Central Ohio Trauma System

An affiliate of the Columbus Medical Association

REGIONAL FIRST RESPONDER INFECTIOUS EXPOSURE GUIDELINES
EMERGENCY SERVICES COMMITTEE

INTRODUCTION

This document is intended to promote consistency among the Central Ohio prehospital and hospital community with regards to the treatment and follow-up of first responder personnel who incur an occupational exposure. Processes established between first responder agencies and private occupational health clinics, including a hospital employee health clinic that is contractually serving as an occupational health clinic for first responder exposures, are outside the purview of these guidelines. A first responder may include but is not limited to emergency medical services (EMS), fire departments, law enforcement, funeral directors, etc.

EMS agencies shall maintain a designated and available Infection Control Officer (ICO) on staff always. It is recommended that all first responder agencies identify an ICO. Per National Fire Protection Association (NFPA) standards, the ICO shall serve as the liaison between a healthcare facility and EMS provider in cases of known or suspected infectious exposure.[1] Additionally, hospitals shall maintain personnel, often the Infection Control Practitioner (ICP) or the Emergency Department (ED) charge nurse, designated to work with exposed first responders. ICOs and designated hospital personnel need to be aware of these guidelines and their own organizational operating procedures related to post-exposure care.

These guidelines address the following exposures:

- Blood or Body Fluid Exposures
- Airborne Exposures
- Blood and Body Fluid/Airborne Exposures by Coroner's Cases
- Other Exposures
- Exposed Bystanders Who Contact First Responders

First responders reduce the potential for acquiring infectious diseases from their patients/clients by donning the appropriate personal protective equipment (PPE) prior to delivering care. Gloves, masks, goggles, and moisture barrier gowns are warranted in cases of active bleeding or seepage of potentially infectious body fluids. Similarly, appropriate PPE (i.e. gloves, masks, googles) should be worn when caring for patients suspected of suffering from a respiratory infectious disease, as recommended by the Centers for Disease Control (CDC).[2]

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I. BLOOD OR BODY FLUID (B/BF) EXPOSURE

B/BF exposure is defined as:

- Puncture by a used needle or other sharps
- B/BF splash to eyes nose or mouth
- B/BF splash to non-intact skin
- Human bite that breaks the skin and the biter has a bloody mouth

B/BF exposure can occur from blood, semen, vaginal secretions, or spinal, synovial, pleural, peritoneal, pericardial, or amniotic fluid.[3] Sputum, saliva, urine, and stool are not sources of B/BF exposure unless they contain visible blood (Please refer to the **Other Exposures** section of this document for these).

IMMEDIATE ACTIONS OF THE B/BF EXPOSED FIRST RESPONDER

1) Immediately irrigate the involved area.

    - Flush eyes with copious amounts of normal saline.
    - Wash skin vigorously with soap and water. If soap and water are not available, rinse area with other solution, such as normal saline or a water-based liquid. Waterless hand cleaners are not for post-exposure gross decontamination.[4]

2) Notify the ICO that the exposure occurred. Federal regulations dictate that "following report of an exposure, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up."[5]

3) At the direction of the ICO, report to one of the following:

    - The occupational health program of the first responder's agency (Note: processes established between first responder agencies and private occupational health clinics are outside the purview of these guidelines)
    - The destination ED of the source patient
    - Another local ED if the source patient is not transported and there is no occupational health program available

4) First responders who choose to report to a hospital for their own testing and/or prophylaxis shall:

    - Notify the ED charge nurse upon arrival of the exposure and how it occurred
    - Be triaged without delay
    - Complete the appropriate *Request for Notification of Test Results* form
    - Be required by hospital policy to register as an ED patient for their testing and/or prophylaxis

- Be aware that source patient testing and the first responder's prophylaxis as medically warranted are considered priorities

5) If the source patient is not transported by the exposed first responder (i.e. is transported by another first responder or critical care transport team), the exposed first responder or the ICO should:
    - Call the ED charge nurse of the patient's destination and notify him/her of the exposure in order to obtain baseline testing of the source patient.
    - Complete the *Request for Notification of Test Results* form and fax it to the ED charge nurse as soon as possible.

