A. POLICY STATEMENT

This policy directive was developed to provide guidance to State-operated psychiatric inpatient facilities for providing appropriate assessment, treatment, and follow-up to employees who are exposed to Blood Borne pathogens in the course of performing their duties. It also outlines the requirements of the facility Exposure Control Plan, which is required in federal regulations promulgated by the Occupational Safety and Health Administration, U.S. Department of Labor (OSHA).

Health care workers, particularly those who may be exposed to blood or other potentially infectious materials are at risk of acquiring infections caused by HIV, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and other microbial agents. While blood is most frequently associated with the transmission of infections, significant exposure to other body fluids, tissue and tissue secretions, e.g., semen, urine, saliva, vaginal secretions, biopsy and autopsy specimens and cerebrospinal, synovial, pericardial, pleural, peritoneal and amniotic fluids, has been reported as a potential source of infection.

Each State-operated psychiatric inpatient facility shall be responsible for ensuring compliance with this policy directive, for making it readily available and accessible to staff, and for assuring that it is appropriately reflected in individual facility policies and procedures.

Please note the following related OMH Official Policy Manual directive:

PC-1412 Management of Blood Borne Pathogens/ HIV/AIDS Testing and Notification Requirements – Continues to provide direction on providing for safe care and treatment of patients with HIV/AIDS, includes updated relevant statutes and standards, and places the provision for treatment within the framework of providing care for all blood borne pathogens. Also, provides guidance in meeting the most current testing, counseling, and reporting requirements specifically associated with HIV/AIDS and includes updated relevant statutes and standards.

B. RELEVANT STATUTES AND STANDARDS

29 CFR § 1910.1030 (OSHA regulations: Blood Borne Pathogens)
Public Health Law Article 21 (Control of Acute Communicable Diseases)
Public Health Law Article 27-F (HIV and AIDS related information)
Labor Law Section 27-a (Public Employee Safety and Health Act)
New York State Department of Health AIDS Institute: (HIV Prophylaxis following Occupational Exposure - March, 2001)
New York State Department of Health Policy Statement 8-92(Prevention of HIV/HBV Transmission through Medical Procedures)

Center for Disease Control and Prevention (CDC):

MMWR 41, no. RR-17 (HIV case definition)

MMWR 37, no. 24;377 06/24/1988 *Perspectives in Disease Prevention and Health Promotion Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, and other Blood Borne Pathogens in Health-Care Settings.*

MMWR 47 RR-19; 1-39 (Recommendations for Prevention and Control of Hepatitis C Virus(HCV) Infection and HCV- Related Chronic Disease)

MMWR 50, no. RR-11 (Recommendations and Reports - Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis - June 29, 2001)

"Control Workbook for Designing, Implementing and Evaluating a Sharps Injury Prevention Program" - February 2004

www.hivguidelines.org

www.cdc.gov/sharpssafety/

NIH Consensus Development Conference Statement: (Management of Hepatitis C:2002; Final Statement - 9/2002)

OSHA Publication 3186-06R 2003, "Model Plans and Programs for the OSHA Blood borne Pathogens and Hazard Communications Standards"

NOTE: Because of the rapidly changing body of knowledge related to blood borne pathogens and resulting infections, these standards may be superseded by the most recent information or policy documents of State and Federal agencies.

C. DEFINITIONS:

1) ***Acquired Immunodeficiency Syndrome (AIDS):*** means the clinical condition of disease resulting from HIV infection. The course from infection to disease may take many years or can occur more rapidly. AIDS is defined as HIV infection and either a CD4 + T-lymphocyte count of less than 200/UL , or the presence of an AIDS indicator condition. The AIDS indicator conditions are specific illnesses that are associated with depleted immunologic function.

2) ***Blood borne pathogens***: means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

3) ***Blood borne pathogen committee:*** means a facility committee consisting of a psychiatrist, a non-psychiatric physician, an infection control coordinator, a representative from education and training, a member of the facility

administration, a representative from support services as appropriate, and any other staff who may be deemed appropriate. **The committee may be a subcommittee of the facility's infection control committee.** The committee has the responsibility for developing the facility's policies and procedures on blood borne pathogens, updating them where appropriate, and coordinating their implementation and ongoing monitoring in conjunction with the infection control committee.

