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Culture - The process whereby bacteriological specimens are grown in an incubator. In the case of tuberculosis, this can take weeks.

Droplet nuclei - Microscopic particles (i.e., 1-5 mm in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets produced by an infectious TB patient can carry tubercle bacilli and can remain suspended in the air for prolonged periods of time and be carried on normal air currents in the room.

Ethambutol - One of the first-line anti-tuberculosis drugs, given during the first 2 months of therapy. Care is required in its use as it can cause visual disturbance (blurred and red/green color disturbance) and irreversible eye damage. Patients should be told that if they experience any visual disturbance they should stop taking the drug and seek medical advice.

Ethionamide - A drug used to treat cases of drug resistant tuberculosis.

Exposure -- The condition of being subjected to something (e.g. infectious agents) that could have a harmful effect. A person exposed to M. tuberculosis does not necessarily become infected.

First line drugs - Active, drug-sensitive TB disease is treated with a standard six-month course of four antimicrobial drugs: Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. These are referred to as first line drugs for treating TB.

Fluoroquinolones - A class of antibiotics used to treat drug-resistant tuberculosis and some diseases caused by environmental mycobacteria. Examples include ofloxacin, ciprofloxacin and moxifloxacin.

Haemoptysis (or Hemoptysis) - Expectoration (coughing up) of blood or of blood-stained spit from the bronchi, larynx, trachea, or lungs.

Health Disparity - a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

Healthcare Worker (HWC) - Those working for the agency that care directly for patients/clients.

Immunosuppressed - A condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed persons are at greatly increased risk for developing active TB after they have been infected with M. tuberculosis. No data are available regarding whether these persons are also at increased risk for infection with M. tuberculosis after they have been exposed to the organism.

Incubation period - The interval between infection and the development of clinically evident disease.

Isoniazid - A synthetic agent and one of the first line anti-tuberculosis drugs. It is particularly effective against actively replicating bacilli in the lung cavities. It is also used for preventive therapy in those with latent tuberculosis.

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Latent tuberculosis - A term applied to the status of those infected with the tubercle bacillus but remaining healthy. It is assumed that the tubercle bacilli are in some dormant or resting 'persister' state.

Miliary tuberculosis - A form of disseminated tuberculosis occurring in patients with relatively good immune responses. The lesions are millet-seed sized granulomas (Latin: milium – a millet seed) that are easily seen on chest radiographs and, sometimes, on the retina by use of an ophthalmoscope. Miliary lesions differ from those of cryptogenic disseminated tuberculosis.

Multidrug-resistant TB (MDR TB) – TB disease caused by bacteria resistant to two of the most important medicines: INH and RIF.

Mycobacterium - The name of the genus of bacteria which includes the tubercle and leprosy bacilli and the environmental mycobacteria. The name means 'fungus bacteria', in allusion to the mould-like pellicles they form on liquid culture media.

M. tuberculosis complex -- A group of closely related mycobacterial species that can cause active TB (e.g. M. tuberculosis, M. bovis, and M. africanum); most TB in the United States is caused by M. tuberculosis.

Negative Pressure - An isolation room used for infectious patients from which the air is constantly being extracted to result in slight negative pressure in the room compared with the outside corridor. Any bacteria coughed by the patient will then be extracted through a filter system rather than blowing into the corridor.

Percutaneous - The route of administration through or via the skin.

Prevalence - Prevalence is a measurement of all individuals affected by the disease at a particular time. This is distinct from incidence, which is a measurement of the number of new individuals who contract a disease during a particular period of time.

Positive PPD reaction - A reaction to the purified protein derivative (PPD)- tuberculin skin test that suggests the person tested is infected with M. tuberculosis. The person interpreting the skin-test reaction determines whether it is positive on the basis of the size of the induration and the medical history and risk factors of the person being tested.

Pulmonary tuberculosis - Tuberculosis of the lung. The most common form of tuberculosis. Pulmonary TB is the only form of TB that may be infectious.

Purified Protein Derivative (PPD) - A derivative of tuberculin prepared by harvesting precipitated proteins. It is less likely to give non-specific reactions than unpurified tuberculin.

Purified protein derivative (PPD) - tuberculin - A purified tuberculin preparation that was developed in the 1930s and that was derived from old tuberculin. The standard Mantoux test uses 0.1 ml of PPD standardized to 5 tuberculin units.

