Georgia Department of Public Health

POLICY APPROVAL FORM

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Date Submitted:	Policy Owner:	Division:	Phone #
12/3/2021	Diane Durrence	Medical & Clinical Services/Office of Nursing	404-205-3112
Policy Title:	**PT-21-18005 Bloodborne Pathogen Occupational Exposure Control & Response for Public Health Workers**		

Statement of Need:
The purpose of this policy is to reduce occupational risk of exposure to infectious disease, and to protect patients and the community by preventing or limiting the transmission of infection.

IMPORTANT NOTE: All changes must be made on the document and an (X) placed in the box under "Changes - Yes" on the matrix below. Any comments must be entered under "Notes" below or entered on the document being routed. If additional space is needed for comments and/or changes are made to the attachment, please document under "notes."

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DPH POLICY COMMITTEE APPROVALS						
Co-Chair: ☐ Bill Scott	12/3/2021	Email		X	12/3/2021	
Chair: ☐ Melanie Simon	1/25/2022	Email		X	1/25/2022	
COO: ☑ Rosalyn Bacon	2/3/2022			X	2/3/2022	

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GEORGIA DEPARTMENT OF PUBLIC HEALTH
POLICY # PT-21-18005
BLOODBORNE PATHOGEN OCCUPATIONAL EXPOSURE CONTROL and RESPONSE FOR PUBLIC HEALTH WORKERS

Approval:	Kathleen E. Toomey, M.D., M.P.H., Commissioner	2/3/2022 Date

1.0 PURPOSE

The purpose of this policy is to reduce occupational risk of exposure to infectious disease, and to protect patients and the community by preventing or limiting the transmission of infection.

2.0 AUTHORITY

The Georgia Department of Public Health (DPH) Bloodborne Pathogen Occupational Exposure Control for Public Health Workers is published under the authority of DPH.

2.1 Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen and Needlestick Prevention Standards

2.2 Centers for Disease Control and Prevention (CDC) guidelines for management of occupational exposures to bloodborne pathogens and infection control

2.3 O.C.G.A. § 31-2A-4

3.0 DEFINITIONS

3.1 **Client Care Settings** – facilities where health services are delivered.

3.2 **Environmental Health Settings** – locations where work related to minimizing public health risks due to physical, chemical, and biological factors takes place.

3.3 **Occupational Risk** - any condition of a job that can result in illness or injury.

3.4 **Exposure Determination** - contains job classification lists based on risk of occupational exposure, and tasks or procedures in which occupational exposure may occur.

3.5 **Occupational Exposure** - is defined as reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood, or other potentially infectious materials such as rabies exposure that may result from the performance of an employee's duties.

3.6 **Potentially infectious materials can include:**

3.6.1 The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, saliva in dental procedures, any type of body fluid contaminated with visible blood, and all body fluids when it is difficult or impossible to differentiate between body fluids;

3.6.2 Any fixed tissue or organ (other than intact skin) from a human; and

3.6.3 HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV- containing culture medium or other solutions.

3.6.4 Sewage means and includes human excreta, black water, water-carried wastes, and liquid household waste from residences or commercial and industrial establishments. Sewage from medical facilities are higher risk for bloodborne pathogen exposure.

3.6.5 Saliva from animals introduced into bite wounds, open cuts in skin, or onto mucous membranes.

4.0 SCOPE

This policy applies to all employees, temporary workers, and contractors of the Georgia Department of Public Health.

5.0 POLICY

Certain Public Health personnel work in client care and environmental health settings in which they can be exposed to infectious individuals or materials and transmit infectious disease to vulnerable populations. Because all DPH employees play a critical role in response to a public health emergency and the potential risk of exposure to infectious individuals or materials is inherent in assuming such a role, they must follow this policy and the accompanying attachments, Workforce Safety Guidelines to Protect Public Health Employees and Patients from Exposure to Bloodborne Pathogens and the Occupational Post-Exposure Prophylaxis.

The vaccination status of all employees is important to know in advance of a potential exposure. Public Health vaccination programs are an essential component of infection prevention and control and DPH supports immunizations for public health workers based on the recommendations of the Centers for Disease Control and Prevention (CDC), Advisory Committee for Immunization Practices, and the U.S. Occupational Safety and Health Administration.

6.0 RESPONSIBILITIES

6.1 The Division of Medical & Clinical Services, Office of Nursing is responsible for issuing and updating procedures to implement this policy.

7.0 PROCEDURES

7.1 Methods to reduce or prevent bloodborne pathogen exposure and transmission including standard precautions, personal protective equipment, hepatitis B vaccination, and engineering and work practice controls to minimize employee exposure must be followed as described in Appendix A, Workforce Safety Guidelines to Protect Public Health Employees and Patients from Bloodborne Pathogens.

7.2 Districts are responsible for establishing an Exposure Control Workgroup (ECW) to evaluate and select safe and effective medical devices and work practices. The ECW must include non-managerial employees responsible for direct patient care and can also include other staff who may be at risk of injury involving contaminated sharps including housekeeping and managerial staff. The ECW must meet a least once annually and

maintain meeting minutes that include ECW recommendations, evaluation of devices, and documentation of decisions.

7.3 Record Keeping and Documentation

A record keeping process must be in place that includes documentation of initial and annual review of this policy including attachments. Minutes from the Exposure Control Workgroup (ECW) meetings should be documented and maintained. The chain of command and appropriate reporting structure for reporting a potential exposure should be documented along with the process for employee awareness to ensure immediate reporting.

Follow guidance in Appendix B, Occupational Post-Exposure Prophylaxis for recommended exposure determination and post-exposure follow-up.

7.4 Immunization Records

All District and County employees are expected to provide their immunization record to their supervisor within 30 days of the date of hire. The supervisor is responsible for submitting the record to the Immunization Program Coordinator for assessment and management of compliance with requirements.

7.5 Worker's Compensation

When a potential job-related exposure to blood or body fluids that poses a risk of transmission of a blood borne illness occurs, it should be reported immediately to the employee's supervisor or site leader. After assuring the appropriate medical management, Human Resources should be notified to complete the required processes for Worker's Compensation.

8.0 REVISION HISTORY

REVISION #	REVISION DATE	REVISION COMMENTS
	Initial Issue	

9.0 RELATED FORMS AND REFERENCES

Form #PT-21-18005A: Workforce Safety Guidelines to Protect Public Health Employees and Patients from Bloodborne Pathogens.

Form #PT-21-18005B: Occupational Post-Exposure Prophylaxis.

Georgia Rabies Manual
https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/site_page/ADES_Rabies_Manual_2010_FINAL.pdf

Georgia Tuberculosis Policy and Procedure Manual
https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-publications-reports-manuals-and-guidelines

Workplace Safety Guidelines to Protect Public Health Employees and Patients from Exposure to Bloodborne Pathogens

This guidance is in place for the development of appropriate practices and to assure consistent compliance is observed when handling potentially infectious body fluids and materials.

Public Health Agencies must comply with the requirements of DPH Policy # PT-21-18005, Bloodborne Pathogen Occupational Exposure Control and Response for Public Health Workers, and assure measures required by the Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard are in place. Required measures include:

- Exposure Control Workgroup
- Exposure determination process
- Methods of compliance are in place to eliminate or reduce exposures to bloodborne pathogens (e.g., needleless systems and sharps with engineered sharps injury prevention devices, hepatitis B vaccination)
- Communication of hazards to employees (including how they received input from frontline employees)
- Employee training
- Quality improvement activities
- Recordkeeping
- Post-exposure follow-up (Policy # PT-21-18005 Attachment B)

The Centers for Disease Control and Prevention's (CDC) Guideline for Infection Control in Healthcare Personnel offers recommendations on infrastructure and routine practices for occupational infection prevention and control services.

Exposure Control Workgroup (ECW)

Public Health Agencies that provide clinical services are responsible for establishing an Exposure Control Workgroup (ECW) to evaluate and select safe and effective engineering and work practice controls. Engineering controls include the use of safer medical devices, such as sharps with engineered sharps injury protections and needleless systems. Engineering controls includes all control measures that remove a hazard and may include non-medical devices such as sharps disposal containers and biosafety cabinets.

The ECW must include non-managerial employees responsible for direct patient care and can also include other staff who may be at risk of injury involving contaminated sharps including housekeeping and managerial staff. The ECW must meet a minimum of annually and meeting minutes that include ECW recommendations, evaluation of devices, and decisions should be documented and maintained.

Exposure Determination

Public Health Agencies must identify job classifications, tasks, and procedures that have a risk of exposure to bloodborne pathogens. CDC offers a guidelines and guidance library for infection control and prevention that can used for this purpose.

Methods of Compliance to Eliminate or Reduce Exposure to Bloodborne Pathogens

1. Avoiding exposure is the primary way to prevent transmission of bloodborne pathogens. Districts must ensure that employees follow Standard Precautions for patient care at all

times:

2. Perform hand hygiene according to Guidelines for Hand Hygiene in the Health-care Setting. Districts must provide readily accessible handwashing facilities and products including soap, running water, towels, and alcohol-based hand rubs. Hand-hygiene products should have a low irritancy potential. Districts must also provide hand lotions or creams to minimize the occurrence of irritant contact dermatitis.
3. Use Personal Protective Equipment (PPE) according to Guidance for the Selection and Use of Personal Protective Equipment in Healthcare Settings. Districts must provide, at no cost to employees, appropriate personal protective equipment such as gloves, gowns, lab coats, face shields or masks and eye protection. Mouthpieces, resuscitation bags, pocket masks, or other ventilation devices should be available for use in areas in which the need for resuscitation is probable. PPE should be readily accessible and available in a variety of sizes. Districts must also provide for the cleaning, laundering, or disposal of PPE, and repair or replace required PPE as needed to maintain its effectiveness. CDC offers posters on proper donning and doffing of PPE that districts can use for employee training and compliance.
4. Follow guidelines for Respiratory Hygiene/Cough Etiquette in Healthcare Settings. Districts must ensure that posters educating staff, patients, and visitors on respiratory hygiene/cough etiquette are placed at reception areas of all health departments/clinics and other strategic locations. Districts must provide masks to persons with signs and symptoms of a respiratory infection and observe droplet precautions as outlined in the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
5. Ensure proper patient placement by following Isolation Precautions.
6. Properly handle and properly clean and disinfect patient care equipment and instruments/devices, clean and disinfect the environment appropriately, and handle textiles and laundry carefully according to Guidelines for Environment Infection Control. The district/county must determine and implement a written schedule for cleaning and methods of decontamination based on the facility, environment, and procedures performed at the site. Public Health Agencies must provide supplies for cleaning, disinfection, and sterilization including but not limited to:
    - Brooms and dustpans
    - Utility gloves
    - Vacuums
    - Mops (disposal mop heads when possible) and buckets
    - Trash bags and receptacles
    - Appropriate disposal of non-biohazard waste
    - Detergent and other cleaning agents for wiping down surfaces and cleaning floors
    - Environmental Protection Agency (EPA) approved disinfection agents on List D and E
    - Sodium hypochlorite (household bleach)
    - Protective coverings (plastic wraps)
    - Forceps for picking up glass or other sharps
    - Appropriate containers for sharps disposal
    - Biohazard waste bags and containers
        - Ensure that all biomedical waste is disposed of according to the rules set forth by the Georgia Department of Natural Resources, Environmental Protection Division: Specifically rules 391-3-4 regarding Solid Waste Management which also includes rule 391-3-4-.15 Biomedical Waste,

