Administrative Policies and Procedures: 20.19

Subject:	**Communicable Diseases**
Authority:	TCA 37-5-105(3), 37-5-106, 10-7-504, 68-5-101 ET SEQ, 68-10-104.
Standards:	**ACA**: 4-JCF-4C-16, 4-JCF-4C-22, 4-JCF-4C-23, 4-JCF-4C-24, 4-JCF-4C-26; **COA:** PA-FC 2.04, PA-KC 2.04, PA-RPM 2.01(c), PA-RPM 2.02 (f), PA-ASE 8, PA-CR 2.02, PA-CR 4.10 (c)
Application:	All Department of Children's Services Employees

Policy Statement:

The TN Department of Children's Services (DCS) employees will identify, control and report communicable disease or suspected communicable disease in accordance with the provisions of the statues and regulations governing control of communicable disease in Tennessee and the Tennessee Department of Health. Children or youth will be screened and treated with respect for their individual dignity and privacy. Treatment will be in accordance with best practice standards, the individual medical needs of the child/youth, and the safety and protection of the community.

Purpose:

To ensure the well being of children in care, DCS must have protocols in place to screen and protect children from communicable disease. Furthermore, because some older children may need placement in congregate care, it is important that DCS employees have basic information regarding communicable diseases that may be more prevalent in those settings and will know how to access care for children who may be affected by these diseases.

Procedures:

A. Tuberculosis	1. The overall goals for treatment of tuberculosis (TB) are 1) to cure the individual child/youth, and 2) to minimize the transmission of tuberculosis to other persons. Children/youth with a diagnosis of tuberculosis should be monitored during treatment for compliance with taking their medications, treatment response and relief of symptoms, signs and symptoms of medication toxicity, and signs of treatment failure. Treatment completion is defined by number of doses taken, as well as the duration of treatment administration. 2. Treatment must be tailored and supervision must be based on each child/youth's clinical and social circumstances. The management plan should be individualized to incorporate measures that facilitate adherence to the drug regimen. 3. If a child/youth enters custody and reports they have TB, they will be questioned as to who told them the diagnosis and if they are on TB

	medications. The Regional Health Unit Nurse can be consulted for assistance. TB is a disease that must be reported to the Department of Health so they are a resource to contact to confirm a report by a child/youth or family member that he/she has TB. If there is any question about whether or not a child/youth actually has TB, they will be taken to the nearest emergency room for confirmation. The emergency room staff must be notified ahead of time to advise them you are bringing a child/youth in with possible TB to allow them to prepare. 4. When transporting a child who reports he/she has TB, the child/youth will wear a surgical mask if available. If a surgical mask is not available, transport the child in the car with the windows down to allow fresh air to circulate. If the weather will not allow you to travel with the windows down, turn the air conditioner to fresh air rather than re-circulated air. 5. When a child/youth is diagnosed with tuberculosis, the health care provider will notify the local Health Department. The Health Department will conduct a contact investigation and appropriate surveillance measures.
B. Screening and documentation for children in resource homes	1. All children coming into custody will have an Early Periodic Screening Diagnosis and Treatment (EPSDT) at the local Health Department within 30 days of the custody date. The Health Department nurse, as part of the EPSDT, will conduct a TB assessment to determine the child's risk factors. If the child/youth is not considered to be at high risk, a TB skin test will not be done. If the child/youth is considered to be at risk, a TB skin test will be performed and the child will need to return for a reading in 48 to 72 hours. Any child/youth with a positive skin test result will be referred to their primary care provider and the local Health Department. 2. All TB skin tests must be documented in **TFACTS** including the date and results. The Service Appeals Tracking (SAT) Coordinator will enter the TB test if the results are included in the EPSDT report The Family Services Worker (FSW) enters the test and results in other situations and notifies the SAT Coordinator and Health Unit Nurse.
C. Screening and documentation for children in private provider agency homes	1. Congregate care is any setting other than a foster, adoptive, or kinship care home. This type of placement is considered high risk for tuberculosis. Any child/youth placed in a congregate care setting will need to have a TB assessment and a TB skin test at the time of placement and annually as long as the child/youth remains in a congregate care setting. 2. If a child/youth is transferred from one congregate care setting to another, the TB skin test does not need to be repeated until the annual test is due unless TB symptoms are observed. Any child/youth with a positive skin test result will be referred to their primary care provider and the local Health Department. 3. All TB skin tests must be documented in **TFACTS** including the date and results. The SAT coordinator will enter the TB test if the results are included in the EPSDT. The FSW will enter the test and results in other situations and