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Rifampicin (Rifampin in the USA) - A member of a class of antibiotics termed the rifamycins, it is the most powerful of the first-line anti-tuberculosis drugs. It has the unique property of killing very slowly, replicating bacilli that persist in lesions.

Smear positive/smear negative - Smear positive means that bacteria can be seen when a sample of sputum is specially stained and examined under a microscope. It usually indicates an infectious patient. Smear negative means that the bacteria could not be seen in a specimen. It may mean that disease is absent or that bacteria are too few to be seen.

Sputum – Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB blood test – A test that uses a blood sample to find out if you are infected with TB bacteria. The test measures the response to TB proteins when they are mixed with a small amount of blood. Examples of these TB blood tests include QuantiFERON®-TB Gold In-tube (QFT-GIT).

Tuberculosis - A chronic infectious disease caused by the closely related species [Mycobacterium tuberculosis](#), [M. bovis](#), and [M. africanum](#).

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CROSS REFERENCES:

- Tuberculosis Screening Program
- TST- Administration and Interpretation of TB Skin Test

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APPENDIX A

RESPIRATORY PROTECTION PROGRAM

1. Assignment of Responsibility- Respiratory Care Department.
2. Identify those HCWs to be fit-tested.
3. Select respirator- NIOSH-approved (minimum N- 95).
4. Instruct each HCW to abstain from eating, drinking, and chewing gum for a minimum of 15 minutes prior to being fit-tested.
5. HCW to fill out questionnaire/medical evaluation entitled, "Mandatory Information for those Employees Selected to use a Respirator" to determine the employee ability to use a respirator (see attachment). Evaluate the employee potential health problems that might limit the employee's ability to wear a respirator during performance of normal job duties. (Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used and the medical status of the employee.)
6. Fit-tester to review and determine HCW's ability to be fit-tested and wear N-95 in the clinical setting. If questionnaire results indicate health concerns and inability to wear respirator safely, do not continue with fit-testing. (Refer if needed, as designated by EHS.)
7. Describe to the employee the limitation of the respirator and the consequences for not wearing it correctly.
 - A. Limitations:
 - i) Respirator face-seal leakage is not necessarily 100%.
 - ii) Lack of fit-checking each time used may increase risk of leakage.
 - iii) Qualitative tests rely on the subjective response of the HCW being fit-tested.
 - iv) Considerations of hygiene, damage, and breathing resistance all are factors in its use.
 - B. Consequences:
 - i) Risk of exposure to M. tuberculosis.
8. Train the healthcare worker on:
 - A. How the respirator is to be applied to the face and how to adjust it.
 - B. How to inspect the integrity (physical damage or soil) of the respirator.
 - C. How to fit-check with each use.
 - D. How to maintain the respirator (protect from elements.)
 - E. How to store the respirator (clean, convenient, sanitary area, if it is to be reused.)
 - F. When to dispose of the respirator (damaged or noticeable breathing resistance.)

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- G. How to dispose of the respirator (regular trash.)
 - H. How to obtain additional respirators.
 - I. To return for refit-testing if the employee has facial changes (through weight loss/gain, medical conditions, facial surgery, etc.) or if there are any questions. Training can recur annually or as needed.
 - J. Fit-testing and respirators are at no cost to the employee.
9. Inform the HCW of the ingredients of the fit-test solution and that they will be exposed to a fine mist.
 10. Qualitatively (saccharin) fit-test an appropriate size respirator to the HCW following the instructions of the manufacturer's fit-test kit.
 11. Allow the healthcare worker to practice how it should be worn.
 12. If the HCW cannot be fitted with the available respirators, assign other HCWs to visit the patient.
 13. Maintain documentation of fit-testing in personnel file.