4) ***Blood borne pathogen occupational exposure***: means a contact by means of eye, mouth, other mucous membranes, non-intact skin or parenterally to blood carrying pathogenic microorganisms that can cause disease in humans, such as hepatitis B virus, hepatitis C virus, or human immunodeficiency virus, through the performance of the employee's duties.

5) ***Contaminated:*** means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

6) ***Contaminated sharps***: means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

7) **Employee:** means employee, student or volunteer.

8) ***Engineering and work practice controls:*** means the controls that isolate or remove a blood borne pathogens hazard from the workplace. Examples include sharps disposal containers, self-sheathing needles, and safer medical devices (such as sharps with engineered sharps injury protections and needleless systems).

9) ***Exposure incident:*** means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

10) ***Hepatitis B (HBV):*** means a serious disease caused by the hepatitis B virus, that attacks the liver. The virus is contracted through direct contact with the blood or body fluids of an infected person, and can cause a life long infection, cirrhosis of the liver, liver cancer, liver failures, and death.

11) ***Hepatitis C (HCV)***: means a serious disease of the liver caused by the hepatitis C virus. This virus is spread through contact with the blood of an infected person, blood transfusions and use of injected drugs. This virus is spread through shared use of needles, occupational sharps exposure, or an infected mother during birth.

12) ***Human Immunodeficiency Virus (HIV):*** means the virus that causes AIDS. HIV is a retro virus that has the CD4+ T-lymphocyte as its primary target. The CD4+T-lymphocyte coordinates a number of immunologic functions, and a loss of these functions results in progressive impairment of the immune response. HIV is acquired through sexual contact or through significant exposure to infected blood or body fluids.

13) ***Immunocompromised:*** means the state of a person whose immune system response has been weakened by immunosuppressive drugs, irradiation, malnutrition and/or some disease process.

14) ***Needleless systems***: means a device that does not use needles for:

a) the collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established;

b) the administration of medication or fluids; or

c) any other procedure involving the potential for occupational exposure to blood borne pathogens due to percutaneous injuries from contaminated sharps.

15) ***Occupational exposure:*** means a reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. An exposure is defined as a percutaneous injury (e.g., a needle stick, or cut with a sharp object, or contact of mucous membrane, or damaged skin (chapped, abraded, dermatitis) with blood, tissue, or other body fluids that are potentially infectious.

16) ***Opportunistic infection***: means an infection caused by normally non-pathogenic organisms in an individual whose resistance has been weakened by some other condition such as a disease, surgery, irradiation, or chemotherapy.

17) ***Other potentially infectious materials:*** means:

a) the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

b) any unfixed tissue or organ (other than intact skin) from a human, living or dead; and/or

c) HIV-containing cell or tissue cultures, organ cultures, and HIV or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

18) ***Parenteral:*** means a piercing of the mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

19) ***Personal Protective Equipment (PPE):*** means the specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

20) ***Post-exposure Prophylaxis(PEP***): means the medications prescribed to eliminate or minimize the severity of infections caused by blood borne pathogens after exposure.

21) ***Sharps with engineered sharps injury protections***: means a nonneedle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

22) ***Source Individual :*** means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to: hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

23) ***Standard/Universal Precautions****:* means measures to be practiced by all health care workers in caring for all patients to reduce the transmission of microorganisms from both recognized and unrecognized sources of infection by preventing exposure to blood and body fluids and moist body substances, by approaching infection control as if all human blood and certain human body fluids are treated as infectious for HIV, HBV, and other blood borne pathogens.

D. Body of the Directive

This policy directive consists of 7 components:

1) **Exposure Control Plan**
2) **Methods of Compliance**
3) **Hepatitis B Vaccination and Blood Borne Pathogen Post-Exposure Evaluation and Follow-Up**
4) **Communication of hazards to employees**
5) **Recordkeeping**
6) **Management of Employee Occupational Exposure**
7) **Resources for Consultation**

1) Exposure Control Plan:

a) The Occupational Safety and Health Administration of the U.S. Department of Labor (OSHA) has determined that healthcare workers face a significant risk of occupational exposure to blood borne pathogens. OSHA regulations at 29 CFR §1920.1030 require every employer with the potential for occupational exposure to establish an Exposure Control Plan. The Public Employee Safety and Health (PESH) Bureau of the New York State Department of Labor enforces all health and safety standards, promulgated by OSHA, on public sector employees, including OMH.

