SECTION SEVEN – INSTITUTIONAL POLICIES RELATIVE TO GME PROGRAMS

POLICY NO: 7. 6
SUBJECT: EMPLOYEE HEALTH SERVICE PROCEDURES AND GUIDELINES

I. PURPOSE

To provide management guidelines for Infection Control of healthcare personnel.

II. RESPONSIBILITY/REQUIREMENTS

A. Employees injured or exposed to contagious diseases while on duty will complete an incident report, obtain supervisor's signature and be immediately referred to the Health Service Department or the Emergency Room, as applicable, in accordance with SPUH Policy 6.9 (Workers' Compensation).

B. The Health Service Department or the Emergency Room will render preliminary diagnosis, treatment, care and, when necessary, refer employees to the proper medical specialist for follow-up.

C. The Health Service or Emergency Room physician is responsible for determining direct contact and proper prophylactic treatment to be administered to an employee exposed to a contagious disease while on hospital duty.

Needlestick, Mucous Membrane, or Nonintact Skin Exposures to Blood or Body Fluids

1. Wounds and skin sites that have been in contact with blood or body fluids should be washed with soap and water; mucous membranes should be flushed with water.
2. Any employee who experiences an accidental puncture with a contaminated needle or blade should be given a booster of tetanus and diphtheria toxoids (for adult use - Td 0.50 cc) if one has not been given in the past 10 years. If there is no history of tetanus toxoid immunization, a prophylactic dose of human tetanus antitoxin (HYPER-TET) is recommended as is completion of the primary tetanus toxoid series. The postexposure protocol will also be instituted.
3. If an employee experiences a contaminated needlestick, mucous membrane or non-intact skin exposure to blood or body fluids, the source patient will be informed and written consent obtained by the patient's attending physician for HIV, HBV and Hepatitis C screenings.
4. If the source patient is an HIV infected individual, then the following information, if available, would be helpful in determining the appropriate post exposure prophylaxis (PEP) regimen:
   a. history of antiretroviral therapy
   b. Viral load
   c. stage of disease
5. The source patient is not to be charged for laboratory tests. (Credit for charges can be arranged by notifying the laboratory manager of the patient's name, hospital number and tests to be credited.)
6. If the patient refuses these screening tests, then as much appropriate history as possible should be obtained from the attending physician (i.e. - any history of hepatitis C history of drug use, multiple blood transfusions, high risk behavior, etc).
7. The employee will be screened for HBV, HIV, and hepatitis C after counseling regarding HIV transmission, false or misleading test results for HIV and hepatitis C, and the "window phase", phenomenon and informed consent is obtained.

8. Hepatitis C Ab follow-up serology on the employee will also be obtained at 6 months post exposure.
9. The employee's LFT's should be checked at baseline and 6 months post exposure.
10. There is currently no post exposure prophylaxis for Hepatitis C.
11. If the patient is HIV+ or HIV status is unknown, HIV testing of the employee will be repeated at 6 weeks, 3 months and 6 months post exposure.
12. The employee is advised to report any acute or febrile illness that may occur over the following 12 weeks to the Health Service Department. (See PEP protocol) Section II SPUH Infection Control Manual.
13. If the employee has been exposed to HBV and is not immune, HBIG (0.06 cc/kg IM) will be given as soon as possible, preferably within 48 hours of the exposure and not more than 7 days post exposure. Vaccination should be initiated at the same time.
14. If the employee is a known nonresponder to the vaccine or refuses the vaccine, a second dose of HBIG will be repeated one month post exposure.
15. Hepatitis B vaccine is offered to all high-risk employees and is recommended to be given in conjunction with post exposure prophylaxis if not already initiated.
16. A sharp injury log is maintained in Employee Health in accordance with the Needlestick Safety and Prevention Act, November 6, 2000.
17. Employee education and review of the circumstances of the incident are done by Employee Health.
18. Any employee refusing to comply with the procedure outlined will not be disciplined, as these measures are solely for the benefit of the employee.

Tuberculosis Exposure

Employees exposed to a non-isolated patient with active tuberculosis will be referred to the Employee Health Service Department by their immediate supervisor.