APPENDIX B: MANDATORY INFORMATION FOR THOSE EMPLOYEES SELECTED TO USE A RESPIRATOR

MANDATORY INFORMATION FOR THOSE EMPLOYEES SELECTED TO USE A RESPIRATOR	
1.	Name: _____ Date: _____
2.	Age: _____ 3. Sex: <input type="checkbox"/> M <input type="checkbox"/> F 4. Height: _____ 5. Weight: _____
6.	Job Title: _____
7.	Telephone #: _____ Best time to be reached at this #: _____
8.	Has your employer ever told you how to contact the health care professional who will review this questionnaire: <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Check the type of respirator you will use: <input type="checkbox"/> N <input type="checkbox"/> R or <input type="checkbox"/> P (make, model, style)
10.	Have you ever worn a respirator: <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", what type (s): _____
11.	Do you currently smoke tobacco, or have you smoked tobacco in the last month: <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have you ever had any of the following conditions? A. Seizures (fits): <input type="checkbox"/> Yes <input type="checkbox"/> No B. Diabetes (sugar disease): <input type="checkbox"/> Yes <input type="checkbox"/> No C. Allergic reaction that interferes with your breathing: <input type="checkbox"/> Yes <input type="checkbox"/> No D. Claustrophobia (fear of closed-in places): <input type="checkbox"/> Yes <input type="checkbox"/> No E. Trouble smelling odors: <input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you ever had any of the following pulmonary or lung problems? A. Asbestosis: <input type="checkbox"/> Yes <input type="checkbox"/> No B. Asthma: <input type="checkbox"/> Yes <input type="checkbox"/> No

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	C. Chronic Bronchitis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	D. Emphysema:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	E. Pneumonia:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	F. Tuberculosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	G. Silicosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	H. Pneumothorax (collapsed lung):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	I. Lung Cancer:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	J. Broken ribs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	K. Any chest injuries or surgeries:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	L. Any other lung problem that you've been told about:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Do you currently have any of the following symptoms of pulmonary or lung illness?		
	A. Shortness of breath:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	B. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	C. Shortness of breath when walking with other people at an ordinary pace on level ground:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	D. Have to stop for breath when walking at your own pace on level ground:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	E. Shortness of breath when washing or dressing yourself:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	F. Shortness of breath that interferes with your job:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	G. Coughing that produces phlegm (thick sputum):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	H. Coughing that wakes you early in the morning:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	I. Coughing that occurs mostly when you are lying down:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	J. Coughing up blood in the last month:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	K. Wheezing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	L. Wheezing that interferes with your job:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	M. Chest pain when you breathe deeply:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	N. Any other symptoms that you think may be related to lung problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Have you ever had any of the following cardiovascular or heart problems?		
	A. Heart attack:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	B. Stroke:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	C. Angina:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	D. Heart failure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	E. Swelling in your legs or feet (not caused by walking):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	F. Heart arrhythmia (heart beating irregularly):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	G. High blood pressure:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	H. Any other heart problem that you've been told about:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18.	Have you ever had any of the following cardiovascular or heart symptoms?		
	A. Frequent pain or tightness in your chest:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	B. Pain or tightness in your chest during physical activity:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	C. Pain or tightness in your chest that interferes with your job:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	D. In the past two years, have you noticed your heart skipping	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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	or missing a beat: <input type="checkbox"/> Yes <input type="checkbox"/> No E. Heartburn or indigestion that is not related to eating: <input type="checkbox"/> Yes <input type="checkbox"/> No F. Any other symptoms that you think may be related to heart or circulation problems: <input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Do you currently take medication for any of the following problems? A. Breathing or lung problems: <input type="checkbox"/> Yes <input type="checkbox"/> No B. Heart trouble: <input type="checkbox"/> Yes <input type="checkbox"/> No C. Blood pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No D. Seizures (fits): <input type="checkbox"/> Yes <input type="checkbox"/> No
20.	If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following box and go to question 21: <input type="checkbox"/>) A. Eye irritation: <input type="checkbox"/> Yes <input type="checkbox"/> No B. Skin allergies or rashes: <input type="checkbox"/> Yes <input type="checkbox"/> No C. Anxiety: <input type="checkbox"/> Yes <input type="checkbox"/> No D. General weakness or fatigue: <input type="checkbox"/> Yes <input type="checkbox"/> No E. Any other problem that interferes with your use of a respirator: <input type="checkbox"/> Yes <input type="checkbox"/> No
21.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: <input type="checkbox"/> Yes <input type="checkbox"/> No

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APPENDIX D: TUBERCULOSIS SCREENING PROGRAM AND EMPLOYEE TB SCREENING FORM

