EMPLOYEE EXPOSURE TO INFECTIOUS DISEASES

I. POST EXPOSURE MANAGEMENT

Provide First Aid

1. Secure area to prevent further contamination.

2. Remove contaminated clothing.

3. Wash the injured area well with soap and water, or waterless hand cleanser, and apply an antiseptic.

4. If the eyes, nose, or mouth are involved, flush them well with large amounts of water.

Notification and Relief of Duty

The worker's supervisor should be immediately notified if a worker experiences an occupational exposure involving potentially infectious source material. The supervisor should determine if the worker needs to be relieved of duty.

Assess the Level of Exposure

An occupational exposure is the "exposure to another person's body fluids or airborne fluids. There are two types of occupational exposures: non-significant and significant.

1. **Non-Significant Exposure**

Non-significant exposures are occupational exposures that have little to no risk of transmission of diseases know at this time. All non-significant exposures need to be documented on the "Infectious Disease Exposure Report Form", so at a later date should the occupational exposure be reported by the CDC as having a increased risk, the exposure was documented.

2. **Significant Exposure.**

Significant exposures have increased risk of transmission and acquiring

of disease(s). All significant exposures need documentation and medical follow-up.

Assess Exposures to Blood or Body Fluids.

A significant bloodborne or body fluid exposure is considered a combination of one or more of the types of body fluids and one or more of the injuries listed below.

1. **Body Fluids:**

   a. Blood, serum, and all fluids visibly contaminated with blood.

   b. Pleural, amniotic, peritoneal, synovial, and cerebrospinal fluids.

   c. Uterine/vaginal secretions, semen, feces and urine.

   d. Saliva.

2. **Action or Injury:**

   a. Percutaneous (through the skin injuries such as: needle stick, laceration, abrasion, bites, etc).

   b. Mucous membrane (e.g. eyes, nose, mouth).

   c. Non-intact skin (e.g. cut, chapped or abraded skin). Consider that the larger the area and/or longer the material is in contact, the more difficult it is to verify that all relevant skin area is intact. Also, an increased risk exists if the exposure is within 2 hours of shaving skin, scabs are <24 hours old or if skin is still open.

Assess the Exposure to Airborne Droplets.

A significant airborne exposure is considered a combination of a source exhibiting signs/symptoms of suspected airborne illness and an incident that would place the worker at risk of droplet or airborne exposure:

1. **Source:**

Any aerosolized exhalations containing droplets, sputum, lung secretions, or saliva, either by source coughing, spitting, breathing or by a action by the worker such as suctioning or intubating AND the worker was wearing appropriate respiratory protection (HEPA mask, eye protection).

2. **Action:**

Actions by the worker that have increased risk of airborne disease spread include: suctioning of nasopharynx or oropharynx, active gag reflex upon suctioning or insertion of tracheal tube, Combitube, LMA, OPA, NPA or nasogastric tube.

II. REPORTING, MEDICAL ATTENTION, CONSENT AND TESTING

Report the Exposure.

The worker or immediate supervisor should promptly complete an Exposure Report and submit it to the Designated Infection Control Officer.

Transport.

A significantly exposed worker should be transported to a designated facility within 2 hours for evaluation, testing and treatment options (preferably a facility that offers rapid HIV testing, if the material was blood or bodily fluids). The worker and source patient should be transported to the same medical facility.

Triage.

The worker should be rapidly triaged as possible.

The worker should present to the medical facility an **Infectious Disease Exposure Reporting Form** and an **Employer Information Sheet** that contains information about the employer, the employee's Designated Infection Control

Officer, the employer's Worker's Compensation policy and employer's medical provider's information for follow up care.

Consent and Counseling.

Counseling shall be provided to and consent obtained from both source of the exposure and the exposed worker. (29 CFR 1910.1030 (f)(3)). The Worker's Compensation carrier will incur cost of testing for source and worker.

1. **Informed Consent.**

   Source and exposed worker consent to physician authorizing testing. The source will not incur any cost of said testing.

2. **No Consent** (e.g. source is unconscious or denies consent).

   If consent cannot be obtained from the source of the exposure and a blood sample is available, the facility may conduct testing without consent and attending physician documents the need in the medical record of the worker.

   a. Note: Florida's Omnibus AIDS Act provides for a court order for the source to comply and have testing completed. In this case, prophylaxis treatment may not be completed in a timely manner, medical protocol provides for an "unknown source" category.

Post Exposure Testing for Blood and Body Fluid Exposures.

The facility should perform Acute Hepatitis Panel (CPT 80074), HIV and RPR (syphilis) tests. Testing maybe added as per attending physician request.

Post Exposure Testing for Airborne or Droplet Exposures.

Focus on airborne droplet exposure is focused on alerting the medical facility that a significant exposure has occurred. Testing is administered by the facility targeting a myriad of airborne diseases. If TB exposure is suspected, a tuberculin skin test (PPD) test following the exposure should be performed on source and exposed worker. Do not administer tuberculin skin test (PPD) test if worker has

been tested within the previous 12 weeks or has a history of positive skin test reaction.

Hospital Notification.

If no exposure was reported to the medical facility and the medical facility determined through testing that an increased risk of disease transmission may have occurred, the medical facility shall notify the agency of such event within 48 hours after determination (F.S. Ryan White Act).

Discharge.

The Infectious Disease Exposure Reporting Form should be complete with a discharge summary that includes a description of all diagnostic tests performed on the worker. A copy of the form is routed to the Designated Infection Control Officer and a copy is provided to the worker.

Post exposure Medical Follow-up.

The employer is responsible to provide or make available post exposure monitoring as directed by the medical provider. Follow-up testing for blood and body fluid exposures will be performed after the initial, at week six, week twelve, and week twenty-six after the exposure. Testing after one year may be indicated for high risk significant exposures.