U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

PROGRAM STATEMENT
Infection Prevention and Control

Approved by	William K. Marshall III Director, Federal Bureau of Prisons
DPI	HSD
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Summary of Changes

Program Statement Rescinded: ▪ 6190.04 Infectious Disease Management (6/3/2014)
Changes: ▪ Extensive changes have been made throughout this program statement to improve clarity and align with updates to Bureau of Prisons (Bureau) procedures.

1. **§ 549.10 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.

This program statement outlines components of an effective Infection Prevention and Control (IP&C) Program to reduce infectious disease transmission within Bureau facilities. While Health Services has responsibility for oversight and coordination of the IP&C program, all departments, staff and inmates play an important role in preventing and controlling the transmission of infectious diseases within Bureau facilities.

a. **Program Objectives.**

- Risks of infection and transmission will be reduced by using universal precautions, engineering and work practice controls, medical screening, vaccinations, personal protective equipment, and other infection control measures.
- Staff and inmates will receive appropriate training, education, and counseling on infection prevention and control measures.
- Institutions will comply with relevant laws, regulations, and standards.

b. **Institution Supplement.** None.

2. **§ 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.

- The HSA has administrative oversight of the institution IP&C program. The CD or designee ensures the IP&C program operates within the parameters of evidence-based medical practice.
- The IP&C nurse implements the institution's IP&C program. If the IP&C nurse position is vacant, the HSA may designate either a registered nurse (RN) or advanced practice provider (APP [i.e., nurse practitioner or physician assistant]) to serve in the position.
- Annually, the following local IP&C procedures and plans will be reviewed, updated, and approved by the Governing Body, which consists of individuals with the authority to oversee, direct, and make decisions for an institution:
  - Health Services Unit (HSU) IP&C procedures.
  - IP&C risk assessment and plan.
  - Tuberculosis exposure control plan.
  - Bloodborne Pathogen exposure control plan.

For a description of IP&C procedures and each plan, see Section 3. Required Infection Prevention and Control Procedures and Plans.

- Locally, a Respiratory Illness Pandemic plan will be developed, reviewed, and updated annually by the IP&C nurse, HSA, and Governing Body.
- IP&C meetings are held at least quarterly and documented with meeting minutes. The Central Office Health Services Division (HSD) Population and Correctional Health Branch IP&C Section (referred to as the HSD IP&C Section herein) will establish and make available on the Bureau's intranet site the required template for IP&C meeting minutes to be documented. At a minimum, participants include the CD, HSA, and IP&C nurse (or designees for these positions). The HSA or CD may include other staff based on the institution's needs. During the meetings, surveillance data will be reviewed and summarized, IP&C concerns and strategies will be identified, issues to be brought before the institution Governing Body will be identified, and the IP&C risk assessment and plan will be discussed.
- The IP&C nurse or designee participates in Quality Improvement meetings and other departmental institution meetings when IP&C issues need to be addressed (e.g., quarterly Facilities Work Programming Committee Meetings). The IP&C nurse or designee will provide the HSA with necessary IP&C data for Governing Body meetings.
- IP&C training upon hire and annually will be provided to:
  - All staff (during Introduction to Correctional Techniques [ICT] Phase 1 and Annual

trainings), in accordance with the requirements in Occupational Safety and Health Administration (OSHA) Standards 1910.1030 – Bloodborne pathogens, because they have the potential to be exposed to bloodborne pathogens. In addition, all staff who are required to use respirators will be trained in accordance with the requirements in OSHA Standard and 1910.134 – Respiratory protection.

- Health Services staff who provide direct inmate care. Training topics will include disease surveillance, standard precautions, and transmission-based precautions.
- Inmates in work assignments which staff determine present the potential for occupational exposure to blood or infectious bodily fluids, in accordance with OSHA Standard 1910.1030 – Bloodborne pathogens.
- Staff and inmates, on an as needed basis on relevant topics, must be provided when appropriate (e.g., disease specific training during an outbreak).

3. REQUIRED INFECTION PREVENTION AND CONTROL PROCEDURES AND PLANS

Each institution will develop, then annually update IP&C procedures and plans based upon guidance from the HSD IP&C Section and/or the Medical Director. For each of the following plans, the HSD IP&C Section will establish and make available on the Bureau's intranet site the required template each HSU must complete, maintain, and follow. Each of these plans and procedures must be approved annually by the Governing Body.

a. **Health Services Unit IP&C Procedures.** These procedures must be consistent with this program statement and other Bureau policy and incorporate Centers for Disease Control and Prevention (CDC) guidance and OSHA standards. They will cover:

- Program administration.
- Education and training.
- Infectious disease surveillance.
- IP&C-related reporting.
- Standard precautions.
- Transmission-based precautions.

b. **IP&C Risk Assessment and Plan.** Annually, an institution risk assessment will be conducted, and an IP&C plan developed that includes programmatic goals. Evaluation of progress toward these goals and of the implementation of IP&C strategies and interventions will be reviewed and documented at least annually.

c. **Tuberculosis (TB) Exposure Control Plan.** The plan will include the following components:

- Plan administration and responsibilities.

