**Purpose**

1. To provide testing to residents or employees unknowingly exposed to persons with active pulmonary tuberculosis
2. To provide follow up to residents or employees unknowingly exposed to persons with active pulmonary tuberculosis
3. To ensure that only an authorized prescriber (Physician; Advanced Practice Nurse with a certificate to prescribe; or Physician Assistant with a certificate to prescribe and physician delegated prescriptive authority and, if applicable, consistent with the policies of the health care facility) can initiate or adjust medications.

**Definition**

1. TB infection (positive PPD skin test) in a person who does not have active disease is not considered a case of TB
2. Persons with TB infection who do not have disease:
	1. Cannot infect others
	2. Usually have a positive reaction to the TB skin test
	3. Usually have a negative chest X-ray and no clinical symptoms of TB
	4. Have tubercle bacilli in their bodies
	5. These tubercle bacilli remain viable and capable of producing active disease at any time
3. According to Dr. **Raymond B Otero,** (1999), TB disease does not develop in everyone who is infected. In the United States, about 90% of infected persons remain infected for life and never develop symptoms of TB.

**Procedure**

1. TB Facility Risk Assessment will be done for skilled nursing facilities and assisted living facilities initially then annually to ensure:
	1. Proper implementation of the TB infection control plan
	2. Ongoing TB training and education for Health Care Workers (HCW)
2. Director of Nursing or designee will oversee TB infection control program
3. A two-step PPD (purified protein derivative - 5 units) should be administered to all *new residents upon admission, new employees prior to working and new volunteers that put in 10 or more hours per month*, unless they have documentation of a previous positive reaction. All tests must be recorded in mm of induration.
4. Employees:
	1. A positive finding is when the lesion measures ≥10mm from edge to edge.
	2. If the new employee can provide documentation of a negative TST within the last year (past 12 months), only a one step test is required.
	3. New employees with a previous positive reaction or a history of treatment for TB disease will be assessed for TB symptoms. If the employee does not exhibit symptoms, the assessment will become a part of their file. If the employee exhibits any signs of TB disease, a referral for a chest x-ray will be made and the employee will not start work until cleared by a physician.
	4. There is no exemption for pregnant women. As stated in the CDC “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005, Vol. 54/No. RR-17, pp. 49-50, “No evidence exists that the TST has adverse effects on the preg­nant mother or fetus (*39*). Pregnant HCWs should be included in serial skin testing as part of an infection‑control program or a contact investigation because no contraindication for skin testing exists (*342*). Guidelines issued by the American College of Obstetricians and Gynecologists (ACOG) emphasize that postponement of the diagnosis of infection with *M. tuberculosis* during pregnancy is unacceptable (*343*).”
	5. Results of healthcare worker’s (HCW) PPD testing should be recorded in the individual HCW’s employee record.
		1. After baseline testing for infection with *M. tuberculosis*, additional TB screening is **not** necessary unless an exposure to *M. tuberculosis* occurs.
		2. HCWs with a baseline positive or newly positive test result for TB infection should receive one chest x-ray result to exclude TB disease or an interpretable copy within a reasonable timeframe such as 6 months. Repeat chest x-rays are not needed unless signs or symptoms of TB develop.
	6. All results should be confidential.
	7. PPD conversion rates should be examined at appropriate intervals to estimate the risk of TB exposure.
		1. To calculate PPD conversion rates, the total number of previously PPD negative HCW’s tested in each area or group (i.e., the denominator) and the number of PPD skin conversions among HCW’s in each area or group (i.e., the numerator) must be obtained.
5. All facilities (SNF and AL) that are assessed as low risk for TB infection, DO NOT need to administer routine annual TB tests to employees or residents.
6. An assessment for prompt recognition and evaluation of suspected TB consists of assessing for signs and symptoms of TB which are: fatigue, losses of appetite, weight loss, fever and night sweats. In addition to the general signs and symptoms, pulmonary TB usually causes cough, chest pain, coughing up sputum, and sometimes coughing up blood (hemoptysis).
7. A problem evaluation will be completed if a case of suspected or confirmed TB disease is not promptly recognized, separated from others and transferred. The evaluation will be done in accordance with the “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005, Vol. 54/No. RR-17, beginning on page 32.”
8. A contact investigation should begin as soon as the laboratory or hospital reports positive acid-fast smears or cultures to the health care facility.
	1. All positive smears or cultures need to be reported promptly to the health department by the infection control person.
	2. If a resident’s medical history and clinical findings suggest TB, the health care facility should not wait for culture results before starting a contact investigation.
	3. The health department will assist with contact investigations.
	4. The evaluation should start with residents and staff who are most likely to have been infected. The health department can assist with contact investigations.
	5. Close contacts of the suspected or confirmed case(s) should be PPD skin tested (unless already positive or has had one within the past 3 months) initially and if negative, repeat in 12 weeks.
	6. PPD skin tests that are negative after 12 weeks are considered to be uninfected.
	7. Chest radiographs should be made of all positive reactors.
		1. If the chest film is positive, cultures should be taken to determine whether the lesions were caused by *Mycobacterium* *tuberculosis.*
	8. Family members should be referred to the local TB clinic or their physician for testing and follow up.
9. Employees who have developed active tuberculosis will be referred to a physician for evaluation and treatment.
	1. They may return to work only with written documentation of the presence of negative sputum smears or cultures from a physician.
10. Residents who have developed active tuberculosis will be transported immediately to an acute care setting for inpatient treatment until the presence of negative sputum smears or cultures. Once the determination has been made, Particulate Respirator Mask N95 (McKesson #46761100-35 per case or #46761102-1 each) will be put on the resident and they will be isolated in area away from others until they can be transported.