b) Each OMH inpatient psychiatric facility is required to establish its own Exposure Control Plan, in accordance with this policy directive. The facility's Blood Borne Pathogen Committee, which is required to be established by OMH Official Policy Directive PC-1412 (Inpatient Clinical Management of Blood Borne Pathogens) will be responsible for developing this plan. Each Exposure Control Plan, must, at a minimum, include the following components:

i) Purpose: The purpose of the Exposure Control Plan must be:

(1) to establish individual responsibilities to minimize the risk for healthcare workers of acquiring blood borne disease due to occupational exposure;

(2) to ensure compliance with OSHA regulations/standards; and

(3) to outline facility responsibilities in the event of an occupational exposure.

ii) Exposure Determination: The Exposure Control Plan must include an "exposure determination," which contains a list of all job titles/classifications in which employees may have occupational exposure to blood borne pathogens, and a list of all tasks and procedures (or groups of closely related tasks and procedures) performed by such employees in which occupational exposure may occur.

iii) Schedule and Method of Implementation: For OMH facilities, the Exposure Control Plan must include the schedule and method of implementation for the following categories:

(1) Methods of Compliance (section D.2) of this policy directive);

(2) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow Up (section D.3) of this policy directive);

(3) Communication of Hazards to Employees (section D.4) of this policy directive); and

(4) Recordkeeping (section D.5) of this policy directive).

iv) Procedures: The Exposure Control Plan must include procedures for the evaluation of circumstances surrounding exposure incidents.

v) Each facility director shall ensure that a copy of the Exposure Control Plan is accessible to all employees and staff of the facility.

vi) Annual review: The Exposure Control Plan must be reviewed and updated at least annually, and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure. The review and update shall also address the following:

(1) new or revised employee positions with occupational exposure;

(2) changes in technology that eliminate or reduce the risk of

exposure to blood borne pathogens;

(3) annual documentation reflecting the consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupation exposure; and

(4) solicitation of input from non-managerial employees responsible for direct patient care who are at risk of injury from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls, which shall be documented in the plan.

2) Methods of Compliance

a) Standard/Universal precautions shall be observed to prevent contact with blood and other potentially infectious materials. Where differentiation between body fluid types is difficult or impossible, all body fluids should be considered potentially infectious materials.

b) Engineering and work practice controls.

(i) Engineering and work practice controls are used to eliminate or minimize employee exposure to blood borne pathogens. Facilities shall ensure that where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.

(1) Engineering controls may include, but are not limited to, sharps disposal containers, self-sheathing needles, safer medical devices (e.g., sharps with engineered sharps injury protections and needleless systems), and other methods designed to isolate or remove the blood borne pathogens hazard from the workplace.

(2) Work practice controls include methods intended to reduce the likelihood of exposure by altering the manner in which a task is performed, e.g., prohibiting recapping of needles by a two-handed technique.

(3) New technology shall be evaluated, as it becomes available, and the safest technology shall be used provided it does not interfere with patient care. Each

facility shall establish a committee for this purpose. This may be a sub-committee of the infection control committee.

(ii) Engineering controls shall be examined and maintained/replaced on a regular schedule to ensure their effectiveness.

(iii) Each facility shall provide handwashing facilities which are readily accessible to employees. Handwashing facilities must have an adequate supply of running potable water, soap, and single use towels or hot air drying machines. If this is not feasible, the facility shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleansers or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

(iv) Each facility shall ensure that employees wash hands and any other skin with soap and water immediately following contact with blood or other potentially infectious materials. Mucous membranes should be flushed with water immediately following possible exposure.

(v) Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed. Shearing or breaking of contaminated needles is prohibited in all State operated psychiatric inpatient facilities.

(vi) Eating, drinking, smoking, applying cosmetics or lip balm, and/or handling contact lenses shall be prohibited in work areas where there is a reasonable likelihood of occupational exposure.

(vii) Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets, or on countertops where blood or other potentially infectious materials are present.

(viii) Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited in all State operated psychiatric inpatient facilities.

(ix) Facilities shall take all reasonable steps to ensure that all procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

(c) Personal Protective Equipment (PPE).

(i) Each facility shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

(ii) If a garment is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible. Each facility must institute procedures designed to ensure that all PPE is removed prior to leaving the work area.

