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Introduction

Protecting health care 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 (HCP). 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 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.

Medical Evaluation, Immunizations, and Record Keeping

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

Vaccines Recommendations
Adapted from Immunization Coalition  www.immunize.org

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendations in brief</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td>Give 1 dose of influenza vaccine annually. Give inactivated injectable influenza vaccine intramuscularly or live attenuated influenza vaccine (LAIV) intranasally.</td>
</tr>
<tr>
<td><strong>MMR</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Varicella (chickenpox)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Tetanus, diphtheria, pertussis</strong></td>
<td>Give a one-time dose of Tdap as soon as feasible to all HCP who have not received Tdap previously. Give Td boosters every 10 years thereafter. Give IM.</td>
</tr>
<tr>
<td><strong>Meningococcal</strong></td>
<td>Give 1 dose to microbiologists who are routinely exposed to isolates of N. meningitidis. Give IM or SC.</td>
</tr>
</tbody>
</table>

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

Hepatitis B
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm

Vaccination

All HCP whose work-, training-, and volunteer-related activities involve reasonably anticipated risk for exposure to blood or body fluids should be vaccinated with a complete, ≥3-dose HepB vaccine series. OSHA mandates that vaccination be available for employees within 10 days of initial assignment. HCP trainees should complete the series before the potential for exposure with blood or body fluids, when possible, as higher risk has been reported during professional training (e.g., residency training).

Incompletely vaccinated HCP should receive additional dose(s) to complete the vaccine series. The vaccine series does not need to be restarted for HCP with an incomplete series; however, minimum dosing intervals should be heeded. Minimum dosing intervals are 4 weeks between the first and second dose, 8 weeks between the second and third dose, and 16 weeks between the first and third dose.

HCP lacking documentation of HepB vaccination should be considered unvaccinated (when documentation for HepB vaccine doses is lacking) or incompletely vaccinated (when
documentation for some HepB vaccine doses is lacking) and should receive additional doses to complete a documented HepB series. Health-care institutions are encouraged to seek documentation of "missing" HepB doses in IIS, when feasible, to avoid unnecessary vaccination.

**Postvaccination Serologic Testing**

HCP who have written documentation of a complete, ≥3-dose HepB vaccine series and subsequent postvaccination anti-HBs ≥10 mIU/mL are considered hepatitis B immune. Immunocompetent persons have long-term protection against HBV and do not need further periodic testing to assess anti-HBs levels.

All HCP recently vaccinated or recently completing HepB vaccination who are at risk for occupational blood or body fluid exposure should undergo anti-HBs testing. Anti-HBs testing should be performed 1–2 months after administration of the last dose of the vaccine series when possible. HCP with documentation of a complete ≥3-dose HepB vaccine series but no documentation of anti-HBs ≥10 mIU/mL who are at risk for occupational blood or body fluid exposure might undergo anti-HBs testing upon hire or matriculation. Testing should use a quantitative method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL) (e.g., enzyme-linked immunosorbent assay [ELISA]).

- Completely vaccinated HCP with anti-HBs ≥10 mIU/mL are considered hepatitis B immune. Immunocompetent persons have long-term protection and do not need further periodic testing to assess anti-HBs levels.
- Completely vaccinated HCP with anti-HBs <10 mIU/mL should receive an additional dose of HepB vaccine, followed by anti-HBs testing 1–2 months later. HCP whose anti-HBs remains <10 mIU/mL should receive 2 additional vaccine doses (usually 6 doses total), followed by repeat anti-HBs testing 1–2 months after the last dose. Alternatively, it might be more practical for very recently vaccinated HCP with anti-HBs <10 mIU/mL to receive 3 consecutive additional doses of HepB vaccine (usually 6 doses total), followed by anti-HBs testing 1–2 months after the last dose.

**Vaccine Nonresponders**

Vaccinated HCP whose anti-HBs remains <10 mIU/mL after revaccination (i.e., after receiving a total of 6 doses) should be tested for HBsAg and anti-HBc to determine infection status. Those determined not to be HBV infected (vaccine nonresponders) should be considered susceptible to HBV infection. No specific work restrictions are recommended for vaccine nonresponders.

College of Nursing and Health Profession students should complete the Hepatitis B Nonresponder Acknowledgement Form in CastleBranch.