1. If the employee does not have a documented tuberculin test within the past three months post-exposure, a Mantoux test of 5 tu. PPD (0.1 cc) intradermally will be given immediately to establish a baseline. If negative, it will be repeated 12 weeks post exposure.
2. Mantoux tuberculin tests of 5 tu. PPD (0.1 cc) intradermally will be administered to all exposed, previously negative employees 10-12 weeks postexposure.
3. Employees known to have positive reactions are advised to watch for signs and symptoms of active TB infection i.e. night sweats, increased cough, loss of appetite, loss of weight, fatigue and/or hemoptysis. Please report these symptoms to the Health Service Department immediately.
4. Employees converting from a negative to positive reaction will have a chest X-ray and be followed-up in Employee Health Service for treatment.

Meningococcal Exposure

1. The Health Service physician will determine which individuals in the hospital have had intimate respiratory contact with the meningococcal disease patient and evaluate the duration and degree of contact: e.g., personnel administering mouth-to-mouth resuscitation should be strongly considered for antimicrobial prophylaxis.
2. The drug of choice is Ciprofloxicin 500 mgm po x one dose.
3. Antimicrobial prophylaxis is not indicated for hospital personnel having less than intimate contact: e.g., those providing routine patient care, those cleaning patient's room or exposed to lab specimens.
4. Treatment of these casual contacts may facilitate the emergence of resistant organisms, may unnecessarily expose contacts to drug side effects, and may create a false sense of risk in these persons that does not appear justified by available data.

5. Nasopharyngeal cultures of exposed employees are not necessary, providing prophylaxis with Ciprofloxicin is given to those identified as intimate contacts.
6. Microbiologic surveillance of hospital personnel should not be practiced except as part of an epidemic investigation or special epidemiologic studies: antimicrobial therapy or removal from patient care activities of an asymptomatic employee carrier of meningococci is not necessary or practical (meningococcal carriage in a non-epidemic period equals 4-11%).

Acute Diarrheal Illness

1. Personnel with an acute diarrheal illness that is severe, is accompanied by other symptoms (such as fever, abdominal cramps or bloody stools), or persists more than 24 hours, should be excluded from direct patient contact pending evaluation.
2. Whenever appropriate, specific treatment for documented infection with enteric pathogens should be made available to infected personnel.
3. Personnel with non-typhoidal salmonella enteric infections should be excluded from the direct care of high-risk patients and food-handling responsibilities until stool cultures are salmonella-free on two consecutive specimens collected not less than 24 hours apart.
4. Personnel infected with enteric pathogens other than salmonella may return to work after symptoms resolve.
5. These persons shall be individually counseled before return to work regarding the importance of hand washing.

Herpes Simplex Infections

1. Personnel with primary or recurrent orifacial herpes simplex infections should not take care of high-risk patients, for example, newborns, patients with burns or severely immunocompromised patients until the lesions are healed.
2. Personnel with herpes simplex infections of the fingers or hands (herpetic whitlow) should not have direct contact with patients until lesions are healed.

Active Infections

1. Any employee with a PICC line, Mediport, or receiving IV antibiotics must be evaluated by the Employee Heath physician for ability to work status. Each case will be evaluated based on job description and communicability to patients and other employees.

Staphylococcal Infections (Staph aureus coagulase +)

1. Any employee who develops a boil, ulcer, sty, conjunctivitis or infected ear, cut, wound, etc., must notify his/her supervisor.
2. The infected employee must be examined and cleared by the employee health physician prior to commencing duties.
3. If the physician feels the infected employee is hazardous to patient and other employees, the employee will be sent off duty until the infection is resolved.

Hepatitis B Vaccine

1. The ACIP (Immunization Practices Advisory Committee) recommends the administration of the vaccine to persons at substantial risk of HBV infection.
2. Hepatitis B vaccine is offered to all employees and is especially recommended to those who work in areas where there is significant exposure to blood products.
3. All employees are eligible to receive the vaccine free of charge.
4. "Recombivax HB" (Merck & Co, Inc.) is a noninfectious sub-unit viral vaccine derived from Hepatitis B surface antigen produced in yeast cells. The vaccine confers immunity to over 90% of healthy recipients.

A. Adverse Reactions

1. The vaccine is generally well tolerated. "No serious adverse reactions attributable to the vaccine have been reported during the course of clinical trials. No serious hypersensitivity reactions have been reported. No adverse experiences were reported during clinical trials which could be related to changes in the titers of antibodies to yeast. As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials."[1]
2. Injection site reaction was the most common complaint as reported by 17% of the recipients.