TESTING THE SOURCE PATIENT

A blood sample is required to determine whether a patient has Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV). B/BF testing of a source patient includes the following:[6]

- HIV antibody
- HBV surface antigen
- HCV antibody

If the source patient is transported to a hospital:

1) The ED obtains patient consent and the blood specimen for testing.

2) If the patient refuses to or cannot give consent (i.e. due to an altered level of consciousness), "a hospital's infection control committee, nurse or physician" has the authority to obtain the HIV screening when there has been a significant exposure.[7] Determination of a "significant exposure" is made by the first responder's ICO or agency designee. Patient screening does not involve forcibly obtaining a blood sample.

3) Payment for source patient testing is determined between the first responder's employer and the hospital.

If the source patient ***REFUSES TRANSPORT*** to a hospital:

1) If the patient refuses to consent for blood sampling and refuses transport, the first responder follows up with his/her ICO. At this point it is a legal matter to obtain the source patient's blood for testing.[8] Following a significant exposure in which the source patient refuses to provide a blood sample and refuses transport, the first responder should seek a medical evaluation and counseling.[9] Guidelines for an "unknown source patient" apply here.

2) Oral swab testing is not intended for the prehospital environment.

3) Emergency Departments/hospitals will not test source patient blood samples if the source patient is not a patient at their hospital.

4) The first responder may obtain patient consent in the field and draw the source blood sample, if allowed by SOPs, for the occupational health program to test the sample.

SOURCE PATIENT RESULTS

Hospital-run HIV test results should be available within an hour although HBV and HCV results may not be available for several days. HIV results will be provided verbally as soon as possible by the ED charge nurse or ED physician to the:

- The ICO always
- The exposed first responder if he/she is still in the ED

1) If a first responder and his/her ICO have not been notified of a source patient's HIV results within 90 minutes, the ICO should contact the ED charge nurse for results and to discuss possible referral to an ED, if necessary.

2) Written notification of positive test results shall be provided by the hospital ICP or designee to the exposed first responder's ICO within three days after oral notification.[10] As a courtesy, negative test results should be provided, as well.

3) Confidentiality of the source patient and first responder information shall be maintained always. Only information pertaining to source patient results will be released to the ICO and the first responder who is still present in the ED, as described previously. The ICO and first responder shall not disclose any medical information publicly about the source patient.

FIRST RESPONDER BASELINE TESTING

1) Baseline testing of the first responder is the first responder's choice. First responder agencies should maintain signed statements of first responders who decline testing at the time of exposure.

2) In cases where the source patient tests positive, baseline testing of the first responder may be done at his/her provider of choice such as:

- Private physician
- Occupational health clinic
- Emergency Department. To have baseline testing in the ED, the first responder must sign in as an ED patient

3) For a significant exposure with an unknown source patient, the first responder should seek medical evaluation and counseling.

4) In cases where the source patient testing is negative but the first responder still wants baseline testing, the first responder is encouraged to follow up with his/her private physician or occupational health clinic.

5) Whether the source patient testing is positive or negative, baseline testing of the first responder is not an emergent procedure. Baseline testing of the exposed first responder optimally occurs the next business day and should occur no later than seven days post-exposure.[11]

6) First responder baseline testing includes at minimum:

    - HIV antibody
    - Hepatitis B virus antibody (unless documented previously as positive) *
    - Hepatitis C virus antibody

    *After receiving Hep B Ab results, the first responder may, at the employer's discretion, be sent for Hep B surface antigen testing.

7) First responders have the option of having the HIV sample drawn post-exposure but not immediately.[12] "If the first responder consents to baseline blood collection but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the first responder elects to have the baseline sample tested, such testing shall be done as soon as feasible." First responders who choose this option for a personal baseline HIV screening shall first discuss it with their ICO.

PROPHYLAXIS FOR THE B/BF EXPOSED FIRST RESPONDER

Post-exposure prophylaxis (PEP) is offered to the first responder by the ED if any one of the following:

- The source patient's HIV screen is positive
- The source patient has a documented history of HIV or HBV
- The source patient's blood sample is unavailable but there is a high index of suspicion because of a history of IV drug use, prostitution, multiple sexual partners or unprotected male-with-male sex[13]

Regarding HIV prophylaxis:

1) Decisions about chemoprophylaxis can be modified if additional information becomes available.

