

**COLLEGE OF NURSING
AND HEALTH
PROFESSIONS**

**INFECTION CONTROL
POLICY**

REVISED January, 2011

Introduction

Protecting health professions students from exposures to pathogenic microorganisms is a critical component of the clinical education environment. Clinical situations present the possibility for contact with blood, body fluid, or biological agents which pose infectious disease risk, particularly risk associated with the hepatitis B virus, hepatitis C virus, the human immunodeficiency virus, and tuberculosis.

Medical histories and examinations cannot identify all clients infected with pathogens. Therefore, the concept of **STANDARD PRECAUTIONS** is to be practiced with all clients during treatment and post-treatment procedures. Standard precautions encompass the standard of care designed to protect health care providers and clients from pathogens that may be spread by blood or any other body fluid, excretion, or secretion. Clients must be protected from disease transmission which can occur via contaminated hands, instruments, and other items. Use of appropriate infection control procedures will minimize this risk of transmission.

Guidelines for reducing risk of disease transmission have been issued by many health related organizations. The *Bloodborne Pathogens Standard* issued through the Federal Occupational Safety and Health Administration along with recommendations from the Centers for Disease Control and Prevention, (CDC), provide the basis for the University of Southern Indiana College of Nursing and Health Professions *Infection Control Policy* developed by the College of Nursing and Health Professions Infection Control and HIPAA Committee.

The policies and procedures contained in the *Infection Control Policy* are designed to prevent transmission of pathogens and must be adhered to by all students and faculty in the College of Nursing and Health Professions when participating in clinical education experiences where the potential for contact with blood or other potentially infectious materials (OPIM) exists. These experiences include clinical practice on peers. The goal of the *Infection Control Policy* is to provide procedures and guidelines to be used by students to prevent transmission of infectious diseases while participating in clinical/laboratory activities while enrolled as a student in the College of Nursing and Health Professions.

Exposure to infectious diseases is an integral part of practicing as a health care professional. All students must recognize and accept this risk in order to complete their education and participate fully in their chosen career. Students may not refuse to care for a client solely because the client has an infectious disease or is at risk of contracting an infectious disease such as HIV, AIDS, HBV, HCV, or TB. **PROFESSIONAL STANDARDS OF INDIVIDUAL DISCIPLINES MAY NECESSITATE EXCEPTIONS TO THE PRECEDING STATEMENT.**

All information regarding a client's medical status is considered confidential and shall be used for treatment purposes only. No information about the client's medical status will be disclosed or reported without the client's express written consent, except in those cases as stipulated by law.

The curriculum of each program in the College of Nursing and Health Professions includes information regarding the etiology, symptoms, and transmission of infectious diseases, as well as specific methods of preventing disease transmission to be utilized in various clinical sites. This information will be provided to the student prior to initiation of clinical experiences.

Information contained in the *Infection Control Policy* will be reviewed with students on an annual basis or more often if changes in content occur.

The College of Nursing and Health Professions Infection Control and HIPAA Committee will review the *Infection Control Policy* annually and will make revisions as additional information becomes available that impacts content. The Committee will also evaluate exposure incidents to determine the need for modification of the *Infection Control Policy* policies/procedures.

I. Medical Evaluation, Immunizations, and Record Keeping

A. All students admitted to a program in the College of Nursing and Health Professions are required to undergo comprehensive medical evaluation prior to enrolling in professional courses.

B. Vaccine Recommendations

- Adapted from Immunization Coalition www.immunize.org

Healthcare Personnel Vaccination Recommendations

Vaccine	Recommendations in brief
Hepatitis B	Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Give IM. Obtain anti-HBs serologic testing 1–2 months after dose #3.
Influenza	Give 1 dose of influenza vaccine annually. Give inactivated injectable influenza vaccine intramuscularly or live attenuated influenza vaccine (LAIV) intranasally.
MMR	For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give SC.
Varicella (chickenpox)	For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart. Give SC.
Tetanus, diphtheria, pertussis	Give all HCP a Td booster dose every 10 years, following the completion of the primary 3-dose series. Give a 1-time dose of Tdap to HCP of all ages with direct patient contact. Give IM.
Meningococcal	Give 1 dose to microbiologists who are routinely exposed to isolates of <i>N. meningitidis</i> . Give IM or SC.

Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material.

Hepatitis B

Healthcare personnel (HCP) who perform tasks that may involve exposure to blood or body fluids should receive a 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Test for hepatitis B surface antibody (anti-HBs) to document immunity 1–2 months after dose #3.

- If anti-HBs is at least 10 mIU/mL (positive), the patient is immune. No further serologic testing or vaccination is recommended.
- If anti-HBs is less than 10 mIU/mL (negative), the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series. Retest anti-HBs 1–2 months after dose #3.
- If anti-HBs is positive, the patient is immune. No further testing or vaccination is recommended.
- If anti-HBs is negative after 6 doses of vaccine, patient is a non-responder.

For non-responders: HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood.¹ It is also possible that non-responders are persons who are HBsAg positive. Testing should be considered. HCP found to be HBsAg positive should be counseled and medically evaluated.

Note: Anti-HBs testing is not recommended routinely for previously vaccinated HCP who were not tested 1–2 months after their original vaccine series. These HCP should be tested for anti-HBs when they have an exposure to blood or body fluids. If found to be anti-HBs negative, the HCP should be treated as if susceptible.¹

Influenza

All HCP, including students in these professions, and volunteers, should receive annual vaccination against influenza. Live attenuated influenza vaccine (LAIV) may only be given to non-pregnant healthy HCP age 49 years and younger. Inactivated injectable influenza vaccine (TIV) is preferred over LAIV for HCP who are in close contact with severely immunosuppressed persons (e.g., stem cell transplant patients) when patients require protective isolation.

Measles, Mumps, Rubella (MMR)

HCP who work in medical facilities should be immune to measles, mumps, and rubella.

- HCP born in 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) laboratory confirmation of disease or immunity (HCP who have an “indeterminate” or “equivocal” level of immunity upon testing should be considered nonimmune) or (b) appropriate vaccination against measles, mumps, and rubella (i.e., 2 doses of live measles and mumps vaccines given on or after the first birthday, separated by 28 days or more, and at least 1 dose of live rubella vaccine).

Varicella

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart, history of varicella or herpes zoster based on physician diagnosis, laboratory evidence of immunity, or laboratory confirmation of disease.

Tetanus/Diphtheria/Pertussis (Td/Tdap)

All adults who have completed a primary series of a tetanus/diphtheria-containing product (DTP, DTaP, DT, Td) should receive Td boosters every 10 years. HCP of all ages with direct patient contact should be given a 1-time dose of Tdap, with priority given to those having contact with infants younger than age 12 months.

References

www.immunize.org • www.vaccineinformation.org

- C. All students and faculty who have client contact are required to be immunized or provide documentation of laboratory confirmation of disease or immunity against varicella, mumps, measles, rubella. All students and faculty who have client contact are required to be immunized against tetanus, pertussis and diphtheria, and to receive annual influenza immunization.
- D. All HCPs should receive baseline TB screening upon admission into the College of Nursing and Health Professions, using two-step TST or a single BAMT to test for infection with *M. tuberculosis*.

After baseline testing for infection with *M. tuberculosis*, HCPs should receive TB screening annually (i.e., symptom screen for all HCWs and testing for infection with *M. tuberculosis* for HCPs with baseline negative test results).

HCPs with a baseline positive or newly positive test result for *M. tuberculosis* infection or documentation of previous treatment for Latent Tuberculosis Infection (LTBI) or TB disease should receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCPs should receive a symptom screen annually. This screen should be accomplished by educating the HCP about symptoms of TB disease and instructing the HCP to report any such symptoms immediately to the occupational health unit. Treatment for LTBI should be considered in accordance with CDC guidelines.

- E. Record Keeping
 1. All records related to a student's medical status will be maintained by the student's program administrator.
 2. The records will be maintained separately from all other student records.
 3. The records will be maintained in a secured and confidential manner and will not be disclosed or reported without the student's express written consent.
 4. Student workers will not have access to student or faculty medical records.