B. Eligibility

1. All employees are eligible for the vaccine.

C. Administration

1. The immunization regimen consists of three doses of vaccine intramuscularly - deltoid site.
   - First dose, 1.0 ml IM on elected date
   - Second dose, 1.0 ml IM one month later
   - Third dose, 1.0 ml IM six months after first dose.
2. The vaccine will be administered by the Health Services Department. Consent will be obtained and records will be retained in the employee's health file.
3. Employees are asked to have a Hepatitis B titer 4-6 weeks after immunization is completed.
4. All employees who have not been vaccinated with Hepatitis B must have a signed declination on their Employee Health record as mandated by OSHA.

Mantoux Tuberculin Tests

1. New employees shall be given a Mantoux tuberculin test with 5tu of PPD upon employment, unless the applicant has a history of a positive reaction. If negative, a second Mantoux of the same dosage will be given one week to one month after the first.
2. If the reaction is negative, the test shall be repeated annually for as long as the test remains negative and the employee is assigned to areas where he/she is providing direct patient care.
3. If the test is shows 5 mm or greater of induration, the employee shall be advised and will be required to have a chest X-ray. Further management depends on CXR results (See EHS Policy Manual).
4. If the employee is diagnosed as having active tuberculosis, he/she will not be permitted to work until it is medically documented that the employee is non-contagious.

Influenza Immunization

1. Influenza immunization programs take place as the situation warrants and according to the recommendation of ACIP (Immunization Practices Advisory Committee), the program is usually conducted during the month of October.

Rubella and Rubeola

1. New employees will be asked to bring in immunization records at the time of their pre-employment physical. New employees who do not have documentation of

immunity to rubella and rubeola will be offered vaccination or titers to check for immunity.

2. Employees who are seronegative will be notified and referred to Employee Health Service for vaccination.
3. A log of seronegative employees will be kept in the Health Service Department as well as in a departmental susceptible file.

Varicella

1. New employees who do not have evidence of immunity to varicella (either documentation of vaccination, titer that demonstrates immunity or a reliable history of disease) will be offered vaccination.
2. The Varicella vaccine is available to all employees at no cost. Varicella vaccine requires two doses (elected date and one month later).

Employee Exposure to Communicable Disease

1. All employees exposed to any communicable diseases while working or at home, with no immune status, will be asked not to report for duty during their communicable period. This period varies depending on the communicable disease. Employees will be directed by EHS/Infection Control Department as indicated.
2. Personnel who are absent from work because of any reportable communicable disease, infection, or exposure to infection as defined in N.J.A.C. 8:57, shall be excluded from working in the hospital until they have been examined by a physician and certified by the physician as no longer endangering the health of patients or employees.

Employee Physical Examinations

1. Pre-placement physical examinations will consist of but not necessarily be limited to the following:
    a. Laboratory studies to include: Rubella screening, rubeola and varicella titer and other tests as indicated.
    b. Mantoux tuberculin test (2-step approach, as previously described)
    c. Chest X-ray if clinically indicated
    d. Stool culture for those with a history of typhoid fever
    e. Physical examination (color blindness examination for the following areas: Lab, ED, Peds, Women's Clinic - NST, PECU)
    f. Infection check for Food Service Employees only.
    g. Fit testing for N95 Particulate respirators, if appropriate.

Medical Surveillance Questionaire

1. A Medical Surveillance Questionnaire will be done annually on all employees exposed to hazardous substances. Any employee who experiences any adverse reaction will have a physical examination including blood work.

References: APIC Infection Control and Applied Epidemiology Principles and Practice, Missouri, Mopsby, 2000.
Centers for Disease Control and Prevention. Guideline for Infection Control in Health Care Personnel, AJIC, 1998; 26: 289-354.
CDC. Prevention of Varicella. MMWR July 12, 1996/Vol.45/No.RR 11, pp 1-36.
CDC. Immunization of Health-Care Workers. Recommendations of the Advisory Committee on Immunization Practices and the Hospital Infection Control

Practices Advisory Committee. MMWR December 26, 1997/Vol.46/BNo.RR 18, pp 1-42.
CDC Recommended Post Exposure Prophylaxis for Exposure to HBV. MMWR June 2001. pp 22.