1. General Information

- A. Participation in the MTB screening program is mandatory initially for all, and for HCWs annually thereafter.
- B. PPD skin tests are available to employees at no cost.
- C. Determination shall be made concerning any medical condition or treatment that leads to severely impaired cell-mediated immunity, thereby affecting the reading of a PPD skin test.
- D. An employee shall be counseled regarding the meaning of a PPD skin test result.
- E. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
- F. PPD Positive Interpretation (definition):
 - i) A reaction of ≥ 5 mm is classified as positive in:
 - Persons with HIV infection or risk factors for HIV infection with unknown HIV status.
 - Persons who have had recent contact with persons with active TB
 - Persons who have abnormal chest radiographs consistent with old healed TB
 - ii) A reaction of ≥ 10 is classified as positive in all persons who do not meet any of the criteria above but who have other risk factors for TB including:
 - High-Risk Groups
 - a) Intravenous drug users known to be HIV seronegative
 - b) Persons with other medical conditions that have been reported to increase the risk of progressing from latent TB infection to active TB, including silicosis, gastrectomy, jejunio-ileal bypass surgery, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorder (e.g. leukemia and lymphomas), and other malignancies.

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- High-Prevalence Groups
 - a) Foreign-born persons from high prevalence countries in Asia, Africa and Latin America
 - b) Persons from medically underserved low income populations
 - c) Persons from high-risk populations in their communities, as determined by local public health authorities

- iii) Induration of ≥ 15 mm increase within a 2-year period is classified as positive for persons who do not meet any of the above criteria.

- iv) Recent converters are defined on the basis of both induration and age:
 - ≥ 10 mm increase within a 2-year period is classified as positive for persons < 35 years of age
 - ≥ 15 mm increase within a 2-year period is classified as positive for persons ≥ 35 years of age
 - ≥ 5 mm increase under certain circumstance (see “i” above).

- 2. New Healthcare Workers and PPD Skin Testing:
 - A. Healthcare workers with no documented evidence of PPD skin testing or those with history of BCG vaccine or those new healthcare workers who have documentation of a PPD (-) status, yet the documentation is greater than 12 months:
 - i) New healthcare workers with undocumented history of PPD testing or (PPD-more than 12 months ago) or treatment with BCG shall be tested upon hire using the two-step tuberculin skin testing method. If the first tuberculin test is positive, a second 5-TU shall be administered 1-3 weeks later. A positive second result probably indicates boosting from a past infection or prior BCG vaccination. Persons having a boosted reaction should be classified as a reactor, not a converter. If the second result is negative, the person is probably uninfected and a positive reaction to subsequent tests indicates a true tuberculin skin-test conversion.
 - ii) Use intermediate strength PPD 5 TU/0.1cc intradermal in the forearm.
 - B. PPD Positive New Healthcare Workers
 - i) Known PPD (+) new healthcare workers with professionally documented previous positive reaction or TB infection/treatment, or both, are exempt from further PPD screening and shall be evaluated by symptom review and risk evaluation using the employee screening form. Obtain chest x-ray if indicated.
 - ii) New healthcare workers with a history of possible significant previous reaction which is undocumented should be: 1) strongly encouraged to obtain documentation of previous (+) as many people are unclear on their medical history/testing, 2) probed to describe the “positive” test (i.e. where was it given,

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what did it look like, who told you it was positive, what was the follow-up?), 3) considered for skin testing if answers to questions in 2) clearly indicate that the HCW does not know their PPD history, 4) if unable to obtain documentation of skin test, then obtain chest x-ray at the hospital's provider of employee health services, 5) if the chest x-ray is clear, consider the employee cleared for patient care activities. If the chest x-ray is abnormal, employee health services provider will evaluate for further follow-up/clearance for work. All new healthcare workers who react or convert to PPD (+) will need to be evaluated by chest x-ray and should be medically evaluated for further treatment and clearance for work.