	notifies the SAT Coordinator and Health Unit Nurse.
D. Tuberculosis Protocol for Youth in Development Centers	1. **Requirements** The Health Administrator is responsible for TB infection control within the Youth Development Center (YDC) and should work with the state and local Health Department to monitor essential TB infection control activities. The Health Administrator will ensure that each facility has a local policy and procedures for communicable disease control that includes, but not limited to, the following: a) Designated health professional responsible for communicable disease control; b) Records and reporting procedures; c) Coordination with local Health Department; and d) Each facility must maintain a copy of Regulations Governing Communicable Diseases in Tennessee by the Department of Health. *http://www.state.tn.us/health/*. 2. **Assessment** a) All students entering a YDC will have a TB assessment and skin test during the classification period and annually thereafter. Those students who have suspected or confirmed TB disease will be identified and the case or suspected case reported to the local Health Department promptly. b) The Health Administrator or facility supervisor must ensure that youth refusing to permit the mandatory assessment, testing, or treatment measures during the intake/classification process are isolated as necessary to ensure the safety of the facility population. ***Form CS-0093, Release of Medical Responsibility*** must be signed by youth who refuse assessment, testing or treatment. An evaluation by a physician will determine any further action. 3. **Containment** a) Any student suspected of having infectious TB disease should be immediately isolated from other students and employees, and should wear a surgical mask. Transportation to a hospital or facility that can provide respiratory isolation may be necessary until a differential diagnosis can be made. A medication treatment regimen should be begun as soon as the disease is confirmed. The nursing staff directly observes all tuberculosis medication administration for TB. b) Youth diagnosed with tuberculosis may be given medical leave, if approved by the court, allowing them to stay at home until the disease is resolved and/or they are no longer able to transmit the disease to others. Medical leave may be authorized by the Superintendent on a case-by-case basis, if approved by the court.

	4. **Prevention** a) When a case of transmittable tuberculosis is confirmed, the nursing staff in conjunction with the local Health Department will implement a thorough contact investigation including contact testing and surveillance. b) Students with a positive skin test but no signs or symptoms of tuberculosis (latent TB) should be referred to the local health department TB clinic for preventive medication therapy as appropriate. 5. **Documentation** All TB skin tests must be documented in **TFACTS** including the date and results. The nursing staff enters the results of the TB skin test in **TFACTS** and on form ***CS-0121 Immunization/TB Control Record***. 6. **Health Education** Health education about tuberculosis must be available to students through posters, handouts, individual counseling groups, or group health education programs as deemed appropriate. 7. **Monitoring and Evaluation** The Health Administrator must collect and analyze data to monitor whether the following activities are being implemented successfully: a) Cases of active TB disease are detected; b) Students who have latent TB infection are identified and evaluated; c) Cases of TB disease are promptly reported, counted, and recorded; d) Students who begin medication therapy for active TB disease or latent TB infection complete a recommended course of therapy; and e) Referral to other Primary Care Providers, facilities, health departments, and/or Regional Health Unit Nurses are made in a timely manner if the student is scheduled for release.
E. Sexually Transmitted Disease (STD)	**1. General Information** Adolescents are at a greater risk for STDs because they frequently have unprotected intercourse, are biologically more susceptible to infections, are engaged in partnerships often of limited duration, and face multiple obstacles to utilization of health care. **2. Medical Rights and Confidentiality** a) In accordance with Tennessee Code Annotated 68-10-104, any minor can receive confidential STD testing, treatment and a disease investigation through the Health Department. Medical care for STDs can be provided without parental or DCS consent or knowledge. Any child/youth in DCS custody identified as a contact to an identified STD case will receive testing and appropriate treatment, as well as counseling. b) Adolescents can also consent to HIV counseling and testing. DCS, contract agency employees and foster parents must recognize and acknowledge the

