



U.S. Department of Justice
Federal Bureau of Prisons

PROGRAM STATEMENT

OPI: CPD/CPB
NUMBER: 6190.04
DATE: June 3, 2014

Infectious Disease Management

/s/

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Director, Federal Bureau of Prisons

1. PURPOSE AND SCOPE

§ 549.11 Purpose and scope.

The Bureau will manage infectious diseases in the confined environment of a correctional setting through a comprehensive approach which includes testing, appropriate treatment, prevention, education, and infection control measures.

2. SUMMARY OF CHANGES

Policy Rescinded

P6190.03 Infectious Disease Management (6/28/05)

Section 7.a.5 replaces existing language with the following:

The institution's A&O program meets the HIV pre-test counseling requirement if documentation such as a sign-in roster is obtained and kept on file. Inmates are not required to sign an informed consent form during HIV counseling sessions. When the pre-test counseling is completed, HSD requires risk-based HIV testing per policy, but recommends testing all sentenced inmates unless they choose to opt out of HIV testing.

Federal Regulations from 28 CFR are shown in this type.

Implementing instructions are shown in this type.

Transporting officials will only accept an inmate who has a health record review documenting no evidence of medical complaints/symptoms associated with TB within the past 30 days and has one of the following screening criteria prior to transport:

- A valid negative tuberculin skin test documented in millimeters within the past 12 months.
- A negative chest x-ray result if the tuberculin skin test is positive or the tuberculin skin test is medically contraindicated.

There is no longer a need to have an annual chest x-ray as long as a baseline chest x-ray is documented.

Findings of the evaluation/examination in BOP contract facilities not using BEMR should be documented in the “Additional Information” section of the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659), if symptoms are present.

Findings of the evaluation/examination in BOP institutions and BOP contract facilities using BEMR should be documented under “Comments” in the BEMR Exit Summary for Inmate Intra-system Transfer, if symptoms are present.

One of the above criteria must be documented on the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659) at BOP contract facilities not using BEMR or on the BEMR Exit Summary for Inmate Intra-system Transfer at BOP institutions and BOP contract facilities using BEMR.

3. PROGRAM OBJECTIVES

The expected results of this Program Statement are:

- The incidence and associated health risks of infectious diseases will be reduced.
- Inmates will receive appropriate training, education, and counseling on contagious disease prevention.
- Risks of infection will be reduced by universal precautions, engineering and work practice controls, appropriate treatment, use of vaccinations, use of personal protective equipment, and other infection control measures.
- Occupational Safety and Health Administration (OSHA) standards relevant to infectious disease management will be met.
- Compliance with the “Correction Officers Health and Safety Act of 1998” will be attained.

4. DIRECTIVES AFFECTED

Program Statements

P1351.05	Release of Information (9/19/02)
P1600.09	Occupational Safety, Environmental Compliance, and Fire Protection (10/31/07)
P5050.49	Compassionate Release/Reduction in Sentence (8/12/13)
P5214.04	HIV Positive Inmate Who Pose Danger to Other, Procedures for Handling of (2/4/98)
P5270.09	Inmate Discipline Program (7/8/11)
P5290.14	Admission and Orientation Program (4/3/03)
P5500.14	Correctional Services Procedures Manual (10/19/12)
P5538.05	Escorted Trips (10/6/08)
P5566.06	Use of Force and Applications of Restraints (10/30/05)
P6031.04	Patient Care (6/3/14)
P6090.03	Health Information Management (7/31/12)

Rules cited in this Program Statement are contained in 28 CFR 549.10 through 549.15.

Rules referenced in this Program Statement are contained in 5 CFR 339.102 and 339.301 through 339.305 and 29 CFR § 1910.1030 (Bloodborne Pathogens).

“Correction Officers Health and Safety Act of 1998”, Pub. L. 105-370, November 12, 1998, 112 Stat. 3374, Sec. 2. Testing for Human Immunodeficiency Virus.

5. STANDARDS REFERENCED

- American Correctional Association Standards for Adult Correctional Institutions, 4th Edition: 4-4281, 4-4354, 4-4355, 4-4356, 4-4357, and 4-4358.
- American Correctional Association 4th Edition Performance Based Standards for Adult Local Detention Facilities, 4th Edition: 4-ALDF-4C-08; 4-ALDF-4C-15; 4-ALDF-4C-16; 4-ALDF-4C-17; 4-ALDF-4C-18.
- American Correctional Association Standards for the Administration of Correctional Agencies, 2nd Edition: 2-CO-4E-01.

6. PROGRAM RESPONSIBILITY

§ 549.11 Program responsibility.