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 students admitted to clinical programs and completing internships will receive annual vaccination against influenza. All HCP students participating in volunteer assignments should follow the guidelines of the facility. 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)*
http://www.cdc.gov/measles/hcp/index.html

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

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 subcutaneously.

- 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 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 and separated by 28 days or more, and at least 1 dose of live rubella vaccine). HCP with 2 documented doses of MMR are not recommended to be serologically tested for immunity; but if they are tested and results are negative or equivocal for measles, mumps, and/or rubella, these HCP should be considered to have presumptive evidence of immunity to measles, mumps, and/or rubella and are not in need of additional MMR doses.

Although birth before 1957 generally is considered acceptable evidence of measles, mumps, and rubella immunity, 2 doses of MMR vaccine should be considered for unvaccinated HCP born before 1957 who do not have laboratory evidence of disease or immunity to measles and/or mumps. One dose of MMR vaccine should be considered for HCP with no laboratory evidence of disease or immunity to rubella. For these same HCP who do not have evidence of immunity, 2 doses of MMR vaccine are recommended during an outbreak of measles or mumps and 1 dose during an outbreak of rubella.

*Varicella*
http://www.cdc.gov/chickenpox/hcp/index.html

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 and signature, laboratory evidence of immunity, or laboratory confirmation of disease.

*Tetanus/Diphtheria/Pertussis (Td/Tdap)*
http://www.cdc.gov/vaccines/vpd-vac/tetanus/default.htm

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.vaccineinformation.org
http://www.cdc.gov

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, and 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.

All students admitted to a clinical program in the College of Nursing and Health Professions will receive baseline TB screening within 12 months prior to admission, using two-step TST, a single BAMT to test for infection with *M. tuberculosis*, t-Spot, or quantiFERON Blood Gold Test.

**Tuberculosis Exposure/Conversion**

http://www.cdc.gov/tb/topic/testing/healthcareworkers.htm

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.

**Two-Step TST Testing**

![Two-Step TST Testing Diagram]

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.

**Record Keeping**

1. All records related to a student's medical status and program required documents will be maintained by CertifiedBackground.com also known as CastleBranch. Reports related to medical records and other documents will be available to program administrators.
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.

**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.

**Exposure Potential**

A. All HCP 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
• airborne infections
• 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

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

A. An exposure that might place HCP at risk for HIV infection is defined as a percutaneous injury (eg, a needlestick or cut with a sharp object) or contact of mucous membrane or non-intact skin (eg, exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious. In addition to blood and visibly bloody body fluids, semen and vaginal secretions are also considered potentially infectious. Although semen and vaginal secretions have been implicated in the sexual transmission of HIV, they have not been implicated in occupational transmission from patients to HCP. The following fluids are also considered potentially infectious: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid.

Exposures are 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. An exposure is considered an urgent medical concern. 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 USPHS 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. Testing should be within 2 hours if at all possible.

D. The exposed HCP will be referred for medical attention and counseling by a physician immediately.

Most current recommendations include:
• If source is unknown, the use of Post Exposure Prophylaxis (PEP) is to be decided on a case by case basis taking into consideration of exposure.
• If the source patient from whom the practitioner was exposed has a reasonable suspicion of HIV infection or is HIV positive and the practitioner anticipates that hours or day may be required, antiretroviral medications should be started immediately.
• Severity of the exposure to determine the number of drugs to be offered should no longer be used.
• PEP should be stopped if source patient is determined HIV negative.
• The HCP should receive base-line testing for the HIV virus.
• Follow-up counseling should be within 72 hours of exposure with additional follow up in 6 and 12 weeks and again at 6 months.
• The full article: Updated US Public Health Service Guidelines for the management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post-exposure Prophylaxis can be read at:

http://www.jstor.org/stable/10.1086/672271

Hepatitis B Post Exposure Procedure
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5516a3.htm?s_cid=rr5516a3_e

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

TABLE 4. Recommended postexposure prophylaxis for percutaneous or permucosal exposure to hepatitis B virus --- Advisory Committee on Immunization Practices, United States (2016)