2) First responders must register as ED patients to receive HIV prophylaxis from the hospital.

3) HIV PEP should be started with hours of exposure.[14]

4) The first responder shall receive an immediate referral for counseling by his/her agency's ICO, Medical Director, agency physician, or designee. Further counseling should be made available through the first responder agency's Employee Assistance Program (EAP) or by contractual agreements.

Regarding Hepatitis Prophylaxis:

1) Hepatitis B Immunoglobulin (HBIG) and Hep B vaccine are not typically given in the ED.

2) In cases of positive source HBV results, the first responder should follow up with his/her occupational healthcare provider for related prophylaxis as soon as possible and within seven days of exposure.

3) There is no prophylaxis for HCV. In cases of positive HCV results, the first responder should follow up with his/her occupational healthcare provider for medical evaluation and care.

II. AIRBORNE EXPOSURE

Airborne exposures:

1) Are defined as contamination with an infectious agent through the respiratory tract.

2) Occur via one of two routes.[15]

    - Via airborne infectious agents with small-particle residue (5 µm or smaller) of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time (i.e. Tuberculosis, Rubeola {Measles} and Varicella Virus)
    - Via droplet infectious agents which are propelled a short distance (less than three feet) through the air by coughing or sneezing. These droplets are acted upon rapidly by gravity (i.e. Meningitis, Pertussis and Influenza)

IMMEDIATE ACTIONS OF THE AIRBORNE-EXPOSED FIRST RESPONDER

1) Don personal protective equipment (PPE) as soon as possible at the scene or while in route if the patient is known to have a respiratory infection or is coughing or spraying secretions.

2) If secretions are splashed or coughed in the eyes or other mucous membranes, flush with copious amounts of normal saline, as soon as possible.

3) The first responder who suspects an airborne exposure should:

- Notify the ICO that an exposure has occurred
- Notify the ED charge nurse of the exposure upon delivery of the patient
- Complete the *Request for Notification of Test Results* form
- Anticipate that typically no immediate treatment or prophylaxis is given

TESTING THE SOURCE PATIENT

Source testing for airborne exposures is done by the hospital based on patient symptomology.

SOURCE PATIENT TESTING RESULTS

1) The ICP or designated hospital personnel will notify the first responder's ICO of the infectious agent as soon as the determination is made that the source patient has an airborne infectious disease, but not later than 48 hours after the determination is made.[16]

2) The ICO will assess the potential exposure of the first responder based on the interaction with the source patient.

3) Confidentiality of source patient and the first responder information shall be maintained always. Only information pertaining to source patient results will be released to the ICO and a first responder who is still present in the ED, as described previously. The ICO and the first responder shall not disclose any medical information publicly about the source patient.

PROPHYLAXIS FOR THE AIRBORNE-EXPOSED FIRST RESPONDER

1) Prophylaxis may be offered by the hospital or the first responder may be referred to an occupational healthcare provider for prophylaxis and follow up.

2) Hospital policies require that the exposed first responder register as an ED patient for medical screening and prophylaxis to occur in the ED.

III. B/BF & AIRBORNE EXPOSURES BY CORONER'S CASES

Rarely, exposure of a first responder occurs from a deceased victim who must remain at a scene for an extended period pending coroner's investigation and/or transported to the Coroner's Office instead of the hospital.

IMMEDIATE ACTIONS OF THE B/BF-EXPOSED FIRST RESPONDER

1) Decontaminate self as described in previous sections.

2) Notify the ICO that the exposure has occurred.

3) At the direction of the ICO, seek treatment at an ED or occupational health clinic.

4) Anticipate that prophylaxis is based on the index of suspicion.

IMMEDIATE ACTIONS OF THE ICO

The Franklin County Coroner's Office (FCCO) shall be notified as soon as possible by the ICO that an exposure has occurred.

