

## **MUSC Occupational Bloodborne Pathogen Protocol Off Campus Procedure Packet**

MUSC has established these protocols in accordance with the OSHA Bloodborne Pathogen Standard and Center for Disease Control recommendations for Occupational Blood and Body Fluid exposure. CDC strongly recommends HIV prophylaxis start as soon as possible (ASAP) in the event of occupational bloodborne exposure, please perform the following emergency medical care:

### **Instructions for Employees/Students:**

#### **Know or carry your Hepatitis B (HBV) vaccination information and your HBV antibody results**

#### **In the event of a blood or body fluid exposure:**

1. **Wash the site immediately with soap and water.** Splashes to the eye should be flushed for 5-10 minutes with water.
2. **Go to the nearest Emergency Facility** immediately, preferably to a Hospital Emergency Department.
3. **Report the BBP exposure immediately** by calling the Employee Health Services (EHS) at (843) 792-2991 Monday – Friday 7 am – 4 pm. Students report by calling Student Health Services (SHS) at (843) 792-3664 Monday – Friday 8:00 am – 4:30 pm. **After hours** contact the MUSC Medical Center Hospital Supervisor by calling the operator at (843) 792-2123. For general instructions on BBP, call the BBP Hotline 24 hours a day at (843) 792-4422.

#### **Leave the following information on the recording:**

- **Employee/Student name and phone number**
  - **Date and time of exposure**
  - **Name of the BBP Source, medical record #**
  - **Name of facility, ER, MD who will treat you for BBP exposure**
  - **Name and phone number of health care worker to contact for lab follow up**
4. **Immediately complete the ACORD form (Worker's Compensation First Report of Injury Form). Fax the ACORD form with documentation of the medical provider's name, facility location and phone number to the Worker's Compensation office at fax (843) 792-3473.**

**Employee/Student results and source results must be submitted to Worker's Compensation and EHS/SHS.**

## Instructions for Care of MUSC Employee/Student with BBP exposure

Please complete the following medical evaluation for our Employee/Student. If outside South Carolina, refer to the appropriate state law.

Responsible Area	Instruction
Medical Provider	1. Identify and obtain blood from BBP Source. Perform labs. Draw Stat HIV, HIV 1 and 2, HbsAG, HCV AB if available.
	2. Obtain exposed employee's/student's blood. Perform labs. HIV 1 and 2 (with employee/student written consent).
	3. Evaluate employee/student for Hep B exposure risk. See Hep B chart. Provide care as indicated. Hep B surface antibody (for unknown titer only).
	4. Counsel the employee/student on HIV exposure.
	5. Offer Post Exposure Prophylaxis (PEP) as per CDC recommendation. See chart on page 4.
	6. If the employee/student elects PEP, please perform these labs as a PEP baseline:
	1. Blood chemistry: Sodium                      Calcium Potassium                      Protein Chloride                      Albumin Glucose                      Total Bilirubin BUN                      AST Creatinine                      ALK
	2. Uric Acid
	3. Lipase
	4. Amylase
	5. Complete blood count + Diff.
	6. CPK or CK
	7. Routine urinalysis
	8. HCG pregnancy test (female only)
	Provide wound care as indicated. Tdap booster as indicated.
Billing Manager	For Billing or Worker's Compensation questions contact the following: 1. Nancy Sifford (843) 792-1775 (MUSC) 2. Tanis Koester (843) 852-3100 (UMA) 3. Julie Reese (843) 792-3664 (Students)
Reporting	Please forward all documentation to: MUSC Employee Health Provider 57 Bee Street Charleston, SC 29403 (843) 792-2991 (phone)/(843) 792-1200 (fax) MUSC Student Health Provider 30 Bee Street Charleston, SC 29403 (843) 792-3664 (phone)/(843) 792-2318 (fax)

### Hepatitis B Prophylaxis Following Blood Exposure

**TABLE 3. Recommended postexposure prophylaxis for exposure to hepatitis B virus**

Vaccination and antibody response status of exposed workers*	Treatment		
	Source HBsAg <sup>†</sup> positive	Source HBsAg <sup>†</sup> negative	Source unknown or not available for testing
Unvaccinated	HBIG <sup>‡</sup> × 1 and initiate HB vaccine series <sup>†</sup>	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated			
Known responder <sup>**</sup>	No treatment	No treatment	No treatment
Known nonresponder <sup>**</sup>	HBIG × 1 and initiate revaccination or HBIG × 2 <sup>††</sup>	No treatment	If known high risk source, treat as if source were HBsAg positive
Antibody response unknown	Test exposed person for anti-HBs <sup>‡‡</sup> 1. If adequate, <sup>**</sup> no treatment is necessary 2. If inadequate, <sup>**</sup> administer HBIG × 1 and vaccine booster	No treatment	Test exposed person for anti-HBs 1. If adequate, <sup>†</sup> no treatment is necessary 2. If inadequate, <sup>†</sup> administer vaccine booster and recheck titer in 1-2 months

\* Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis.