(iii) Facilities must ensure that when PPE is removed, it is placed in an appropriately designated area or container for storage, washing, decontamination, or disposal.

(iv) Gloves.

(1) Gloves must be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin when performing vascular access procedures and when handling contaminated items.

(2) Latex gloves should not be used.

(3) Disposable gloves, such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or when their ability to function as a barrier is compromised. Disposable gloves shall not be washed or decontaminated for re-use.

(v) Masks, Eye protection, and Face Shields. Masks, in combination with eye protection devices, shall be worn whenever splashes, spray spatter, droplets of blood, or other potentially infection materials, may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

(vi) Gowns, aprons, and other protective clothing shall be worn in occupational exposure situations.

(d) Housekeeping**.**

(i) Each facility shall ensure that the worksite is maintained in a clean and sanitary condition. The facility must develop and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

(ii) All equipment and environmental and working surfaces must be cleaned and decontaminated after contact with blood or other potentially infectious materials.

(1) Contaminated work surfaces must be decontaminated with an appropriate disinfectant after completion of procedures, immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials.

(2) Protective coverings, such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment and environmental surfaces shall be removed and replaced as soon as feasible when they become overtly contaminated.

(3) All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

(4) Broken glassware that might be contaminated shall not be picked up directly with the hands.

(5) Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

3) Hepatitis B Vaccination and Blood Borne Pathogen Post-Exposure Evaluation

and Follow-Up:

(a) Health care workers, particularly those who may be exposed to blood or other potentially infectious materials, are at risk of acquiring infections caused by the human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV) and other microbial agents.

(b) If not available on-site, state-operated psychiatric inpatient facilities must have a written agreement with an acute care facility to provide medical assessment/initial treatment for a significant occupational exposure to blood borne pathogens*.*

(c) Each facility shall make available the hepatitis B vaccine and vaccination series in accordance with OMH Official Policy Manual Directive OM-400 (Employee Vaccination Programs for Hepatitus B) to all of its employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident.

(d) Each facility shall require that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

(i) made available to the employee at no cost;

(ii) made available to the employee at a reasonable time and place;

(iii) performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional in accordance with New York State law; and

(iv) provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place.

(e) Each facility shall require that all laboratory tests be conducted by an accredited laboratory at no cost to the employee.

(f) Blood Borne Pathogen Post-Exposure Evaluation and Follow-Up.

(i) Each facility must have a plan which defines the steps to be taken in handling an employee occupational exposure to HIV, HBV and/or HCV, which must contain at least the following:

(1) identification of employee responsibility, e.g., washing of the exposed area, immediate reporting to designated representative of the facility, and completion of appropriate accident reporting materials;

(2) identification of a facility representative (on each shift) to be notified in the case of an occupational exposure to HIV, HBV and/or HCV. This person will be responsible for ensuring that the employee who sustains an occupational exposure is offered the opportunity for a medical evaluation, preferably within one hour after the incident; for facilitating the medical evaluation as needed; and for supplying the health care provider with necessary information;

(3) identification of a detailed procedure to be followed in case of an occupational exposure to HIV, HBV and/or HCV including procedures designed to:

A. provide immediate care to the exposure site (e.g., wash wound and skin with soap and water; flush mucous membranes with water);

B. provide initial assessment of risk associated with exposure by type of fluid[1] (e.g., blood, bloody fluid, other potentially infectious fluid or tissue, and concentrated virus) and type of exposure (e.g. percutaneous, mucosal, non-intact skin, bite resulting in blood exposure);

C. evaluate the exposure source and the exposed person, including identification of who will administer the initial evaluation and counseling;

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1 Potentially infectious body fluids: semen, vaginal secretions cerebrospinal fluid, synovial, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid. Semen and vaginal secretion have been implicated in the sexual transmission of HBV, HCV, and HIV, but not in occupational transmissions to health workers. Feces, nasal secretions, saliva, sputum, sweat, tears, urine, vomitus are not considered potentially infectious, unless they contain blood. The risk for transmission of HBV, HCV, HIV from these fluids is extremely low. For human bites, the clinical evaluation must include the possibility that both the person bitten, and the person who inflicted the bite were exposed to blood borne pathogens. HBV, HIV infection only rarely have been reported by this route.