Each institution's Health Services Administrator (HSA) and Clinical Director (CD) are responsible for the operation of the institution's infectious disease program in accordance with applicable laws and regulations.

a. The HSA will provide:

- Infectious disease procedures written in accordance with this Program Statement and other Bureau policy.
- Infectious disease procedures that incorporate and reference, as applicable, standards, guidelines, and recommendations from other Federal agencies including the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), and the National Institutes for Occupational Health (NIOSH). Applicable standards and guidelines will be provided to the Infection Control Officer (ICO).
- An institution occupational exposure control plan for bloodborne pathogens and tuberculosis (TB) in accordance with applicable OSHA Standards.
- The CDC Morbidity and Mortality Weekly Report (MMWR) is available to institution clinical staff for review either as hard copy or on-line.
- A Registered Nurse (RN) or Mid-Level Practitioner (MLP) will be designated, through attrition, as the institution ICO. He/she is responsible for implementing the institution infection control program. The responsibilities of the designated person will be defined in writing (refer to the Quality Improvement/ Infection Control Officer position description).
- Infectious disease procedures will be reviewed annually by the HSA and CD to ensure clinical accuracy.
- The CD, HSA, ICO, and other appropriate institution staff will meet at least quarterly to review the implementation of the institution's infection control and surveillance program.
- Evidence of, at a minimum, quarterly Infection Control meetings (minutes) and review of surveillance activities that are documented and included as part of the institution's Quality Improvement Program (QIP).

7. TESTING

§ 549.12 Testing.

All HIV testing will be conducted using a Food and Drug Administration (FDA)-approved method. All HIV testing requires pre- and post-test counseling. Classification of HIV testing includes:

- **Voluntary.** Voluntary testing is done when the inmate requests testing via an Inmate Request to Staff Member (BP-A0148) form, which will be turned into Health Services.
- **Mandatory.** Mandatory testing is performed when there are risk factors and the test is clinically indicated and/or surveillance testing is required. Inmates must participate in mandatory HIV testing programs. If an inmate refuses mandatory testing, staff will initiate an incident report for failure to follow an order. Inmate written consent is not required.
- **Involuntary Testing.** Involuntary testing is performed following an exposure incident. Written consent of the inmate is not required. If an inmate refuses testing, testing will be conducted in accordance with the Program Statement on Use of Force.

a. Human Immunodeficiency Virus (HIV)

(1) Clinically Indicated. The Bureau tests inmates who have sentences of six months or more if health services staff determine, taking into consideration the risk as defined by the Centers for Disease Control guidelines, that the inmate is at risk for HIV infection. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Inmates housed in BOP institutions, regardless of commitment status, who have risk factors for HIV infection or clinical evidence of HIV infection, will be tested in accordance with clinical guidance from the Medical Director.

(2) Exposure Incidents. The Bureau tests an inmate, regardless of the length of sentence or pretrial status, when there is a well-founded reason to believe that the inmate may have transmitted the HIV infection, whether intentionally or unintentionally, to Bureau employees or other non-inmates who are lawfully present in a Bureau institution. Exposure incident testing does not require the inmate's consent.

An exposure incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious body fluids.

Inmates involved in an exposure incident will be tested for HIV infection. If an inmate refuses, institution medical staff will test the inmate involuntarily with authorization from the Warden. A court order is not required.

The Warden, or designee, will determine whether inmates who are subject to an incident report for failure to obey an order are placed in administrative detention/segregation.

After the inmate is involuntarily tested for HIV, the CD will send a message to the Bureau Medical Director with a copy to the Regional Director. The message must contain:

- The inmate's name and register number.
- The specific diagnosis.
- A description of the exposure incident.
- An indication that education and counseling have been provided to the inmate prior to testing.

(3) Surveillance Testing. The Bureau conducts HIV testing for surveillance purposes as needed. If the inmate refuses testing, staff may initiate an incident report for refusing to obey an order.

Surveillance testing may include but is not limited to testing of newly incarcerated inmates with serial retesting or a random sampling of institutional populations. This testing is conducted based upon guidance from the Medical Director.

(4) Inmate Request. An inmate may request to be tested. The Bureau limits such testing to no more than one per 12-month period unless the Bureau determines that additional testing is warranted.

HIV testing that is requested by an inmate is considered voluntary testing.

(5) Counseling. Inmates being tested for HIV will receive pre and post-test counseling, regardless of the test results.

Medical staff will provide HIV counseling to inmates in accordance with guidance from the Medical Director and CDC recommendations. Counseling will be provided in a language that is easily understood by the inmate.