Amended.
    - Ensure employees comply with Guideline for Disinfection and Sterilization.
7. Follow safe injection practices. Public Health Agencies must ensure that principles of infection control and aseptic technique are reinforced during staff training. Policies related to infection control and aseptic technique should be monitored for adherence.
8. Properly handle needles and other sharps (glass, lancets, scalpels, etc). Public Health Agencies must provide:
    - Appropriate, effective, and commercially available safety devices.
    - Leak-proof, closable, puncture-resistant sharps containers for disposal of contaminated sharps and arrange for disposal of sharps containers according to rules set forth for biomedical waste.
    - Public Health Agencies that provide clinical services must establish and maintain an Exposure Control Workgroup to identify and select needleless systems, sharps with engineered sharps injury protection (ESIP), and other devices that reduce exposure to bloodborne pathogens. The National Institute for Occupational Safety and Health (NIOSH) offers resources on preventing needlesticks and sharps injuries.

Other Infection Control Measures

Public Health Agencies must offer free hepatitis B (HBV) vaccinations to all employees with occupational exposure to blood or other potentially infectious materials (Policy # PT-21-18005, Appendix B, Hep B Vaccination guidance). Public Health agencies must ensure:

- Employees do not eat, drink, smoke, apply cosmetics or lip balm, and/or handle contact lenses in work areas where there is a reasonable likelihood of an occupational exposure.
- Food and drink are not kept in refrigerators, freezers, shelves, cabinets, or on countertops where blood or other potentially infectious materials are present.
- Employees avoid or limit the use of cell phones or other mobile devices in work areas where there is likelihood of contamination.
- For locations with Dental Clinics:
    - Precautions for preventing transmission of bloodborne pathogens in dental practice in institutional and non- institutional settings.
    - For more information on a comprehensive infection control plan for dental settings, see CDC, "Guidelines for Infection Control in Dental Health-Care Settings – 2003," *MMWR*, Vol. 52, No. RR-17, December 19, 2003.

Handling of Laboratory Specimens

Public Health Agencies must ensure that employees place blood and body fluid specimens in a well-constructed, double-walled container with a secure lid to prevent leaking during transport. The container must be color-coded red or have a biohazard label. If the specimen could puncture the primary container, it should be placed it in a secondary container. Public Health Agencies are responsible for securing approved shipping containers and for ensuring employees comply with the Georgia Department of Public Health Laboratory Shipping Plan.

- Employees should avoid contaminating the outside of the container and the laboratory form accompanying the specimen.
- Provide appropriate specimen collection equipment and ensure that employees use mechanical pipetting devices for manipulating laboratory specimens or potentially infectious materials.
- **Note**: Mouth pipetting/suctioning is not a safe or acceptable technique and must not be

done.

Precautions for Laboratories

Safety of laboratory employees requires additional precautions to limit occupational exposure to bloodborne pathogens. Laboratory employees must adhere to the other precautions listed throughout this document and the following additional precautions. Georgia Public Laboratories must ensure that laboratory employees:

1. Utilize the appropriate personal protective equipment as outlined in the section on Personal Protective Equipment and below:
   - Wearing medical gloves (e.g., latex, vinyl, or nitrile gloves) when handling or processing blood and body fluid specimens.
   - Wearing N95 respirators (for which you have been respirator fit tested) and protective eyewear with solid non-perforated side shields, or chin-length face shields, if mucous membrane contact with blood or body fluids is a potential hazard. Note: Respirator fit testing is required on an annual basis
2. Change gloves and wash hands with antimicrobial soap after completion of specimen processing.
3. Use biological safety cabinets (Class I or II) whenever procedures are conducted that have a high potential for generating aerosols or droplets. These include activities such as blending, sonicating and vigorous mixing.
4. Use mechanical pipetting devices for manipulating all liquids in the laboratory. Mouth pipetting is not a safe or acceptable technique and must not be done.
5. Limit the use of needles and syringes to situations in which there is no alternative and follow the recommendations for preventing injuries with needles outlined in the section of Sharps Injury Prevention. Consider use of sharps with ESIP and other safety devices.
   - Decontaminate laboratory work surfaces with an appropriate EPA approved antimicrobial chemical product such as freshly prepared 10% bleach solution after a spill of blood or other body fluids and when work activities are completed. **Note**: Appropriate PPE must be worn when cleaning.
   - Clean-up material becomes biomedical waste and must be disposed of appropriately. **Note**: With large spills of cultured or concentrated infectious agents in the laboratory, cover the contaminated area with an absorbent germicide before cleaning, then decontaminate with fresh germicidal chemical. The used absorbent germicide and cleaning materials are now biomedical waste.
6. Disinfect contaminated materials used in laboratory tests using an acceptable method before reprocessing. Place used clean-up materials in biomedical waste (i.e., with the international biohazard symbol or red bags) and dispose of appropriately.
7. Clean and decontaminate according to manufacturer's instructions, equipment that has been contaminated with blood or other body fluids before reusing, or before being repaired in the laboratory, or transported to the manufacturer. Equipment that cannot be cleaned must be marked with the international biohazard label and packaged according to the Department of Transportation and manufacturer's guidelines. Equipment that cannot be cleaned must be marked with a proper biohazard label.
8. Wash hands with water and antimicrobial soap after completing laboratory

activities and remove protective clothing before leaving the laboratory.

Employee Health Issues

1. Pregnant employees are not known to be at greater risk of contracting HBV, Hepatitis C virus (HCV) or human immunodeficiency virus (HIV) than workers who are not pregnant; however, some infections can be particularly harmful to the unborn infant (e.g., cytomegalovirus [CMV], measles, rubella), the susceptible pregnant woman (e.g., HBV) or the newborn infant (e.g., HBV, varicella). All employees, including pregnant employees, must follow the exposure control plan.
2. Employees with uncovered, open exudative lesions or weeping dermatitis must refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
3. Health care workers with skin abrasions/cuts must wear gloves or protective clothing when providing patient care and handling patient care equipment and use precautions until condition resolves.
4. Healthcare workers who have respiratory infections should avoid direct patient contact. If this is not possible, then the healthcare worker should wear a mask while providing care. Those workers who develop fever and respiratory symptoms should be instructed not to report to work.

Employee Training

Public Health Agencies must ensure that all employees participate in a training and education program prior to initial assignment to tasks or procedures where occupational exposure may occur. Training must be provided by persons knowledgeable about subject contact and be available during work hours at no cost to employees. Training materials should be appropriate in content and vocabulary to the educational level, literacy, and language background of employees. Employees must receive annual refresher training and training must be provided on use of new devices or products prior to implementation of the device/product.

1. Training must include the following:
   - Access to the BBP standard (29 CFR 1910.1030)
   - Information on the epidemiology and symptoms of bloodborne diseases
   - Information on modes of transmission of bloodborne pathogens
   - How to recognize tasks that may involve exposure to blood or other potentially infectious materials
   - Use and limitations of methods to reduce exposure, including engineering controls, work practices, and personal protective equipment
   - Information on the Hepatitis B vaccine
   - What to do and whom to contact after an exposure
   - Information on post-exposure evaluation and follow-up
   - Opportunity for questions and answers

2. The following courses are **required** for public health employees:
   - Basics of the OSHA Bloodborne Pathogen Standard for the Healthcare Setting
   - Basic Infection Prevention in the Ambulatory Care Setting: Personal Protective Equipment and Safe Surfaces
   - Additional training **required** for some public health employees:

- Clinical staff (RNs, APRNs, Physicians, Dentists, etc): must also complete the AETC National HIV Curriculum 2nd Edition Occupational Post-exposure Prophylaxis Lesson
- Staff that collect and ship laboratory specimens must also complete: Packing and Shipping Dangerous Goods: What the Laboratory Staff Must Know

Quality Improvement Activities

Public Health Agencies should conduct ongoing quality improvement activities to eliminate or minimize employee exposure to bloodborne pathogens. Resources for designing quality improvement activities related to occupational exposure include:

- Infection Control Assessment Tools
- Toolkit for Evaluating Environmental Cleaning
- Tools for Designing, Implementing and Evaluating a Sharps Injury Prevention Program
- Training for Development of Innovative Control Technologies Project
- Sample employee health and safety checklist: Quality Assurance/Quality Improvement (QA/QI) for Public Health Nursing Practice Manual.
- CDC Guideline for Infection Control in Healthcare Personnel

Record keeping

Public Health Agencies must maintain training records for seven years from the date on which the training occurred. Training records must include:

- The dates of the training sessions
- The contents or a summary of the training sessions
- The names, job titles and affiliations of all persons attending the training session
- The names, qualifications, and affiliations of persons conducting the training

Occupational Post-Exposure Prophylaxis (oPEP)

Occupational Post-Exposure Prophylaxis (oPEP)

These guidelines were created to ensure timely medical management of exposures. Exposures must be considered urgent medical concerns requiring immediate attention. This includes the appropriate use of oPEP, education, counseling, vaccines, and continued assessment of primary prevention and use of safety devices. Therefore, these guidelines will be reviewed annually and adjusted based on updates provided by the Center of Disease Control, Morbidity and Mortality Weekly Report, and any other appropriate supportive literature. The goal of these guidelines is to optimize the appropriate use of oPEP, prevent bloodborne pathogen infections, improve education, be cost effective, reduce future exposures, and improve the use of safety devices.