how medication, if indicated, will be provided; qualifications of the identified providers; how many days of on-site medication will be provided and where it will be located; and who will administer follow-up care. It is highly recommended that a referral agreement be established with an acute care facility in the area that would agree to provide post-exposure evaluation, counseling, and treatment;

D. provide transport to an acute care facility or post-exposure prophylaxis (PEP) with consultation, for exposures posing risk of infection transmission[2].Each facility must arrange a referral agreement with a local medical institution or expert clinician to provide follow-up PEP care. Such agreement shall identify who should be contacted at that site, as well as who will escort the exposed employee to that site, and what procedures will be employed in the event of a failure to locate the primary designated care giver must be identified; and

(4) a specific description on how employees will be advised of, and trained in, this procedure, in accordance with D.4) of this policy directive.

(ii) For cases of occupational exposure to HIV:

(1) all blood drawn at the facility and sent for HIV antibody testing as a result of occupational exposure must be labeled in a manner consistent with OSHA guidelines and infection control policies. OSHA guidelines require that all post-exposure samples be saved for at least 90 days;

(2) employees occupationally exposed to HIV should receive

[2] A pregnancy test should be offered to all women of childbearing age not known to be pregnant. If the exposed employee is pregnant, she should consult her obstetrician about the advisability of taking antiviral drugs. In this circumstance, the risk of transmission of HIV, HBV and/or HCV to the employee must be considered in light of the potential harm to the unborn child. As with other difficult post-exposure prophylaxis issues, consultation with a clinical expert in AIDS care is recommended. Certain drugs should be avoided in pregnant women. Efinavir (EFV) possibly teratogenic D4T (Stavudine) and DDI (Didanosine) in combination reported to have caused fatal lactic acidosis. IDV Indinavir a protease inhibitor increases the risk of hyperbilirubinemia in newborns.

follow up care. Post-exposure prophylaxis should begin as soon as possible. NYSDOH recommendations for the implementation of prophylaxis indicate that treatment should ideally begin within 1 to 2 hours after exposure;

(3) each facility must execute a referral agreement with an area primary care facility that would be available to the employee for follow up care if he or she so desires. The facility must identify and ensure that there is a local pharmacy that will supply appropriate medications for follow-up care. Follow-up care should include:

A. post-exposure counseling;

B. medical evaluation;

C. HIV antibody tests at baseline, 6 weeks, 12 weeks and 6 months; and

D. counseling to avoid secondary transmission; and

(4) if an HIV Specialist is not immediately available for the initial assessment/prescription of antiretroviral therapy, the facility is required to have a standard prophylaxis kit available on site for immediate administration should the need arise. This kit must include at least 48 hours of the appropriate medications on site. In addition, each facility should ensure that there is local access to 24 hour availability of drugs and post-exposure counseling[3].

4) Communication of hazards to employees:

(a) Warning labels, which meet OSHA requirements, must be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport, or ship blood or other potentially infectious materials. Red bags or red containers may be substituted for labels.

[3] This might include 24 hour access to a local infectious disease specialist or an inter-facility memorandum of agreement with a local hospital.

(b) Training.

(i) Each facility shall ensure that all employees with occupational exposure participate in a training program, which must be provided at no cost to the employee, and must be provided during working hours.

(ii) Training must be provided at the time of initial assignment to tasks where occupational exposure may take place, and at least annually thereafter.

(iii) Additional training must be provided when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

(iv) The training program must consist of at least the following elements:

(1) an accessible copy of the text of OSHA regulations governing blood borne pathogens (29 CFR §1910.1030), and an explanation of its contents;

(2) a general explanation of the epidemiology and symptoms of blood borne diseases;

(3) an explanation of the modes of transmission of blood borne pathogens;

(4) an explanation of the facility's exposure control plan and the means by which the employee can obtain a copy of the written plan;

(5) an explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

(6) an explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

(7) information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment;

(8) an explanation of the basis for selection of personal protective equipment;

(9) information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

(10) information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(11) an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

(12) information on the post-exposure evaluation and follow-up that the facility is required to provide for the employee following an exposure incident;

(13) an explanation of the labels required in subparagraph (a) of this paragraph; and

(14) an opportunity for interactive questions and answers with the person conducting the training session.

