

# Summary of Changes to the Department of State Health Services (DSHS) Standing Delegation Orders (SDO): Tuberculosis (TB) Clinical Services Provided by Registered Nurses and Licensed Vocational Nurses, 2013-2014, revised January 2014

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1. Reformatted to be more consistent with HHSC Style Guide guidance.
2. The title of the SDOs renamed from “TB Prevention and Control Services” to “TB Clinical Services”.
3. The first SDO “Global 0” and Service #1 combined into the revised main TB Clinical Services SDO with changes recommended by the DSHS Office of General Counsel (OGC).
4. “Services” have been renamed “Attachments”.
5. Replaced the word “patient”, “children”, “persons”, “individual” with the word “client” in keeping with the Texas Nursing Practice Act (except in sections where it is more helpful to refer to children or adolescents generally).
6. Replaced the words “treating physician” with the words “authorizing physician” to emphasize that the authorizing physician who delegates clinical services retains responsibility for the treatment of clients. The authorizing physician will now need to sign or cosign all TB-400A and TB-400B forms (OGC recommendation). The statement in the SDO reads: *“For clients receiving treatment for LTBI or TB disease, recommended treatment regimens must be reviewed by the authorizing physician and cannot be implemented until form TB-400A or TB-400B is signed by the authorizing physician.”*
7. Tables and Figures reformatted.
8. Added Attachment 1: Attestation of Authorized Licensed Nurse. Each nurse will now need to sign an attestation that is individually attached to the SDO (OGC recommendation).
9. Changed TB Services Branch to TB and Refugee Health Services Branch.
10. Removed references to performing all relevant activities under procedure #1.
11. Deleted the statement that female clients taking rifampentine should avoid pregnancy up to two weeks after stopping the medicine.
12. Added “using form TB-201 to “Develop a management plan”.
13. Added albumin to recommended labs.
14. Revised timing of sputum collection to be at least 8 (not 8-24) hours apart and that at least one be observed.
15. Clarified that pyridoxine supplementation should be given to breastfeeding infants only if the infant is the one receiving INH.
16. Other changes to text:
  - Main SDO
    - “Definitions” removed.
    - Added requirement for authorized licensed nurses to be CPR certified.
    - References updated and some less clinically-oriented references removed. The deleted references will be reflected in the updated Standards of Performance.

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- Added details for training and initial and continuing evaluation of competence.
- Under Section E. Procedures to be Followed by Authorized Licensed Nurses, added the word “documented” when attempting to contact a client that fails to return for follow-up.
- Under Section E, number 4 now reads, perform HIV screening using the opt-out method for all persons with newly diagnosed or suspected TB disease unless the patient has HIV positive documentation or has documented negative HIV test result from a specimen collected within the last 14 days.
- Added a section about dosing of medications and completing the medication pharmacy label.
- Added medication allergies to the information to be included in a client’s medical record.

## Attachment 2

- Added clarifying language for window prophylaxis and specifically for immunosuppressed clients.
- Removed reference to individuals with untreated extrapulmonary TB disease under sputum examination not indicated exceptions.
- Clarified language about PA and lateral CXR for those under 18.
- Added that a physical exam (in addition to a CXR) should be performed if symptoms of TB develop prior to the start of LTBI therapy.
- Changed DSHS TB Expert Panel to Texas TB Expert Panel.
- Added “When treating with INH alone for LTBI, the length of treatment is 9 months for children and adolescents. INH for 6 months should not be recommended.”
- Clarified that INH should be withheld for elevated transaminase levels.
- Added a statement regarding pyridoxine supplementation when using INH-RPT.
- Calculated minimum number of doses required for completion of therapy of 5 day/week regimens.

## Attachment 3

- Added background information.
- Provided clarification that positive IGRA OR TST is acceptable for use of INH-RPT.
- Clarified recommendation for alternative LTBI treatment for clients with HIV infection.
- Added allergy to INH as a “not recommended” indication for using INH-RPT.
- Clarified that no TB disease should be considered for LTBI treatment.

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- Changed “AST” to “aminotransferase” as criteria to consider discontinuation of INH-RP.

## Attachment 4

- Added PZA should undergo susceptibility testing.
- Clarified that monthly sputums should be collected until 2 consecutive samples are documented to be negative.
- Excluded streptomycin from the list of resistant drugs that would warrant a DSHS-recognized expert TB physician consultation.
- Changed statement: “If the client is *M.tb* culture positive at diagnosis, a repeat CXR at completion of 2 months of treatment is recommended” instead of “may be useful but is not essential”. Also added: “Having a CXR to determine treatment response can be useful when combined with the culture data.”
- Changed order of Section E: Special Considerations for treatment of TB disease apply to the following populations to make the differences in extrapulmonary disease and pediatrics more clear.
- Removed the following statements about children: “Three times weekly therapy is not recommended.” And “EMB is not used routinely in children.”
- Changed the recommended dose of EMB for children.
- Added INH-RPT to Figure 2 since it is our top recommended regimen.
- Added clarifying language about coordination of care between the authorizing physician and infectious diseases physician providing care for HIV clients.

## Attachment 5

- Changed order of Section B. TST.
- Added clarifying directions for administering TST.
- Clarified that a TST that is not measured on time/measured and recorded in mm must be repeated at the earliest time possible.
- Added the mycobacterial species that could affect IGRA testing results.
- Added “Unknown significance of reversions and their high incidence in HCWs” to limitations of IGRAs.
- Clarified that IGRAS ARE the standard test for diagnosis of TB infection in Texas.
- Clarified when phlebotomy is impractical.
- Changed order of Section G. Documentation. TST.
- Added form TB 400 and/or TB340 for recording results of TST.