II. HIV Positive, HBV, or HCV Chronic Carrier Students and Faculty

- A. Students and faculty are encouraged to know their HIV, HbsAG, and anti-HCV status and report positive status to the Dean and the Infection Control and HIPAA Committee of the College of Nursing and Health Professions. Such individuals should consult with their health care provider to assess the risks of clinical practice to their health and to others. The health care provider should make written recommendations related to the student's education experience. The Dean and the Infection Control and HIPAA Committee will review each case individually and, if indicated, will recommend appropriate modifications of the clinical experiences.
- B. All information regarding a student's medical status will be considered confidential and will not be disclosed or reported without the student's express written consent.
- C. A student's HIV, HBV and/or HCV status will not determine a student's opportunity to be admitted or progress in a program. The HIV, HBV, and/or HCV status will be considered only as it relates to: (1) the student's ability to safely carry out the normal assignments associated with the course of study and (2) the student's long term health.

III. Tuberculosis Exposure/Conversion

A student or faculty who is exposed to tuberculosis or whose negative PPD test converts to positive, will be referred to the Vanderburgh County Public Health Department for evaluation.

IV. Exposure Potential

- A. All students in the College of Nursing and Health Professions participating in clinical activities have the potential for skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (contained in the following list) and will adhere to policies and procedures contained in the *Infection Control Policy*. Adherence is required without regard to the use of personal protective equipment.
- B. Other Potentially Infectious Materials (OPIM)
 - semen
 - vaginal secretions
 - cerebrospinal fluid
 - synovial fluid
 - pleural fluid
 - pericardial fluid
 - peritoneal fluid
 - amniotic fluid
 - breast milk
 - saliva/sputum
 - body fluids visibly contaminated with blood
 - any unfixed tissue or organ (other than intact skin) from a human (living or dead)
 - HIV containing cells or tissues cultures
 - HIV, HBV, or HCV containing culture medium or other solutions
 - blood, organs, or other tissues from experimental animals infected with HIV, HBV, or HCV

V. Percutaneous/Mucous Membrane Exposure to Blood or Other Potentially Infectious Materials (Exposure Incident)

- A. Any percutaneous (needlestick, cut, human bite, splash to non-intact skin, etc.) or mucous membrane (splash to eye, lips, or mouth) exposure to blood, blood products, or other body fluids is to be reported **immediately**, (within 2 hours of the incident), by the student to the clinical instructor so that appropriate post-exposure procedures can be initiated. A delay in reporting/treatment of the incident may render recommended HIV post-exposure prophylaxis, (PEP), ineffective. If a delay occurs, (defined as later than 24-36 hours after the incident), it is advised that expert consultation for HIV/PEP be sought. **The clinical instructor will complete the agency incident report, the University Injury or Illness Report, and the College of Nursing and Health Professions Student Exposure Incident Report, and Acknowledgement of Refusal if applicable.** The completed college report and the university report will be submitted to the College of Nursing and Health Professions Infection Control and HIPAA Committee for review. The University report will be forwarded by the College of Nursing and Health Professions Infection Control and HIPAA Committee to appropriate University personnel. The clinical instructor will also notify the course coordinator and program administrator of the exposure incident.
- B. After a percutaneous or mucous membrane exposure to blood or body fluids, the student is to follow CDC and clinical site policy for immediate post-exposure wound cleansing/infection prophylaxis such as cleansing the affected area with antimicrobial soap, irrigation of the eyes or mouth with large amounts of tap water or saline.
- C. The source client, if known, should be tested serologically for evidence of HIV, HbsAg and anti-HCV. HIV consent must be obtained from the source client prior to testing.
- D. HIV/AIDS Procedure
1. If the source client is seronegative for HIV and has no clinical evidence or risk for HIV infection or AIDS, no further follow-up is indicated.
 2. If the source client is diagnosed with AIDS, is seropositive for HIV, or refuses to be tested, as soon as possible following the exposure, the student will be referred for baseline serologic testing for evidence of HIV. The student will also be referred to a designated faculty member for post-exposure counseling about the risk of infection, prevention of transmission of HIV during the follow-up period, and the need for appropriate follow-up medical care.
 3. The exposed student will have follow-up HIV testing at 6 weeks, 3 months, 6 months, and 12 months post-exposure.

