# INDUSTRIAL MEDICINE PROGRAM

# BLOODBORNE PATHOGENS (BBP) POLICY AND PROCEDURES- POST-EXPOSURE EVALUATION AND FOLLOW-UP

## I. GENERAL CONSIDERATIONS:

1. **Bloodborne Pathogen Exposures are to be given the highest priority**. Evaluations and treatment, if needed, should be initiated within the first two or three hours of an exposure.

2. **Responsibilities for implementing policy are outlined as follows:**

   A. **The Initial TIM Contact**, . . may be any TIMW employee. Whoever takes the initial call or makes the initial contact regarding a real or potential BBP exposure will "immediately" bring the relevant information to the attention of the Nurse Coordinator or Physician. There should be no delay in any relevant communication.

   B. **The Triage Nurse or Tech** may be any nurse or technical professional trained to triage BBP exposures. This person will take charge of the initial triage by determining the urgency of the exposure. If appropriate, they will facilitate the process of getting the patient to our clinic and obtaining necessary specimens from the source.

   C. The **Physician** is to be notified promptly of any relevant information. The physician will also order appropriate testing, counsel the patient, and arrange follow-up care in compliance with OSHA standards.

3. **Expert consultation is available 24 hours a day:** The following resources and physicians on the RRMC staff may be consulted if there are questions regarding the exposure and treatment.
   A. National Clinicians' Post-Exposure Hotline (24 hrs/day) 1-888 -448- 4911
   B. HIV Telephone Consultation Service (24 hrs/day) 1-800 -933- 4313
   C. Emergency Room (24 hrs/day)
   D. Industrial Medicine and Urgent Care (8-7 M-F)

4. **Guidelines from the MMWR are to be followed:** This policy is intended to follow the recommendation of the Centers for Disease Control as found in the MMWR June 29, 2001 / 50 (RR11); 1-42 Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendation for Post-exposure Prophylaxis.

## II. TRIAGE CONSIDERATIONS FOR POTENTIAL BBP EXPOSURES

This section is intended to help differentiate between true Bloodborne Pathogen exposures (which may require urgent investigations and treatment) from other incidents and exposures which are of a non-emergent nature.

**1. True Bloodborne Pathogen Exposures involve**

A. A potentially infective "body fluid, " and See Table 1 below

B. A potentially infective "exposure". See Table 2. below :

**BOTH** must be present to constitute a BBP exposure

Table 1. Potentially Infected Body Fluids

| |
|---|
| 1. Blood and blood component |
| 2. Any body fluid with visible blood |
| 3. Semen and vaginal secretions |
| 4. The following fluids (even without visible blood): |
| Cerebrospinal Peritoneal Amniotic Bile |
| Synovial Pericardial Pleural |

Table 2. Potentially Infective Exposures

| |
|---|
| 1. Needle sticks or cuts with any sharp object |
| 2. Splash or other contact with mucous membranes, open wound, or non-intact skin. |
| 3. Excessive or prolonged contact with intact skin. |

**2. Non-Bloodborne Pathogen Incidents occur if the incident involves:**

A. A non-bloodborne pathogen containing fluid, or

B. An incident not known to transmit bloodborne pathogens.

If **EITHER** is present, then it is *probably* not a BBP exposure.

Table 3. Non-bloodborne Pathogen Containing Fluids:

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|---|
| 1. Tears, saliva, and nasal secretions (unless blood is visible). |
| 2. Sweat, sputum, and vomitus. (unless blood is visible). |
| 3. Non-bloody urine,feces, or naso gastric secretions. |
| 4. Any body fluids whose potential for infectivity has been nullified by significant exposure to viricidals, heat, and other extreme conditions. |

Table 4. Non-bloodborne Pathogen Transmitting Incidents:

| |
|---|
| 1. Fingernail scratches in the absence of potentially infected body fluid from the source. Even if source has poor hygiene. |
| 2. Scratches, cuts, or abrasions from objects exposed to air for several hours, i.e. environmental exposures. |
| 3. Most human bites, unless source's mouth contains blood |
| 4. Most needle sticks from IV piggy-back connections involving saline solutions. |

## III. SEQUENCE OF EVENTS FOR BBP EXPOSURES

1. **Initial Contact Person** (may be any TIMW or WUC employee) **Notifies Nurse or Tech immediately so that triage can be started.**

2. **Receptionist should initiate patient care "before" registration:**
   A. Try to register patient by phone prior to patient's arrival. Make chart with BBP packet.
   B. Notify Triage Nurse as the patient arrives.
   C. First-aide, if not performed at time of injury, should not be delayed for registration.
   D. Necessary registration may be done at the same time as triage.
   E. Create chart, using the usual forms as would be used for any Workers Comp patient, but include the BBP. Patient Packet. See Attached example.