Individual and confidential pre-test (unless random) and post-test counseling will be the institution physician's responsibility; however, any appropriately trained health care provider

may conduct the actual counseling. The physician or the ICO will counsel all post-test inconclusive inmates. The physician will counsel all post-test positive inmates.

Pre and post-test counseling will address the limitations of the test, i.e., the inability to detect early infections, false positives, false negatives, and the possible need for additional testing as well as the complications and consequences of a negative or positive test result.

Pregnant inmates who test positive will be advised the virus may be transmitted to the fetus and of current treatment options to prevent perinatal transmission.

All inmates testing positive will be referred to the Psychology Department for follow-up counseling.

The institution's A&O program meets the HIV pre-test counseling requirement if documentation such as a sign-in roster is obtained and kept on file. Inmates are not required to sign an informed consent form during HIV counseling sessions. When the pre-test counseling is completed, HSD requires risk-based HIV testing per policy, but recommends testing all sentenced inmates unless they choose to opt out of HIV testing.

The HIV Post-Test Counseling forms BP-A0491 and BP-A0492 will be used for post-test counseling documentation. The forms will be signed by the inmate and retained in the medical record. All forms are available on Sallyport.

b. Tuberculosis (TB)

(1) The Bureau screens each inmate for TB within two calendar days of initial incarceration.

Contagious pulmonary TB disease must be eliminated as a potential diagnosis prior to placing an inmate into general population. Screening for active TB disease for newly incarcerated inmates includes the following:

All inmates will be assessed by a health care professional for clinical signs and symptoms (i.e., weight loss, chronic cough, hemoptysis) of active pulmonary TB during intake screening. The clinical assessment must be documented in the health record. All inmates with symptoms of pulmonary TB will be further evaluated with a chest radiograph.

Tuberculin skin test screening with the PPD (purified protein derivative) skin test, must be initiated within two calendar days of initial incarceration to screen for both latent TB infection and TB disease unless a previously positive tuberculin skin test has been adequately documented.

It is recommended that the TB skin test be placed during intake screening. Inmates with a documented previously positive tuberculin skin test, should not be retested, but should be screened for active TB disease by chest radiograph.

A self-reported, undocumented previous positive tuberculin skin test is not a contraindication to receiving a tuberculin skin test unless a severe previous reaction (e.g. whole arm swelling or severe blistering) has been documented or described by the inmate.

Asymptomatic inmates with a positive tuberculin skin test at intake, or a previously positive tuberculin skin test, will have a chest radiograph completed within 14 calendar days to screen for TB disease unless the inmate has a documented negative chest x-ray subsequent to the positive skin test.

An inmate may not request to substitute a chest radiograph for a screening tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin skin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.

Refer to Subsection (4) below for information on inmates who refuse PPD skin testing.

Inmates will be evaluated and treated for latent TB infection or TB disease in accordance with guidance from the Medical Director.

(2) The Bureau conducts screening for each inmate annually as medically indicated.

All inmates without prior TB infection must be screened annually for newly acquired TB infection, including the following:

- An evaluation by a health care professional for signs and symptoms of TB disease.
- An annual tuberculin skin test for all inmates with a prior negative tuberculin skin test who have no medical contraindications for testing.
- A chest x-ray for all inmates with a newly positive annual tuberculin skin test will be completed within 14 calendar days of the annual tuberculin skin test, or sooner if the inmate has symptoms of TB disease. If the inmate is symptomatic, immediately obtain a chest radiograph and place the inmate in a negative pressure isolation room (NPIR) or make arrangements to transport the inmate to the community hospital.

- An inmate may not request to substitute a chest radiograph for an annual tuberculin skin test. The only exception is when there is a medical contraindication to tuberculin testing or in instances where involuntary testing may cause significant injury to the staff or inmate. The CD or designee is the approving authority for ordering a screening chest radiograph in lieu of an otherwise indicated tuberculin skin test.

(3) The Bureau will screen an inmate for TB when health services staff determine that the inmate may be at risk for infection.

Inmates who have clinical evidence of active TB or a recent exposure to TB will be evaluated in accordance with guidance from the Medical Director.

(4) An inmate who refuses TB screening may be subject to an incident report for refusing to obey an order. If an inmate refuses skin testing, and there is no contraindication to tuberculin skin testing, then, institution medical staff will test the inmate involuntarily.

The physician will document the education and counseling as well as the specific diagnostic evaluation or procedure in the inmate's health record.

Inmates who refuse TB screening will not be placed in medical isolation unless there is a clinical indication for such isolation.

For tracking purposes, after involuntary tuberculin testing for TB infection, the CD will send a message to the Bureau Medical Director with a copy to the respective Regional Director. The message must contain:

- The inmate's name and register number.
- The specific diagnosis.
- A description of the exposure incident.
- Some indication that education and counseling have been provided to the inmate.