TYPE OF EXPOSURE	SOURCE MATERIAL	ANTIRETROVIRAL PROPHYLAXIS
Percutaneous	-Blood <ul style="list-style-type: none"> ▪ Highest risk ▪ Increased risk ▪ No increased risk 	Recommend Recommend Offer
	-Fluid containing visible blood, other potentially infectious fluid, or tissue	Offer
	-Other body fluid	Not offer
Mucous membrane	-Blood	Offer
	-Fluid containing visible blood, other potentially infectious fluid, or tissue	Offer
	-Other body fluid	Not offer
Skin	-Blood	Offer
	-Fluid containing visible blood, other potentially infectious fluid, or tissue	Offer
	-Other body fluid	Not offer

Provisional Public Health Service recommendations for chemoprophylaxis after exposure to HIV, by type of exposure and source material - 2001

E. Hepatitis B Procedure

The following chart outlines the CDC recommendations for hepatitis B post-exposure prophylaxis following percutaneous exposure.

EXPOSED PERSON	SOURCE CLIENT HBsAg POSITIVE	SOURCE CLIENT HBsAg NEGATIVE	SOURCE CLIENT UNKNOWN
Unvaccinated	Administer HBIG* X 1 and HB vaccine	Initiate HB vaccine	Initiate HB vaccine
Previously vaccinated Known responder	Test exposed person for anti-HBs 1. If inadequate, HB vaccine booster dose 2. If adequate, no treatment	No treatment	No treatment
Previously vaccinated Known non-responder	HBIG X 2 or HBIG X 1 plus 1 dose HB vaccine	No treatment	If known high risk source, may treat as if +
Previously vaccinated Response unknown	Test exposed person for anti-HBs 1. If inadequate, HBIG X 1, plus HB vaccine booster dose 2. If adequate, no treatment	No treatment	Test exposed person for anti-HBs 1. If inadequate, HB booster 2. If adequate, no treatment

* ***The Centers for Disease Control and Prevention recommend that HBIG, when indicated, be administered as soon as possible after exposure, and within 24 hours if possible.***

F. Hepatitis C Procedure

The following chart outlines the CDC recommendations for hepatitis C post-exposure prophylaxis following percutaneous exposure.

EXPOSED INDIVIDUAL	SOURCE CLIENT
Perform baseline testing for anti-HCV and alanine aminotransferase (ALT) activity	Perform testing for anti-HCV
Perform follow-up testing at 4-6 months for anti-HCV and ALT activity	

For additional information related to management of exposure incidents refer to:

http://www.cdc.gov/oralhealth/InfectionControl/faq/bloodborne_exposures.htm

National Clinicians' Post-exposure Prophylaxis Hotline

http://www.nccc.ucsf.edu/about_nccc/pepline/

Needlestick Reference

<http://www.mercydurango.org/srvcsmedical/Needlestick!%20Help%20Files.pdf>

Immunization Action Coalition

www.immunize.org & www.vaccineinformation.org

VI. Methods of Reducing Potential for Exposure to Pathogens

A. STANDARD PRECAUTIONS

Standard precautions refer to the prevention of contact with blood, all body fluids, secretions, and excretions except sweat, and must be used with every client. Exposure of non-intact skin and mucous membranes to these fluids must be avoided. All body fluids shall be considered potentially infectious materials.

B. ENGINEERING AND WORK PRACTICE CONTROLS

Engineering and work practice controls shall be used to eliminate or minimize exposure to blood or OPIM. An example of an engineering control would include the use of safer medical devices, such as sharps with engineered sharps injury protection and needleless systems. Where potential exposure remains after institution of these controls, personal protective equipment shall also be used.

