

**CENTRAL OHIO TRAUMA SYSTEM
PRE-HOSPITAL COMMITTEE**

REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES

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INTRODUCTION

This document is intended to promote consistency among the Central Ohio prehospital and hospital community with regards to the treatment and follow-up of emergency medical services (EMS) personnel who incur an occupational exposure. Processes established between EMS agencies and private occupational health clinics---including a hospital employee health clinic that is contractually serving as an occupational health clinic for EMS exposure---are outside the purview of these guidelines.

EMS agencies shall maintain a designated and available Infection Control Officer (ICO) on staff at all times. Per National Fire Department Protection Agency (NFPA) standards, the ICO shall serve as the liaison between a health care facility and EMS Provider in cases of known or suspected infectious exposure (2005: NFPA 1581). Likewise, hospitals shall maintain personnel designated to work with exposed EMS providers. ICOs and designated hospital personnel need to be aware of these guidelines and their own organizational operating procedures related to post-exposure care. The Central Ohio Trauma System (COTS) shall maintain a list of EMS agencies' ICOs and hospitals' infection control practitioners (ICPs) by name for use by respective healthcare providers in the region.

These guidelines address three types of exposures: (I) *Blood or Body Fluid Exposures (B/BF)*, (II) *Airborne Exposures* and (III) *Other Exposures*.

EMS providers reduce the potential for acquiring infectious diseases from their patients by donning personal protective equipment (PPE) prior to delivering care. Gloves, masks, goggles and moisture-barrier gowns are warranted in cases of active bleeding or seepage of potentially infectious body fluids. Similarly EMS colleagues should always wear appropriate PPE (e.g. gloves, masks, goggles) when caring for patients who they suspect may have a respiratory infectious disease.

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

B/BF exposure is defined as:

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

B/BF exposure can occur from blood, semen, vaginal secretions, or spinal, synovial, pleural, peritoneal, pericardial or amniotic fluid (ORC §3701.24). Sputum, saliva, urine and stool are not sources of B/BF exposure unless they contain visible blood. Please refer to Section III (*Other Exposures*) of this document for these.

IMMEDIATE ACTIONS OF THE B/BF-EXPOSED EMS PROVIDER

- 1) Immediately irrigate the involved area.
 - Flush eyes with copious amounts of normal saline.
 - Wash skin vigorously with soap and water. If soap and water are not available, rinse area with other available solution such as normal saline or a water-based liquid. Waterless hand cleaners are *not* recommended for post-exposure gross decontamination (*Bio Basics Fact Sheet: Microbial and Toxin Decontamination & Spill Clean-up*, University of Minnesota: www.abc.umn.edu/chemicalDecontaminate.html).
- 2) Notify the ICO that the exposure occurred. Federal regulations dictate that “following report of an exposure, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up” (OSHA 29 CFR).
- 3) At the direction of the ICO, report to one of the following:
 - The occupational health program of the EMS provider’s agency (Note: processes established between EMS agencies and private occupational health clinics are outside the purview of these guidelines)
 - The destination emergency department of the source patient
 - Another local emergency department if the patient is not transported and there is no occupational health program available
- 4) EMS providers who choose to report to a hospital for their own testing and/or prophylaxis:
 - Shall notify the emergency department (ED) charge nurse upon arrival of the exposure and how it occurred
 - Shall be triaged without delay
 - Shall complete the regional *Request for Notification of Test Results* form
 - Will be required by hospital policy to register as an ED patient for their testing and/or prophylaxis
 - Should be aware that source patient testing and the EMS provider’s prophylaxis as medically warranted are considered priorities
- 5) In the event that the source patient is not transported by the exposed EMS provider (i.e. is transported by another EMS provider or Medflight), the exposed EMS provider or their ICO may call the ED charge nurse of the patient’s destination and notify them of the exposure to obtain baseline testing of the source patient. The written *Request for Notification of Test Results* form shall be faxed to the ED charge nurse as soon as possible by the EMS provider or their ICO.