(5) The Bureau conducts TB contact investigations following any incident in which inmates or staff may have been exposed to tuberculosis. Inmates will be tested according to paragraph (b)(4) of this section. (For WITSEC inmates, refer to Section 10.)

All active pulmonary TB cases will be investigated when indicated according to CDC guidelines. The investigation and evaluation will be conducted in consultation with the local health

department and Regional and Central Office administrative staff (see Section 8. for surveillance reporting).

(6) **Refusal of Treatment.** Refer to the Program Statement **Patient Care**, Involuntary Medical Treatment/Refusal of Treatment when an inmate refuses treatment for active tuberculosis disease and the inmate poses a risk to others by refusing treatment.

(7) **Medical Clearance for Transporting Inmates.** BOP inmates (including all holdover status inmates; i.e., DEA, U.S. Marshals Service, Bureau of Immigration and Customs Enforcement (ICE), FBI, etc.) who have not been screened for TB are prohibited from transfer between Bureau institutions. Transporting officials will only accept any inmate who has a health record review documenting no evidence of medical complaints/symptoms associated with TB within the past 30 days and has one of the following screening criteria prior to transport:

- A valid negative tuberculin skin test documented in millimeters within the past 12 months.
- A baseline negative chest x-ray result if the tuberculin skin test is positive or the tuberculin skin test is medically contraindicated.

There is no longer a need to have an annual chest x-ray as long as a baseline chest x-ray is documented.

Inmates who have been evaluated for symptoms such as a cough or chills within the past 30 days will be evaluated prior to transport, as clinically indicated.

Findings of the evaluation/examination in BOP contract facilities not using BEMR should be documented in the “Additional Information” section of the BP-A0659, if symptoms are present.

Findings of the evaluation/examination in BOP institutions and BOP contract facilities using BEMR should be documented under “Comments” in the BEMR Exit Summary for Inmate Intra-system Transfer, if symptoms are present.

One of the above criteria must be documented on the Medical Summary of Federal Prisoner/Alien in Transit (BP-A0659) at BOP contract facilities not using BEMR or on the BEMR Exit Summary for Inmate Intra-system Transfer at BOP institutions and BOP contract facilities using BEMR.

For security reasons, the CD may recommend the requirement for a tuberculin skin test or chest x-ray be waived prior to the immediate transport of an inmate, (e.g., an uncooperative inmate where the risk of injury to the inmate or staff precludes involuntary forced testing). An institution physician will examine and clear such inmates for transfer and document this

recommendation. If the tuberculin skin test or chest x-ray is waived, the inmate will be tested upon arrival at the receiving institution.

c. Diagnostics. The Bureau tests an inmate for an infectious or communicable disease when the test is necessary to verify transmission following exposure to bloodborne pathogens or to infectious body fluid. An inmate who refuses diagnostic testing is subject to an incident report for refusing to obey an order.

Testing for viral hepatitis, sexually transmitted infections (STI) and other infectious diseases will be performed based upon clinical indications and guidance from the Medical Director.

d. Disease Prevention. Influenza, Pneumococcal, Tetanus/Diphtheria, and Measles/Mumps/Rubella immunizations will be provided routinely to inmates in accordance with CDC guidelines and guidance from the Medical Director.

All inmates who receive vaccinations will be provided information, based on the Center for Disease Control and Prevention (CDC) Vaccine Information Statements (VIS), about the risks and benefits of the vaccine including specific side effects that may occur.

Informed consents are recommended in accordance with State laws.

Health Services staff will maintain the immunization record in each inmate's health record.

8. MONITORING, BUREAU REPORTING, AND SURVEILLANCE

All Bureau reportable infectious diseases are identified on the Sensitive Medical Data (SMD) Outpatient Morbidity and Procedures Classification Reporting. Each institution will ensure that all cases of infectious diseases are entered into the SENTRY SMD system consistent with current policy. The ICO will monitor prevalence and incidence data by retrieving data from the SENTRY SMD system or other tracking mechanism.

The ICO will ensure that infectious disease outbreaks or infectious diseases with outbreak potential are reported to the Health Services Division, Central Office, on the Infectious Disease Outbreak Record form (BP-A0664).

The ICO will ensure all active TB cases are reported to the Health Services Division, Central Office, on the Tuberculosis Case/Suspect Record and Referral form (BP-A0665), if a state reporting form is not available for submission.

Consultation on specific TB control, evaluation measures, and treatment will be provided to the institution CD.