Table of Contents

Management of Occupational Blood Exposures

1. Provide immediate care to the exposure site:
   - Wash wounds and skin with soap and water
   - Flush Mucous membranes with water
   - Avoid wound squeezing and caustic topical agents such as bleach

2. Notify supervisor immediately:
   - Proceed to the clinic immediately for evaluation of oPEP
   - Notify Human Resources, Office of Nursing and APRN or the Infectious Disease Provider
     - If exposure occurs after hours proceed with oPEP evaluation and contact these individuals ASAP
   - Complete accident reports
     - These reports should not delay the evaluation process and initiation of oPEP
   - Reports to be filed with the immediate supervisor and with Human Resources

3. Determine risk associated with exposure:
   - Complete the Bloodborne Pathogen Occupational Exposure Report Form (Appendix B) including:
     - Details of exposure, where and how the exposure occurred, and the exposure device
     - Type of fluid and severity of exposure (percutaneous, injury depth, mucous membrane, fluid volume, skin condition)

4. Evaluate exposure source:
   - Assess risk of infection using available information
   - Counsel patient concerning incident
   - Test: HIV (prefer rapid HIV 1/2 Ag/Ab testing), HB sAg, anti-HCV Ab (or RNA), if not recently completed
   - Check previous therapy and viral load in patients with known HIV
   - Start oPEP drug therapy within 60 to 90 minutes. Although, oPEP can be given up to 72 hours after the exposure, any delays in initiating prophylaxis should be minimized.
   - Link all persons with a new HIV diagnosis or anyone with HIV who has fallen out of care
   - For unknown sources assess risk of exposure as noted below
   - Do **not** test needles or syringes for virus contamination

5. Evaluate exposed patient:
   - Date, time, and type of exposure
   - Counsel patient concerning incident
   - If evaluation/ therapy is refused, then ask the individual to sign the "Refusal of Treatment" form (Appendix A)
   - Test: HIV (rapid HIV 1/2 Ag/Ab testing preferred), HB sAg and anti-HCV Ab, if not recently completed
   - Review previous vaccine response (Anti-HB sAb >10 mIU/mL), if available
   - Counseling, post-exposure management and follow-up should be discussed with the individual
   - Seek immediate evaluation if lymphadenopathy, fever and/or rash occur within 3-months of exposure

6. Reports to be completed and sent to the District Nursing and HR:
   - Unusual occurrence form
   - Complete Bloodborne Pathogen Occupational Exposure Report Form
   - Consent or Declination of Consent Forms
   - Acceptance/Refusal of Treatment
   - Worker's Comp 1st Report of Injury

7. Assess need of oPEP for exposures posing risk of disease transmission

Occupational Post-Exposure Prophylaxis (oPEP)

Quick Reference Flow Chart

Testing unless already has chronic disease [HIVHBV//HCV] or immunity [HBV])

Exposure to Blood or Visibly Bloody Body Fluids

Exposed Person ⟷ Source Patient

Exposed Person

1. Wash exposure site with soap and water
   Do not squeeze or use bleach or other strong cleaning agents on exposure site
2. If mucous membrane exposure; flush with water
3. Notify Supervisor on site immediately

Supervisor on site

Collect the following:
1. HIV Screen
   (Rapid HIV 1/2 Ag/Ab testing preferred)
2. Hepatitis B surface antigen (HB sAg)
3. Anti-Hepatitis C antibody (anti-HCV Ab) or RNA
4. Complete Metabolic Panel
5. Pregnancy test: persons of childbearing potential

Source Patient

Request that patient remain in clinic

Supervisor on site

1. Obtain source patient consent for testing
2. Collect the following:
   - HIV Screen
     (Rapid HIV 1/2 Ag/Ab testing preferred)
   - Hepatitis B surface antigen (HB sAg)
   - Anti-Hepatitis C antibody (anti-HCV Ab) or RNA

1. Notify Ryan White Program or ID Medical Consultant at: xxx-xxx-xxxx: to request NP or Physician guidance for risk assessment and treatment plan
2. Have exposed person read and sign the "Consent/Refusal of Treatment" form
3. Follow-up appointments should begin within 72 hours of the initial assessment with the employee's medical provider
4. Initial therapy as indicated based on assessment. Minimize delays in initiating prophylaxis (see below)

1. Notify District Nursing Director, District Health Director or Lab/Agency Leadership) at xxx-xxx-xxxx
2. Notify Human Resources Office at xxx-xxx-xxxx

1. Complete Workers' Comp 1st Report of Injury form; employee & supervisor call DOAS at 1-877-656-7475. DOAS will transfer the call to AmeriSys or you will be directed to call 1-800-900-1582.
   Mail copy of 1st Report of Injury to _____; Address _____ marked as "Confidential."
2. Complete Report of Unusual Occurrence form and mail to _____;
   attention _____.
3. Complete Bloodborne Pathogen Occupational Exposure Report Form and send to _____; attention _____

Quick Reference Verification

(Check List: testing unless already known to have chronic disease [HIV/HBV/HCV] or immunity [HBV])

Source Patient: (Source of the exposure: blood and/or visibly bloody fluid)

- ☐ HIV screen — Rapid HIV 1/2 Ag/Ab testing preferred
- ☐ Hepatitis B surface antigen — HB sAg
- ☐ Anti-Hepatitis C antibody — anti-HCV Ab or HCV RNA if previously treated

Exposed Patient: (Individual who was exposed: needle stick, cut, blood and/or bloody fluid)

- ☐ HIV screen — Rapid HIV 1/2 Ag/Ab testing preferred
- ☐ Hepatitis B surface antigen — HB sAg
- ☐ Anti-Hepatitis C antibody — anti-HCV Ab or HCV RNA if previously treated
- ☐ Complete Metabolic Panel — CMP
- ☐ Pregnancy test — Persons of childbearing potential
- ☐ Report of Unusual Occurrence and Workers' Comp 1st Report of Injury
  - Complete forms on site
- ☐ Hepatitis B Immunoglobulin 0.06 mL/kg IM x 1 (see page 7)
  - If known non-responder or not vaccinated
- ☐ Hepatitis B vaccine 1cc IM x 1 at time of exposure (see page 7)
  - Vaccinate per manufacturer's specifications if no history of vaccination **or**
  - No response to initial vaccine series (e.g. Anti-HB sAb <10 mIU/mL)
- ☐ Assess need for oPEP as outlined in guidelines
  - Refer to Guidelines for Initiation of HIV oPEP in this packet
- ☐ Medication counseling completed with Exposed Person
- ☐ Instructions to notify the above noted contact person(s) concerning any questions regarding the initiation of HIV medications or any other issues
- ☐ Instruction given to the exposed individual for expected follow-up
  - See detailed discussions below for follow-up lab and assessment
  - HCV Ab (unless known to have chronic active HCV) and CMP at 4- and 6-months with reflex to quantitative HCV RNA if HCV Ab positive
  - HIV Ag/Ab (unless known to be HIV positive) at 6-weeks, 3-and 6-months. Check at 12-months if known to have chronic HCV infection
    - If fourth-generation HIV 1/2 Ag/Ab test is utilized, then test at 6-weeks and 4-months
    - Use rapid HIV testing system only at the time of the initial injury
    - Check CMP at baseline and at 4-weeks

Determined Risk Assessment: _____

_____

Date oPEP Plan Initiated: _____

Treatment Regimen (if given): _____

This information is to be used as a quick reference guide in order to rapidly assess and treat individuals involved in an exposure. This information should be used with the extended guidelines included within this packet. Notification of the elected contact person or the Infectious Disease Provider should take place if questions arise concerning the initiation of oPEP and for appropriate follow-up. Rapid HIV 1/2 Ag/Ab testing should be used to evaluate the initial HIV status of the source and exposed individuals.

Local Contact Information

Contacts:	Office Number	Home / Cell Number
_____ Immediate Supervisor	_____	_____
_____ Secondary Supervisor	_____	_____
_____ Ryan White Program NP or MD	_____	_____
_____ Additional Contact	_____	_____
_____ Infectious Disease (ID) Provider	_____	_____

PEP Assistance

PEPline

The National Clinicians' PEP Hotline

Phone: 1-888-448-4911
http://nccc.ucsf.edu/clinician-consultation/PEP-post-exposure-prophylaxis/

Resources

The Antiretroviral Pregnancy Registry at http://www.apregistry.com

FDA (for reporting unusual or severe toxicity to antiretroviral agents) at http://www.fda.gov/medwatch; telephone: 888-463-6332

The CDC's Cases of Public Health Importance (COPHI) coordinator (for reporting HIV infections in HCP and failures of oPEP) at 404-639-2050 or 404-639-0934

HIV Treatment Information Service:

http://aidsinfo.nih.gov
www.aidsinfonet.org,
http://www.jstor.org/stable/10.1086/672271
https://www.cdc.gov/hiv/risk/PEP/
https://www.hiv.uw.edu/
https://cdc.train.org/cdctrain/

Medication Access

General patient assistance:	RxAssist - Patient Assistance Programs
Truvada™:	Gilead Advancing Access® program
Generic FTC/TDF:	https://www.tevahivgenerics.com/truvada-generic/support
Raltegravir:	https://merckhelps.com/ISENTRESS
Dolutegravir:	https://www.viivconnect.com/

Hepatitis B (HBV)

The overall risk of Hepatitis B transmission following occupational exposure is 5 to 35 percent. Immediate evaluation after exposure should take place even when exposed to old, contaminated material, since Hepatitis B can remain infectious on dried blood for 1 week. Education and the offer of vaccination should be provided for all employees that have not received or responded to an initial vaccine series. The primary goal is for vaccination to prevent or minimize seroconversion. Vaccination is 70 to 75 percent effective in preventing disease after exposure in those in require vaccination therefore, early vaccine administration is essential. HBV vaccine may be given during pregnancy and lactation and has a very safe profile with only 1 in 600,000 incidences of anaphylaxis. Both the exposed and source patients should be counseled concerning the exposure and written consent obtained prior to giving Hepatitis B Immunoglobulin (HBIG) or the vaccination series. Both exposed and source individuals need to have Hepatitis B surface antigen (HBsAg) drawn and evaluated as indicated below.