TESTING THE SOURCE PATIENT

A blood sample is required to determine whether a patient has Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV). B/BF testing of a source patient includes the following (MMWR, 2001):

- HIV antibody
- HBV surface antigen (HBsAg)
- HCV antibody

If the source patient is TRANSPORTED to a hospital:

- 1) The emergency department obtains patient consent and the blood specimen for testing.
- 2) In the event that the patient refuses to or cannot give consent (i.e. due to an altered level of conscious), “a hospital’s infection control committee, nurse or physician” has the authority to obtain the HIV screening when there has been a significant exposure (ORC §3701.242). Determination of a “significant exposure” is made by the EMS provider’s ICO or EMS agency’s designee. Patient screening does not involve forcibly obtaining a blood sample.
- 3) Payment for source patient testing is determined between the EMS provider’s employer and the hospital.

If the source patient REFUSES TRANSPORT to a hospital:

- 1) If the patient refuses to give consent for blood sampling and refuses transport, the EMS provider follows up with his ICO. At this point it is a legal matter to obtain the source patient’s blood for testing (ORC §3701.247). Following a significant exposure in which the source patient refuses to provide a blood sample and refuses transport, the EMS provider should seek medical evaluation and counseling for him/herself (MMWR; Sept. 30, 2005). Guidelines for an “unknown source patient” apply here.
- 2) Oral swab testing is not intended for the prehospital environment (per OraQuick[®] manufacturer specifications).
- 3) Emergency departments/hospitals will not run source patient blood samples if the source patient is not a patient at their hospital.
- 4) The EMS provider may obtain patient consent in the field and draw the source blood sample if allowed by SOPs for the occupational health program to run the sample.

SOURCE PATIENT RESULTS

Hospital-run HIV test results should be available within an hour; HBV and HCV results may not be available for several days.

HIV results will be provided verbally as soon as possible by the ED charge nurse or ED physician to:

- The ICO at all times
- The exposed EMS provider if the EMS provider is still in the ED

- 1) If an EMS Provider and his/her ICO have not been notified of a source patient's HIV results within 90 minutes, the ICO should contact the ED Charge Nurse for results and to discuss prophylaxis if warranted.
- 2) Written notification of positive test results shall be provided by the hospital ICP to the EMS ICO within three days after oral notification (ORC §3701.248).
- 3) Confidentiality of the source patient and EMS provider information shall be maintained at all times. Only information pertaining to source patient results will be released to the ICO and an EMS provider who is still present in the ED as described above. The EMS ICO and the EMS Provider shall not disclose any medical information publicly about the source patient.

EMS PROVIDER BASELINE TESTING

- 1) Baseline testing of the EMS provider is the EMS provider's choice. EMS agencies should maintain signed statements of EMS providers who decline baseline testing at the time of an exposure.
- 2) In cases where the source patient tests positive, baseline testing of the EMS provider may be done at their provider of choice such as:
 - Private physician
 - Occupational health clinic
 - Emergency department. To have baseline testing done in the ED, the EMS provider must sign in as an ED patient.
- 3) For a significant exposure with an unknown source patient, the EMS provider should seek medical evaluation and counseling.
- 4) In cases where the source patient testing is negative but the EMS provider still wants baseline testing, the EMS provider is encouraged to follow up with their private physician or occupational health clinic.
- 5) Whether the source patient is positive or negative, baseline testing of the EMS provider is not a stat procedure. Baseline testing of the exposed EMS provider optimally occurs the next business day and should occur no later than seven days post-exposure [MMWR, 2001].
- 6) EMS provider baseline testing includes at minimum:
 - HIV antibody
 - Hepatitis B antibody (unless documented previously as positive)*
 - Hepatitis C virus antibody

*After receiving HepBAb results, the EMS provider may, at the employer's discretion, be sent for Hep B surface antigen testing.
- 7) EMS providers have the option of having their HIV sample drawn post-exposure but not immediately tested. (OSHA 29 CFR, Part 1910.1030) "If the employee consents to baseline blood collection but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible." EMS providers who choose this option for a personal baseline HIV screening shall first discuss it with their ICO.