The Central Office will be notified of all investigation outcomes, i.e.:

- Number of inmates and number of staff screened.
- The number of exposures (or conversions) for each group (inmates and staff).
- The number(s) treated.

9. PROGRAMMING, DUTY, AND HOUSING RESTRICTIONS

§ 549.13 Programming, duty, and housing restrictions.

a. The CD will assess any inmate with an infectious disease for appropriateness for programming, duty, and housing. Inmates with infectious diseases that are transmitted through casual contact will be prohibited from work assignments in any area, until fully evaluated by a health care provider.

b. Inmates may be limited in programming, duty, and housing when their infectious disease is transmitted through casual contact. The Warden, in consultation with the CD, may exclude inmates, on a case-by-case basis, from work assignments based upon the security and good order of the institution.

Inmates with infectious diseases that are not foodborne or transmitted by casual contact; i.e., HBV, HCV, HIV, are not prohibited from assignment to Food Service based solely upon the diagnosis of the infectious disease. The primary care provider will determine the inmate's suitability for Food Service.

c. If an inmate tests positive for an infectious disease, that test alone does not constitute sole grounds for disciplinary action. Disciplinary action may be considered when coupled with a secondary action that could lead to transmission of an infectious agent. Inmates testing positive for infectious disease are subject to the same disciplinary policy that applies to all inmates (see 28 CFR 541, subpart B). Except as provided for in our disciplinary policy, no special or separate housing units may be established for HIV-positive inmates.

In addition to standard precautions, all institutions will utilize appropriate transmission-based **precautions**, such as:

- Airborne precautions for small particle organisms.

- Droplet precautions for large particle organisms.
- Contact precautions for direct skin-to-skin touching or when indirect spread may occur.

Necessary containment measures will be used to transport, isolate, restrict contact of inmates with potentially communicable disease, until no longer contagious.

Only those institutions equipped with the proper engineering controls to house inmates in a negative pressure isolation room (NPIR) that comply with the current CDC recommendations, have the option to isolate and treat inmates with suspected TB or other airborne disease (requiring airborne precautions) that may remain suspended in the air and be spread by casual contact.

Refer to Section 11, for NPIR controls under engineering controls and personal protective equipment (PPE). Otherwise, arrangements will be made to transport the inmate to the local hospital with the necessary facilities to isolate and treat until the inmate is no longer contagious.

(1) **Containment** will include the following:

- Until the inmate is transported to a local hospital, he or she will be immediately removed from the institution's general population.
- The inmate will be placed in a low traffic flow area until transported to a local hospital.
- When transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room, special respirator precautions will be taken.
- Escort personnel will wear an appropriately fitted NIOSH-certified Respirator (N95 efficiency or better) whenever interacting with the inmate in a room or closed environment.
- The inmate is to be moved from the holding area to R&D in a manner to eliminate or minimize contact with other staff or inmates. The inmate will be issued and wear a standard "surgical-type" mask.
- No other inmates will be transported with an inmate suspected of or diagnosed with a contagious communicable disease.

(2) **Appearances at Court, ICE, or U.S. Parole Commission (USPC) Hearings.** If for any reason an inmate with suspected TB or other communicable contagious disease is scheduled to appear in Court, before an Executive Office of Immigration Review (EOIR) judge or Cuban Review Panel, an ICE or USPC hearing, the Warden will ensure the appropriate hearing authority is notified that the inmate is undergoing treatment for a communicable contagious disease and cannot be moved until the treating physician determines that the inmate is considered no longer contagious.

If possible, a tentative treatment timetable and date of inmate availability should be given to the hearing authority.

(3) Staff Escorting Inmates with TB, Suspected TB or Other Communicable Contagious Diseases. Special respiratory protection measures will be taken when transporting the inmate in a vehicle or when interacting with the inmate in a negative pressure room.

Escort personnel, including contract guard services, clinical staff, and others in close contact with the inmate will wear a NIOSH approved respirator (N-95 or better).

Prior to use of a respirator, staff will be medically cleared, fit-tested and trained in accordance with the current OSHA standard on respiratory protection.

10. CONFIDENTIALITY OF INFORMATION

§ 549.14. Confidentiality of information.

Any disclosure of test results or medical information is made in accordance with:

a. The Privacy Act of 1974, under which the Bureau publishes routine uses of such information in the Department of Justice Privacy Act System of Records Notice entitled “Inmate Physical and Mental Health Record System, JUSTICE/BOP-007”; and

b. The Correction Officers Health and Safety Act of 1998 (codified at 18 U.S.C. § 4014), which provides that test results must be communicated to a person requesting the test, the person tested, and, if the results of the test indicate the presence of HIV, to correctional facility personnel consistent with Bureau policy.