3. Annual Healthcare Worker Evaluation for Clinical Employees:

All employees must have a PPD skin test annually (unless already documented positive). If the HCW converts their skin test to a (+), assess for symptoms of TB and refer to hospital's provider of employee health services for chest x-ray, further medical evaluation, treatment if indicated, and clearance for work:

4. TB Exposure Incident:

- A. Definition- An exposure incident is defined as any unprotected exposure to a patient/client with a (+) AFB smear, which results in identification as MTB, or if clinical diagnosis of MTB is confirmed by the health department.
- B. Follow-up- Administer PPD skin testing to non-reactors 12 weeks after the exposure.
 - i) If the skin test is negative, the healthcare worker shall revert to annual skin testing schedule.
 - ii) If the skin test is positive, refer to PPD converter section above and work with the health department for proper follow-up.
- C. Investigate the exposure incident for transmission risks, need for further education, procedural changes, and further employee contacts/exposures.

APPENDIX E: CLIENT/FAMILY EDUCATION MATERIAL

1. Healthcare workers from SVMC are practicing **Airborne Precautions** until deemed unnecessary. SVMC is dedicated to protecting the health and safety of its employees. The healthcare workers entering the patient's room will wear a special mask called a respirator at all times. The reason for these **Airborne Precautions is that the patient has been diagnosed with or has symptoms/diagnostic test results indicating suspicion of active tuberculosis:**

- The patient has been diagnosed by a physician as having clinical signs/symptoms of active tuberculosis.
- The health department has determined that the patient has or is suspicious for having active tuberculosis.


SUBJECT: TUBERCULOSIS CONTROL PLAN	SECTION: Page 30 of 32
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- One of the laboratory tests done by the hospital indicates that they may have active tuberculosis (+ AFB sputum test).
- 2. You may contact the Tulare County Department of Health Services if you have additional questions. They will be involved with following up on contacts and exposed individuals. You may also contact your primary care physician.
- 3. Active pulmonary/laryngeal TB is carried in airborne particles, or droplet nuclei, that can be generated when persons who have pulmonary or laryngeal TB sneeze, cough, speak, or sing. The particles are tiny, and normal air currents can keep them airborne for prolonged periods of time. Infection occurs when a susceptible person inhales droplet nuclei containing the TB bacteria.
- 4. It is important that you take your anti-TB medicines exactly as prescribed.
- 5. Visitors in the home- the Health Department will determine when it is safe for you to have visitors in the home.
- 6. Do not leave your home until deemed safe by the health department. If you must go to a doctor's appointment or the Health Department, wear a regular mask until you are no longer considered infectious.
- 7. While at home, always use tissues to cover your mouth and nose when coughing or sneezing. Take any other precautions that the Health Department has instructed you in.

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 <p>Tulare County Health & Human Services Agency Public Health Branch Tuberculosis Program</p>	TUBERCULOSIS DISCHARGE TREATMENT PLAN
<p>Discharge of a Suspected or Confirmed Tuberculosis Patient</p> <p>As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB may not be discharged or transferred without prior Health Department approval. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria. (See Below)</p> <p>Tuberculosis Control Program (TBC) Response Plan</p> <p>For Weekday Discharge- Non Holiday: Monday - Thursday 8:am - 5:00pm. Upon a receipt of a completed discharge request form, TB staff will provide a response within 24 hours. To expedite your request, please include all laboratory and/or radiology reports.</p> <p>TBC staff will review the request and notify the submitter of approval, or will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day notification.</p> <p>Holiday and Weekend Discharge</p> <p>If you anticipate a discharge on a weekend or holiday, please contact the TB Control Program immediately. For discharge planned Friday through Sunday, a completed form must be received no later than 5pm on Wednesday. For holiday discharge, a completed form must be received no later than 5pm on the second preceding business day.</p> <p>Discharge Criteria</p> <p>Approval of patient discharge is dependent upon compliance of the discharge treatment plan meeting the guidelines included below. Final approval for discharge is granted by the Health Officer after receipt and review of the discharge plan. Forms must be filled out in entirety to avoid delay in approval.</p> <ol style="list-style-type: none"> 1. Home with no at risk individual(s) in the home: <ul style="list-style-type: none"> - Patient is on appropriate drug regimen - Patient is clinically stable - Patient deemed an acceptable candidate for home isolation 2. Home with high risk individual(s) in the home who have not been exposed: <ul style="list-style-type: none"> - Patient is on appropriate drug regimen >1 week - Patient is clinically stable - Patient deemed an acceptable candidate for home isolation - Contact(s) considered for or placed on prophylaxis 3. High Risk Setting: <ul style="list-style-type: none"> - Patient is on appropriate drug regimen >2 weeks - Patient clinically improving - Three consecutive negative AFB smears <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>In all instances, an accurately completed Discharge Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge. If these criteria cannot be satisfied, discharge cannot be approved and the patient MUST be held until the next business day for appropriate arrangements to be made.</p> </div> <p>Contact Information: TB Coordinator, (559) 685-5715 • Fax TB Program (559) 713-3720</p>	

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PURPOSE:

To define the guidelines for decision-makers to determine that life-sustaining treatment may be withheld or withdrawn.