TESTING THE SOURCE PATIENT

The FCCO shall make every effort to test a source patient by the next business day after being notified of the exposure. In some cases, the Coroner may elect to send a specimen to an outside lab for testing. The first responder should not wait for a Coroner's screen before seeking medical evaluation.

- The FCCO will determine if the sample is of appropriate size for evidentiary purposes.

SOURCE PATIENT RESULTS

- Upon receipt of lab results, the FCCO will send a notification to the requesting agency's ICO. Oral notification of source HIV status (positive or negative) shall be provided to the ICO upon receipt or within two days of test results, and written notification of positive test results shall be provided within three days after oral notification.[17]
- The FCCO will invoice the requesting agency for all lab fees associated with this process.

IV. OTHER EXPOSURES / EVENTS

Rarely, other exposure or infectious disease events can occur that warrant reporting and possible screening. These include:

- Exposures by source patient body fluids such as diarrhea or emesis
- First responders who witness a cluster of patients over a period of a few weeks with similar symptomology
- A group of first responders from the same station/unit/agency who become ill with identical symptoms over a period of a few days or weeks

In these instances, first responders shall notify their ICO. First responders and their ICOs may consult with their medical directors, agency physician, hospital ICP, or designated personnel and/or their local health agency to determine the most appropriate course of action.

V. EXPOSED BYSTANDERS WHO CONTACT EMS

At times, an EMS agency may be contacted by the public who suspect or fear a potentially hazardous infectious exposure because of direct patient contact while attempting to render aid at a scene.

ASSESSMENT

Bystanders who contact an EMS agency shall be assessed via oral history and/or physical exam for the likelihood of an exposure. The EMS personnel shall notify the ICO for guidance.

ACTIONS

If a bystander's exposure history is deemed credible:

1) The bystander's exposed areas (i.e. mucous membranes/skin) should be washed immediately if prior decontamination has not occurred.

2) The bystander should be instructed to follow up with a primary care physician or urgent care for further assessment unless he/she is within the first few hours of exposure. If within the first few hours of exposure, EMS should encourage the bystander to seek medical evaluation at the same hospital ED that received the source patient.

3) If the bystander desires EMS transport to a hospital ED for further care:

    - EMS shall transport per their agency's protocol
    - If possible, consideration should be given to transferring the bystander to the same hospital destination as the source patient
    - EMS shall anticipate that the bystander will be assessed by ED personnel but that the bystander, now a patient, may be directed to the triage area upon arrival

FOLLOW UP

Follow up with the bystander about the exposure is the responsibility of the healthcare provider that provides medical evaluation and treatment. EMS is not responsible for follow up.

FIRST RESPONDER INFECTIOUS EXPOSURE INCIDENT CHECKLIST FOR B/BF EXPOSURES

FIRST RESPONDER PROCEDURE AFTER SIGNIFICANT B/BF EXPOSURE

If the exposure involves non-intact skin, wash area with soap & water

- If the exposure involves eyes, irrigate with copious amount of normal saline
- Report the exposure to the Infection Control Officer (ICO) immediately
- Report to Occupational Health Clinic or hospital emergency department (ED) if significant exposure determination is made by the ICO. To have baseline testing done in the ED, the first responder must sign in as a patient
- If the first responder goes to a hospital ED, notify the charge nurse of the exposure
- Complete the *Request for Notification of Test Results* form
- Submit a written incident report (agency specific) to supervisor within 24 hours

HOSPITAL PROCEDURE AFTER SIGNIFICANT B/BF EXPOSURE

- Triage the first responder without delay
- Obtain source patient consent for testing. If patient is unconscious or refuses, testing can be done under Ohio Revised Code, Section 3701.242
- Obtain baseline serum HIVAb, HBVsAg, and HCVAb screens of source patient
- Obtain first responder baseline testing per agency policy AND at the request of the first responder
- If source patient is known to be HIV positive or at high risk for HIV, initiate post-exposure prophylaxis (PEP) of the first responder per CDC recommendations

FOR BOTH FIRST RESPONDER AND HOSPITAL AFTER SIGNIFICANT B/BF EXPOSURE

- Maintain confidentiality of the source patient and exposed first responder always
- If there is not consensus regarding the significance of the exposure, or the need for PEP, between the first responder, the ICO, the ICP/ designated hospital personnel, and/or ED treating physician, consultation may be held in conjunction with the EMS Medical Director, agency physician, or designee.