Relevant infectious disease data will be disclosed as follows:

(1) To State Health Departments and/or the Center for Disease Control, pursuant to state and/or federal laws requiring notice of cases of reportable infectious diseases;

If the inmate is a WITSEC, and circumstances mandate that an infectious disease be reported to the Public Health Department (county or state), Inmate Monitoring, Central Office, must be notified prior to any release of the inmate’s name and/or any communication (telephone, face-to-face, etc.) between the inmate and public health officials.

The HSA or designee will ensure that the respective State Health Department is informed of all cases of reportable infectious disease.

(2) Findings of all contact investigations will be reported, as required, to the State Health Department.

(3) The Community Corrections Manager will receive a copy of the Medical/Psychological Pre-Release Evaluation form (BP-A0351), included in the request for CCC placement. This form will identify inmates known to be HIV positive, or under treatment for exposure to, or active TB.

(4) To the physician/provider of a Bureau or non-Bureau staff, or other person exposed to a bloodborne pathogen while lawfully present in a Bureau facility, for the purpose of providing prophylaxis or other treatment and counseling;

(5) To Department of Justice employees who have a need to know in the performance of their duties including, but not limited to, Health Care Personnel, Social Workers, Unit Management staff, and Psychologists.

(6) All parties, with whom confidential medical information regarding another individual is communicated, will be advised not to share this information, by any means, with any other person. Medical information may be communicated among medical staff directly concerned with an inmate's case in the course of their professional duties.

11. EXPOSURE CONTROL PLAN

Each institution will have a written Exposure Control Plan (ECP) that will comply with and contain the elements as defined in 29 CFR 1910.1030, Bloodborne Pathogens. Staff will be trained on compliance with 29 CFR 1910.1030 on employment and during annual training.

a. **Exposure Determination.** All Bureau employees assigned to correctional facilities are required to perform tasks which potentially could expose them to blood and body substances. All Bureau employees are covered by, and must comply with, all aspects of the ECP.

Each institution will identify in the ECP the classification of work assignments for inmates based upon risk of occupational exposure.

b. Methods of Compliance

(1) **Universal Precautions (Standard Precautions).** This method of infection control requires all employees and inmates to assume that all human blood and specified human body fluids are infectious for HIV, HBV, and other bloodborne pathogens.

(2) **Engineering and Work Practice Controls.** The institution ECP will define the position or department responsible for examining, maintaining, and/or replacing engineering and work practice controls on a regular schedule to ensure their effectiveness.

(3) **Personal Protective Equipment (PPE).** The institution ECP will identify the person or department responsible for:

- Requiring the use of personal protective equipment.
- Providing personal protective equipment.
- Ensuring that personal protective equipment is properly used, stored, cleaned, laundered, repaired, replaced, or discarded as needed.
- Investigating and documenting circumstances in which ppe was not used in order to determine whether changes can be instituted to prevent such occurrences in the future.

Inmates may **never refuse** to wear personal protective equipment.

(4) **Housekeeping.** Each institution will develop a housekeeping plan to assign responsibilities in keeping a clean and sanitary environment. The plan will include a written cleaning schedule.

The Warden will assign a person to be responsible for developing and maintaining the plan. The HSA will review the plan to ensure it complies with the requirements of 29 CFR 1910.1030.

(5) **Regulated Medical Waste.** Each institution will have local policies and procedures for the handling, collecting, transporting, and storing regulated medical waste. Regulated waste management must meet OSHA standards and comply with respective state and local requirements, and local security procedures.

The HSA and Safety Manager have joint responsibility for written procedures for the management of regulated medical waste.

Disposal of all regulated medical waste must be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Regulated waste will be stored in a manner and location that maintains the integrity of the packaging and provides protection from outside elements, rodents, and vermin. Regulated waste will be stored in the following manner:

- Out of sight of inmates and visitors in a non- congested area.
- In a locked storage area with a biological hazard symbol posted on the door.
- The storage area must have an exhaust system to the outside and a smooth, impervious floor.

(6) **Laundry.** Each institution will include in the Health Services Policy and Procedure Manual procedures for the handling and bagging, laundering (on-site), storage, and transport of linens contaminated with blood or body fluids in accordance with the 29 CFR 1910.1030, Bloodborne Pathogen Standard, state and local sanitation requirements.

c. **Bloodborne Pathogen Post-Exposure Evaluation and Follow-Up**

(1) Inmates at risk of work exposures who believe that they have been exposed to an infectious disease, blood, or body fluids while on duty will report the exposure to their supervisor and the Health Services Unit where an Inmate Injury Assessment and Follow-Up (BP-A362) will be completed.