Testing:

- Test the source and exposed individuals for HBsAg
- Testing not indicated if known to have chronic active HBV or HBV immunity

	Source		
Exposed:	**HBsAg+**	**HBsAg –**	**Unknown / Unavailable**
Unvaccinated:	HBIG x 1 + Vaccination Series	Vaccination Series	Vaccination Series
Vaccinated:			
Responder:	No Therapy	No Therapy	No Therapy
Non-Responder:	HBIG x 1 + Vaccination OR HBIG x 2 doses	Vaccination series	Treat if source high-risk

Prophylaxis:

Responder: Anti-HBsAb > 10 mIU/mL
Non-Responder: Anti-HBsAb < 10 mIU/mL

- HBIG x 1 + vaccine series in those who did not complete the initial vaccine series or was a non-responder
- HBIG x 2 doses (1 month apart) who had 2 vaccine series and no documented immune response
- HBIG: Dosed 0.06 mL/kg IM (**Give ASAP preferably within 24h but up to 7 days**)
- Vaccine series: Dose one at time of exposure and next dose per manufacturer's recommendation

For individuals without a documented immune response following the first completed HBV vaccine series, repeat the vaccination series as 30 to 50 percent of individuals will respond to the second series. Those that require a second series should be retested for response to vaccination 1 to 2 months following completion of the vaccine series. If there is continued lack of immune response following the second vaccination series, document in the record and immediately administer HBIG following future exposures. Provide education on exposure prevention. HBV vaccination may be provided during pregnancy and lactation. Individuals should refrain from donating blood, plasma, organs, tissue, or semen until the exposure evaluation has been completed.

NOTE: 10 to 20 percent of seroconverters develop chronic disease. New therapies are available for individuals and referral/consultation to Infectious Disease or Gastroenterology providers should be provided for those that develop chronic HBV disease.

Hepatitis C (HCV)

Unfortunately, there is no vaccination or oPEP available following HCV exposures. The overall seroconversion rate is 1.8 percent with the majority due to large-bore needle exposures. Seroconversion is rare with mucous membrane exposure and no cases have been reported to intact or non-intact skin exposures (e.g., chapped skin, abrasions, or dermatitis). The likelihood of developing chronic HCV disease is 75 to 85 percent; therefore, prevention and education are the major defense in minimizing Hepatitis C exposures and conversion to chronic disease.

Testing:

- Test the source and exposed individuals for Hepatitis C antibody (anti-HCV Ab) or HCV RNA if previously treated
- Testing not indicated if known to have chronic HCV

Source:

- Check HCV Ab and, if positive, confirm with a quantitative HCV RNA

Exposed:

- Check HCV Ab and CMP at exposure, at 4-months and at 6-months.
- If HCV Ab positive, confirm with a quantitative HCV RNA
- If quantitative HCV RNA positive, schedule with the ID, GI or HCV Provider
- Educate on exposure prevention.

NOTE: Repeat Hepatitis C quantitative viral load testing may be necessary in high-risk exposures since the viral load does not stabilize until after the first year of infection.

Prophylaxis:

- No prophylaxis is recommended
- Immune globulin, interferon or ribavirin are not effective for prevention

Individuals at risk for HCV should undergo counseling concerning the risk of acquiring Hepatitis C. Individuals who are confirmed to have active chronic disease should be referred immediately to an ID, GI or HCV specialist for assessment and treatment consideration. Current therapy is available with a potential cure rate of over 90 percent with all oral direct acting agents and treatment ranging from 8 to 12 weeks in naïve patients (https://www.hcvguidelines.org/). Individuals should refrain from donating blood, plasma, organs, tissue, or semen until the exposure evaluation has been completed.

Human Immunodeficiency Virus (HIV)

HIV exposure should be considered a medical emergency. Education, evaluation, and oPEP (if necessary) should all take place within 60 to 90 minutes following an exposure. Use of oPEP in a timely manner has demonstrated a 79 percent reduction in HIV transmission. The overall transmission rate is 0.33 percent but is related to the volume of blood and concentration of viral inoculum from the source patient. The risk of transmission from other exposures is greatly decreased, e.g., 0.09 percent for mucous membrane exposures, less than 0.09 percent for non-intact skin exposures and no cases reported for intact skin or exposure to suture needles. Due to the multiple side effects that occurs in 50 percent of patients, approximately 33 percent of individuals discontinue oPEP therapy (note: side effects are greatly diminished with use of newer antiretroviral medications). oPEP should only be given in accordance with the guidelines. If questions arise concerning the use of oPEP, an expert in HIV care should be contacted immediately. Do not wait for a response in high-risk patients, instead, start oPEP while awaiting evaluation. Stress adherence to medications since the greatest risk of seroconversion occurs during the first 6 to 12-weeks following exposure.

Next Steps:

- Counsel individuals on exposure and reason for obtaining HIV testing (rapid testing is preferred)
- Test source and exposed individuals if HIV status unknown or previous HIV test negative
- Initiate oPEP within 60 – 90 minutes, if recommended by current guidelines
- Although, oPEP can be given up to 72 hours after the exposure, any delays in initiating prophylaxis should be minimized.
- **Treat for 28-days but stop therapy if source test returns negative.**

NOTE: The likelihood of being in the window period without symptoms is extremely rare and to date no such instances of occupational transmission have been detected in the United States. Therefore, oPEP should be discontinued if the source test for HIV returns negative.

NOTE: oPEP is not offered in instances of non-occupational exposures, e.g., non-occupational post-exposure prophylaxis.

Monitoring:

Seronegative individuals should be tested for HIV at the time of injury with repeat testing at 6-weeks, 3 and 6 months:

- If a fourth-generation HIV 1/2 Ag/Ab test is utilized for follow-up HIV testing of exposed HCP, testing may be concluded 4-months after exposure (6-week and 4-month testing)
- Check at 12-months if the patient is co-infected with Hepatitis C
- Use the rapid HIV testing system only at the time of the initial exposure
- Check CMP at baseline and at 4-weeks. Additional testing may be indicated based on results
- Discontinue further testing if the source patient is negative or the exposed patient seroconverts
- If seroconversion occurs, contact the Infectious Disease or HIV Provider immediately
- Exposed individuals should be advised to practice safe sex or abstain until serology is negative at 6-months or 4-months in fourth-generation HIV 1/2 Ag/Ab testing (not indicated if source patient is negative).

oPEP Regimen:

- Do NOT delay initiation of oPEP if oPEP is indicated
- Notify Infectious Disease provider or Ryan White Program provider
- Initiate oPEP within 60-90 minutes of exposure. Although oPEP can be given up to 72 hours following an exposure, any delays in initiating should be minimized
- Educate patient on side effects of oPEP to improve adherence: pg. 13-15 and www.Aidsinfonet.org
- Schedule follow-up appointments within 72 hours of initial assessment with employee's provider.
- Pregnancy should not preclude oPEP, but breastfeeding must be discontinued immediately, if possible

- If alternative medication is required (e.g. pediatric dosing, renal failure), consult ID or HIV Provider immediately

Initial oPEP Regimen

- Follow Guidelines for Initiation of HIV oPEP below
- Due to the complexity and high risk of resistance in the HIV population, if available, obtain the active and historical medication list and all resistance testing (e.g. genotype, phenotype, tropism, etc.) to offer a more reliable oPEP regimen based on resistance patterns. Do not wait on this information to initiate oPEP if it will take an extended time.
- Consult Infectious Disease or HIV Provider if source individual has HIV or questions arise concerning oPEP.

Guidelines for Initiation of HIV oPEP

Exposure Type (ET): ____ **ET 3** percutaneous exposure, more severe
(e.g. large-bore hollow needle, deep puncture; needle used in vein or artery)

(Check one)

____ **ET 2** percutaneous exposure, less severe (e.g. solid needle, superficial scratch) **OR** mucous membrane or compromised skin exposure, large volume (e.g. major splash) or duration of contact ≥ several minutes. Skin is considered compromised if there is evidence of chapping, dermatitis, abrasion, or open wound/lesion.

____ **ET 1** mucous membrane or compromised skin exposure, small volume: few drops, brief duration of contact.

____ **Exposure involved intact skin only**
If the exposure involved a large quantity of blood, extensive skin area, or prolonged contact with blood, consider risk for HIV transmission.

Source patient HIV Status Class (SC):

____ **SC 2** HIV-infected,
Class 2: symptomatic or acute HIV infection, stage-3 HIV, or high viral load

____ **SC 1** HIV-infected,
Class 1: asymptomatic, high CD4, or low viral load (e.g. <1,500 RNA copies/ml)

(Check one)

____ **SC unknown** (HIV status unknown)

____ **Uninfected with HIV**

ET	SC
1-3	1 or 2

oPEP Recommendation:

- Recommend 3 (or more) tolerable drugs for all exposures. The medical provider and the exposed worker should consider whether the potential benefits of oPEP outweigh potential toxicities.

Preferred oPEP regimen: (may substitute generic FTC/TDF for Truvada™)

- Truvada™ 1 pill daily orally + Raltegravir (Isentress™)

NOTE: Isentress 400mg PO twice a day. Isentress HD not FDA approved for oPEP. Notify the infectious disease/HIV physician, delegating provider, and/or call the PEPLINE if alternative oPEP regimens are indicated, e.g., pediatric dosing, renal failure, hepatic failure, drug-drug interactions, etc.
http://www.gilead.com/~/media/Files/pdfs/medicines/hiv/truvada/truvada_pi.pdf

OR

- Truvada™ 1 pill daily orally + Tivicay™ 50mg daily orally
- DTG is preferred during all stages of pregnancy. For the latest data on neural tube defects (NTDs) in infants born to women prescribed dolutegravir (DTG), use of Folic Acid, and counseling is found at

https://clinicalinfo.hiv.gov/en/guidelines/perinatal/appendix-d-dolutegravir-counseling-guide-health-care-providers?view=full

1-3 Unknown — If the source or setting where the exposure occurred suggests a possible risk for HIV consider a 3-drug regimen.