For issues regarding these guidelines, contact the Central Ohio Trauma System Executive Director at (614) 240-7419

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FIRST RESPONDER INFECTIOUS EXPOSURE INCIDENT CHECK LIST FOR

AIRBORNE EXPOSURES

FIRST RESPONDER PROCEDURE AFTER SIGNIFICANT AIRBORNE EXPOSURE

- Don personal protective equipment (PPE) as soon as possible at the scene or while in route if the patient is known to have a respiratory infection or is coughing or spraying secretions
- If secretions are splashed or coughed in the eyes or other mucous membranes, flush with copious amounts of normal saline, as soon as possible
- Report the exposure to the Infection Control Officer (ICO) immediately
- Report to Occupational Health Clinic or hospital emergency department (ED) if significant exposure determination is made by the ICO. To have baseline testing done in the ED, the first responder must sign in as a patient
- If the first responder goes to a hospital ED, notify the charge nurse of the exposure
- Complete the *Request for Notification of Test Results* form
- Submit a written incident report (agency specific) to supervisor within 24 hours
- Anticipate that no immediate treatment of prophylaxis is given

HOSPITAL PROCEDURE AFTER SIGNIFICANT AIRBORNE EXPOSURE

- Triage the first responder without delay. Source testing for airborne exposures is done by the hospital based on patient symptomology
- The ICP or designated hospital personnel will notify the first responder's ICO of the infectious agent as soon as the determination is made that the source patient has an airborne infectious disease, but not later than 48 hours after the determination is made
- The ICO will assess the potential exposure and course of action based on hospital feedback and interaction with the source patient

FOR BOTH FIRST RESPONDER AND HOSPITAL AFTER SIGNIFICANT AIRBORNE EXPOSURE

- Maintain confidentiality of the source patient and exposed first responder always
- If there is not consensus regarding the significance of the exposure, or the need for PEP, between the first responder, the ICO, the ICP/designated hospital personnel, and/or ED treating physician, consultation may be held in conjunction with the EMS Medical Director, agency physician, or designee.

For issues regarding these guidelines, contact the Central Ohio Trauma System Executive Director at (614) 240-7419

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FIRST RESPONDER INFECTIOUS EXPOSURE CHECKLIST FOR BYSTANDER EXPOSURES

EMS PROCEDURE AFTER SIGNIFICANT BYSTANDER EXPOSURE

- Assess bystander via oral history and/or physical exam
- Notify Infection Control Officer (ICO) for guidance
- If not decontaminated, wash exposed area or flush eyes and/or mucous membranes as necessary
- If within a few hours post-exposure, encourage bystander to seek medical evaluation at the same hospital emergency department (ED) that received the source patient
- If after a few hours post-exposure, instruct the bystander to follow up with primary care physician or urgent care

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ACRONYMS USED IN THE REGIONAL FIRST RESPONDER INFECTIOUS EXPOSURE GUIDELINES

B/BF	Blood/Body Fluids
CDC	Centers for Disease Control
EAP	Employee Assistance Program
ED	Emergency Department
EMS	Emergency Medical Services
FCCO	Franklin County Coroner's Office
HBIG	Hepatitis Immunoglobulin
HBV	Hepatitis B Virus
HBVsAg	Hepatitis B Virus Surface Antigen
HCV	Hepatitis C Virus
HCVAb	Hepatitis C Virus Antibody
HIV	Human Immunodeficiency Virus
HIVAb	Human Immunodeficiency Virus Antibody
ICO	Infection Control Officer
ICP	Infection Control Practitioner
NFPA	National Fire Protection Agency
ORC	Ohio Revised Code
PEP	Post Exposure Prophylaxis
PPE	Personal Protective Equipment
SOP	Standard Operating Procedure

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REFERENCES

1. National Fire Protection Association Code 1581. Standard on Fire Department Infection Control Program.

2. Centers for Disease Control and Prevention (CDC), Division of Healthcare Quality Promotion Quality Promotion and Division of Viral Hepatitis (2003). Exposure to Blood: What Healthcare Personnel Need to Know.

3. Ohio Revised Code, Section 3701.24. Report As To Contagious or Infection Diseases – AIDS and HIV.

4. BioBasics Fact Sheet: Biohazards Decontamination & Spill Clean Up, University of Minnesota. Http://www.dehs.umn.edu.

5. Occupational Safety & Health Administration (OSHA), U.S. Department of Labor, CFR 29, Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, Needlesticks and Other Sharps Injuries.

6. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report; June 29, 2001. Management of Occupational Blood Exposures.

7. Ohio Revised Code, Section 3701.242. Informed Consent to HIV Test Required.

8. Ohio Revised Code, Section 3701.247. Order Compelling HIV Testing.

9. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report; September 30, 2005. Updated U.S. Public Health Service Guidelines For The Management of Occupational Exposures to HIV and Recommendations For Post-exposure Prophylaxis.

10. Ohio Revised Code, Section 3701.248. Emergency Medical or Funeral Services Worker Exposed to Contagious or Infectious Disease May Request Notice of Test Results.

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11. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report; June 29, 2001. Management of Occupational Blood Exposures.

12. Occupational Safety & Health Administration, U.S Department of Labor. CFR 29, Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, Needlesticks and Other Sharps Injuries.

13. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report; June 29, 2001. Management of Occupational Blood Exposures.

14. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report; September 30, 2005. Updated U.S. Public Health Service Guidelines For The Management of Occupational Exposures to HIV and Recommendations For Post-exposure Prophylaxis.

15. Centers for Disease Control and Prevention; Rational For Isolation Precautions in Hospitals (1996).

16. Public Law 111-87; Ryan White Comprehensive AIDS Resources Emergency Act Of 1990, Revised 2009. 104th Congress.

17. Ohio Revised Code, Section 3701.248. Emergency Medical or Funeral Services Worker Exposed to Contagious or Infectious Disease May Request Notice of Test Results.

REQUEST FOR NOTIFICATION OF SOURCE PATIENT TEST RESULTS FOLLOWING AN INFECTIOUS EXPOSURE

A SIGNIFICANT EXPOSURE MEANS: A percutaneous break in skin or mucous membrane exposure (eyes, nose, mouth) to the blood, semen, vaginal secretions, or spinal, synovial (joint, tendon), pleural (lung), peritoneal (abdomen), pericardial (heart), or amniotic fluid of another person.

EXPOSED FIRST RESPONDER EMPLOYEE INFORMATION: This box is to be filled out by the exposed person. Please note this is a two-sided form. A copy of this page should be made for the exposed employee.

FIRST RESPONDER Employee Name: _____

FIRST RESPONDER Employee Phone: _____

FIRST RESPONDER Employee Address: _____

Medic/Unit Number: _____ or **Incident Number:** _____

FIRST RESPONDER Agency Name: _____

Agency Address: _____

Agency Phone: _____ **Agency Fax:** _____

ICO Name: _____ **ICO Phone:** _____

Type of Exposure: _____ **Blood/Body** _____ **Airborne** _____ **Other:** _____

Exposure Date: _____ **Time:** _____ **Location:** _____

Explain How Exposure Occurred: _____

_____

Source Patient Name: _____ **DOB:** _____

Other Information: _____

_____

Exposed FIRST RESPONDER Employee Signature: _____ **Date:** _____

ED Charge Nurse Signature: _____ **Date:** _____

Hospital: _____

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SOURCE PATIENT TEST RESULTS: This box is to be filled out by the hospital staff person providing results to the exposed first responder or Infection Control Officer.

Name & Credentials of Person Providing Results: _____

Test Results: _____**HIV** _____**HBVsAg** _____**HCVAb** _____**Other**

Other Info: _____

_____

_____

Source Patient Results Provided To:

_____**Exposed FIRST RESPONDER Employee:** **Name:** _____

_____**FIRST RESPONDER Infection Control Officer:** **Name:** _____

_____**Other** **Name:** _____

Signature of Person Providing Results: _____ **Date:** _____

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