5) Recordkeeping:

(a) Medical Records:

(i) Each facility shall establish and maintain an accurate record for each employee with an occupational exposure, which shall include:

(1) the name and social security number of the employee;

(2) a copy of the employee's hepatitis B vaccination status;

(3) a copy of the results of examinations, medical testing and follow-up procedures;

(4) the employer's copy of the healthcare professional's written opinion; and

(5) a copy of the information provided to the healthcare professional.

(ii) The facility shall ensure that employee medical records are kept confidential, and are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by state or federal law[4];

(iii) The facility shall maintain the records required for at least the duration of employment, plus 30 years.

(iv) Copies of such medical records shall be provided upon request for examination and copying by the subject employee, or anyone having his or her written consent.

(b) Training Records: Training records shall include the following information and be maintained for 3 years from the date on which the training occurred

(i) date of training session;

(ii) content or a summary of the training provided;

(iii) names and qualifications of persons conducting the training; and

(iv) names and job titles of all persons attending the training.

(c) Availability: Each facility shall ensure that all records required to be maintained in this policy directive shall be made available upon request to the Occupational Health and Safety Administration of the US Department of Labor.

[4] For purposes of this policy directive, these medical records are considered "employee records" and are not otherwise considered "clinical records" for purposes of the HIPAA Privacy regulations. Nonetheless, protected health information found in these records must be appropriately safeguarded consistent with other sensitive employee information.

(d) Sharps Injury Log: Each facility shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. This information shall be collected and maintained in such a manner as to protect the confidentiality of the injured employee. The sharps log should contain, at a minimum:

(i) type and brand of device involved in the incident;

(ii) ward/work area where the exposure incident occurred; and

(iii) an explanation of how the incident occurred.

6) Management of Employee Occupational Exposure

a) The immediate management of the exposure incident includes thorough washing of the site. The injured employee should be seen without cost to the employee, by a medical practitioner preferably within one hour of the incident so that the risk of the infection might be evaluated and necessary medical attention provided. Disclosure of the HIV status of the source individual of the occupational exposure is permitted if:

i) an exposure incident report documenting the detail of the exposure, including witnesses to the incident, if any, is on record with supervisory staff; and

ii) a request for disclosure of the HIV status of the source is made to the medical care provider of the source by a medical officer designated by the facility or by the exposed person or by the medical care provider of the exposed person as soon as possible after the alleged exposure if a decision regarding the initiation or continuation of post-exposure prophylaxis is being considered; and

iii) the medical provider of the exposed person or the medical officer designated by the facility reviews, investigates and evaluates the incident and certifies that:

(1) the information is necessary for immediate decisions regarding the initiation or continuation of post-exposure prophylaxis for the exposed person; and

(2) the exposed person's status is either HIV negative or unknown and that if a person's status is unknown, the

person has consented to an HIV test; and

(3) if such a test result becomes known as positive prior to the receipt of the sources's HIV status, no disclosure of the source's HIV status will be made to the person; and

(4) documentation of the request is placed in the medical record of the exposed person; and

(5) the provider of services to the source or the medical officer designated by the facility determines that a risk of transmission has occurred or is likely to have occurred in the reasonable exercise of his/her professional judgment. The provider or medical officer may release the HIV status of the source, if known. The provider or medical officer may consult with the municipal health commissioner or district health officer to determine whether a risk of transmission exists. If consultation occurs, both the provider and the local health officer must be in agreement if the HIV information is to be disclosed. In the disclosure process the name of the source shall not be provided to the exposed person. Redisclosure of the HIV status of the source is prohibited except when made in conformance with Public Health Law Article 21, Title III.

Recent studies have shown that post-exposure anti-retroviral prophylaxis may reduce the risk of HIV transmission due to occupational exposure. As a result of the changes in the CDC guidelines, the clinical management of occupational HIV exposure has become more complex and requires careful evaluation and occasional consultation to determine the best course of action. The key step in obtaining appropriate care is prompt evaluation. When indicated, anti-retroviral prophylaxis should be initiated within two hours post-exposure. In the event of an exposure the Infection Control Nurse must be notified as soon as possible.

b) Risk of Transmission

Occupational transmission of HIV by percutaneous exposure to known HIV infected blood is low. Transmission of HIV occurs in only 0.3% of reported cases. Risk of occupational transmission of HIV is increased in

circumstances where:

i) exposure involves a deep injury;

ii) there was visible blood on the instrument causing the injury;

iii) the device causing the injury had been placed in the source patient's vein or artery; or

iv) the source patient had a high viral titer of HIV.