NOTE: It is recommended that all individuals be tested for the presence of chronic hepatitis B virus (HBV) before initiating Truvada™ (Viread + Emtriva). Severe acute exacerbations of HBV have been reported in patients who discontinue Truvada™. In some patients infected with HBV and treated with Emtriva, exacerbations of HBV were associated with liver decompensation and liver failure. Patients who are infected with HBV should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping treatment with Truvada™. If appropriate, initiation of anti-hepatitis B therapy may be warranted and vaccination offered. http://www.gilead.com/~/media/Files/pdfs/medicines/hiv/truvada/truvada_pi.pdf

Situations for Which Expert Consultation for HIV oPEP is Recommended:

1. Delayed exposure report (e.g., later than 72 hours)
   - Interval after which benefits from oPEP are undefined

2. Unknown source (e.g., needle in sharps disposal container or laundry)
   - Use of oPEP to be decided on a case-by-case basis
   - Consider severity of exposure and epidemiologic likelihood of HIV exposure
   - Do not test needles or other sharp instruments for HIV

3. Known or suspected pregnancy in the exposed person
   - Provision of oPEP should not be delayed while awaiting expert consultation
   - Preferred oPEP medications in pregnancy: Truvada™ and Isentress™

4. Breast-feeding in the exposed person
   - Provision of oPEP should not be delayed while awaiting expert consultation

   Note: Based on published data, FTC and tenofovir have been shown to be present in human breast milk. It is not known if the components of Truvada™ affect milk production or have effects on the breastfed child. Therefore, alternate feeding should be considered while taking oPEP.

5. Known or suspected resistance of the source virus to antiretroviral medications
   - If source patient's virus is known or suspected to be resistant to 1 or more of the drugs considered for oPEP, selection of drugs to which the source patient's virus is unlikely to be resistant, is recommended
   - Do not delay initiation of oPEP while awaiting any results of resistance testing of the source patient's virus

6. Toxicity of the initial oPEP regimen
   - Symptoms (e.g. gastrointestinal symptoms and others) are often manageable without changing oPEP regimen by prescribing antimotility or antiemetic agents
   - Counseling and support for management of side effects is very important, as symptoms are often exacerbated by anxiety

7. Serious medical illness in the exposed person
   - Significant underlying illness (e.g. renal disease) or an exposed provider

already taking multiple medications may increase the risk of drug toxicity and drug-drug interactions

8. Expert consultation can be made by calling those listed on page 3 of this document

Follow-Up of Healthcare Personnel (HCP) Exposed to Known or Suspected Human Immunodeficiency Virus (HIV)–Positive Source

1. Counseling: at the time of exposure and at follow-up appointment

- Exposed HCP should be advised to use precautions (e.g. use of barrier contraception and avoidance of blood or tissue donations, pregnancy, and, if possible, breast-feeding) to prevent secondary transmission, especially during the first 6- to 12-weeks after exposure.
- Exposures for which oPEP is prescribed, HCP should be informed of the following:
  - Possible drug toxicities including rash and hypersensitivity reactions that could imitate acute HIV seroconversion and the need for monitoring
  - Possible drug interactions
  - Need for adherence to oPEP regimens and the completion of the entire 28-days

- Early reevaluation after exposure:
  - Regardless of whether a healthcare provider is taking oPEP, reevaluation of exposed HCP within 72 hours after exposure is strongly recommended, as additional information about the exposure or source person may be available.

- Follow-up testing at a minimum should include the following:
  - HIV testing at baseline and at 6-weeks, 3-months, and 6-months after exposure; alternatively, if the clinician is certain that a fourth-generation combination HIV p24 antigen–HIV antibody test is being utilized, then HIV testing could be performed at baseline, 6-weeks after exposure, and 4-months after exposure
  - Complete Metabolic Panel (CMP);
    - at baseline and 4-weeks after exposure
    - further testing may be indicated if abnormalities are detected
    - HCV Ab and CMP at exposure, 4-months and 6-months, if HCVAb positive, confirm with a quantitative HCV RNA

NOTE: HIV testing results should preferably be given to the exposed healthcare provider in person.

Patient Education Sheets

AIDS InfoNet www.aidsinfonet.org **Fact Sheet Number 421**

TRUVADA (Tenofovir + Emtricitabine)

WHAT IS TRUVADA?

Truvada is a combination pill that contains two drugs used to fight HIV: tenofovir DF (Viread) and emtricitabine (Emtriva). Truvada is manufactured by Gilead Sciences. Generic versions are approved under PEPFAR (see fact sheet 925.)

The drugs in Truvada are called nucleoside analog reverse transcriptase inhibitors, or nukes. These drugs block the reverse transcriptase enzyme. This enzyme changes HIV's genetic material (RNA) into the DNA. This occurs before HIV's genetic code gets inserted into an infected cell's chromosome.

WHO SHOULD TAKE TRUVADA?

Truvada was approved in 2004 for treatment of people with HIV infection in combination with other antiretroviral drugs.

Truvada is also approved for daily use by adults confirmed to be HIV negative, don't have symptoms of recent HIV infection and at high risk of becoming infected. PrEP should be used in combination with safer sex practices. This use is called pre-exposure prophylaxis (PrEP, see fact sheet 160).

While antiretroviral therapy is recommended for all persons living with HIV, there are no absolute rules about when to start antiretroviral therapy (ART). You and your health care provider should consider your CD4 cell count, your viral load, any symptoms you are having, and your attitude about taking ART. Fact Sheet 404 has more information about guidelines for the use of ART.

If you take Truvada with other antiretroviral drugs (ARVs), you can reduce your viral load to undetectable levels, and increase your CD4 cell counts. This should mean staying healthier longer.

Truvada is not approved for treating people who have hepatitis B infection (HBV). Some people with HBV get worse after they stopped taking Truvada, Get tested for hepatitis B before you start taking Truvada to treat HIV.

Truvada provides two drugs in one pill. It can be more convenient to use Truvada than some other combinations of drugs. This could mean fewer missed doses and better control of HIV.

WHAT ABOUT DRUG RESISTANCE?

Many new copies of HIV are mutations. They are slightly different from the original virus. Some mutations can keep multiplying even when you are taking an ARV. When this happens, the drug will stop working. This is called "developing resistance" to the drug. See Fact Sheet 126 for more information on resistance.

Sometimes, if your virus develops resistance to one drug, it will also have resistance to other ARVs. This is called "cross-resistance."

Resistance can develop quickly. It is very important to take ARVs according to instructions, on schedule, and not to skip or reduce doses.

HOW IS TRUVADA TAKEN?

Truvada is taken by mouth as a tablet. The normal adult dose is one tablet, once a day. Each tablet includes 300 milligrams (mg) of tenofovir DF (Viread) and 200 mg of emtricitabine (Emtriva).

Truvada can be taken with or without food. If you have kidney problems, you may need to take Truvada less often.

WHAT ARE THE SIDE EFFECTS?

When you start any ART, you may have temporary side effects such as headaches, high blood pressure, or a general sense of feeling ill. These side effects usually get better or disappear over time.

Truvada is usually very well tolerated. The most common side effects of Truvada are the same as with tenofovir DF (Viread) and emtricitabine (Emtriva). They include headache, nausea, vomiting, rash and loss of appetite. In some people, tenofovir can increase blood chemicals called creatinine and transaminases. High levels can indicate injury to kidneys or the liver.

Tenofovir DF can cause bone problems by reducing bone mineral density (BMD). This is especially true for people an issue for people with osteopenia or osteoporosis (see fact sheet 557). BMD tests should be considered in people taking Truvada who have had bone fractures or other risks for osteoporosis.

Levels of lactic acid in the blood (lactic acidosis, see Fact Sheet 556) increase in some people taking nucleoside analog drugs. Liver problems including "fatty liver" may also occur.

In rare cases, people taking emtricitabine had some limited changes in skin color.

HOW DOES TRUVADA REACT WITH OTHER DRUGS?

Truvada can interact with other drugs or supplements you are taking. **These interactions can change the amount of each drug in your bloodstream and cause an under- or overdose. New interactions are constantly being identified. Make sure that your health care provider knows about ALL drugs and supplements you are taking.**

Tenofovir DF levels can be increased with the HCV drug ledipasvir/sofosbuvir. (Harvoni, see fact sheet 686), especially when given with a boosted protease inhibitor. Kidney function should be monitored before and during HCV treatment in people taking this combination of medications.

Tenofovir DF increases levels of ddI (Videx). The dose of ddI taken with Truvada should be reduced to 250 mg for people weighing 60 kg (132 lbs) or more. There is no information on ddI dosing for people weighing less than this.

Truvada should not be used with **tenofovir (Viread), emtricitabine (Emtriva, FTC), Descovy** or with drugs containing **lamivudine (Epivir, 3TC)** including Combivir, Trizivir or Epzicom.

There are no data on interactions between emtricitabine and **methadone.** Tenofovir does not affect blood levels of methadone.

Tenofovir lowers the levels of the HIV protease inhibitor atazanavir (Reyataz). When taken with Truvada, atazanavir should be taken with ritonavir (Norvir).

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Permission to Use Fact Sheets

AIDS InfoNet www.aidsinfonet.org Fact Sheet Number 465

RALTEGRAVIR (Isentress, Isentress HD)

WHAT IS RALTEGRAVIR?

Raltegravir (Isentress) is a drug used for antiviral therapy against HIV. It was formerly known as MK-0518. It is manufactured by Merck.

Raltegravir is the first integrase inhibitor. When HIV infects a cell, it combines its genetic code into the cell's own code. This is shown in fact sheet 400, step 5. Raltegravir blocks this process. When raltegravir blocks integration, HIV infects a cell but cannot make more copies of itself.

WHO SHOULD TAKE IT?

Raltegravir was approved in 2007 as an antiviral drug against HIV as part of an antiviral regimen. It is approved for use for initial treatment or for people who have had other treatment regimens.

Isentress HD is a once-daily formulation of raltegravir was approved in 2017 for use in people for initial treatment or those already taking initial treatment with Isentress.

While antiretroviral therapy (ART) is recommended for all people living with HIV, independent of your symptoms or CD4 count, you and your health care provider should consider your CD4 cell count (see fact sheet 124) your viral load (see fact sheet 125) any symptoms you are having, and your attitude about taking HIV medications. Fact Sheet 404 has more information about guidelines for the use of antiviral medications.