- Risk assessment.
- Education and training for staff.
- Staff screening and surveillance.
- Inmate screening and surveillance.
- Identification, medical isolation, and treatment of inmates with suspected or confirmed TB.
- Contact investigations.
- Airborne Infection Isolation Rooms (AIIRs).
- Respiratory protections (consistent with 29 CFR 1910.134 (Respiratory Protection)).
- Plan evaluation.

d. **Bloodborne Pathogen Exposure Control Plan.** The plan must be consistent with 29 CFR 1910.1030 (Bloodborne Pathogens) and will contain the following components:

- Plan administration and responsibilities.
- Exposure determination.
- Methods of implementation and control.
- Annual sharps review.
- Hepatitis B virus (HBV) vaccination program.
- Engineering and work practice controls.
- Management of exposures for staff, contractors, volunteers, and inmate workers in high-risk details (see Section 15(c). Diagnostics).
- Procedures for evaluation of the circumstances surrounding an exposure incident.
- Training of staff, contract health care staff, and inmate workers in high-risk details.
- Recordkeeping.

For additional information, see Program Statements **Management of Staff Exposure to Bloodborne Pathogens** and **Employee Health Care**.

4. CORRECTIONAL STANDARD PRECAUTIONS

Standard precautions are designed to protect staff and inmates from exposure to infectious diseases and must be followed regardless of whether a person is known to be infectious. Training for staff on standard precautions is provided to staff at Introduction to Correctional Techniques (ICT) Phase 1 and Annual Training. Training for inmates is provided at Admission and Orientation (A&O) with emphasis on hand hygiene. Standard precautions training must include the following components:

- Hand hygiene (see Section 5. Hand Hygiene Program).
- Personal protective equipment (see Section 6. Personal Protective Equipment (PPE)).
- Cough etiquette.
- Safe handling of sharps, including discovered sharps (see Section 7. Sharps Safety Program).

- Routine cleaning and disinfection (see Section 8. Routine Cleaning and Disinfection).
- Safe handling of laundry (see Section 9. Laundry).

5. HAND HYGIENE PROGRAM

a. **Overview.** Each institution must have a program to facilitate and promote hand hygiene among staff and inmates.

- **Health Services.** Areas used for hand hygiene in the HSU must be supplied with readily available soap, water, and alcohol-based hand rub that contains at least 60% alcohol. In accordance with CDC guidelines on hand hygiene for healthcare workers, hand hygiene must be performed before and after contact with an inmate, regardless of whether gloves are worn.
- **Staff.** The institution assures areas for hand hygiene are available for all staff with access to soap and water and/or hand sanitizer. Hand hygiene will be performed after gloves are removed.
- **Inmates.** The institution assures inmates are provided with an adequate supply of soap and areas to wash hands frequently throughout the day.

b. **Health Care Worker Hand Hygiene Auditing.** Institution Health Services procedure manuals will outline a method to periodically monitor compliance with hand hygiene by health care workers in the HSU. The IP&C nurse (or designee) will review trends in hand hygiene compliance at the IP&C meetings.

c. **Fingernails.** In accordance with CDC guidelines, health care workers who provide direct medical care for inmates at high risk for acquiring infections must not wear artificial nails and must keep natural nails short (extending less than ¼ inch). In the Bureau, this includes health care staff working in Advanced Care Units (ACUs), Nursing Care Center Units, operating rooms, dialysis centers, oncology units, and other medical care areas as deemed necessary by the CD or designee.

6. PERSONAL PROTECTIVE EQUIPMENT

a. **Overview.** The HSA in conjunction with the Safety Administrator must conduct a hazard assessment of all areas covered by this program statement. If contact with blood or other potentially infectious materials occurs, gloves are indicated to protect hands from contact; surgical masks, face/eyewear, and gowns are indicated to protect from sprays and splashes; and shoe covers are to be used when cleaning up large blood spills.

While institution management officials are responsible for purchasing and providing PPE, they must coordinate with their Occupational Safety and Health Department when purchasing respirators to ensure staff are only supplied with those for which they have been fit-tested.

Institution management officials are also responsible for:

- Ensuring PPE is used in accordance with the institution Bloodborne Pathogen and Tuberculosis exposure control plans.
- Ensuring training is conducted in accordance with 29 CFR 1910.134 (Respiratory Protection) and 29 CFR 1910.1030 (Bloodborne Pathogens).
- Investigating and documenting circumstances in which PPE was indicated but not used to determine whether changes can be instituted to prevent such occurrences in the future.

Refer to Program Statement **National Occupational Safety and Health Policy** for additional information regarding hazard assessments and PPE**.**

b. **Puncture Resistant Gloves.** Puncture resistant gloves are to be worn in accordance with Program Statement **Cut and Puncture Resistant Gloves**.

c. **Respirators.** Respiratory protection devices help prevent exposure to airborne diseases acquired through inhalation of infectious airborne particles. Such equipment must be National Institute for Occupational Safety and Health (NIOSH)-certified.

- Respirators must be available in work areas where clinical assessment and identification of an inmate with a suspected airborne infectious disease may occur, including in Health Services and Receiving and Discharge, where AIIRs are located, and for staff who require respiratory protection while transporting inmates.
- Respirators must be fitted and worn in accordance with 29 CFR 1910.134 (Respiratory Protection).