Post-exposure prophylaxis is effective in preventing HIV infection. Retrospective studies of the effectiveness of AZT (also referred to as ZDV or zidovudine) in cases of significant occupational exposure to HIV show a reduction in the rate of viral transmission by nearly 80%. Therefore, post-exposure prophylaxis is recommended in cases where there is a significant occupational exposure to HIV.

If the exposed employee is pregnant, she should consult her obstetrician about the advisability of taking antiviral drugs. In this circumstance, the risk of transmission of HIV to the employee must be considered in light of the potential harm to the unborn child. As with other difficult post-exposure prophylaxis issues, consultation with a clinical expert in AIDS care is recommended.

c) Initiation of Prophylaxis

Post-exposure prophylaxis should begin as soon as possible. Recommendations for the implementation of prophylaxis indicate that treatment should ideally begin within 1 to 2 hours after exposure. It is therefore required that all facilities have a standard prophylaxis kit available on site for immediate administration should the need arise. This kit should include, at least 48 hours of the appropriate medications on site. In addition, each facility should ensure that there is local access to 24 hour availability of drugs and post-exposure counseling. This might include 24 hour access to a local infectious disease specialist or an inter-facility memorandum of agreement with a local hospital.

d) Payment for Post-Exposure Prophylaxis

Health care workers who are exposed to blood borne pathogens in the course of their employment at an OMH facility are not expected to pay out of pocket for post-exposure prophylaxis. The cost for any employee

receiving post-exposure prophylaxis will be paid through appropriate state funding sources.

e) Follow-Up Care

For cases of occupational exposure to blood borne pathogens, the employee should receive follow-up care. Follow-up care for HIV exposure should include: post-exposure counseling; medical evaluation; HIV antibody tests at baseline, 6 weeks, 12 weeks and 6 months; and counseling to avoid secondary transmission. Expert follow-up should be arranged. **Each facility must arrange a referral agreement with an area primary care facility that would be available to the employee if he/she so desires.** The facility must ensure that there is a local pharmacy that will supply appropriate medications for follow-up care. Make sure that all blood drawn at the facility and sent for HIV antibody testing as a result of occupational exposure is labeled in a manner consistent with OSHA guidelines and infection control policies. OSHA guidelines require that all post-exposure samples be saved for at least 90 days.

7) Resources for Consultation:

The AIDS Institute's Infection Control Program can be contacted between 8:30 AM and 5:00PM Monday through Friday for consultation and referrals by phoning (518) 474-2914 or (212) 613-2428. During weekends and non-working hours the NYSDOH operator will put callers in touch with a duty officer who can refer the caller to an appropriate resource in his/her geographic area. The number is (518) 465-9720. These numbers should be prominently posted for all staff.

APPENDIX A

EFFICACY OF POST EXPOSURE PROPHYLAXIS IN HEPATITIS B

A regimen combining Hepatitis B immunoglobin (HBIG) and the initiation of the HBV vaccine series is eighty-five to ninety-five per cent effective in preventing HBV infection, based upon mother to infant transmission studies. HBV vaccine has been found to be safe when administered to infant children and adults after administration to one hundred million people in the USA.

EFFICACY OF POST EXPOSURE PROPHYLAXIS TO H.I.V

Seroconversion is infrequent following an occupational exposure to HIV infected blood. Antiretroviral ZDV(AZT) when administered to pregnant mothers and to the infant after delivery reduced transmission by sixty-seven per cent. They have been twenty-one reported cases of PEP failure to prevent HIV infection. The current antiretroviral regimen is largely empiric. The recommendation for two or three PEP regimens is based on the level of risk for HIV transmission represented by the exposure.

Side effects associated with NRTIs (nucleoside reverse transcriptase inhibitors) are chiefly gastrointestinal (e.g. nausea, diarrhea).

PIs (Protease inhibitors) are associated with new onset Diabetes Mellitus, Diabetic Keto-acidosis and dyslipid anemias.

NNRTIs (Non nucleoside reverse transcriptase inhibitors) are associated with the Steven-Johnson syndrome, toxic epidermal necrolysis skin reaction, hepatotoxity and fatal hepatic necrosis.