Raltegravir is taken twice a day. If you take raltegravir with other antiviral drugs, you can reduce your viral load and increase your CD4 cell counts. This should mean staying healthier longer.

WHAT ABOUT DRUG RESISTANCE?

The HIV virus is sloppy when it makes copies of its genetic code (RNA). Many new copies of HIV are mutations: they are slightly different from the original virus. Some mutations can continue to multiply even when you are taking an antiviral drug. When this happens, the drug will stop working. This is called "developing resistance" to the drug. See Fact Sheet 126 for more information on resistance.

Raltegravir has shown activity against HIV that already has resistance to several other HIV medications.

With combination therapy (taking more than one antiviral drug at the same time), HIV mutates much more slowly. Resistance takes longer to develop. **It is very important to take antiviral medications according to instructions, on schedule, and not to skip or reduce doses.**

Sometimes, if you develop resistance to one drug, you will also have resistance to other antiviral drugs. This is called "cross-resistance". Resistance to raltegravir is uncommon. Because raltegravir is an integrase inhibitor, resistant virus may be resistant to other integrase inhibitors, but not to other drug types.

HOW IS RALTEGRAVIR TAKEN?

Raltegravir may be taken with or without food. The adult dosage of Isentress is 400 mg twice daily. Isentress HD is dosed as two 600 mg tablets, once daily.

Raltegravir can be used by children who are 4 weeks and older. Dosage for children is based on their weight and is available as chewable tablets or an oral suspension.

WHAT ARE THE SIDE EFFECTS?

Raltegravir is usually very well tolerated. In studies, the most common side effects in people taking raltegravir were diarrhea, nausea, and headache. Reports from people using raltegravir also include rash and depression. In rare cases, skin rash can be severe and life-threatening. **Contact your health care provider immediately if you develop a serious rash while taking raltegravir.**

Elevations in creatine kinase, a lab test of muscle injury, have been seen in people taking raltegravir. There have been reports of muscle injury.

HOW DOES IT REACT WITH OTHER DRUGS?

Raltegravir has been studied to see if it interacts with other drugs. Rifampin, a antibiotic used to treat tuberculosis (see fact sheet 518) decreases blood levels of raltegravir. A higher dose of raltegravir must be used.

Aluminum- or magnesium containing antacids interfere with the absorption of raltegravir. This effect is not changed by separating the dose of raltegravir. It is recommended that you **do not take aluminum or magnesium antacids if you take raltegravir. Isentress HD should also not be taken with rifampin or calcium carbonate.**

Raltegravir has not been studied with all medicines, over-the-counter drugs or vitamin or herbal supplements. Be sure your doctor knows about all medications and supplements that you are taking.

THE BOTTOM LINE

Raltegravir is the first integrase inhibitor. It stops HIV from inserting its genetic code into an infected cell. This prevents the virus from making new copies of HIV. Raltegravir is one of several medications recommended for use for initial treatment of HIV. It is also approved for use in people who have earlier treatment experience.

Reviewed October 17, 2017

A Project of the International Association of Providers of AIDS Care. Partially funded by the National Library of Medicine. Fact Sheets can be downloaded from the Internet at http://www.aidsinfonet.org

AIDS InfoNet www.aidsinfonet.org **Fact Sheet Number 467**

DOLUTEGRAVIR (TIVICAY)

WHAT IS DOLUTEGRAVIR?

Dolutegravir is a drug used for antiviral therapy against HIV. It is manufactured by Viiv Healthcare.

Dolutegravir is the third "integrase inhibitor" drug. When HIV infects a cell, it combines its genetic code into the cell's own code. This is shown in fact sheet 400, step 5. Dolutegravir blocks this process. When dolutegravir blocks integration, HIV infects a cell but cannot make more copies of itself.

WHO SHOULD TAKE IT?

Dolutegravir was approved in 2013 as an antiviral drug against HIV. It is approved for adults and children age 6 years and older, who weigh at least 66 pounds (30 kilograms).

There are no absolute rules about when to start antiviral drugs. You and your health care provider should consider your CD4 cell count (see fact sheet 124) your viral load (see fact sheet 125) any symptoms you are having, and your attitude about taking HIV medications. Fact Sheet 404 has more information about guidelines for the use of antiviral medications.

WHAT ABOUT DRUG RESISTANCE?

The HIV virus is sloppy when it makes copies of its genetic code (RNA). Many new copies of HIV are mutations: they are slightly different from the original virus. Some mutations can continue to multiply even when you are taking an antiviral drug. When this happens, the drug will stop working. This is called "developing resistance" to the drug. See Fact Sheet 126 for more information on resistance.

Dolutegravir has shown activity against HIV that already has resistance to several other HIV medications, including some viruses with resistance to other HIV integrase inhibitors.

Resistance to dolutegravir is not yet well understood. Sometimes, if you develop resistance to one drug, you will also have resistance to other antiviral drugs. This is called "cross-resistance". Because dolutegravir is in a fairly new class of antiviral drugs, it seems to have no cross-resistance with antiviral drugs in older classes. However, some cross-resistance is expected between raltegravir (Isentress, see fact sheet 465), elvitegravir (see fact sheet 466) and dolutegravir.

With combination therapy (taking more than one antiviral drug at the same time), HIV mutates much more slowly. Resistance takes longer to develop. **It is very important to take antiviral medications according to instructions, on schedule, and not to skip or reduce doses.**

HOW IS DOLUTEGRAVIR TAKEN?

Dolutegravir is taken as one 50 mg tablet once daily for people on HIV integrase inhibitor treatment for the first time who weigh 88 pounds. It may be prescribed twice daily if you have already used raltegravir or elvitegravir and have viral resistance.

For children between ages 6 and 12 who weigh more than 66 pounds, 10 and 25 mg tablets are also available. There are ongoing studies in younger children.

Dolutegravir can be taken with or without food or with regard to time of day. Dolutegravir should be taken 2 hours before or 6 hours after certain antacids, sucralfate, calcium or iron supplements. These can be overcome if dolutegravir and the supplement is taken with food.

WHAT ARE THE SIDE EFFECTS?

Dolutegravir is usually very well tolerated. If side effects occur, the most common side effects are diarrhea, nausea, and headache.

Among some individuals with hepatitis B or C virus infection, cases of liver inflammation were observed. Laboratory testing before starting therapy and monitoring for liver toxicity during therapy are recommended in patients with underlying liver disease. Reports from people using dolutegravir include rash. In rare cases, skin rash can be severe and life threatening. **Contact your health care provider immediately if you develop a serious rash while taking dolutegravir.**

HOW DOES IT REACT WITH OTHER DRUGS?

Dolutegravir has been studied to see if it interacts with other drugs. Rifampin, used to treat tuberculosis (see fact sheet 518), and the HIV medications efavirenz (see fact sheet 432), fosamprenavir/ritonavir (see fact sheet 448) and tipranavir/ritonavir (see fact sheet 449) decrease blood levels of dolutegravir. If dosed with and of these medications, dolutegravir should be dosed 50 mg twice daily. In these situations, dolutegravir is dosed twice daily. Dolutegravir should not be taken with the heart medication dofetilide.

Dolutegravir has not been studied with all medicines, over-the-counter drugs or vitamin or herbal supplements. Studies are underway. Be sure your doctor knows about all medications and supplements that you are taking.

THE BOTTOM LINE

Dolutegravir is the third integrase inhibitor drug. It stops HIV from inserting its genetic code into an infected cell. This prevents the virus from making new copies of HIV. Dolutegravir helps control HIV, even when it is resistant to other medications.

Revised Oct 17, 2017

A project of the International Association of Providers of AIDS Care. Fact Sheets can be downloaded from the Internet at http://www.aidsinfonet.org

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Appendix A

Quick Reference Guides

Management of Occupational Blood Exposures

1. Provide immediate care to the exposure site:
   - Wash wounds and skin with soap and water
   - Flush Mucous membranes with water
   - Avoid wound squeezing and caustic topical agents such as bleach

2. Notify supervisor immediately:
   - Proceed to the clinic immediately for evaluation of oPEP
   - Notify Human Resources, Office of Nursing and APRN or the Infectious Disease Provider
     - If exposure occurs after hours proceed with oPEP evaluation and contact these individuals ASAP
   - Complete accident reports
     - These reports should not delay the evaluation process and initiation of oPEP
   - Reports to be filed with the immediate supervisor and with Human Resources

3. Determine risk associated with exposure:
   - Complete the Bloodborne Pathogen Occupational Exposure Report Form (Appendix B) including:
     - Details of exposure, where and how the exposure occurred, and the exposure device
     - Type of fluid and severity of exposure (percutaneous, injury depth, mucous membrane, fluid volume, skin condition)

4. Evaluate exposure source:
   - Assess risk of infection using available information
   - Counsel patient concerning incident
   - Test: HIV (prefer rapid HIV 1/2 Ag/Ab testing), HB sAg, anti-HCV Ab (or RNA), if not recently completed
   - Check previous therapy and viral load in patients with known HIV
   - Start oPEP drug therapy within 60 to 90 minutes. Although, oPEP can be given up to 72 hours after the exposure, any delays in initiating prophylaxis should be minimized.
   - Link all persons with a new HIV diagnosis or anyone with HIV who has fallen out of care
   - For unknown sources; assess risk of exposure as noted below
   - Do **not** test needles or syringes for virus contamination

5. Evaluate exposed patient:
   - Date, time, and type of exposure
   - Counsel patient concerning incident
   - If evaluation/ therapy is refused, then ask the individual to sign the "Refusal of Treatment" form (Appendix A)
   - Test: HIV (rapid HIV 1/2 Ag/Ab testing preferred), HB sAg and anti-HCV Ab, if not recently completed
   - Review previous vaccine response (Anti-HB sAb >10 mIU/mL), if available
   - Counseling, post-exposure management and follow-up should be discussed with the individual
   - Seek immediate evaluation if lymphadenopathy, fever and/or rash occur within 3-months of exposure

6. Reports to be completed and sent to the District Nursing and HR:
   - Unusual occurrence form
   - Complete Bloodborne Pathogen Occupational Exposure Report Form
   - Consent or Declination of Consent Forms
   - Acceptance/Refusal of Treatment
   - Worker's Comp 1st Report of Injury