For additional information regarding respirators, refer to Program Statement **National Occupational Safety and Health Policy.**

7. SHARPS SAFETY PROGRAM

Each institution will establish a sharps safety program as a component of the institution's Exposure Control Plan (ECP). A sharps safety program is a structured organizational plan designed to prevent injuries from needles, scalpels, and other sharps-related injuries, primarily to reduce exposure to bloodborne pathogens, such as Human Immunodeficiency Virus (HIV), hepatitis B, and hepatitis C (HCV). It focuses on proper handling, safer devices, and comprehensive prevention programs. The ECP will define the person or department responsible for the program and will consist of the following:

a. **Sharps Injury Log.** The IP&C nurse or designee in conjunction with the Safety Administrator will ensure sharp injuries are tracked on an ongoing basis to include information that will identify high risk areas and assist in the review and selection of safety devices. Evaluation of injuries and medical devices will be documented and reported at the IP&C committee meetings.

b. **Annual Review.** The annual review and/or update of the ECP will reflect the process for evaluating and implementing commercially available, technologically innovative, and safer medical devices. It will also reflect the solicitation of input from non-supervisory staff responsible for direct medical care, since they have the potential for exposure injuries from contaminated sharps. The annual reviews will assist in the identification, evaluation, and selection of effective engineering and work practice controls.

8. ROUTINE CLEANING AND DISINFECTION

Each institution will develop a housekeeping plan as part of the Bloodborne Pathogens ECP and assign responsibilities in keeping a clean and sanitary environment. The plan will include a written cleaning schedule and information on use of the appropriate cleaning products and techniques.

9. LAUNDRY

Each institution will include, in their Health Services Procedure Manual and their ECP, procedures for the handling and bagging, laundering, storage, and transport of linens contaminated with blood or body fluids in accordance with 29 CFR 1910.1030 (Bloodborne Pathogens), state, and local sanitation requirements.

10. REGULATED MEDICAL WASTE (RMW)

a. **Local Policies.** Each institution must have local procedures that comply with state and local regulations for handling, collecting, transporting, and storing RMW.

b. **Written Procedures.** The HSA and the Safety Administrator are responsible for written procedures for RMW management that meet OSHA standards, state and local environmental regulations, and local security procedures. RMW is stored in a manner and location that maintains the integrity of the packaging and protects it from outside elements, rodents, and vermin, namely:

- 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 locked storage area must have a smooth, impervious floor and a mechanism to contain odors.

- Storage containers must be elevated from the floor surface on a pallet or other platform.
- Any additional storage requirements outlined in state and local regulations.

c. **Disposal.** RMW is disposed of as per applicable regulations of state and local governments. Each HSA and Safety Administrator will keep on file the waste disposal laws and regulations for the state in which the institution is located.

11. SURVEILLANCE AND REPORTING

a. **Reporting Infectious Disease Concerns.** Staff are instructed during ICT Phase 1 and Annual Training that if they identify inmates with potential infectious diseases or clusters of infectious diseases (e.g., cough, skin rash or lesions, diarrhea, vomiting, respiratory illness, fever), they are to report the information to Health Services. Inmates are instructed at A&O to report potential infectious disease concerns at any time.

b. **Surveillance for Infectious Diseases.**

- An institution's IP&C nurse or designee, in collaboration with the CD and HSA, conducts surveillance activities and identifies the occurrence of infectious diseases and establishes prevention measures.
- Surveillance data are collected, recorded, and reported in a format and timetable defined by the HSD IP&C Section and made available on the Bureau's intranet site.
- Surveillance data are analyzed and trends identified with data discussed at institution quarterly IP&C Committee meetings.
- Surveillance data are reviewed at Governing Body meetings to discuss implications and recommended actions.

c. **Infectious Disease Reporting.** The HSA will assign an individual, typically the IP&C nurse, the responsibility of infectious disease reporting. Reports will be sent to the Population and Correctional Health Branch and to public health authorities.

- **Reporting to the Population and Correctional Health Branch.**
  - The Population and Correctional Health Branch will determine the specific diseases that are to be reported and the reporting formats.
  - Reporting will be initiated and completed using the Reportable Infectious Disease system (RIDs), and information will be updated as additional clinical data are collected. RIDs can be found on the Population and Correctional Health Branch page of the Bureau's intranet site.
  - Reportable infectious diseases and multiple cases of certain infectious diseases, as outlined in RIDs, must be reported.

- **Reporting to public health authorities.**
  - The HSA or designee will keep on file the communicable disease reporting laws and regulations for the jurisdiction in which the institution is located and will review them annually. They will also ensure reportable infectious diseases, outbreaks, and findings of all contact investigations are reported, if required, to local public health authorities.
  - Inmate authorization for release of information is not needed before making legally mandated communicable disease reports to public health authorities. However, if an inmate is in the Witness Security Program (WITSEC), see Section 19. Confidentiality of Information for additional information.

12. MEDICAL ISOLATION AND QUARANTINE

Medical isolation is an infection control strategy that involves segregating infected inmates from other inmates when the routes of disease transmission are not completely interrupted using standard precautions. These additional precautions, referred to as transmission-based precautions by the CDC, include:

- Airborne precautions.
- Droplet precautions.
- Contact precautions, including contact enteric precautions which are used to prevent the spread of gastrointestinal infections and require enhanced barrier precautions.

Quarantine is an infection control strategy that involves segregating apparently well inmates, who have been or potentially have been exposed to an infectious disease and thus have a risk of developing the disease, from other inmates.