<table>
<thead>
<tr>
<th>Vaccination and antibody response status of exposed person</th>
<th>Source HBsAg-positive</th>
<th>Source HBsAg-negative</th>
<th>Source not tested or status unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unvaccinated</strong></td>
<td>HBIG x 1; initiate HB vaccine series</td>
<td>Initiate HB vaccine series</td>
<td>Initiate HB vaccine series</td>
</tr>
<tr>
<td><strong>Previously vaccinated</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known responder</td>
<td>No treatment</td>
<td>No treatment</td>
<td>No treatment</td>
</tr>
<tr>
<td>Known nonresponder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After 3 doses</td>
<td>HBIG x 1 and initiate revaccination</td>
<td>No treatment</td>
<td>If known high-risk source, treat as if source were HBsAg-positive</td>
</tr>
<tr>
<td>After 6 doses</td>
<td>HBIG x 2 (separated by 1 month)</td>
<td>No treatment</td>
<td>If known high-risk source, treat as if source were HBsAg-positive</td>
</tr>
<tr>
<td><strong>Antibody response unknown</strong></td>
<td>Test exposed person for anti-HBs</td>
<td>No treatment</td>
<td>Test exposed person for anti-HBs</td>
</tr>
<tr>
<td></td>
<td>If adequate, * no treatment</td>
<td></td>
<td>If adequate, * no treatment</td>
</tr>
<tr>
<td></td>
<td>If inadequate, * HBIG x 1 and vaccine booster</td>
<td></td>
<td>If inadequate,* initiate revaccination</td>
</tr>
</tbody>
</table>
Abbreviations: HBsAg = Hepatitis B surface antigen; HBIG = hepatitis B immune globulin; anti-HBs = antibody to hepatitis B surface antigen; HB = hepatitis B.

Source: Adapted from CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP). Part II: immunization of adults. MMWR 2006;55(No. RR-16).

* A seroprotective (adequate) level of anti-HBs after completion of a vaccination series is defined as anti-HBs ≥10 mIU/mL; a response < 10 mIU/mL is inadequate and is not a reliable indicator of protection.

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

<table>
<thead>
<tr>
<th>Exposed Individual</th>
<th>Source Client</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform baseline testing for anti-HCV and alanine aminotransferase (ALT) activity</td>
<td>Perform testing for anti-HCV</td>
</tr>
<tr>
<td>Perform follow-up testing at 4-6 months for anti-HCV and ALT activity</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information
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://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/

Needlestick Reference:
http://www.cdc.gov/niosh/topics/bbp/emergnedl.html

Immunization Action Coalition:
http://www.immunize.org/
http://www.cdc.gov/vaccines/

Morbidity and Mortality Weekly Report:
http://www.cdc.gov/mmwr/index.html

Methods of Reducing Potential for Exposure to Pathogens

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.

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.

- Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Antiseptic soaps and detergents are the next most effective and non-antimicrobial soaps are the least effective.
- When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting.
- Soap and water are recommended for cleaning visibly dirty hands

**During Routine Patient Care:**

<table>
<thead>
<tr>
<th>Wash with soap and water</th>
<th>Use an Alcohol-Based Hand Sanitizer</th>
</tr>
</thead>
<tbody>
<tr>
<td>When hands are visibly dirty</td>
<td>For everything else</td>
</tr>
<tr>
<td>After known or suspected exposure to <em>Clostridium difficile</em> if your facility is experiencing an outbreak or higher endemic rates</td>
<td></td>
</tr>
<tr>
<td>After known or suspected exposure to patients with infectious diarrhea during norovirus outbreaks</td>
<td></td>
</tr>
<tr>
<td>If exposure to <em>Bacillus anthracis</em> is suspected or proven</td>
<td></td>
</tr>
<tr>
<td>Before eating</td>
<td></td>
</tr>
<tr>
<td>After using a restroom</td>
<td></td>
</tr>
</tbody>
</table>


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
   a. Reusable heat stable instruments are to be sterilized by acceptable methods.
   b. 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.

**Personal Protective Equipment**

1. Personal protective equipment including 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.

**Housekeeping**

**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.

**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 / Professional

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.