(2) Inmates in non-work related situations who believe they have been exposed to an infectious disease will report to the Health Services Unit for clinical evaluation.

(3) The CD/staff physician will determine the occurrence of a bloodborne exposure.

(4) The CD will promptly order mandatory testing on any inmate sentenced to a term of imprisonment for a Federal offense, or ordered detained before trial, when there is well-founded reason to believe the inmate may have intentionally or unintentionally transmitted HIV to any officer or employee of the United States, or to any non-inmate who is lawfully present in a correctional facility.

(a) Consistent with this Program Statement, when there is a determination of an exposure to HIV, medical staff will inform any person who may have been exposed to HIV (in, as appropriate, confidential consultation with the person's physician), of the potential risk involved and, if warranted by the circumstances, that prophylactic or other treatment should be considered.

(b) The inmate who may have transmitted HIV will be tested promptly for the presence of HIV, and the test results will be communicated to the inmate tested.

- (c) Employees will be told if an exposure incident was negative for HIV.
- (d) If the results of a test indicate a source positive for the presence of HIV, the BOP will:
- Advise the tested inmate that the test was positive for the presence of HIV, and provide the inmate with appropriate counseling, health care, and support services.
 - Provide the affected officer or employee of the United States access to medically necessary health care.
 - Provide all other non-inmate individuals who are lawfully present in the correctional facility with information about national hotlines, health care referral centers, and other resources of information concerning treatment for HIV and AIDS. **The local procedure for providing and documenting the information provided to these individuals will be defined in the ECP.**
- (5) If there has been a determination of a bloodborne exposure to an infectious disease other than HIV, the source inmate will be tested according to 28 CFR 549.12. Refer to Section 7.c., Diagnostics, of this Program Statement.
- (6) Once a determination is made that a bloodborne exposure has occurred, the exposed inmate will be offered emergency care, evaluation, and prophylaxis in accordance with the U.S. Public Health Service recommendations, 18 U.S.C. § 4014, and guidance from the Medical Director.
- (7) If the inmate is due for release from custody and will require continuation of recommended treatment, the inmate must sign an Authorization for Release of Medical Information form (BP-A0621) to allow release of the information to a community provider. Preparation for transitional medical needs should be initiated in advance for continuity of prescribed treatments.
- (8) The CD will ensure that all post-exposure medical evaluation and follow-up is documented in the medical record. At a minimum, this documentation will include:
- The routes of exposure and a detailed account of how the exposure occurred (work related or non-work related).
 - All medical and prophylactic treatments received and counseling.
 - Completion of the Inmate Consent/Declination for HIV Post-Exposure Prophylaxis (PEP) form (BP-A1053), when indicated.
 - Assurance that the exposed inmate has been informed of potential risks of infection, precautions to prevent potential transmission of infection, and the results of the evaluation, including any medical conditions resulting from the exposure incident, that may require further evaluation or treatment.
 - Protection of the privacy of the exposed/injured person according to the Privacy Act.

- Exclusion of specific names of source individuals on the medical record for inmate exposures.

d. **Communication of Hazards: Use of Labels and Signs.** Each institution will include in the Health Services Policy and Procedure Manual procedures for the use of labels and signs that are in compliance with 29 CFR 1910.1030, federal, state, and local regulations.

12. INFECTIOUS DISEASE TRAINING AND PREVENTIVE MEASURES

§549.15. Infectious disease training and preventive measures.

a. **The HSA will ensure that a qualified health care professional provides training, incorporating a question-and-answer session, about infectious diseases to all newly committed inmates, during Admission and Orientation.**

b. **Inmates in work assignments which staff determine to present the potential for occupational exposure to blood or infectious body fluids will receive annual training on prevention of work-related exposures and will be offered vaccination for Hepatitis B.**

(1) **Inmate Orientation.** All inmates entering Bureau facilities will receive education on the following infectious disease topics:

- HIV infection, including general review of current information on HIV transmission, prevention, disease course, and treatment options.
- Tuberculosis, including general review of current information on tuberculosis transmission, prevention, surveillance (skin-testing), latent TB infection, disease course, and treatment.
- Viral Hepatitis and sexually transmitted diseases, including general review of current information on transmission, treatment, and prevention.

(2) **Bloodborne pathogen and TB control training** will be provided to all inmate workers consistent with the requirements stipulated in 29 CFR 1910.1030 and will contain the following elements:

- Obtaining copies of applicable regulatory texts with an explanation of their contents.
- Information on the epidemiology and symptoms of bloodborne diseases and TB.
- Ways in which bloodborne pathogens and TB are transmitted.
- Explanation of the ECP and how to obtain a copy.
- Information on recognizing tasks that might result in occupational exposure.