AFFECTED PERSONNEL/AREAS: *ALL STAFF*

PROCEDURE:

Rights of the Resident

Sierra View Medical Center recognizes that an adult person who has capacity has the right to make his/her own health care decisions after having been fully informed about the benefits, risks and consequences of treatment alternatives, even when such decisions might result in shortening the individual's life.

For adult residents who lack capacity, the patient may have his/her wishes followed, if they are known, or decisions made on their behalf by a decision-maker, as described below.

For the purposes of this policy:

1. **“Capacity”** means a resident's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives. Capacity shall be determined by the resident. A resident is presumed to have the capacity to make a healthcare decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. The physician is required by law to document any finding regarding a resident's capacity in the resident's medical record.
2. **“Health care decision”** – means a decision made by a resident or the resident's primary health care decision maker, power of attorney for health care, conservator, or surrogate, regarding the resident's health care, including the following:
 - a. Selection and discharge of health care providers and institutions.
 - b. Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.
 - c. Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
3. **“Individual health care instruction”** means a resident's written or oral direction concerning a health care decision for the resident.
4. **“Life-sustaining treatment”** -- includes, but is not limited to, medically administered hydration and nutrition, blood products, antibiotics, chemotherapy and radiation therapy, pressor agents,

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renal dialysis, surgery, endotracheal intubation, and mechanical ventilation. Cardiopulmonary resuscitation is the subject of a separate Do Not Resuscitate (DNR) policy.

Decision-Makers for Adult Residents Who Lack Capacity

1. The decision-maker for an adult resident who lacks capacity is, in the following descending order of legal priority:
 - a. The resident's designated agent under a valid power of attorney for health care (PAHC);
 - b. A court appointed conservator; or
 - c. A surrogate decision-maker designated by the resident or otherwise selected by the physician as provided in Section 2 below.

Unless otherwise stated in the PAHC, the agent in the PAHC has priority over all other decision-makers including court-appointed conservators. When no agent under a valid PAHC, court appointed conservator, or designated surrogate decision-maker is reasonably available and willing to make the decision, the physician may identify an appropriate surrogate decision-maker.

2. In seeking to identify the appropriate surrogate decision-maker for a resident who has no PAHC agent, conservator or designated surrogate decision-maker reasonably available and willing to make the decisions, the physician may consider family members who:
 - a. Know the resident's feelings and wishes regarding treatment,
 - b. Have expressed concern for the resident's comfort and welfare, and
 - c. Have expressed an interest in the resident by visits or inquiries to the resident's physician or hospital staff.

California law provides no guidance on the order of family members for physicians to select to make a resident's health care decisions. In addition to family members, the physician may select as a surrogate decision-maker a non-family member who satisfies the above criteria and is willing to make decisions.

3. The PAHC agent, conservator or surrogate decision-maker must make the decision in accordance with the resident's individual health care instructions, if any, and other wishes to the extent known to the PAHC agent, conservator or surrogate decision-maker.
4. If the resident did not write or otherwise express individual healthcare instructions, or the PAHC agent, conservator or surrogate decision maker does not know the resident's wishes, the decision is to be made in accordance with the PAHC agent's, conservator's or surrogate decision-maker's determination of the resident's best interest. That determination is to be made by analyzing the resident's personal values to the extent known to the PAHC agent, conservator or surrogate decision-maker, the comparative benefits and burdens of continued treatment and such factors as

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- b. The outcome of any consultations, if any, with other physicians. Physicians who provide consultations must document their findings and recommendation.
 - c. A statement indicating the basis upon which particular person(s) have been identified as appropriate decision-maker(s) for the resident.
 - d. A statement summarizing the outcome of consultations with the resident, or, if the resident lacks capacity, the resident's parent, agent under a valid PAHC, court appointed conservator, guardian, or surrogate decision-maker.
4. The resident's physician is responsible for the decision regarding disconnecting medical devices such as ventilators, pacemakers, etc.
- a. A physician may delegate the function of discontinuing life-sustaining treatment to a registered nurse.
 - b. If the registered nurse wishes to decline, the nursing manager must be notified immediately and an alternate, qualified healthcare provider be assigned who is willing to comply.
5. Brain Death: When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be an independent confirmation by another physician.