The institution will identify appropriate rooms in the institution to utilize for medical isolation and quarantine, including consideration for accommodating large scale medical isolation and quarantine activities, to include co-horting inmates together who have the same infectious disease process.

Decisions about initiating and discontinuing medical isolation and quarantine are made by the CD or designee in accordance with CDC guidance. While in medical isolation and quarantine, a daily clinical assessment must be completed and documented in the medical record by a healthcare provider.

- **Airborne Infection Isolation Rooms.** Only those institutions equipped with a functional and professionally validated AIIR have the option to medically isolate and treat inmates with suspected or diagnosed tuberculosis (TB) or other airborne diseases, as determined by the CD or designee. Facilities that do not have a validated AIIR must arrange to medically isolate inmates at another institution with a validated AIIR or the local hospital. AIIRs must function in accordance with CDC recommendations.

The HSA or designee assures negative pressure is maintained by monitoring AIIRs (e.g., using visual methods such as flutter strips or single ply tissues). Results are documented on a log:

- Before occupancy.
- Daily (when occupied).
- Monthly (when not occupied).

The Facilities Manager or designee assures AIIRs are validated by a professional with expertise in air balancing at least annually. The validation includes:

- Measuring negative pressure.
- Calculating air exchanges per hour.
- Ensuring AIIRs are equipped with functioning emergency power.
- Ensuring AIIRs are either vented at least 25 feet away from air intakes, windows and walkways, or they are equipped with High Efficiency Particulate Air (HEPA) filtration prior to venting.

The Facilities department will maintain validation and maintenance records and will ensure exterior exhaust pipes from AIIRs have been labelled as "Infectious Exhaust."

13. MANAGEMENT OF INFECTIOUS DISEASE OUTBREAKS

An outbreak is defined as an increase in the number of observed cases of an illness over a specified period compared to the usual or expected number of cases. Infectious disease outbreaks must be reported to public health authorities and within the Bureau. See Section 11c. Infectious Disease Reporting for additional information.

When a communicable disease outbreak occurs in a Bureau institution, decisions must be made that include whether the outbreak warrants utilization of the Incident Command System and whether consultation with public health authorities regarding outbreak management should be initiated.

a. **Components of an Outbreak Response.** Of the below listed components of an outbreak response, several may be performed simultaneously or in a different order based on the response.

- Reporting the outbreak (e.g., to HSD IP&C staff, local and/or state health departments).
- Documenting cases in RIDs.
- Developing a case definition and counting cases.
- Coordinating the outbreak response.
- Implementing prevention and control measures (e.g., hand hygiene, disinfection, medical isolation and/or quarantine, holding inmate movement).
- Communicating with staff, contractors, volunteers, inmates, and visitors about the

outbreak.

- Identifying new cases and determining who is at risk of becoming ill.
- Collecting data in a systematic fashion.
- Utilizing standardized line lists orienting the data in terms of time, place, and person.
- Analyzing data.
- Ensuring provision of clinical care for urgent health care needs (e.g., dehydration).
- Preparing a written report and communicating findings to those who need to know.

b. **Potential Foodborne Outbreaks.** Foodborne outbreaks are suspected when there is a sudden increase in the number of inmates who report gastroenteritis (e.g., vomiting, diarrhea, or a cluster of ill inmates known to have consumed the same food). Suspected foodborne outbreaks are reported within one working day to the Regional Food Service Office, HSD Food Service Branch, and the HSD Population and Correctional Health Branch, and are managed in accordance with technical guidance provided by HSD and posted on the HSD page of the Bureau's intranet site.

14. **IMMUNIZATIONS**

Immunizations are available for inmates to prevent infectious diseases based upon clinical guidance from the Medical Director and CDC recommendations. All inmates in work assignments with the potential for exposure to blood or body fluids will be offered the HBV vaccine. See Section 20c. Hepatitis B Vaccination for additional information.

For each vaccine dose administered, inmates are given an opportunity to review the current CDC Vaccine Information Statement (VIS) about the risks and benefits of the vaccine and ask questions. They sign the appropriate informed consent form, either for each vaccine dose administered, or in the case of multiple doses in a primary vaccine series, for each primary vaccine series administered. Vaccinations will be documented in the medical record.

15. **TESTING AND SCREENING**

Testing for communicable diseases includes the following:

- Voluntary testing – occurs when an inmate sends a request for testing to Health Services.
- Mandatory testing – occurs when an inmate is deemed at risk for an infectious disease and the test is clinically indicated and/or surveillance testing is required to monitor trends and prevent an outbreak. Inmates must participate in mandatory testing. If they refuse, staff should initiate incident report codes 227 (refusing to participate in a required physical test or required examination unrelated to testing for drug abuse) and 307 (refusing to obey an order of any staff).
- Involuntary testing – occurs either when an inmate is known to be at risk for an infectious disease after an exposure or is the known source of an exposure incident, and the test is

clinically indicated. Inmate written consent is not required for involuntary testing. If the inmate refuses testing, staff should initiate incident report codes 227 (refusing to participate in a required physical test or required examination unrelated to testing for drug abuse) and 307 (refusing to obey an order of any staff). Involuntary testing will be conducted in accordance with Program Statement **Use of Force, Application of Restraints, and Firearms**.