<sup>†</sup> Hepatitis B surface antigen.

<sup>‡</sup> Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly.

<sup>‡‡</sup> Hepatitis B vaccine.

<sup>\*\*</sup> A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥ 10 mIU/mL).

<sup>††</sup> A nonresponder is a person with inadequate response to vaccination (i.e., serum anti-HBs < 10 mIU/mL).

<sup>†††</sup> The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

<sup>‡‡‡</sup> Antibody to HBsAg.

### Hepatitis C (HCV) Exposure:

1. **HCV Negative Source** – No treatment is indicated.

2. **HCV Positive Source** – Draw a Hepatitis C antibody titer on the employee/student.

Instruct the Employee/Student to contact their Employee/Student Health provider for follow up. There is currently no prophylaxis for HCV exposure.

## **Blood and Body Fluid Exposure: New Guidelines for Management**

### **Introduction**

Exposure to another person's blood or body fluids by needle stick, splash or other exposure may place a worker at risk for exposure to HIV, Hepatitis B, Hepatitis C or other infectious agents. Medication is available that may reduce a workers risk of HIV transmission. A vaccine is available for Hepatitis B. There is no proven treatment for Hepatitis C.

### **Risk of Work Related Bloodborne Infection**

Actual transmission of HIV in the workplace is rare. Studies of health care workers show that even the greatest risk of HIV infection due to injury with a hollow needle stick with HIV positive blood into the skin is (0.3%). That means even with the highest risk the chances of getting HIV from one such exposure is 1 in 300. The risk of HIV for splashes to the face and eyes is 1 in 900. Risk factors for Hepatitis infection depends on illness in the source, the type of Hepatitis virus, and previous vaccination status. Workers should always seek medical care immediately for any bloodborne pathogens.

### **Management of Work Related HIV Exposure**

Treatment for blood or body fluid exposure is based on recommendation by the CDC (Center for Disease Control). Only workers with the highest risk of HIV exposure should receive post exposure combination therapy. Medical treatment at the time of exposure with AZT and/or in combination with other medications appears to protect workers from HIV following exposure about 79% of the time.

### **Medication Information**

Tell your doctor about any drug allergy and name all medicines that you are currently taking. Treatment following blood exposure should be started within 2 hours post exposure.

AZT (ZDV, Zidovudine)-may cause headache, nausea, fatigue, anemia, low white blood cell count, low platelet count, muscle soreness, and rarely drug induced inflammation of the liver.

3TC (Lamivudine)-is generally will tolerated alone in combination with AZT.

IDV (Indinavir, Crixivan)-may cause kidney stones, stomach or abdominal discomfort, changes in taste, or high bilirubin in the blood. During drug testing of IDV, it was reported that 4% of patients taking IDV developed kidney stones. Taking Seldane, Hismanal, Propulsid, Halcion, or versed and IDV is not recommended. Take your medication exactly as prescribed. Notify Employee/Student Health Services if you cannot tolerate your medication.

### **Follow up**

When you are seen for a blood or body fluid exposure you will be given a follow up appointment. On follow up you will be told lab results for yourself and the patient source of exposure. Further follow up depends on these results. Exposure management decisions are made by MUSC Employee/Student Health Services.

### **Additional Information**

<http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf>

Managing Occupational Exposures to HIV & Hepatitis

National Clinicians' Post-Exposure Prophylaxis Hotline – 1-888-448-4911 (24 hours a day, 7 days a week)

Clinical Management Warmline – 1-800-933-3413

## INFORMATION FOR HUMAN IMMUNODEFICIENCY (HIV) TESTING

**HIV INFORMATION:** HIV is spread through contact with certain body fluids from an infected person. This can occur during sexual intercourse, receiving infected blood products, exposure to blood and infectious body fluids, during the birth process, or by sharing needles for intravenous drug use. HIV is not known to be spread by other contact and infection can be prevented by avoiding the contact described above.