The following engineering controls will be utilized:

1. Hand washing is a significant infection control measure which protects both the student and the client. Students will wash their hands before donning gloves and immediately or as soon as feasible after removal of gloves or other personal protective equipment. Students will wash hands and any other skin with soap and water or flush mucous membranes with water immediately or as soon as feasible following contact with blood or OPIM. No nail polish or artificial fingernails are allowed during clinical activities. Jewelry has the potential to harbor microorganisms. Refer to individual program handbooks for specific guidelines regarding wearing jewelry during clinical activities.
2. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in treatment areas or any other area where there is a reasonable likelihood of exposure to blood or OPIM.

3. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on counter tops or bench tops where blood or OPIM are present.
4. All procedures involving blood or OPIM shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.
5. Mouth pipetting/suctioning of blood or OPIM is prohibited.
6. **Sharps Management**

Sharps are items that can penetrate skin and include injection needles, scalpel blades, suture needles, irrigation cannulas, instruments, and broken glass. It is recommended that the clinician select the safest medical device and/or technique available to help reduce needlesticks and other sharps injuries. The use of needles should be avoided where safe and effective alternatives are available.

 - All disposable contaminated sharps shall be disposed of immediately or as soon as feasible in closable, puncture resistant, leak proof on sides and bottom, and labeled containers. The container must be maintained in an upright position and must not be overfilled.
 - Sharps disposal containers must be readily accessible and located in reasonable proximity to the use of sharps
 - Containers containing disposable contaminated sharps are not to be opened, emptied, or cleaned manually or in any other manner which could create a risk of percutaneous injury.
 - Contaminated needles and other contaminated sharps shall not be bent, sheared, recapped or removed unless no alternative is feasible or is required by a specific procedure. If recapping is necessary, a one handed technique or mechanical recapping device must be used.
 - Reusable contaminated sharps shall be placed in leak proof, puncture resistant, labeled containers while waiting to be processed.
 - Sharps containers must be closed before they are moved.
 - HCP are not to reach by hand into containers of contaminated sharps.
 - Contaminated broken glass should be picked up using mechanical means such as a brush and dust pan, tongs, or forceps.
 - Whenever possible, sharps with engineered sharps injury protection or needleless systems should be used.
7. Specimens of blood or OPIM shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. The container must be closed before being stored, transported, or shipped. If outside contamination of the primary container occurs, or if the specimen could puncture the primary container, the primary container shall be placed within a secondary container which prevents leakage, and/or resists puncture during handling, processing, storage, transport, or shipping.
8. **Equipment Sterilization**
 - Reusable heat stable instruments are to be sterilized by acceptable methods.
 - Heat sterilization equipment will be monitored for effectiveness and records will be maintained.
9. Equipment which may be contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary. Equipment which has not been fully decontaminated must

have a label attached with information about which parts remain contaminated.

C. **PERSONAL PROTECTIVE WEAR**

1. Personal protective equipment such as gloves, gowns, laboratory coats, face masks, eye protection or face shields, resuscitation bags, pocket masks or other ventilation devices shall be used whenever there is the potential for exposure to blood or OPIM.
2. Personal protective equipment must not permit blood or OPIM to pass through to or reach the student's clothes, skin, eyes, mouth, or other mucous membranes.
3. All personal protective equipment must be removed prior to leaving the treatment area. When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination, or disposal.

Gloves

Gloves shall be worn in the following situations:

- when it can be reasonably anticipated that hands may contact blood, OPIM, mucous membranes, or non-intact skin.
- when performing vascular access.
- when handling or touching contaminated items or surfaces.

Disposable gloves

- shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.
- shall be replaced if excessive moisture develops beneath the glove.
- shall not be washed or decontaminated for re-use.
- if contaminated, must be covered by over gloves when handling non-contaminated items (e.g. client charts)

Utility gloves

- may be decontaminated for re-use if the integrity of the glove is not compromised.
- must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

Masks

- Masks shall be changed between clients.
- Masks shall be changed when excessive moisture develops beneath the surface.

