The phrase "short-term, high-risk facility" refers to jails and residential commitment programs that detain or house adults. It does not include detention centers and residential commitment programs that house only children and adolescents.*

F. Medical Evaluation and Treatment for TB

a. The medical evaluation and treatment of latent or active TB will be the responsibility of the Designated Health Authority or designee. The physician will collaborate with the local Department of Health in the medical management of a youth for TB disease and will provide medical treatment in accordance with the Department of Health and Center for Disease Control standards and regulations.
b. The Designated Health Authority or designee will be responsible for the reporting all youth with confirmed TB disease to the Department of Health. The departmental facility will utilize the Department of Health reporting form to report TB infection in accordance with DOH policy and procedures.

(Disease Reporting is conducted via phone call to the County Health Department's Epidemiology Unit

c. If the youth is prescribed anti-tuberculosis medication, this should be noted on the Infectious and Communicable Disease form. Additionally, the actual administration of TB medications should be documented on the Medication Administration Record (MAR).

G. Respiratory Protection

a. The facility will use the following guidelines in accordance with the US Occupational Safety and Health Administration (OSHA and Center for Disease Control.

b. The required (OSHA) components of the Respiratory Protection Program include:
    i. Assignment of responsibility
    ii. Youth and Employee training
    iii. Respiratory Protection

c. NIOSH (National Institute for Occupational Safety and Health) approved disposable particulate TB respiratory masks without exhalation valves, labeled N, R. or P, will be utilized to provide respiratory protection to youth and staff to facilitate the prevention and transmission of Tuberculosis. ARJDC will maintain a supply of small, medium, and large masks to assure the availability of proper size mask for all youth and employees.
d. Individual mask fit testing (done individually or in groups) will be performed by the facility nurse at the time that the mask is provided to the youth or employee. The licensed health care professional or trained staff member will assure that the youth and/or employee receives a mask that appropriately fits in accordance with manufacturer's standards of use.

H. Environmental Controls

a. Environmental controls will be used to remove or inactivate tuberculosis in areas in which the organism can be transmitted. Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation and diluting and removing contaminated air by using general ventilation. These controls help prevent the spread and reduce the concentration of airborne infectious droplet nuclei. Secondary environmental controls consist of controlling the airflow to prevent contamination of air in the areas adjacent to the source (negative pressure air flow rooms) and cleaning the air.
b. The detention superintendent in conjunction with the DHA will be responsible for the development and implementation of TB environmental controls in accordance with Center for Disease Control, OSHA, and Department of Health rules and regulations. (Refer to CDC MMWR report Prevention and Control of Tuberculosis in Correctional and Detention facilities, 2011).
c. Regional Detention staff will be notified of any youth with active TB in a detention center to determine if the facility is adequately equipped for a youth with TB.

I. Transportation

a. Youth with confirmed infectious TB disease will be transported by ambulance whenever possible. Respiratory precautions will be maintained when transporting a youth with suspected or confirmed infectious TB disease. Drivers or other persons who are transporting these youth in a closed vehicle will wear a disposable respirator mask. If the youth has signs or symptoms of infectious TB disease the youth will wear a TB particulate respirator mask during transport and when around other persons. Any bio-hazardous materials will be disposed of appropriately.

J. Transfer to Another Facility

a. If a youth receives a PPD test, but is to be released from detention prior to reading and interpreting the test result, the youth's JPO and the parent/guardian will be informed

that the youth should report to the local DOH or private physician for reading of the test with specific instructions on the date and location for the interpretation.

b. In the event that the youth does report to the DOH/private physician as directed, the telephone report from the nurse at the DOH/Private physician where the test is read to the nurse at the detention center from which the youth was released is acceptable, for recording purposes.
c. If a youth was released from detention prior to having the TST/PPD skin test administered the residential commitment program at which the youth is placed may accept the youth, as long as symptom screening from detention is on file in the Individual Health Care Record and symptom screening is conducted upon admission to the residential commitment program.
d. If a youth has received a TST/PPD, but is transferred directly from detention to a residential commitment program prior to the test's interpretation, the transferring facility nurse will notify the receiving facility nurse by telephone to facilitate the timely reading of the youth's PPD skin test. The placement of the TST shall also be documented on the MAR and the MAR be forwarded to the receiving facility along with the complete IHCR for continuity of care. If a youth is housed in a detention center during transport the interpretation will be performed there as warranted. It will also be noted in the Health Discharge Summary/Transfer Note or the Medication Receipt Transfer Disposition form.

K. Discharge from the Department of Juvenile Justice

a. The facility will notify the Department of Health of any youth with suspected or confirmed active TB disease that is being discharged from the Department of Juvenile Justice custody. A youth receiving medication therapy for latent TB infection will be referred to the Department of Health in the county the youth resides upon release into the community.