- Explanation of standard precautions, the use and limitations of work practice, engineering controls, and personal protective equipment.
- Information on the types, selection, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment.
- Information on hepatitis B vaccination such as safety, benefits, efficacy, methods of administration, and availability.
- Information on who to contact and what to do in an emergency.
- Information on reporting an exposure incident and on the post-exposure evaluation and follow-up.
- Information on warning labels, signs (where applicable), and color-coding.
- Question and answer session on any aspect of the training.

(3) **Preventive Measures (Hepatitis B Vaccination).** Each institution will include in the ECP which inmate work assignments have the potential for exposure to blood and body fluids and includes, but is not limited to:

- Inmates who are assigned to a blood/body fluid spill team.
- Inmate workers who handle laundry contaminated with blood or body fluids.
- Inmates assigned to Health Services.

Inmates will be offered the Hepatitis B vaccine in compliance with 29 CFR 1910.1030.

If vaccine administration is deemed appropriate and the individual consents, the health care provider will review the CDC Vaccine Information Statement on Hepatitis B vaccine with the inmate and complete the BP-A0808, Vaccine Consent – Inmates.

The hepatitis B vaccine and vaccination series will be initiated within 10 working days of initial assignment to inmates who have occupational risk for exposure to blood or other potentially infectious materials and according to the institution's ECP unless:

- The individual declines the vaccination; **or**
- The individual has previously received the complete hepatitis b vaccination series; **or**
- Medical contraindications exist.

Inmates who decline the vaccination will sign the BP-A0808, indicating that they are declining the vaccine. An inmate may request and obtain the vaccination at a later date if he/she continues to be in an exposure-prone job.

(4) **Training Records.** Each institution's ECP will identify the person or department responsible for maintaining the training records as required by 29 CFR 1910.1030.

13. SHARPS SAFETY PROGRAM.

Each institution will establish a Sharps Safety Program as a component of the institution ECP. The ECP will define the person or department responsible for the program. The program will consist of the following:

a. Sharps Injury Log

(1) The Safety Manager is responsible for establishing and maintaining a Sharps Injury Log for the recording of percutaneous injuries from contaminated sharps. All sharps injuries must be reported to the Safety Manager.

(2) The Infection Control Officer in conjunction with the Safety Manager will ensure that sharp injuries are tracked on an ongoing basis to include information that will identify high risk areas and assist in the selection and review of safety devices.

b. Evaluation of injuries and medical devices will be documented and reported to Infection Control, Safety, and Quality Improvement Program committees.

c. The annual review and update of the ECP will reflect the process for documentation of the evaluation and implementation of appropriate commercially available and effective safer medical devices.

The annual review and update of the ECP will reflect the process for solicitation of input from non-managerial employees responsible for direct patient care. This will include employees who have the potential for exposure injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and documentation of this solicitation in the ECP.

d. The Sharps Safety Program will account for the actions necessary to reduce exposure to bloodborne pathogens by incorporating technologic innovations.

14. EXPOSURE TO AIRBORNE DISEASES

Respiratory protection devices help prevent exposure by inhalation of infectious airborne nuclei. Such equipment must be NIOSH certified and provide a filter efficiency of 95% or better (i.e., N95 or a high efficiency particulate air filter).

Each institution will purchase NIOSH certified particulate respirators (N95 or HEPA) of appropriate sizes necessary for all staff designated for fit-testing and store them in the Health Services storage area. Particulate respirators should be available in work areas where clinical assessment and identification of a TB suspect may occur.

- a. The cost of purchasing NIOSH respirators and training and fit-testing will be incurred locally.

The Safety Manager is to provide the Business Office a list of recommended vendors for purchase.

- b. The Safety Manager or designee at each institution is to be trained in the necessary functions to provide fit testing of TB respirators for inmates that require training. Subsequently, the Safety Manager or designee, will provide each inmate at risk of work-related exposure who is fitted with a NIOSH respirator, the training necessary in its wear and use.

All training for the inmate worker at risk on TB respirator use is to be documented and placed on inmate's training record. The HSA will ensure inmate training records are placed in the Inmate's Central File.

- c. **Tuberculosis Exposures.** Following an incident in which an inmate(s) may have been exposed to tuberculosis, the inmate(s) will be tested according to 28 CFR 549.12(b). 20 CFR 549.12(b) refers to Section 7.b.(3),(4), and (5) of this Program Statement.

Once an institution physician determines a TB exposure has occurred, the exposed individuals will be offered evaluation and treatment for latent TB in accordance with the U.S. Public Health Service recommendations and guidance from the Medical Director.