Eye Protection

- goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever splashes, spray, spatter, aerosols, or droplets of blood or OPIM may be generated and eye, nose or mouth contamination can be reasonably anticipated.

Protective Body Clothing

- Appropriate protective clothing such as gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in potential exposure situations.
- Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated.
- Protective body clothing must be changed when visibly contaminated with blood or OPIM or if they become torn or punctured.

D. HOUSEKEEPING

1. Equipment and Environmental and Working Surfaces
 - Contaminated work surfaces shall be decontaminated after completion of procedures using a tuberculocidal chemical disinfectant having an Environmental Protection Agency (EPA) registration number. Decontamination must occur between clients, immediately or as soon as feasible when surfaces are contaminated, or after any spill of blood or OPIM.
 - Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and surfaces are to be removed and replaced as soon as feasible when they become contaminated. Protective coverings do not replace decontamination with tuberculocidal chemical disinfectant.
 - Reusable bins, pails, cans, and similar receptacles are to be regularly inspected for contamination with blood or OPIM and decontaminated as needed.

E. INFECTIOUS WASTE MANAGEMENT

1. Infectious waste is defined as:
 - contaminated disposable sharps or contaminated objects that could potentially become contaminated sharps
 - infectious biological cultures, infectious associated biologicals, and infectious agent stock
 - pathological waste
 - blood and blood products in liquid and semi-liquid form
 - carcasses, body parts, blood and body fluids in liquid and semi-liquid form, and bedding of laboratory animals
 - other waste that has been intermingled with infectious waste
2. Infectious waste must be placed in labeled containers which are closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping.
3. Containers must be closed prior to moving/removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. If the outside of the container becomes contaminated it is to be placed in a second container which must have the same characteristics as the primary container.

Definitions of Terms/Abbreviations

AIDS

Acquired Immune Deficiency Syndrome

A disabling or life threatening illness caused by HIV (human immunodeficiency virus). It is the last stage on the long continuum of HIV infection and is characterized by opportunistic infections and/or cancers.

Anti-HBs - Hepatitis B Surface Antibody

The presence of anti-HBs (hepatitis B surface antibodies) in an individual's blood indicates immunity to hepatitis B disease. This is the test used to indicate that a person has had a serologic response to hepatitis B immunization and has developed antibodies to the infection.

Anti-HCV – Hepatitis C antibody virus

Indicates past or present infection with hepatitis C

CDC

Centers for Disease Control and Prevention

The branch of the U.S. Public Health Service whose primary responsibility is to propose, coordinate and evaluate changes in the surveillance of disease in the United States.

Delayed Report

Not reporting an exposure incident until 24 hours or more hours following the exposure.

Exposure Incident

A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

HBIG Hepatitis B Immune Globulin

A type of vaccine administered in the event of an exposure to hepatitis B disease. The administration of this preparation confers a temporary (passive) immunity or raises the person's resistance to hepatitis B disease.

HBsAg - Hepatitis B Surface Antigen

A surface antigen of the hepatitis B virus. Indicates potential infectivity.

HCP

Health Care Personnel

HIV - Human Immunodeficiency Virus

The organism that causes AIDS.

LTBI – Latent Tuberculosis Infection

OPIM - Other Potentially Infectious Materials

Materials other than human blood that carry the potential for transmitting pathogens.

Standard Precautions

Treating all clients as if they are infected with a transmissible disease.

Universal Precautions

Treating all clients as if they are infected with a transmissible bloodborne disease.



UNIVERSITY OF SOUTHERN INDIANA

Management of Exposure Incidents

Any percutaneous (needle stick, cut, human bite, splash to non-intact skin, etc.) or mucous membrane (splash to eyes, lips, or mouth) exposure to blood, blood products, other body fluids, or air borne exposures must be reported immediately by the student to the clinical faculty so that appropriate post-exposure procedures can be initiated. The Public Health Services (PHS) recommends that treatment should be recommended to healthcare workers who experience occupational high-risk exposures. Please see the College of Nursing and Health Profession's Infection Control Manual for further information.