§ 549.12 Testing.

(a) ***Human Immunodeficiency Virus (HIV) —***

The Bureau utilizes different testing strategies and performs counseling for HIV infection as indicated below.

(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.

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

The Bureau also uniformly uses opt-out testing. In opt-out testing, all inmates are informed upon admission, either orally or in writing, that HIV testing will be performed unless they refuse testing. If the inmate was previously tested within the Bureau and has been continuously incarcerated since their HIV test was performed or if there is documentation of a prior positive HIV test result, subsequent HIV testing is risk-based.

(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.

However, inmates who are identified as a source in an exposure incident will be informed of the need for testing and provided education and counseling about it prior to testing being performed. If the inmate refuses testing, staff will initiate and complete incident report codes 227 (refusing to participate in a required physical test or required examination unrelated to testing for drug abuse) and 307 (refusing to obey an order of any staff). If the inmate continues to refuse testing, involuntary testing will be conducted to ensure the safety of staff and the inmate in accordance

with the Program Statement **Use of Force, Application of Restraints, and Firearms**. The use of force for involuntary testing must be authorized by the Warden or their designee.

(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.

(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.

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

Additional Bureau counseling requirements include:

- Written informed consent for testing is not required.
- Pre-test counseling will address, at a minimum, the limitations of the test (i.e., the inability to detect early infections, false positive and false negative results), the possible need for additional testing, and the complications and consequences of a positive or negative test result. The institution's A&O program will meet the HIV pre-test counseling if these requirements are discussed.
- All post-test counseling will include information about the meaning of the test results, the benefits of antiretroviral treatment (if appropriate), and avoiding risky behaviors.
- Pregnant inmates who test positive for HIV infection will also be counseled that the virus may be transmitted to the fetus. They will be provided with information on current treatment options to prevent perinatal transmission.
- All inmates testing positive will be counseled by a physician and referred immediately to Psychology Services for evaluation and follow-up needs.
- Inmates testing negative will be provided with post-test counseling through an education encounter documented in the medical record by a licensed health care provider.

(b) ***Tuberculosis (TB).***

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

Due to the contagious nature of TB and risk of serious illness, active pulmonary TB must be excluded as a potential diagnosis at intake. Screening for active TB in newly incarcerated inmates includes the following:

- TB Symptom Screen.
  - All inmates, including holdover and pretrial inmates, must be assessed by a health care provider for symptoms of active pulmonary TB (e.g., cough, coughing up blood, fever,

night sweats, and unexplained weight loss), using an interpreter or language translation service if necessary.
- Inmates returning from writ must also undergo a TB symptom screen.
- The symptom screen must be documented in the inmate's medical record.
- Inmates with symptoms suspicious for active pulmonary TB must wear a surgical mask, be medically isolated, and further evaluated by Health Services.

Medical isolation consists of placing the inmate suspected of having active pulmonary TB in a functional AIIR, or if one is not available at the institution, the inmate must be transported to an institution or hospital with AIIR capacity. They must wear a surgical mask and be kept in a single cell until transport can be accomplished. For transport infection control measures, see Section 17b. Transport.

- TB Testing.
  - The preferred TB test in the Bureau is the Tuberculin Skin Test (TST). However, in limited situations, a TB Interferon-Gamma Release Assay (IGRA) may be used.
  - TB testing must be initiated within two calendar days of initial Bureau incarceration to screen for active TB and latent TB infection.
  - Inmates with a documented previously positive TB test while in Bureau custody should not be retested.
  - If an inmate had a previous negative TB test, repeat testing is required if the inmate has been out of Bureau custody for more than 14 calendar days.
  - A self-reported, undocumented, previous positive TB test is not a contraindication to receiving a repeat TB test. However, if a severe reaction to a TST (e.g., whole arm swelling or severe blistering) was documented in the medical record or is described by the inmate, then an IGRA must be used.
  - An inmate may not request to substitute a chest radiograph for a TB test. See subsection (4) below for information on inmates who refuse testing.
  - TB testing exception: Inmates who are in-transit or holdover status and stay at a Bureau institution for less than four calendar days require only a TB symptom screen as long as they meet the requirements in Section 16a. Tuberculosis (TB) Clearance Prior to Transport of Inmates.

The types of tests used to diagnose latent TB infection and the indications for testing are based upon guidance from the Medical Director. Health care providers who place and/or read TSTs must have documented competency in TST placement and interpretation at least every two years.

- Chest radiographs (CXRs).
  - Inmates with symptoms suspicious for active pulmonary TB are medically isolated and a CXR is obtained as soon as possible.
  - Asymptomatic inmates with a new, positive test for TB must have a CXR completed within 14 calendar days of the positive test.

- Inmates transferring within the Bureau, who have a history of a positive TB test and negative CXR performed after the initial positive test, do not require an additional CXR.
- Inmates with a previous positive TB test in the Bureau who have been out of continuous Bureau custody for 30 calendar days or more require a new CXR within 14 calendar days of arrival.

Based upon data on the incidence of active pulmonary TB in an institution, the CD or designee may request routine CXRs on all new intakes.