PROPHYLAXIS FOR THE B/BF-EXPOSED EMS PROVIDER

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

- The source patient's HIV screen is positive
- The source patient has a documented history of HIV or HBV
- The source patient's blood sample is unavailable but there is a high index of suspicion because of a history of IV drug use, prostitution, unprotected male-with-male sex, or multiple sexual partners (refer to MMWR [June 29, 2001] for determining degree of risk)

Regarding HIV prophylaxis:

- 1) Decisions about chemoprophylaxis can be modified if additional information becomes available.
- 2) EMS providers must register as ED patients to receive HIV prophylaxis from the hospital.
- 3) HIV PEP should be started within hours of exposure (MMWR, September 30 2005).
- 4) Consideration should be given by the ED for expert consultation and guidance on HIV PEP (e.g. infectious disease physician, MMWR [September 30, 2005] or the National Clinicians' Post-Exposure Prophylaxis Hotline @ #888-448-4911).
- 3) The EMS provider shall receive an immediate referral for counseling by his agency's ICO, medical director or Fire Department physician. Further counseling should be made available through the EMS agency's employee assistance program (EAP) or by contractual agreements.

Regarding Hepatitis Prophylaxis:

- 1) HBIG and the Hep B vaccine are not typically given in the ED.
- 2) In cases of positive source HBV results, the EMS provider should follow up with his occupational health care provider for related prophylaxis as soon as possible and within seven days of exposure.
- 3) EMS providers who are known non-responders to the HBV vaccine should discuss HBIG prophylaxis with their health care provider or ICO.
- 4) There is no prophylaxis for HCV. In cases of positive source HCV results, the EMS provider should follow up with their occupational health care provider for medical evaluation and care.

II. RESPIRATORY EXPOSURE

Respiratory exposures:

- Are defined as contamination with an infectious agent through the respiratory tract
- Occur via one of two routes (CDC, *Rationale for Isolation Precautions In Hospitals*, 1996):
 1. Via airborne infectious agents with small-particle residue [5 µm or smaller] of evaporated droplets containing microorganisms that remain suspended in the air for long periods of time (example is tuberculosis, rubeola and varicella virus)

2. Via droplet infectious agents which are propelled a short distance (less than three feet) through the air by coughing or sneezing; these droplets are acted upon rapidly by gravity (examples are meningitis, pertussis and influenza)
- May not be immediately known by the EMS provider if the patient is not overtly symptomatic

IMMEDIATE ACTIONS OF THE AIRBORNE-EXPOSED EMS PROVIDER

- 1) Don PPE as soon as possible at the scene or en route if the patient is known to have a respiratory infection or is coughing or spraying secretions.
- 2) If secretions are splashed or coughed into the eyes or other mucous membranes, flush with copious amounts of normal saline as soon as possible.
- 3) The EMS provider who suspects a respiratory exposure should:
 - Notify the ICO that an exposure occurred
 - Notify the ED charge nurse of the exposure upon delivery of the patient
 - Shall complete the *Request for Notification of Test Results* form
 - Anticipate that typically no immediate treatment or prophylaxis is given

TESTING THE SOURCE PATIENT

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

SOURCE PATIENT RESULTS

- 1) The hospital ICP or designee will notify the EMS ICO of the infectious agent as soon as possible after symptoms of clinical presentation or within 48 hours of a positive infectious agent determination.
- 2) The ICO will assess the potential exposure of the EMS provider based on the interaction history with the source patient.
- 3) Confidentiality of source patient and the EMS provider information shall be maintained at all times. Only information pertaining to source patient results will be released to the ICO and an EMS provider who is still present in the ED as described above. The EMS ICO and the EMS Provider shall not disclose any medical information publicly about the source patient.

PROPHYLAXIS FOR THE AIRBORNE-EXPOSED EMS PROVIDER

- 1) Prophylaxis may be offered by the hospital, or the EMS provider may be referred to an occupational health care provider for prophylaxis and follow up.
- 2) Hospital policies require that the exposed EMS provider register as an ED patient for medical screening and prophylaxis to occur in the ED.

B/BF & AIRBORNE EXPOSURES BY CORONER'S CASES

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

IMMEDIATE ACTIONS OF THE B/BF-EXPOSED EMS PROVIDER

- 1) Decontaminate self as described in previous sections
- 2) Notify the ICO that the exposure occurred
- 3) At the direction of the ICO, seek treatment at an ED or occupational health clinic
- 4) Anticipate that prophylaxis is based on the index of suspicion

IMMEDIATE ACTIONS OF THE EMS ICO

The Coroner shall be notified as soon as possible by the ICO that an exposure has occurred.