Management of Exposure Incidents Checklist

For exposures other than air-borne exposures: The affected area was cleansed with antimicrobial soap. Water was run through glove if puncture was suspected. Eyes: The eyes were irrigated for one minute. Mouth: The mouth cleansed with tap water for fifteen minutes.

Injury or Illness Report completed.

Student Exposure Incident Report completed.

Clinical Facility's Incident Report completed.

Exposed student provided a copy of the Student Exposure Incident Report and sent by clinical faculty for treatment. (Refer to clinical site policy for exposure incident treatment.) *[For TB exposures, students will receive notice of exposure to suspected or active cases of TB through either the employee health department of the clinical facility where they were exposed or, in cases of active TB, through the county health department. Instructions for follow-up are provided by the notifying department.]*

Source Patient Management: The source client, if known, should be serologically tested for evidence of HIV, HbsAg, and anti-HCV. Please circle one:

Source patient known and tested Source patient known and refused testing Source patient unknown

Clinical faculty signature _____ Date: _____

The completed Injury or Illness Report, Student Exposure Incident Report and exposure check list returned to Clinical Coordinator within 24 hours or as soon as possible.

Clinical Coordinator signature _____ Date: _____

Postexposure management/counseling completed. Students have the right to be counseled about exposure by university faculty if desired. Please Circle One:

Counseling completed Counseling denied

University Faculty Signature: _____ Date: _____

INSTRUCTIONS FOR COMPLETING THE INJURY OR ILLNESS REPORT

1. Completion of Forms

- A. Employee and Student Worker injury or illness will be completed by security and or student health services if first aid or medical treatment is needed. If first aid or additional medical treatment is not needed, this form is completed by the department head or supervisor and forwarded to human resources. The form should be completed and returned to Human Resources within 24 hours of occurrence.
- B. Student and Visitor (non-employee) injury or illness reports will always be completed by security and or Student Health Services.
- C. Acknowledgement of refusal to seek management of exposure incident must be completed if the person in question refuses to seek management of exposure incident.

2. Timeliness of Reporting

Any accidents or injuries which are reported late, i.e., not within a few hours of the occurrence, should be reported directly to the department head or supervisor, whom will then be responsible for completing the entire injury or illness report. The form should then be sent to Human Resources within 24 hours of the occurrence.

3. Distribution of Field Injury or Illness Reports

- A. Employee and Student Worker reports with sections A and B completed are to be sent (in whole) to Human Resources. Human Resources will then distribute copies to Security, Purchasing, Student Health Services, the Department Head or Supervisor, and the Vice President for business Affairs, while retaining a copy in Human Resources.

After the Department Head/ Supervisor receives the report from Human Resources with sections A and B completed, the Department Head/Supervisor should review the injury/accident situation, complete section C on the report, and return it to human resources.

- B. Student and Visitor reports retained in Student Health Services (if not Originating in this department, the report should be sent there.) Copies are distributed by Student Health Services to the Security and Purchasing departments.



University of Southern Indiana
College of Nursing and Health Professions

ACKNOWLEDGEMENT OF REFUSAL TO SEEK MANAGEMENT OF EXPOSURE INCIDENT

Any percutaneous (needlestick, cut, human bite, splash to non-intact skin, etc.) or mucous membrane (splash to eye,lips, or mouth) exposure to blood, blood products, body fluids, or airborne pathogens is to be reported immediately by the student to the clinical faculty so that appropriate post-exposure procedures can be initiated. The Public Health Services, (PHS), recommends that treatment should be recommended to healthcare workers who experience occupational high-risk exposures. Please refer to the College of Nursing and Health Professions Infection Control Policy.

I understand that I have been advised to seek prompt management of an exposure incident. At this time, I am refusing referral to a healthcare professional for recommendation regarding the need for evaluation and the need for chemoprophylaxis.