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

- The Bureau also conducts TB testing annually as medically indicated.
- Inmates with a prior negative test for TB must be screened for symptoms and tested annually for potentially newly acquired TB.
- Inmates who test positive for TB must have a follow-up CXR within 14 calendar days. If the inmate has signs or symptoms of active TB, the inmate must be medically isolated and a CXR obtained as soon as possible.
- Follow-up CXRs are usually not indicated after a baseline negative CXR has been documented following a positive test for TB – except if the inmate:
  - refuses latent TB infection treatment,
  - develops symptoms and/or signs of active TB, or
  - has certain TB risk factors in accordance with guidance from the Medical Director.
- The conversion rate of annual inmate TB tests is calculated monthly by the IP&C nurse or designee and compared to previous conversion rates. Conversion rates that exceed the usual rate for the institution are investigated, in consultation with the HSD IP&C Section, to assess the possibility of an undetected case of active TB in the population.

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

The Bureau will also conduct TB testing when health services staff determine an inmate may be at risk for infection. For example, when there has been a recent exposure to active TB or there is clinical suspicion of active TB.

(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.

- Involuntary testing will be conducted in accordance with the Program Statement **Use of Force, Application of Restraints, and Firearms**.
- An inmate may not request to substitute an IGRA test or CXR in lieu of a TST. The only exceptions are when there is a medical (including a psychiatric) or legally determined

contraindication to testing or where involuntary testing may cause significant injury to staff or the inmate.

- Legal contraindications (e.g., religious exemptions) are approved by the Warden in consultation with the Office of General Counsel.
- The CD or designee is the approving authority for ordering an IGRA test or screening CXR in lieu of a TST when there is a medical contraindication.
- Inmates who refuse TB testing are not placed in an AIIR unless there is a clinical indication for medical isolation.
- A health care provider must document the inmate's refusal of testing, and the education and counseling provided to them.
- Incident report codes 227 (refusing to participate in a required physical test of required examination unrelated to testing for testing for drug abuse) and 307 (refusing to obey an order of any staff) should be used for those who refuse testing without a verified legal or medical contraindication.

An inmate with a positive TB test who refuses a CXR may also be subject to incident reports 227 (refusing to participate in a required physical test or required examination unrelated to testing for drug abuse) and 307 (refusing to obey an order). If the inmate has symptoms suspicious for active pulmonary TB, they must be housed in an AIIR until active pulmonary TB has been ruled out.

(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.

The investigation will be conducted in consultation with the HSD Population and Correctional Health Branch and local public health authorities. Once it has been determined a TB exposure has occurred, the exposed inmate will be offered evaluation and treatment for active TB or latent TB infection in accordance with guidance from the Medical Director.

(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.

An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials. Exposure incidents can lead to infection with HBV, HCV, HIV, other bloodborne pathogens, or other infectious diseases.

Testing will be performed based upon clinical indications and guidance from the Medical Director. If an inmate refuses testing, staff should initiate and complete incident report codes 227

(refusing to participate in a required physical test or required examination unrelated to testing for drug abuse) and 307 (refusing to obey an order of any staff member).

The identity of the inmate who was the potential source of the exposure will not be revealed to the exposed inmate(s) or staff and will not be recorded in the exposed inmate's medical record.

16. TRANSPORT AND MOVEMENT OF INMATES

a. **Tuberculosis (TB) Clearance Prior to Transport of Inmates.** Bureau inmates, including those in holdover status from the U.S. Marshals Service (USMS), who have not been screened and/or tested for TB are prohibited from transferring between Bureau institutions. Transporting officials will only accept an inmate who meets the following criteria prior to transport:

- Health record documentation indicates no evidence of medical complaints or symptoms potentially associated with suspected active TB within the past 30 calendar days.
- Documentation of one of the following:
  - A negative test for TB within the previous 12 months. A negative TST must be documented in millimeters.
  - A negative CXR taken after an initial positive TB test. Annual CXRs are not required and not recommended once a baseline negative CXR has been documented in the Bureau.
  - A negative CXR taken in the previous 12 months if there is no evidence of a TB test on record and the inmate is in holdover status less than four calendar days or is housed at the Federal Transfer Center.

Inmates who had potential TB symptoms (e.g., a cough) within the past 30 calendar days will be evaluated and cleared prior to transport as clinically indicated. Findings of the evaluation must be documented in the Bureau medical record exit summary. Non-Bureau institutions may use the BP-A0659, Medical Summary of Federal Prisoner/Alien in Transit form when transferring inmates to the Bureau.

For security reasons, the CD in collaboration with the regional IP&C consultant may recommend the requirement for a test for TB or CXR be waived prior to the immediate transport of an inmate between Bureau institutions (e.g., an uncooperative inmate where the risk of injury to the inmate or staff precludes involuntary forced testing). A Medical Officer (i.e., physician) will examine and clear such inmates for transfer and document the recommendation. If the test or CXR is waived, the inmate will be tested upon arrival at the receiving institution.

b. **Medical Hold.** The CD or designee must place an inmate on medical hold to prevent transfer, if the inmate is undergoing a workup for suspected active TB, is on treatment for active TB or latent TB infection, has another communicable disease, or if they are known to have been exposed to a communicable disease. If transfer is necessary, the institution must consult with the

HSD IP&C Section prior to transfer. If transfer clearance is provided, inmates on treatment must have treatment and follow-up recommendations included in their Bureau medical record exit summary.

c. **Appearances at Court, ICE, or U.S. Parole Commission (USPC) Hearings.** If for any reason an inmate with suspected active TB or other communicable disease is scheduled to appear in court or an ICE or USPC hearing, the Warden will ensure the hearing authority is notified the inmate is undergoing surveillance or treatment for a communicable disease and must not attend in-person proceedings until cleared by the CD or designee. If possible, a tentative treatment timetable and date of availability should be given to the hearing authority.

d. **Precautions during Transport.** When a decision is made to transport an inmate with a communicable disease, precautions must be followed in accordance with guidance from the Medical Director. For guidance on transporting inmates with suspected TB, see Section 17b. Transport.