	importance of confidentiality for minors and should strive to follow policies that comply with TCA 68-10-104 to ensure the confidentiality of STD and HIV-related services. Refer to DCS policy *20.22 HIV/AIDS*. **3. Assessment and Counseling** When a child/youth enters custody, form ***CS-0543, Health Information and History,*** should be completed including information about sexual activity. Discussions should be appropriate for the child/youth's developmental level and should identify risky behaviors (e.g., sex and drug-use behaviors). Careful counseling and thorough discussions are particularly important for adolescents who may not acknowledge that they engage in high-risk behaviors.
F. STD screening in resource homes and private provider agency placements	**1. Testing** Every child/youth entering custody will have an EPSDT exam within 30 days, however an EPSDT screening does not include testing and treatment for STDs. Any child/youth that is symptomatic or is sexually active should be referred to the local Health Department STD Clinic or to their PCP for testing and treatment. **2. Documentation** Since STD testing and treatment are confidential according to state law, the child/youth would have to give permission for the Health Department to share that information with their caregiver, FSW or Regional Health Nurse. If that information was received through consent, it can be documented in **TFACTS.** There can be no documentation regarding this subject without a signed consent from the child. FSWs should contact the Regional Health Nurse with any questions regarding documentation.
G. STD Protocol for Youth Development Centers	**1. Testing** Each youth entering a YDC will have the opportunity for STD diagnosis and treatment. When a case of STD is confirmed, the nursing staff will assist the local Health Department in conducting a disease investigation including contact testing and surveillance. When a YDC student is identified as a contact to a disease case, that student will be provided with appropriate testing and treatment, as well as counseling. **2. Documentation** STD diagnostic testing and treatment will be documented in the youth's medical record. The nursing staff should obtain consent from the youth before sharing testing and treatment information with non-medical employees and documentation in **TFACTS**. **3. Health Education** Health education directed toward prevention of STDs includes information related to the disease, routes of transmission, risk factors for infection, methods of prevention, disease outcomes, and treatment options.

H. Hepatitis A	**1. <u>Vaccine</u>** a) Hepatitis A vaccine is now universally recommended for all children at age one year (12-23 months). The two doses in the series should be administered at least six (6) months apart. b) Immune globulin is available for short-term prevention. The vaccine series is also recommended for travelers to countries with a high prevalence of hepatitis A, males who have sex with males, illegal drug users and persons with chronic liver disease. c) If a child/youth's placement is changed, it is important that follow-up treatment is provided to ensure tracking and completion of hepatitis A vaccine series **2. <u>Documentation</u>** Documentation of the hepatitis A vaccine should be included in **TFACTS** and the medical record, as well as in any medical record provided to other health-care providers.
I. Hepatitis B	**1. <u>Testing</u>** Hepatitis B can be transmitted from an infected mother to her newborn baby. Therefore, hepatitis B testing is recommended for all pregnant women as soon as the pregnancy is recognized, irrespective of hepatitis B vaccination history or previous test results. In addition, young women with risk factors for hepatitis B infection during their pregnancy (e.g., intercurrent STDs, multiple sex partners, sex partners and household contacts of hepatitis B positive person, or clinically apparent hepatitis) need retesting for hepatitis B late in pregnancy because of the high risk for HBV infection. **2. <u>Vaccine</u>** a) Hepatitis B vaccine is available for all age groups. All children/youth in custody should receive 3 doses of the hepatitis B vaccine, if they have not already received it prior to custody. b) If a child/youth's placement is changed, it is important that follow-up treatment is provided to ensure tracking and completion of hepatitis B vaccine series. **3. <u>Documentation</u>** Documentation of the Hepatitis B vaccine should be included in **TFACTS** and the medical record, as well as in any medical record provided to other health-care providers. In addition, caretakers, parents or guardians should be provided a personal immunization record.

J. Hepatitis C	**1. <u>Vaccine</u>** There is currently no vaccine against hepatitis C and having one form of hepatitis does not protect you from getting other forms. Patients with hepatitis C who also contract hepatitis A are at high risk for fulminant hepatitis, a very deadly, quickly developing form of the disease. Therefore it's strongly recommended that hepatitis C patients be vaccinated against hepatitis A. **2. <u>Health Education</u>** Health education programs aimed at reducing the risk of infection with hepatitis viruses include discussion of hepatitis A prevention, hygiene practices, and the significance of vaccination for persons at risk for infection. Curricula addressing HBV and HCV infections include information concerning the similar modes of transmission and means for prevention, and information about hepatitis B vaccination and risk reduction.
K. Methicillin Resistance *Staphylococcus Aureus* (MRSA)	**1. <u>Treatment for Staph and MRSA</u>** a) If a staph or MRSA infection is suspected, the child/youth will see their primary care provider. Most staph bacteria and MRSA are susceptible to several antibiotics. Furthermore, most staph skin infections can be treated by draining the abscess or boil and may not require antibiotics. Drainage of skin boils or abscesses is to be done only by a primary care provider. b) If antibiotics are prescribed, all of the doses must be given, even if the infection is getting better, unless the health care provider directs the child/youth to stop taking it. Tell the primary care provider if the infection does not get better. Do not share antibiotics with other people or save unfinished antibiotics to use at another time. **2. <u>Staph and MRSA Infections in Congregate Care Settings</u>** Children/youth entering a congregate care setting will be screened for skin lesions at the time of their health orientation and initial screening and/or EPSDT screening. Any suspected lesions or infections should be referred to a health care provider. a) All draining lesions will be cleaned and covered completely with a gauze dressing or bandage and changed daily, whenever gauze is saturated or as directed by a health care provider using universal precautions. b) If the child/youth is prescribed antibiotics, the full course of medications will be completed as directed by the primary care provider. c) If the infection does not improve, notify the health care provider. d) All children/youth should have regular daily showers with soap and running hot and cold water. The shower will be disinfected after use. e) Good hand hygiene and access to soap, sinks, running water and disposable paper towels or clean towels. f) Avoid sharing of personal items; this includes razors, towels, clothing, combs, and all other like items.

g) Personal clothing and bedding should be laundered on a regular basis (at least weekly). Personal clothing and bedding of an infected child/youth should be segregated, washed last or separately and the machine cleansed by running a cycle through with bleach in water.

h) Child/youth should be discouraged from popping pimples, boils, or touching lesions.

i) Diagnosis, treatment, and outcome information is to be entered in **TFACTS** by the FSW or YDC Health Clinic staff.

j) Information regarding a child/youth's MRSA-positive status will be provided to other facilities upon transfer.

k) Children/youth will be educated regarding good personal hygiene practices and appropriate hand hygiene.

l) Education of prevention of MRSA will be given to all employees.

6. Youth Development Centers

The Health Clinic staff in Youth Development Centers may refer to the *Federal Bureau of Prisons Clinical Practice Guidelines for Management of Methicillin-Resistant Staphlyococcus aureus (MRSA) Infections (August 2005)* to develop their own individual protocols for an outbreak.

L. Universal precautions

General Information

1. Universal precautions are guidelines to help prevent the spread of infection. Infectious diseases are caused by viruses, bacteria, parasites, and fungi. These organisms can be spread from person to person through blood and other body secretions, droplets breathed, sneezed, or coughed out from the nose or mouth, skin-to-skin contact, and sexual contact. Universal precautions should be followed when you are exposed to blood, semen, vaginal secretions, and certain other body fluids that would only be encountered in the hospital setting (synovial fluid, cerebrospinal fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid). Universal precautions do not apply to nasal secretions, sputum, sweat, tears, urine, feces, vomit, or saliva unless there is visible blood present.

a) Gloves - Use latex gloves any time contact with blood or other body fluids may occur. Wash your hand before and after using gloves. Change gloves if they're torn and after contact with each person. Do not reuse disposable gloves.

b) Hand washing - Wash your hands immediately after taking off gloves. Wash your hands immediately before and after each contact with a child/youth.

c) Abrasions – If you have cuts or sores on your hands, cover these with a bandage or similar protection as an additional precaution before donning gloves.

2. Exposure

a) Contact a health care provider immediately if the following incidents occur:

- A needle stick injury or other cut or puncture
- Splashing of blood or other body fluids into mouth, eyes or nose
- Direct contact with a large amount of blood or other infectious fluids
- Prolonged contact with blood or other body fluids

b) Wash the exposed skin area immediately. Save any sharps or other items involved for possible testing. Take proper safety precautions with these items so others won't be exposed. If soap and water are not immediately available, use antiseptic towelettes or an antiseptic hand cleanser along with a clean cloth or paper towels. Washing with soap and running water still must be done as soon as possible.

3. Clean-up

a) Clean up blood and other body fluids promptly. Always use an approved disinfectant such as bleach added to water any time a surface is contaminated with blood or other body fluids. A solution of 5.25% sodium hypochlorite (household bleach) diluted between 1:10 and 1:100 with water. The standard recommendation is to use at least a quarter cup of bleach per one gallon of water. Be sure to wear gloves and any other necessary protective clothing to prevent contact with blood or other body fluids.

b) If you are cleaning up a spill of blood, you can carefully cover the spill with paper towels or rags, then gently pour the 10% solution of bleach over the towels or rags, and leave it for *at least 10 minutes*. This will help ensure that any blood borne pathogens are killed before you actually begin cleaning or wiping the material up. By covering the spill with paper towels or rags, you decrease the chances of causing a splash when you pour the bleach on it.

Forms:	***CS-0543, Health Information and History*** ***CS-0093, Release of Medical Responsibility*** ***CS-0683, HIV Antibody Test Informed Consent*** ***CS-0121, Immunization/TB Control Record***
Collateral documents:	Attachment to Policy 20.19 *Federal Bureau of Prisons Clinical Practice Guidelines for Management of Methicillin-Resistant Staphlyococcus aureus (MRSA) Infections (August 2005)*