PEP
- Post Exposure Prophylaxis

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.
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 airborne 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
- Not applicable

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: ____________________
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: ____________________
College of Nursing and Health Professions

Student Exposure Incident Report

Exposed Student Information:
Program: _____________________________________________________________

Student Name: ________________________________________________________ DOB: ________________

Date Incident Occurred: _______ Time Incident Occurred: _______ Time Reported: _______

Does the student have a positive hepatitis B titer? [ ] yes [ ] no

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 may need to receive additional medical evaluation as prescribed by the physician. I authorize the release of the information related to this exposure incident for treatment, payment activities, and healthcare operations.

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 ____________

Revised July 2005/May 2007/August 2007

Instructions for Completing the Injury or Illness Report

Print off the document below

OR

Proceed to electronic version to complete and print for your USI Department Chair

http://www.usi.edu/riskmanagement/forms/accidentinjury-forms

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.
### ACCIDENT / INJURY INVESTIGATION REPORT

**UNIVERSITY OF SOUTHERN INDIANA**

**MUST BE COMPLETED AND RETURNED WITHIN 24 HOURS OF ACCIDENT**

<table>
<thead>
<tr>
<th>Employee</th>
<th>Student Worker</th>
<th>Student</th>
<th>Visitor</th>
<th>Volunteer</th>
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<tbody>
<tr>
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**Date of Report**

**Time of Report**

<table>
<thead>
<tr>
<th>A.M.</th>
<th>P.M.</th>
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### INJURED PERSON INFORMATION

<table>
<thead>
<tr>
<th>Name of Injured</th>
<th>Male</th>
<th>Female</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Permanent Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>USI Employee ID #</th>
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<table>
<thead>
<tr>
<th>Telephone: Home/Cell</th>
<th>Telephone: Work</th>
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<table>
<thead>
<tr>
<th>Department</th>
<th>Job Title</th>
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<table>
<thead>
<tr>
<th>Number of hours scheduled to work per week</th>
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### WITNESS INFORMATION

<table>
<thead>
<tr>
<th>Name(s) of Witness</th>
<th>Telephone: Home/Cell</th>
<th>Telephone: Work</th>
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### STATEMENT OF INJURED PERSON OR WITNESS

<table>
<thead>
<tr>
<th>Date of Accident</th>
<th>Time of Accident</th>
<th>A.M.</th>
<th>P.M.</th>
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<thead>
<tr>
<th>Location of Accident</th>
<th>Type of Injury (e.g., strain, laceration)</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Cause of Injury (e.g., slip/fall, lifting)</th>
<th>Part of Body Affected (e.g., arm, leg, back)</th>
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<table>
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<tr>
<th>Description of Accident</th>
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<tr>
<th>Is Treatment being sought? If so, where?</th>
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I authorize the release of any medical information relating to this injury / illness to the University’s relevant insurers for review of this claim.

**Signature of Injured Person**

**Date**

SECOND PAGE MUST BE COMPLETED BY SUPERVISOR OR PROGRAM DIRECTOR

1 of 2
TO BE COMPLETED BY THE SUPERVISOR OF THE ACTIVITY OR PROGRAM DIRECTOR
(attach additional information if necessary)

<table>
<thead>
<tr>
<th>Name of Injured Person</th>
<th>Time employee's work day began (if employee)</th>
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<tbody>
<tr>
<td></td>
<td>☐ A.M. ☐ P.M.</td>
</tr>
</tbody>
</table>

Evaluation of how accident occurred / contributing factors

Possible Preventative Actions (actions that have been / will be taken to prevent recurrence)

Work Phone of Supervisor or Program Director

Signature of Supervisor or Program Director

Printed Name of Supervisor or Program Director

FOR HUMAN RESOURCES USE ONLY

Lost Time ☐ Yes ☐ No

Number of Days

Anticipated Release Date

Work Restrictions

Medical Treatment

EMPLOYEE OR STUDENT WORKER:
FILL IN FORM, FORWARD TO SUPERVISOR FOR COMPLETION. SUPERVISOR FORWARD TO HUMAN RESOURCES.

STUDENT, VISITOR OR VOLUNTEER: FILL IN FORM, FORWARD TO SUPERVISOR OR PROGRAM DIRECTOR.
SUPERVISOR OR PROGRAM DIRECTOR PLEASE FORWARD TO THE DEPARTMENT OF RISK MANAGEMENT.