17. MANAGEMENT OF ACTIVE TUBERCULOSIS (TB) AND LATENT TB INFECTION

a. **Medical Isolation.** Inmates with suspected active pulmonary TB must be medically isolated alone in an AIIR. For more information on AIIRs, see the Airborne Infection Isolation Rooms subsection in Section 12. Medical Isolation and Quarantine.

- Only institutions with a functional and validated AIIR can medically isolate and treat inmates with suspected active TB within the institution. While an inmate is in an AIIR, staff or inmates entering the room must wear a respirator (N-95 efficiency or better) for which they have been trained and fit tested. For additional information, see Section 6c. Respirators.

b. **Transport.** Facilities without an AIIR must transport inmates with suspected active TB to a local hospital or another Bureau institution with the capability of isolating and treating the inmate. The following precautions are followed while awaiting transport and during transport:

- The inmate must wear a standard, surgical type mask without an exhalation valve.
- The inmate must be removed from the general population and placed in a low traffic area.
- Escort personnel must wear a fit tested respirator (N-95 efficiency or better). For additional information, see Section 6c. Respirators.
- No other inmate may be transported with an inmate who has suspected active TB.
- The vehicle ventilation system must bring in as much outdoor air as possible and not be placed in recirculation mode.
- The vehicle fan must be set to high.

- Front seat windows may be rolled down in transport vehicles to increase fresh air ventilation, if weather permits.
- After transporting an inmate with suspected or confirmed active TB, the vehicle must be aired out for at least one hour before entering it without a respirator.

c. **Hospital Escort.** Staff assigned to provide hospital escort for inmates who are housed in AIIRs must wear an approved respirator (N-95 efficiency or better) for which they are currently enrolled in the Respiratory Protection Program whenever they are in the inmate's room or anteroom.

- The Bureau institution will provide staff with the size and type of respirators for which they were fit tested.
- Staff must not wear N-95 respirators provided by the hospital or other entities unless they have been fit tested for that specific N-95 respirator size and type.

d. **Discontinuation of Medical Isolation.** Prior to discontinuing medical isolation and returning an inmate to the general population, the inmate must meet the criteria for discontinuing medical isolation as defined in guidance from the Medical Director.

e. **Monitoring.** While in medical isolation, a daily clinical assessment must be completed and documented in the medical record by a healthcare provider. Inmates with suspected or confirmed active TB are monitored to ensure they are receiving an appropriate workup or treatment for TB in accordance with guidance from the Medical Director. Monitoring assures the workup is proceeding in a timely fashion and ensures compliance with treatment. It also assesses clinical improvement, bacteriologic response to treatment, and signs and symptoms of adverse reactions to medication(s).

Inmates with latent TB infection who agree to take treatment are also monitored. This ensures treatment and follow-up, including assessment of potentially adverse reactions to medications, is appropriate and in accordance with guidance from the Medical Director.

f. **Release Planning.** If an inmate will be released without having completed treatment for active TB or latent TB infection, planning for continuity of TB treatment must begin as soon as the inmate is diagnosed with the condition.

- The projected release date is researched in the applicable Bureau inmate management system.
- If the projected release date falls before the anticipated treatment completion date or the projected release date is unknown, release planning must begin immediately in accordance with the Bureau's TB clinical guidance.

g. **Refusal of Treatment.** If an inmate refuses clinically indicated treatment for active TB and poses a risk to others by continuing to refuse treatment, they must be medically isolated in an AIIR until they meet criteria for discontinuation of medical isolation, adhere to treatment, and/or are determined to be noninfectious. Consult with HSD Population and Correctional Health Branch staff for further directions, if needed.

18. PROGRAMMING, DUTY, AND HOUSING RESTRICTIONS DUE TO INFECTIOUS DISEASE

§ 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.

- Infectious diseases not transmitted by casual contact include HBV, HCV, and HIV. Inmates with these diseases are allowed to work in Food Service or other work assignments, but still require an evaluation for clearance.
- Inmates with foodborne illnesses will be prohibited from work assignments until they have been fully evaluated and cleared by a health care provider.
- The Warden, in consultation with the CD or designee, will determine an inmate's suitability for work details in accordance with Program Statement **Patient Care**.

(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.

(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 part 541, subpart B). Except as provided for in our disciplinary policy, no special or separate housing units may be established for HIV-positive inmates.

See Bureau disciplinary Program Statements **Inmate Discipline Program** and **Special Housing Units** for additional information.

When there is reliable evidence that an inmate who is infected with HIV is engaging in high-risk behaviors that pose a health risk to another inmate or staff, they can be placed in controlled

housing status in accordance with Program Statement **HIV Positive Inmates Who Pose Danger to Other, Procedures for Handling of**.