7. Assess need of oPEP for exposures posing risk of disease transmission.

Occupational Post-Exposure Prophylaxis (oPEP)
Quick Reference Flow Chart
Testing unless already has chronic disease [HIVHBV//HCV] or immunity [HBV])

Exposure to Blood or Visibly Bloody Body Fluids

Exposed Person ⟷ Source Patient

Exposed Person

1. Wash exposure site with soap and water
   Do not squeeze or use bleach or other strong cleaning agents on exposure site
2. If mucous membrane exposure; flush with water
3. Notify Supervisor on site immediately

Supervisor on site

Collect the following:
1. HIV Screen
(Rapid HIV 1/2 Ag/Ab testing preferred)
2. Hepatitis B surface antigen (HB sAg)
3. Anti-Hepatitis C antibody (anti-HCV Ab) or RNA
4. Complete Metabolic Panel
5. Pregnancy test: persons of childbearing potential

Source Patient

Request that patient remain in clinic

Supervisor on site

1. Obtain source patient consent for testing
2. Collect the following:

- HIV Screen
  (Rapid HIV 1/2 Ag/Ab testing preferred)
- Hepatitis B surface antigen (HB sAg)
- Anti-Hepatitis C antibody (anti-HCV Ab) or RNA
- Source patient may leave the office

1. Notify contact person(s) at: xxx-xxx-xxxx
2. Ask for NP or Physician for risk assessment and treatment plan
3. Have exposed person read and sign the "Consent/Refusal of Treatment" form
4. Follow-up appointments should begin within 72 hours of the initial assessment with the employee's medical provider
5. Initial therapy as indicated based on assessment. Minimize delays in initiating prophylaxis (see below)

1. Notify _____ at xxx-xxx-xxxx
2. Notify Human Resources Office at xxx-xxx-

1. Complete Workers' Comp 1st Report of Injury form; employee & supervisor call DOAS at 1-877-656-7475. DOAS will transfer the call to AmeriSys or you will be directed to call 1-800-900-1582. Mail copy of 1st Report of Injury to _____; Address _____ marked as "Confidential."
2. Complete Report of Unusual Occurrence form and mail to _____attention _____.
3. Complete Bloodborne Pathogen Occupational Exposure Report Form and send to _____; attention _____

Quick Reference Verification

(Check List: testing unless already known to have chronic disease [HIV/HBV/HCV] or immunity [HBV])

Source Patient: (Source of the exposure: blood and/or visibly bloody fluid)

- ☐ HIV screen — Rapid HIV 1/2 Ag/Ab testing preferred
- ☐ Hepatitis B surface antigen — HB sAg
- ☐ Anti-Hepatitis C antibody — anti-HCV Ab or HCV RNA if previously treated

Exposed Patient: (Individual who was exposed: needle stick, cut, blood and/or bloody fluid)

- ☐ HIV screen — Rapid HIV 1/2 Ag/Ab testing preferred
- ☐ Hepatitis B surface antigen — HB sAg
- ☐ Anti-Hepatitis C antibody — anti-HCV Ab or HCV RNA if previously treated
- ☐ Complete Metabolic Panel — CMP
- ☐ Pregnancy test — Persons of childbearing potential
- ☐ Report of Unusual Occurrence and Workers' Comp 1st Report of Injury
  - o Complete forms on site
- ☐ Hepatitis B Immunoglobulin 0.06 mL/kg IM x 1 (see page 7)
  - o If known non-responder or not vaccinated
- ☐ Hepatitis B vaccine 1cc IM x 1 at time of exposure (see page 7)
  - o Vaccinate per manufacturer's specifications if no history of vaccination **or**
  - o No response to initial vaccine series (e.g. Anti-HB sAb <10 mIU/mL)
- ☐ Assess need for oPEP as outlined in guidelines
  - o Refer to Guidelines for Initiation of HIV oPEP in this packet
- ☐ Medication counseling completed with Exposed Person
- ☐ Instructions to notify the above noted contact person(s) concerning any questions regarding the initiation of HIV medications or any other issues
- ☐ Instruction given to the exposed individual for expected follow-up
  - o See detailed discussions below for follow-up lab and assessment
  - o HCV Ab (unless known to have chronic active HCV) and CMP at 4- and 6-months with reflex to quantitative HCV RNA if HCV Ab positive
  - o HIV Ag/Ab (unless known to be HIV positive) at 6-weeks, 3-and 6-months. Check at 12-months if known to have chronic HCV infection
    - If fourth-generation HIV 1/2 Ag/Ab test is utilized, then test at 6-weeks and 4-months
    - Use rapid HIV testing system only at the time of the initial injury
    - Check CMP at baseline and at 4-weeks

Determined Risk Assessment: _____

_____

Date oPEP Plan Initiated: _____

Treatment Regimen (if given): _____

This information is to be used as a quick reference guide in order to rapidly assess and treat individuals involved in an exposure. This information should be used with the extended guidelines included within this packet. Notification of the elected contact person or the Infectious Disease Provider should take place if questions arise concerning the initiation of oPEP and for appropriate follow-up. Rapid HIV 1/2 Ag/Ab testing should be used to evaluate the initial HIV status of the source and exposed individuals.

Contact Information

Contact Person	Office Number	Home / Cell Number
_____ Immediate Supervisor	_____	_____
_____ Secondary Supervisor	_____	_____
_____ Wellness Center Contact	_____	_____
_____ Additional Contact	_____	_____
_____ Infectious Disease (ID) Provider	_____	_____

PEP Assistance

PEPline

The National Clinicians' PEP Hotline

Phone: 1-888-448-4911
http://nccc.ucsf.edu/clinician-consultation/PEP-post-exposure-prophylaxis/

Resources

The Antiretroviral Pregnancy Registry at http://www.apregistry.com

FDA (for reporting unusual or severe toxicity to antiretroviral agents) at http://www.fda.gov/medwatch; telephone: 888-463-6332

The CDC's Cases of Public Health Importance (COPHI) coordinator (for reporting HIV infections in HCP and failures of oPEP) at 404-639-2050 or 404-639-0934

HIV Treatment Information Service:

http://aidsinfo.nih.gov
http://www.jstor.org/stable/10.1086/672271
https://www.hiv.uw.edu/
www.aidsinfonet.org,
https://www.cdc.gov/hiv/risk/PEP/
https://cdc.train.org/cdctrain/

Medication Access

General patient assistance:	RxAssist - Patient Assistance Programs
Truvada™:	Gilead Advancing Access® program
Generic FTC/TDF:	https://www.tevahivgenerics.com/truvada-generic/support
Raltegravir:	https://merckhelps.com/ISENTRESS
Dolutegravir:	https://www.viivconnect.com/

Recommended Evaluation for Occupational Post-Exposure

- All labs should be collected immediately following the occupational exposure occurrence.
- Follow-up should begin within 72 hours of the initial assessment with the exposed person
- Additional testing as below if initial tests are non-reactive and
- Additional testing not indicated if person already known to have chronic disease [HIV/HBV/HCV] or immunity [HBV])

HIV:

- ☐ HIV test reactive
  - o Immediately refer for assessment
  - o Results should preferably be given at face-t- face appointments

- ☐ HIV test nonreactive
  - o HIV oPEP initiated ☐ Yes ☐ No
  - o Testing schedule 6-weeks, 3- and 6-months
  - o If a fourth-generation HIV 1/2 Ag/Ab test is utilized, then testing may be concluded at 4-months
    - test at 6-weeks and 4-months
  - o Check HIV 1/2 Ag/Ab test at 12-months if co-infected with Hepatitis C
  - o Refer all reactive tests for assessment
  - o Stop testing if source HIV test non-reactive
  - o CMP at 4 weeks
    - further testing may be indicated if abnormalities are detected

- ☐ Advise exposed individual to use precautions to prevent pregnancy and avoid breastfeeding to prevent potential secondary transmission especially during the first 6–12 weeks post exposure.

Hepatitis B:

- ☐ Hepatitis B surface antigen (HB sAg) reactive
  - o refer for assessment
- ☐ Hepatitis B surface antigen (HB sAg) non-reactive
  - o assess for vaccination

Hepatitis C:

- ☐ Check HCV RNA if previously treated for HCV
- ☐ Hepatitis C Virus Ab (HCV Ab) reactive
  - o confirm with a quantitative HCV RNA
  - o if HCV RNA reactive, refer for assessment
- ☐ Hepatitis C Virus Ab (HCV Ab) non-reactive
  - o check HCV Ab and CMP at 4-months and at 6-months
  - o if HCV Ab reactive then confirm with quantitative HCV RNA and refer if positive

_____

Signature of staff member counseling person Date / Time

_____

Signature of exposed person Date / Time

Appendix B

Consent and Declination Forms

Acceptance of Treatment

I have received counseling and education concerning a blood or body fluid exposure. I understand the risk and benefits of receiving occupational post-exposure prophylaxis (oPEP) and the importance of follow-up concerning laboratory studies. I understand the importance of adhering to medication and vaccines offered to me. All my questions have been answered and I understand the material presented to me. I have been provided an after-hours contact name and number if I experience any problems or have any questions.

Signature of staff member counseling person Date / Time

Signature of exposed person Date / Time

Refusal of Treatment

I have been advised on recommended follow-up for a blood or body fluid exposure. I understand the risk of refusing post-exposure follow-up and decline to receive this evaluation. I am aware of the potential health consequences of this decision.

Signature of staff member counseling person Date / Time

Signature of exposed person Date / Time

Place the original copy in the medical file, send one copy to the HR Director attached to the Unusual Occurrence Report, and one copy to the Exposed Person.

Georgia Department of Public Health

Employee Statement of Declination to HBV Vaccination

I understand that, due to my occupational exposure to blood or potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B at no charge to me. However, I decline HBV vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, do not have chronic Hepatitis B and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I decline hepatitis B vaccination at this time for the following reason
(check the appropriate response)**:**

☐ I have already received 2-vaccine series, per manufacturer's specifications, of hepatitis B vaccine in the past.

☐ I have a history of HBV infection (diagnosed in the past).

☐ I choose not to receive hepatitis B vaccination now, but understand I may request it in the future, if I remain Hepatitis B negative.