REFERENCES:

- CANHR Long term Care Justice and Advocacy. Feb 4, 2016. Retrieved from <https://canhr.org/newsroom/releases/2016/PDFs/CANHRv.Chapman.pdf>.
- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 United States of America, Med Pass Inc.

CROSS REFERENCES:

- Nursing Administration Manual: [PRONOUNCING CESSATION OF LIFE SIGNS](#)
- House-Wide Manual: [DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA](#)

SUBJECT: WOUND CULTURE - SWAB	SECTION: <i>Provision of Care, Treatment and Services (PC)</i>
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To identify and quantify bacteria located within wounds. Anaerobic bacterial cultures are performed to identify bacteria that grow only in the absence of oxygen. Aerobic bacterial cultures are performed to identify bacteria that can live and grow in the presence of oxygen.

POLICY:

Wound infection occurs when microorganisms on the wound surface penetrate into the wound tissues. Cultures are indicated for wounds/incision lines with signs and symptoms of systemic infection, infection beyond wound perimeter and wounds that have shown no signs of healing.

DEFINITIONS:

Systemic infection – Fever, chills, leukocytosis (Bryant & Nix, 2016). Confusion/delirium and anorexia in older adults.

Criteria for wound infection – Assess tissue within a minimum of 4 cm of wound edges. NERDS – Non-healing wound, Exudate, Red and bleeding wound, Debris, Smill from wound. Other signs of infection include induration with defined edges, crepitus, temperature changes, pain. (Bryant & Nix, 2016).

Non-healing wound – Wound that fails to progress within 2-4 weeks after multiple interventions. Classic signs of infection may be muted or absent when inflammatory response is impaired, as in cases of malnutrition, steroid therapy, immunosuppression and wound chronicity (Bryant & Nix, 2016).

EQUIPMENT:

- Gloves, clean or sterile
- **Normal Saline** (Avoid wound cleanser. This is a bacteriostatic solution that will inhibit recovery of pathogens)
- 4 x 4s
- Specimen collector – Culturette
- Lab label
- Appropriate dressing material

PRECAUTIONS:

1. Do not use purulent matter to culture.

SUBJECT:

WOUND CULTURE - SWAB

SECTION:

*Provision of Care, Treatment and
Services (PC)***Page 2 of 2****Printed copies are for reference only. Please refer to the electronic copy for the latest version.**

2. Do not swab over hard eschar.
3. Use a sterile calcium alginate or rayon swab, not cotton.
4. If possible, obtain culture prior to initiation of antibiotics.

(Infection resides in viable tissue, culturing pus, eschar or necrotic tissue will reflect the microflora of that site but will not provide an accurate profile of the microflora in the tissue).

AFFECTED AREAS/PERSONNEL: *RNs, LVNs, CNAs, RESPIRATORY THERAPISTS***PROCEDURE:**

1. Obtain doctor's orders for culture of wound.
2. Cleanse wound with normal saline. Blot dry with sterile gauze.
3. Select site for culture where tissue is viable and not covered with eschar or exudate.
4. Rotate the end of a sterile alginate-tipped applicator over a 1-2 cm² area. Apply sufficient pressure to swab to cause tissue fluid to be expressed. If wound bed is too dry, moisten swab with normal saline without preservative.
5. Place swab into culturette tube without contaminating swab.
6. Redress wound according to dressing change procedure.
7. Label specimen appropriately and transport to the lab within 1 hour.

REFERENCES:

- Bryan, R., & Nix, D. (2016). *Acute & Chronic Wounds*. 5th ed. St. Louis: Mosby.
- Centers for Disease Control and Prevention. (2015). Clinician guide for collecting cultures. Retrieved from <https://www.cdc.gov/antibiotic-use/healthcare/implementation/clinicianguide.html#p3>