19. **CONFIDENTIALITY**

§ 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:

- To Bureau staff 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.
- To public health authorities in accordance with legally required reporting. See Section 11c. Reporting to public health authorities for additional information.
  - If an inmate is in the WITSEC and circumstances mandate a disease be reported to public health authorities, the HSA or designee will notify the Central Office Inmate Monitoring Section, Correctional Programs Branch, before releasing the inmate's name or initiating communication between the inmate and public health officials, including telephone and face-to-face communication.
- To non-Bureau staff (e.g., US Marshals, state or local law enforcement) who were lawfully present in a Bureau institution or performing work for the Bureau while exposed to blood or other potentially infectious body fluids, and their health care providers.
  - Inmate source case test results must be provided for the purpose of prescribing prophylaxis or other treatment and counseling. Documentation that may not be provided includes the source case's personal identifiable information (e.g., name, date of birth, or register number).

20. INFECTIOUS DISEASE TRAINING AND WORK-RELATED IMMUNIZATION REQUIREMENTS

§ 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.

a. **General Infectious Disease Training.** All inmates entering Bureau facilities will receive education on the following topics:

- Correctional standard precautions with emphasis on hand hygiene.
- Infectious diseases, including their transmission and prevention:
  - Tuberculosis, including the importance of reporting a chronic cough to Health Services.
  - Sexually transmitted infections.
  - Hepatitis B.
  - Hepatitis C.
  - HIV, including the Bureau's opt out policy and pre-test counseling. See Section 15(a). Human Immunodeficiency Virus (HIV) for additional information.
  - Respiratory diseases, including influenza and COVID-19 with emphasis on the importance of annual vaccination.
  - Methicillin Resistant Staphylococcus Aureus (MRSA), including preventive measures in recreation and sweat lodges.
  - Other infectious diseases as indicated, based on geographic or population specific risk factors.
- How to report potential infectious disease concerns.

b. **Work-Related Infectious Disease Training.**

(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.

- The local Bloodborne ECP identifies inmates who have the potential for occupational exposure. The training will include elements required by 29 CFR 1910.1030 (Bloodborne Pathogens).
- The local Bloodborne ECP will identify the person or department responsible for maintaining the training records as required by 29 CFR 1910.1030 (Bloodborne Pathogens).

- Inmate Health Services orderlies must also be provided with initial and annual training on hand hygiene, disinfection, and bloodborne pathogens using HSD IP&C Section training materials found on the Bureau's intranet site.

c. **Hepatitis B Vaccination.** The institution Bloodborne Pathogens ECP identifies inmate workers in high-risk details including those assigned to Health Services and blood spill clean-up teams. Inmate workers in high-risk details must be offered hepatitis B vaccination within 10 calendar days of assignment.

Vaccination will be provided unless:

- The vaccination is declined.
- The individual has documentation of immunity.
- Medical contraindications exist.

Vaccinations are provided in accordance with guidance from the Medical Director. If an inmate worker in a high-risk detail declines the HBV vaccine, they must sign the refusal form indicating they are declining the vaccine. Inmates who refuse vaccination may request and obtain the vaccination later.

REFERENCES

Program Statements
Cut and Puncture Resistant Gloves
Employee Health Care
HIV-Positive Inmates Who Pose Danger to Other, Procedures for Handling of
Inmate Discipline Program National Occupational Safety and Health Policy
Management of Staff Exposure to Bloodborne Pathogens
Patient Care
Special Housing Units
Use of Force, Application of Restraints, and Firearms

Bureau Forms
BP-A0659 Medical Summary of Federal Prisoner/Alien in Transit

Federal Statutes
Correction Officers Health and Safety Act of 1998, Pub. L. 105-370, §1, November 12, 1998, 112 Stat 3374, Sec. 2. Testing for Human Immunodeficiency Virus.

Federal Regulations
28 CFR § 549.10 through § 549.15
28 CFR Part 549 Subpart A. Infectious Disease Management
29 CFR § 1910.134 (Respiratory Protection)
29 CFR § 1910.1030 (Bloodborne Pathogens)

Other References
Centers for Disease Control and Prevention Guidelines and Guidance Library.
Occupational Safety and Health Administration. *Occupational safety and health standards: Bloodborne Pathogens* (OSHA Standard No. 1910.1030).
Occupational Safety and Health Administration. *Occupational safety and health standards: Respiratory protection* (OSHA Standard No. 1910.134).

ACA Standards
Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ACI-6A-09, 5-ACI-6A-12M, 5-ACI-6A-13, 5-ACI-6A-14M, 5-ACI-6A-15M, 5-ACI-6A-16M, 5-ACI-6A-17M, 5-ACI-6A-20, 5-ACI-6B-05, 5-ACI-6B-06, 5-ACI-3D-08

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities (5th Edition): 5-ALDF-4C-09, 5-ALDF-4C-14M, 5-ALDF-4C-15, 5-ALDF-4C-16, 5-ALDF-4C-17, 5-ALDF-4C-18, 5-ALDF-4C-22, 5-ALDF-4C-23M, 5-ALDF-4D-06, 5-ADLF-4D-07

Standards for the Administration of Correctional Agencies, 2nd Edition: 2-CO-4E-01

Records Retention Requirements

Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on the Bureau's intranet site.