**OCCUPATIONAL HIV EXPOSURE:** The body fluids to which universal precautions apply have been defined by the CDC as blood, semen, vaginal secretions; and spinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids but not urine feces, sweat, saliva or tears unless they contain visible blood. All but four of the published accounts of occupational HIV transmission have arisen from puncture wounds from sharp instruments freshly contaminated with HIV- infected blood or blood containing body fluids. In persons sustaining percutaneous exposure to blood from a known HIV positive individual, the risk of transmission is about 4 in 1000.

**TEST INFORMATION:** The test is done on a sample of your blood. The purpose is to look for the presence of antibodies to HIV. Antibodies are produced in the blood in response to infection most people will develop antibodies to HIV within six month of infection.

**CONFIDENTIALLY:** The HIV results will be considered confidential and released only to the health professions who have responsibility for your care and to the SC Department of Health and Environmental Control (DHEC), as required by state law. Information about this may not be released to any other persons without your written approval except by a valid court order or subpoena. Due to the highly confidential nature of the test, results will only be given in person to the employee/student being tested. Therefore, it will be the responsibility of the employee/student to schedule a brief follow up visit a week later to receive their results.

**NEGATIVE TEST RESULTS:** A negative result means that no antibodies were detected. On rare occasions, this can occur if you are infected but have not yet developed antibodies to HIV.

**POSITIVE TEST RESULTS:** A positive result means you are infected with HIV. A positive test does not mean you have already developed AIDS. Your physician will discuss with you the need for further testing. Counseling will be provided to you at the time you receive your test results. An HIV test has been ordered for you. This test is entirely voluntary and you can refuse without stopping your medical care. I understand the above information and have had the opportunity to have my questions answered. I will schedule a follow up visit to receive the lab results in one week.

Signature of Employee/Student/Date \_\_\_\_\_

Signature of Counselor/Date \_\_\_\_\_

**I WOULD LIKE/DISLIKE TO TAKE THE POST EXPOSURE PROPHYLAXIS AND AGREE TO ABIDE BY THE PROTOCOL.**

\_\_\_\_\_  
Employee/Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Health Care Provider

\_\_\_\_\_  
Date

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## **POST EXPOSURE CHEMOPROPHYLAXIS IN OCCUPATIONALLY EXPOSED HEALTH CARE WORKERS**

### **VOLUNTARY STATEMENT OF INTENT TO AVOID PREGNANCY: WOMEN**

To the best of my knowledge, I am not currently pregnant. Furthermore, I agree to avoid pregnancy while I am taking Chemoprophylaxis during the next four weeks and for four weeks thereafter. Should I have sexual relations during this period, I will practice a form of birth control (e.g. abstinence, oral contraceptives, intrauterine device, diaphragm plus condoms) that is deemed reliable by my clinician. I may decline to sign this statement; my declining to sign will have no effect on future treatment by my physician except that I will not be treated with chemoprophylaxis

\_\_\_\_\_  
Employee/Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

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### **VOLUNTARY STATEMENT OF INTENT TO AVOID PREGNANCY: MEN**

Should I have sexual relations during the next four weeks and for four weeks following completion of chemoprophylaxis treatment, I will practice a form of birth control with my partner(s). (e.g. abstinence, oral contraception, condoms plus diaphragm, intrauterine device) that is deemed reliable by my clinician. I may decline to sign this statement; my declining to sign will have no effect on future treatment by my physician except that I will not be treated with chemoprophylaxis.

\_\_\_\_\_  
Employee/Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Print)

**Bloodborne Pathogen Exposure/Follow-up**



**EMPLOYEE/STUDENT HEALTH SERVICES**

57 Bee Street /30 Bee St.  
Charleston, South Carolina 29403  
Telephone: 843-792-2991/843-792-3664  
Fax: 843-792-1200/843-792-2318

\_\_\_\_\_  
Employee/Student name                      Social Security Number  
\_\_\_\_\_  
Home Phone                                      Work Phone/Ext.  
\_\_\_\_\_  
Employer    Department

Date & time of exposure \_\_\_\_\_ / \_\_\_\_\_ am/pm      Location: \_\_\_\_\_

Type of exposure:  Needle stick     Laceration     Bite     Splash     Other \_\_\_\_\_

Circumstances of Exposure: \_\_\_\_\_  
\_\_\_\_\_

Identifiable Source:

Name: \_\_\_\_\_ Med Record #: \_\_\_\_\_

Pt. Location: \_\_\_\_\_

Blood contamination screen drawn on source patient?:                       Yes     No

Attending MD Name: \_\_\_\_\_

Known communicable disease?: \_\_\_\_\_

**Employee/Student's Medical History and Treatment:**

- ◆ Employee/Student completed Hepatitis B vaccine series?                       Yes     No
- ◆ HIV consent and Pre-HIV counseling MD signature?                       Yes     No
- ◆ Blood contamination screen drawn on employee/student?                       Yes     No
- ◆ Post exposure protocol (PEP) initiated?                       Yes     No
- ◆ Baseline (PEP) labs drawn?                       Yes     No
- ◆ PEP counseling by MD completed?                       Yes     No
- ◆ PEP consent or declinations signed?                       Yes     No
- ◆ Employee/Student instructed to call and make follow-up appt in 3 days?     Yes     No
- ◆ Copy of all medical records prepared for Employee/Student Health Services?     Yes     No

Nurse Signature (initial BBP visit): \_\_\_\_\_ Date: \_\_\_\_\_

**Source Blood Contamination Results**

HIV \_\_\_\_\_ HbsAG \_\_\_\_\_ RPR \_\_\_\_\_ HCV \_\_\_\_\_

**Employee/Student Blood Contamination Results**

AHBsAG \_\_\_\_\_ HIV \_\_\_\_\_ Other labs \_\_\_\_\_

**Post Exposure Follow-up (patient please initial)**

\_\_\_\_\_ I have been informed of the results of the post exposure evaluation  
\_\_\_\_\_ I have been informed of any medical conditions resulting from exposure to blood or  
other potentially infectious materials which require evaluation or treatment.  
\_\_\_\_\_ I have been counseled about adherence to Universal Precaution procedures and  
maintaining confidentiality of the sources' medical information.

Employee/Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: Required fields are yellow!**

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS					
Employer(Name & Address with Zip Code)		Carrier/Administrator Claim Number		Report Purpose Code	
		Jurisdiction		Jurisdiction Claim Number	
		Insured Report Number			
SIC Code	Employer Fein	Employer's Location Address(if different)		Location #:	
				Phone #	
CARRIER/CLAIMS ADMINISTRATOR					
Carrier(Name, Address & Phone No)		Policy Period	Claims Administrator(Name, Address & Phone Number)		
		To			
		Check if Appropriate			
		Self Insurance			
Carrier Fein	Policy/Self-Insured Number			Administration Fein	
Agent Name & Code Number					
EMPLOYEE / WAGE					
Name (Last, First, Middle)		Birth Date	Social Security Number	Hire Date	State of Hire
Address (include Zip Code)		Sex	Marital Status	Occupation/Job Title	
			Unmarried single/divorced		
				Employment Status	
				NCCI Class Code	
Phone	# Dependents				
Rate	Per <input type="checkbox"/> Day <input type="checkbox"/> Month	# Days Worked/Week	Full Pay for Day of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Week <input type="checkbox"/> Other:		Did Salary Continue? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OCCURANCE/TREATMENT					
Time Employee Began Work	Date of Injury/Illness	Time of Occurrence	Last Work Date	Date Employer Notified	Date Disability Began
Contact Name / Phone Number		Type of Injury/Illness		Part of Body Affected	
Did Injury/Illness Exposure Occur on Employer's Premises?		Type of Injury/Illness Code		Part of Body Affected Code	
Yes <input type="checkbox"/> No <input type="checkbox"/>					
Department or Location Where Accident or Illness Exposure Occurred			All Equipment, Materials, or Chemicals Employee was using when Accident or Illness Exposure Occurred		
Specific Activity the Employee was Engaged in When the Accident or Illness Exposure Occurred			Work Process The Employee was engaged in When Accident or Illness Exposure Occurred		
How Injury or Illness/Abnormal Health Condition Occurred. Describe the Sequence of Events and Include Any Objects or substances that Directly Injured the Employee or Made the Employee Ill				Cause of Injury Code	
Date Return(ed) To Work	If Fatal, Give Date of Death	Were Safeguards or Safety Equipment Provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Were They Used		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician/Health Care Provider(Name & Address)		Hospital(Name & Address)		Initial Treatment	
				No Medical Treatment	
Witness (Name & Phone #)					
Date Administrator Notified	Date Prepared	Preparer's Name & Title		Phone Number	

Submit