Date of exposure incident: _____

Time of exposure incident: _____

Institution where incident took place: _____

Summary of incident: _____

Student Name: _____

Student Signature: _____ Date/Time: _____

Advising Faculty: _____ Date: _____

**University of Southern Indiana
College of Nursing and Health Professions
Student Exposure Incident Report**

Exposed Student Information:

Program:

- Dental Assisting Nursing Radiologic Technology
 Dental Hygiene Occupational Therapy Respiratory Therapy
 Diagnostic Medical Sonography Occupational Therapy Assistant

Student name: _____ DOB: _____

Date incident occurred: _____ Time incident occurred: _____ Time reported: _____

Has the student completed the hepatitis B vaccination series? yes no

If yes, dates of vaccination: 1st _____ 2nd _____ 3rd _____

Post-vaccination HBV antibody status, if known: positive negative unknown

Date of last tetanus vaccination: _____

Date of last tuberculin test: _____

Exposure Incident Information:

Agency/site where incident occurred (include specific unit): _____

Type of incident:

- needle stick
 instrument puncture
 bur laceration
 injury from other sharp object _____
 blood/other body fluid splash or spray
 human bite
 other _____

Area of body exposed: _____

Type of body fluid/tissue/airborne pathogen exposed to: _____

Describe incident in detail: _____

What barriers were being used by the student when the incident occurred?

gloves mask eye wear gown other _____

Source Patient Information:

Review of source patient medical history: yes no

Verbally questioned regarding:

History of hepatitis B, hepatitis C, or HIV infection yes no

High risk history associated with these diseases yes no

Patient consents to be tested for HBV, HCV, and HIV yes no

Referred to (name of evaluating healthcare professional/facility): _____

Incident report completed by: _____

Student Signature: _____

Date: _____

Post-exposure management/counseling:

Date: _____ Time: _____
Comments:

Counselor signature: _____

University Injury of Illness Report Completed:
Signature: _____ Date _____

Clinical Instructor signature: _____

Date: _____

Student Acknowledgment:

I have reviewed and confirm the accuracy of the information contained in this report. I acknowledge that I have been referred for medical evaluation and the need to receive additional medical evaluation for the presence of HIV infection at 6 weeks, 3 months, 6 months, and 12 months following the occurrence of this exposure incident. I authorize the release of the information related to this exposure incident for treatment, payment activities, and healthcare operations according to the policies contained in the College of Nursing and Health Professions HIPAA documents.

Student Signature: _____

Date: _____

**TO BE COMPLETED BY THE COLLEGE OF NURSING AND HEALTH PROFESSIONS
INFECTION CONTROL COMMITTEE**

Corrective action needed: _____

Has this action been taken? yes no
Is further investigation needed? yes no

Comments:

Signature: _____ Date _____

INJURY OR ILLNESS REPORT

Employee

Date of Report ___/___/___

Student Worker

Time _____ a.m. p.m.

Student

(See reverse side for instructions)

Visitor

Name of Injured _____ Male Female

Permanent Address _____

City _____ State _____ Zip Code _____

Telephone Home (____) _____ Work (____) _____ SSN _____

Name(s) Witness _____

Telephone Home (____) _____ Work (____) _____

Statement of Injured Person or Witness

(If injured person or witness is unavailable, information is to be completed by individual completing report.)

Date of Accident ___/___/___ Time _____ a.m. p.m.

Location of Accident _____

Summarize how injury, illness, or exposure occurred _____

Kind of Injury _____

Part of Body Affected (Specific part of the body, i.e., left wrist, right leg) _____

Describe any contributing factors or objects _____

Signature of injured person or witness _____

To be Completed by first Aid Provider

Symptoms and complaints of the injured person _____

Describe the nature and extent of the injury _____

Treatment, recommendations, and referral _____

Signature of First Aid Provider _____

To be Completed by Supervisor for Employee Injury/ Illness
(attach additional information if necessary.)

Evaluation of how accident occurred/ contributing factors _____

Possible preventive actions _____

For Human Resources Only

Lost Time Yes No Number of days _____ Anticipated release _____

Work Restrictions _____

Medical Treatment _____

Employee and Student Worker reports to Human Resources Department Student and Visitor Reports to Student Health Services

Must be completed within 24 hours of the accident