S.C. Department of Health and Environmental Control

TB Risk Assessment (Short Form)

ONLY APPROVED FOR USE BY THE FOLLOWING FACILITY TYPES:
(Please check the appropriate box)

☐ Ambulatory Surgical Facility
☐ Day Care Facility for Adults
☐ In-Home Care
☐ Community Residential Care

Date: _____

Facility Name: _____ Permit Number: _____

Number of Licensed Beds or Clients: _____

Address: _____

City: _____ Zip: _____ County: _____

Phone: _____

Name of Person Completing Form: _____

Title of Person Completing Form: _____

Part A – Incidence of TB

1. Number of TB cases identified **in your facility** in the past year? (*Check only one box)*

☐ No cases within the last 12 months.
☐ Less than 3 cases identified in the past year.
☐ 3 or more cases identified in the past year.
☐ Evidence of ongoing M. tuberculosis transmission.

2. Number of TB cases identified in your County in the last year?
(This information may be obtained from the TB Control Section of the South Carolina Department of Health and Environmental Control's website.)

3. Number of TB cases identified in the State of South Carolina the last year? _____
(This information may be obtained from the TB Control Section of the South Carolina Department of Health and Environmental Control's website.)

Part B – TB Infection Control Procedure

☐ Yes ☐ No Are all residents screened for TB prior to admission and all new hires/private sitters screened before initial resident contact?

☐ Yes ☐ No Does the facility have a written procedure for isolating confirmed or suspected TB cases?

☐ Yes ☐ No Does this procedure assure prompt detection, appropriate isolation, transfer and treatment of potentially infectious persons?

Part C – Assigning a Risk Classification (*check only one box*)

☐ If there have been **NO** cases of TB identified in the facility in the past 12 months, this facility may be classified as **LOW RISK**.

☐ If there have been **less than 3 cases** of TB identified in the facility in the past 12 months, this facility may be classified as **LOW RISK**.

☐ If there have been **3 or more cases** of TB identified in the facility in the past 12 months, this facility may be classified as **MEDIUM RISK**.

☐ There is evidence of **ongoing *M. tuberculosis* transmission** and the facility has reported the events to the Health Department and appropriate measures have been implemented. (***This is a temporary classification only warranting immediate investigation. After the ongoing transmission has ceased, the setting will be reassessed for classification)***

This TB risk assessment is performed annually to assess and assign an appropriate risk classification.

Date of next TB Risk Assessment Review (annually) _____

This form was developed by the Division of Health Licensing for the intended use as a guide to assist facilities in meeting the regulatory requirement in conducting TB Risk Assessments. Facilities are not required to utilize this particular format and may edit/revise the form as necessary to meet the developed policies and procedures of the facility.

Assigning TB Risk Classification & TB Screening For Employees and/or Residents Based on Risk	
<u>Low Risk Setting</u> Less than 3 TB cases/year (see Part A) ➢**AND** No risk factors are present (See Part B)	**<u>Low Risk TB Screening</u>** • Baseline two step TST or single BAMT upon hire/prior to resident contact & upon admission. • Medical evaluation, symptom assessment & chest x-ray if TST is positive or if symptomatic. • **NO ANNUAL** TST or BAMT required. • Perform annual symptom assessment if positive TST or prior active TB disease. • Persons identified as a contact to an infectious case and having unprotected exposure will be evaluated in accordance with the Health Department's contact investigation protocols.
<u>Medium Risk Setting</u> 3 or more TB cases/year (see Part A) ➢**OR** Other risk factors apply (see Part B)	**<u>Medium Risk TB Screening</u>** • Baseline two step TST or single BAMT upon hire/prior to resident contact & upon admission • Medical evaluation, symptom assessment & chest x-ray if TB screening test is positive or if the person is symptomatic for TB. • Perform **ANNUAL** TB screening test (either TST, BAMT or symptom review risk assessment) for each staff and resident. • Perform **ANNUAL** symptom assessment if positive TST or prior active TB disease. • Persons identified as contact to an infectious case and having unprotected exposure will be evaluated in accordance with the Health Department's investigation protocols.
<u>Potential Ongoing Transmission Setting</u> Evidence of ongoing *M. tuberculosis* transmission *This is a temporary classification only, warranting immediate investigation. After the ongoing transmission has ceased, the setting will be reassessed for classification.*	**<u>Potential Ongoing Transmission TB Screening</u>** • **Report** to local health department **immediately.** • Persons identified as a contact to an infectious case and having unprotected exposure will be evaluated in accordance with the Health Department's contact investigation protocols. • Medical evaluation, symptom assessment & chest x-ray if TST positive or if symptomatic. • Either a TST, BAMT or symptom review risk assessment will be performed for each staff and resident on an annual basis. • Perform annual symptom assessment if positive TST or prior active TB disease. • Baseline two-step TST for TB or single BAMT upon hire/prior to resident contact & upon admission.

Sample
Indications for Two-Step Tuberculin Skin Testing – TST

Employee & Resident TST Situation	**Recommended TST Testing**
1. No previous TST result.	1. Two-step baseline TST or single BAMT, upon hire/prior to resident contact or upon admission
2. Previous negative TST result > 12 months before new employment.	2. Two-step baseline TST or single BAMT upon hire/prior to resident contact or upon admission.
3. Previous documented negative TST result within 12 months before employment.	3. Single TST or single BAMT needed for baseline testing; this will be the second step.
4. Previous documented positive TST result.	4. No TST or BAMT; need TB symptom screen and baseline x-ray.
5. Previous undocumented positive TST result.	5. Two-step baseline or single BAMT upon hire/prior to resident contact or upon admission.

Instructions/ Purpose: This form was developed by DHEC Bureau of Health Facilities Licensing and TB Control and intended to be used as guide to assist facilities in meeting the regulatory requirement in conducting annual TB Risk Assessments. Facilities are not required to utilize this particular format and may edit/revise the form as necessary to meet the developed policies and procedures of the facility.