3. **Triage Nurse / Tech** (may be any TIME or WUC nurse or technical staff)

   **A. Provide first** aid if appropriate (do not wait for patient to be registered)
      1) Remove contaminated clothing.
      2) Allow immediate bleeding of the wound.
      3) Immediately wash injured area with soap and water and antiseptic solution.
      4) If eyes, nose, or mouth are involved, immediately flush with lots of water.

   **B. Assess incident**.
      1) Use the **BBP Initial Investigation Form** for documentation, **or** at least collect the same data on the progress notes..
      2) Obtain information on the source's "BBP status" by whatever means necessary (risk factors, BBP status, and the options of obtaining a blood specimen for testing). Supervisory personnel in facility where exposure occurred will usually need to be identified and contacted.
      3) If needed, request lab testing of source. Rapid HIV if possible. See

   **C. Assess patient** in the usual manner as any other Workers Comp. Patient using routine TIMW Workers Comp forms.

   **D. Report the exposure immediately to staff physician**.

   **E. See that patient is properly registered before patient leaves.**

4. **Physician Responsibilities**:

   **A. Assessment and diagnosis**: Determine the need for HIV and/or hepatitis B Post-exposure prophylaxis.
      1) Determine the severity of the exposure
      2) Determine the HIV/Hepatitis Status (risk factors) for the source by whatever means possible. The source hysician may need to be contacted. A STAT HIV test should be ordered if possible. Other tests to be ordered may include:

| | | |
|---|---|---|
| HIV | Hep B S Ag | Hep C Ab (anti-HCV) |
| RPR | Hep B S Ab (anti HBS) | Hep A IGM |

      Consider Hepatitis Comprehensive Profile Quest No. 3164.
      3) Determine the Post-Exposure Recommendation based on the exposure and HIV/Hepatitis B status (or risk factors) of the source.

   **B. Counseling and patient education**: Provide appropriate counseling and answer

patient

questions. This can be done by reviewing the BBP Patient Information Sheets found in the BBP Post Exposure Packet.

C. **BBP Testing of employee**: The tests most commonly needed are outlined on the **Laboratory Requisition Forms** and other forms in the Employee Exposure Packet.

| | | | |
|---|---|---|---|
| | HIV | Hep B S Ag | Hep C Ab (anti-HCV) |
| | RPR | Hep B S Ab (anti HBS) | Hep A IGM |
| Consider | Hepatitis Comprehensive Profile | | Quest No. 3164 |

1) If Post Exposure Medication for HIV is to be taken, baseline tests should include a CBC and comprehensive metabolic panel.

2) If the BBP status of the source so require, then tests on the exposed patient should be done at baseline, and repeated on the exposed patients at 6 weeks, 3 months, and 6 months (HIV, HB, HC, and RPR) See Laboratory Order Forms.

**D. Send the required notifications: (see form letters)**

1) Employer notification can be sent at once as soon as patient hast been seen.

2) Employee notification to be sent after the sources BBP status is determined, or when employee's laboratory values are received.

**E. Offer Post-Exposure Prophylaxis if appropriate**

1) Consent: Provide information on medications and obtain consent for PIP

2) For HIV PEP See Appendix to this Policy, 1. MMWR Appendix C.

a.) Call hospital pharmacy for available regimens. Prescribe weekly times four

b.) Draw baseline lab (CBC and CMP)

c.) Schedule follow-up at 2 and 4 weeks for lab and monitor for side effects.

3) For Hepatitis B See Appendix to this Policy MMWR Table 3 Page 32 of 37.

4) For Hepatitis C There is no current prophylaxis treatment for Hepatitis C

5) For Syphilis: IM penicillin may be considered

**G. Follow-up care – To be included in written notification to patient**

1) Schedule appointments for needed follow-up if retesting is needed.

a.) Source unknown: repeat labs at 6 weeks, 12 weeks, and 6 months

a.) HIV+ source and on PEP CBC and CMP every 2 weeks for 4 wks

b.) Hep B If immune – no testing
If re-vaccinated, test for immunity at 8 weeks

c.) Hep C Consider monthly RNA PCR. Consider referral.

2) Consider Gastroenterology or Infectious Disease referral if employee is found to be infected with HIV, HB, or HC

## IV. ATTACHMENTS

1. BBP Post Exposure Packet
2. Selected references and other information
3. MMWR June 29, 2001

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| Medical Director | Clinical Coordinator | Program Coordinator |
| --- | --- | --- |
| Date __________ | Date__________ | Date__________ |