All of the above groups of drugs have been associated with significant drug interactions and must be evaluated independently, Fifty per cent of PEP recipients have experienced adverse symptoms and thirty - three per cent stopped before the end of the four week course.

EFFICACY OF POST EXPOSURE PROPHYLAXIS TO HCV.

Immune globulin and antiviral agent are not recommended as PEP for HCV infection exposure at this time. No guidelines exist for administration of therapy during the acute phase of HCV infection. Limited data indicate that the combination of Interferon and Ribavirin might be beneficial. When HCV infection is identified early, the person should be referred for Medical Management to a Specialist.

APPENDIX B

HIV CLINICAL EDUCATION CENTERS FOR CONSULTATION
ON ANTIRETROVIRAL PROPHYLAXIS FOR OCCUPATIONAL EXPOSURE TO HIV

Metropolitan New York City Area:

Bronx:

Bronx Lebanon Hospital C enter
HIV AIDS Clinical Education & Training Program
(718)901-8538 (8am – 5pm)
(718)590-1800 (after hours)
Ask for Infectious Disease consult on call
Contact: Susan Young, MS

Brooklyn:

SUNY Downstate Medical Center
HIV Clinical Education Initiative Line
(917)763-1815
24 hour PEP consultation:
For Adults –
(178)270-2121(all hours)
Ask for STAR Clinician on call
For Pediatrics –
(800)921-5617 (all hours) Beeper
Ask for Pediatric Infectious Disease physician on call
Contact : David Odegaard, MPH

Manhattan:

St. Vincent's Catholic Medical Center
St. Vincent's Manhattan
CEI Line:
(212)647-6400 24 hour PEP consultation
For Adults – (212)604-2980
(212)604-8006 (ER) (after Hours)
For Pediatrics –
(212)604-1545 (pediatric ER) work hours
(212)604-8052 (after hours)

Contact: Max Vaval

Long Island

Nassau University Medical Center
AIDS Program
(516)572-5211 (all hours)
Contact: Kathy VanSteen

Queens

NY Hospital Queens
(718)670-1231 (all hours)
Press "0" for an operator and ask for Infectious Disease physician on call
Contact Christine Williams, RN, MPH

Upstate New York Area

Albany

Albany Medical College
Division of HIV Medicine
For Adults –
(518)262-4043 (M-F, 8am-4pm)
(After hours emergency, ask for the AIDS Treatment Center doctor on call)
Contact : Abigail Gallucci
For Pediatrics –
Division of Pediatrics
(518)262-6888 (M-F, 8:30a – 4:30pm)
All other hours ask for pediatric infectious disease physician on call
Contact Mary Ellen Adams

Buffalo

Erie County Medical Center
AIDS Center
(716)898-4119 (M-F, 8:30am – 4:30pm)
(716)898-4167 (ER) all other hours
Ask for Infectious Disease physician on call
Contact: Mary Goodspeed

Glens Falls & North Country

Upper Hudson Primary Care Consortium
(518)748-0162 (beeper all hours)
Contact: Mary Anne Brown, RN

Mid-Hudson

Westchester Medical Center
AIDS Care Center
For Adults –
(914)450-3016 (all hours)
For Pediatrics –
(914)493-8333 (M-F 9am-5pm)
(914)493-7307(all other hours)
Ask for pediatric infectious disease physician on call
Contact: Richard Birchard,MS

Rochester

University of Rochester/Strong Memorial Hospital
For Adults –
AIDS Center
(585)273-8418 ask for ID Team II
Contact Thomas Della Porta, MS
For Pediatrics –
(585)275-5944 (8am – 4pm)
(585)275-2222 (all other hours)
Ask for Pediatric Infectious Disease Physician on call
Contact: Geoffrey Weinberg, MD

Syracuse

SUNY Upstate Medical University, Syracuse
Department of Medicine
For Adults –
(315)464-5533 (M-F, 8:30am – 4pm)
(315)464-5540 (all other hours)
Ask for Infectious Disease physician on call
For Pediatrics
(315)464-6331 (m-F, 8:30am – 4pm)
(315)701-7190 (After hours)

Ask for Pediatric Infectious Disease physician on call
Contact: Lyn Stevens, NP