_____
Employee Name (Please Print)

_____ _____
Employee Signature Date

_____
Witness Name (Please Print)

_____ _____
Witness Signature Date

Georgia Department of Public Health

Employee Statement of Declination of Consent to HBV Testing (HBsAg and anti-HBs) or HBIG and/or Hepatitis B Vaccine After an Exposure

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been advised that it is recommended that I receive HBIG and/or hepatitis B vaccine and/or appropriate HBV antibody and antigen testing because of the following exposure in the workplace (describe type of exposure):

_____

_____

_____

_____

_____

I understand that the vaccine, if needed for this exposure or to protect against Hepatis B infection in any potential future exposures, will be given to me at no charge.

However, I decline hepatitis B vaccination. I understand, that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I am also aware that failure to submit to the recommended HBV antibody and antigen tests may result in my not receiving worker's compensation.

_____

Employee Name (Please Print)

_____ _____

Employee Signature Date

_____

Witness Name (Please Print)

_____ _____

Witness Signature Date

Georgia Department of Public Health

Employee Statement of Declination of Consent to an HCV Antibody Test After an Exposure

I understand, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis C virus (HCV) infection. I have been advised that it is recommended that I receive appropriate HCV antibody testing because of the following exposure in the workplace (describe type of exposure):

_____

_____

_____

_____

_____

I decline to have the test done at this time. I am aware that failure to submit to this test may result in my not receiving workers' compensation should I develop HCV disease or test positive in the future.

.

_____

Employee Name (Please Print)

_____ _____

Employee Signature Date

_____

Witness Name (Please Print)

_____ _____

Witness Signature Date

Georgia Department of Public Health

Employee Statement of Declination to a HIV 1/2 Antigen/Antibody Test After an Exposure

I understand, due to my occupational exposure to blood or other potentially infectious fluids/materials, I may be at risk of acquiring HIV infection. I have been advised that it is recommended that I submit to confidential HIV antibody testing because of the following exposure in the workplace (describe type of exposure):

_____

_____

_____

_____

_____

I decline to have the recommended HIV antibody test done at this time. I am aware that failure to submit to this test may result in my not receiving workers' compensation if I develop HIV disease.

_____

Employee Name (Please Print)

_____ _____

Employee Signature Date

_____

Witness Name (Please Print)

_____ _____

Witness Signature Date

Appendix C
Post-Exposure Incidence Forms

REPORT OF UNUSUAL OCCURRENCE

Date of Incident, Injury or Complaint: _____ Time: _____

Facility Name and Address: _____

Area Where Injury or Incident Occurred: _____

Name of Involved/Affected: _____ Age: _____

Person Responsible if minor or incapacitated: _____ Phone #: _____

Address: _____

Witness: _____ Contact number: _____

Witness: _____ Contact number: _____

Full Description of Injury/Incident/Complaint (add additional sheets as needed):

_____

_____

_____

_____

_____

If Medication Administration Error Select Type (known or suspected error):

☐ Omission of dose

☐ Extra dose given

☐ Incorrect dosage form or route

☐ Incorrect administration time

☐ Wrong drug/vaccine given

Date Administered ___/___/_____

Expiration Date ___/___/_____

☐ Documentation error

☐ Failure to follow Nurse Protocol

☐ Other medical error (please describe)

_____

_____

_____

_____

Complete description of medication error (include medication, effect on patient, dates, times, sequence of events, causes, people involved, witnesses):_____

_____

_____

For all Events: Action Taken (check all that apply)

☐ Communicated event to involved person and/or responsible person/guardian about necessary action needed.

☐ Communicated event to involved person's physician (if applicable).

☐ Counseled and/or reassigned if employee involved.

Immediate resolution and action taken: _____

_____

Physician Examination: Yes _____ No _____

If Yes: What Was Recommendation &/or Diagnosis: _____

Follow-up with person involved: Yes _____ No _____

Outcome of Follow-up/Results: _____

Plan of Correction and Prevention: _____

_____

Person Completing Report: _____ Date: _____
Signature

Nurse Manager/Onsite Manager: _____ Date: _____
Signature

Nursing / Clinical Director: _____ Date: _____
Signature

Send to: District Nursing Director and Human Resources Director

Bloodborne Pathogen Occupational Exposure Report Form

Name : _____ Date: _____

District: _____ County: _____

Address: _____

City: _____ State: _____ Zip code: _____

Instructions:

- *This form must be completed within 72 hours of exposure to blood borne pathogen.*
- *A copy of the form should be maintained as part of the District/County's sharps injury log.*
- Date of Injury/Exposure: _____ Time of Injury/Exposure: _____
- Person completing report form: _____ Phone: _____

Job Classification:

- ☐ Communicable Disease Specialist (CDS)
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Housekeeper/janitor
- ☐ Nurse
- ☐ Phlebotomist/lab tech
- ☐ Physician
- ☐ Public Health Tech
- ☐ Student, type _____
- ☐ Other _____

Location:

- ☐ Community setting, type _____
- ☐ Exam room
- ☐ Home
- ☐ Immunization clinic
- ☐ Laboratory
- ☐ Procedure room
- ☐ Service/utility area
- ☐ Other _____

Type & Severity of Injury/Exposure:

- ☐ Direct contact with concentrated virus
- ☐ Human bite resulting in blood exposure
- ☐ Mucous membrane exposure
  - o Large Volume (major blood splash)
  - o Small Volume (e.g. a few drops)
- ☐ Nonintact skin
  - o Large Volume (major blood splash)
  - o Small Volume (e.g. a few drops)
- ☐ Percutaneous injury
  - o More Severe (large-bore hollow needle, deep puncture, visible blood on device, needle used in patient's artery or vein)
  - o Less Severe (solid needle, superficial injury)
- ☐ Other _____

Exposure Source:

- ☐ Source person:
  - o HBV infected
  - o HBV serology negative
  - o HBV unknown
  - o HCV infected
  - o HCV serology negative
  - o HCV unknown
  - o HIV infected
  - o HIV preliminary positive
  - o HIV serology negative
  - o HIV unknown
- ☐ None (Unknown Source)
- ☐ Other _____

Procedure/Purpose:

- ☐ Fingerstick/heel stick
- ☐ Injection, through skin
- ☐ Lancing
- ☐ Obtaining body fluid or tissue sample
- ☐ Start IV
- ☐ Suturing
- ☐ Venous blood draw
- ☐ Unknown/not applicable
- ☐ Other _____

Body Part Injured/Exposed:

(Check all that apply)

- ☐ Arm o left o right
- ☐ Eye o left o right
- ☐ Face/head
- ☐ Finger o left o right
- ☐ Hand o left o right
- ☐ Leg o left o right
- ☐ Mouth
- ☐ Torso
- ☐ **Other** _____

Type of Body Substance Involved:

- ☐ Blood
- ☐ Fluid containing visible blood
- ☐ Other potentially infectious fluid or tissue

_____

Did the Exposure Incident Occur:

- ☐ After use and before disposal of sharp
- ☐ As a result of body substance splash
- ☐ As a result of specimen leaking/spill
- ☐ Between steps of a multistep procedure
- ☐ Cleaning a room
- ☐ Disassembling
- ☐ During trash disposal
- ☐ During use of sharp
- ☐ While cleaning equipment
- ☐ While putting sharp into disposal container
- ☐ Other _____

Identify Sharp Involved: (if known)

Type: _____

Brand: _____

Model: _____

Did the device being used have engineered sharps injury protection?

- ☐ yes
- ☐ no
- ☐ don't know

Was the protective mechanism activated?

- ☐ yes-fully
- ☐ yes-partially
- ☐ no

Did the exposure incident occur:

- ☐ before protective mechanism activated
- ☐ during protective mechanism activation
- ☐ after protective mechanism removed

Hepatitis B Vaccination and Vaccine-Response Status:

(Employee)

- ☐ Unvaccinated
  - o Partially vaccinated
  - o Not completed per manufactures specifications
- ☐ Previously vaccinated:
  - o Known responder
  - o Known non responder
  - o Anti-HBs response unknown

Personal Protective Equipment (PPE) Used:

(Check all that apply)

- ☐ Gloves
- ☐ Fluid-resistant gown/apron
- ☐ Resuscitation bag
- ☐ Lab coat
- ☐ Face shield or mask
- ☐ Eye Protection
- ☐ Mouth Piece
- ☐ Other _____

Initial Employee Post-Exposure Management:

(Check all that apply)

- ☐ Immediate First Aid
  - o Wash exposed area/injury
  - o Flush nose, mouth or skin
  - o Irrigate eye(s) for 15-20 minutes
- ☐ Medical Evaluation
- ☐ Counseling/education
- ☐ Baseline testing:
  - o Anti-HBs
  - o Anti-HCV or RNA and CMP
  - o HIV antibody
- ☐ Hepatitis B vaccination
- ☐ HBIG
- ☐ HIV Post-exposure prophylaxis
  - o Medications used _____
    _____
  - o Baseline drug toxicity testing (CBC, CMP)

Exposed employee: If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury?

- ☐ yes
- ☐ no

Explain: _____
_____

Exposed employee: Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury?

- ☐ yes
- ☐ no

Explain: _____
_____

_____
Employee's Signature (optional) Date

_____
Witness' Signature (optional) Date

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg, etc.)	
Address		Phone Number	Employer FEIN	
		Employer E-mail		
INSURER / SELF-INSURER	Name	Claims Office Address		
CLAIMS OFFICE	Name		Insurer/Self-Ins /Claims FEIN	
SBWC ID # (five digit no.)	Insurer/ Self-Insurer File #	Claims Office Phone	Claims Office E-mail	

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
List Normally Scheduled Days Off				
INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ pm	County of Injury	Date Employer Notified	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor By Employer ❑ Minor Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date Returned at what wage per Week If Fatal, Enter Complete Date of Death	

Report Prepared By (Print or Type)	Telephone Number	Date of Report

B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ❑ Yes ❑ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability

Date of first Payment: _____ Compensation paid: $_____ or Date salary paid: _____ Penalty paid: $_____

BENEFITS ARE PAYABLE FROM _____ FOR:

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of _____% to _____ for _____ weeks

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because

D. MEDICAL ONLY INJURY ❑ No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filing Form)	Signature	Date
Phone and Ext.	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19)

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov