SANTA BARBARA COUNTY DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Programmatic Policy and Procedure

Section	Psychiatric Health Facility (PHF)	**Effective:**	5/25/2007
Sub-section	Nursing	**Version:**	2.1
Policy	Tuberculosis (TB) Screening for Patients	**Last Revised:**	DRAFT

Director's Approval _____ **Date** _____
Alice Gleghorn, PhD

PHF Medical Director's Approval _____ **Date** _____
Ole Behrendtsen, MD

Supersedes: TB Screening for Patients rev. 5/23/2018 **Audit Date:** DRAFT

1. PURPOSE/SCOPE

1.1. To describe the process for tuberculosis screening for all patients at the Santa Barbara County Psychiatric Health Facility (hereafter the "PHF").

2. DEFINITIONS

The following definitions are limited to the purposes of this policy:

2.1. **TST** – a tuberculin skin test. This test uses Tuberculin Skin Test ("TST") Solution, also known as Purified Protein Derivative ("PPD") Solution.

3. POLICY

3.1. All patients admitted to the PHF will undergo tuberculosis screening and symptom review on admission to the unit (see Attachment A).

4. PROCEDURES

4.1. Consider the patient's history of treatment for tuberculosis.

1. If the patient does not have a history of testing "positive" on a tuberculin skin test ("TST"), perform a TST.
2. If the patient has had a "positive" TST or has been treated for tuberculosis, ~~perform a symptom review.~~ inform the PHF Internist and await orders. The patient may need a chest x-ray.

4.2. The staff administering the test should educate the patient about the purpose and method of the test prior to administering the test.

4.3. Staff may refer to the Mantoux Tuberculin Skin Test information produced by the Centers for Disease Control and Prevention (CDC) for guidance on how to administer the TST, and to the Lippincott Nursing Procedures for general guidance on how to administer intradermal injections.

REFERENCE

Code of Federal Regulations
Title 42, Section 482.42(a)

Centers for Disease Control and Prevention (CDC)
Tuberculin Skin Testing. Retrieved from http://www.cdc.gov/tb/education/mantoux/

Lippincott Nursing Procedures
Published by Wolters Kluwer Health/Lippincott Williams & Wilkins. Print.

ATTACHMENTS

Attachment A – Tuberculosis Screening form

REVISION RECORD

DATE	VERSION	REVISION DESCRIPTION

Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).

Tuberculosis Screening

1. **Has the patient ever had Tuberculosis (TB) ?** □ Yes* □ No □ Unknown

If Yes, When & Where:_____

2. **Has the patient ever had a skin test for Tuberculosis?** □ Yes □ No □ Unknown

Has the patient had a skin test done in the last 90 days? □ Yes □ No □ Unknown

If Yes, When & Where:_____
(Clinic, Hospital, School ,Jail, Etc.)

Result: □ Positive □ Negative □ Unable to obtain results

3. **Has the patient ever had a chest x-ray?** □ Yes □ No □ Unknown

If Yes, When & Where:_____
(Clinic, Hospital, School ,Etc.)

4. **Has the patient ever had a BCG (Bacillus-Calmette-Guerin) vaccine to prevent TB?** □ Yes ** □ No □ unknown
** May receive a PPD. In some people, the BCG vaccine may cause a positive PPD when they are not infected. Consult with MD if positive.

5. Consult MD if patient has symptoms of active TB disease:
☐ cough > 3 weeks ☐ hemoptysis ☐night sweats ☐ fever ☐ worsening fatigue ☐unexplained weight loss

6. If the patient has ever been diagnosed with TB, or has a history of positive TB skin test do not repeat the skin test. Consult with MD and obtain chest x-ray order.

Staff Completing Screening: _____ **Date:** _____

Patient refusal to participate in screening (document date, reason and staff signature:)

_____

_____

Date & Time PPD Given:_____ Site: □ **LFA** □ RFA Nurse Signature:_____
(also documented on the Medication Record)

Date read (48 hours):_____ Results (mm):_____□ Positive □ Negative Nurse Signature:_____

Date read (72 hours):_____ Results (mm):_____□ Positive □ Negative Nurse Signature:_____

Date Chest x-ray done:_____ Result:_____ Where:_____
date

PATIENT NAME: _____

➢**form to be kept with patient Medication Administration Records**
Updated 10.31.2018

PATIENT NUMBER: _____