TESTING THE SOURCE PATIENT

The Coroner shall make every effort to test a source patient by the next business day of being notified of the exposure. In some cases, the Coroner may elect to send a specimen to an outside lab for testing. *The EMS provider shall not wait for a Coroner's screen to seek medical evaluation.*

SOURCE PATIENT RESULTS

The Coroner or Deputy Coroner shall notify the EMS ICO of source patient test results as soon as possible. Oral notification of source HIV status (positive or negative) shall be provided to the EMS ICO within two days of test results, and written notification of positive test results shall be provided within three days after oral notification (ORC §3701.248).

OTHER EXPOSURES / EVENTS

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

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

In these instances, EMS providers shall notify their ICO. EMS providers and their ICOs may consult with their medical directors, hospital ICPs and/or their local public health agency to determine the most appropriate course of action.

REFERENCES/RESOURCES

Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion and Division of Viral Hepatitis. (2003). Exposure to blood: what healthcare personnel need to know.

Centers for Disease Control and Prevention, Hospital Infection Control Practices Advisory Committee. Guideline for Isolation Precautions in Hospitals. (1996). Part II. Recommendations for isolation precautions in hospitals: Rationale for isolation precautions in hospitals. www.cdc.gov/ncidod/dhqp/gl_isolation_ptII.html (as of 12/06).

Morbidity and Mortality Weekly Report (MMWR). (2005, Sept 30). Updated U.S. public health service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. 54(RR-9). Department of Health & Human Services, Centers for Disease Control & Prevention.

MMWR. (2001, June 29). Updated U.S. public health service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. 50(RR-11).

National Clinicians' Post-Exposure Prophylaxis Hotline (PEpline), National HIV/AIDS Clinicians' Consultation Center. www.ucsf.edu/hivcntr/ (as of 12/06). San Francisco, CA.

National Fire Department Protection Agency (NFPA). (2005). NFPA 1581 Standard on Fire Department Infection Control Program. Quincy, Massachusetts.

Ohio Department of Health Communicable Disease Chart. Bureau of Early Intervention Services, Ohio Department Health, and the Bureau of Child Care and Development, Ohio Department of Job & Family services: April 2006; #ODJFS 08087.

Ohio Revised Code, Sections:

- §3701.24: Report as to contagious or infectious diseases; AIDS and HIV
- §3701.241: AIDS and HIV related duties of director of health
- §3701.242: Informed consent to HIV test, counseling, anonymous testing
- §3701.243: Disclosure of HIV test results or diagnosis
- §3701.247: Action for order compelling HIV testing
- §3701.248: Exposed emergency medical or funeral services worker may request notice of test results
- §4167.28: Employer's duties concerning exposure incidents; variances
- §4123.026: Costs of medical diagnostic services after peace officer, Fire Department fire fighter, or emergency medical worker's exposure to blood or other body fluid

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

Ohio Bureau of Workers Compensation, Billing and Reimbursement Manual (2006). Chapter 3, Exposure or contact with blood or other potentially infectious materials with or without physical injury. 79-84. www.ohiobwc.com/provider/services/brmdefault.asp (12/06).

OraQuick® Rapid HIV-1 Antibody Test. (2003). Specification item #3001-0951. OraSure Technologies, Inc. Bethlehem, PA.

Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Revised 1996. 104th Congress. Public Law 104-146.

EMS Infectious Exposure Incident Report

(Inclusive of ORC 4167.28)

The following shall be documented by the EMS Provider after potentially infectious exposure and kept on file per agency protocol and federal, state, and local regulations. Written documentation of the exposure shall be provided to the hospital receiving the source patient and from whom the medical screening is being requested. **PLEASE PRINT.**

Name / Identification Code of Affected EMS Provider _____

Last 4 digits of SSN _____ Home Phone (_____) _____

EMS Agency _____ Agency Phone (_____) _____

Job Classification: EMT-P EMT-I EMT-B Other: _____

EMS Agency Address: _____

Incident No. _____ Incident Date _____ Incident Time _____

Source Patient's Name _____

Patient Transported To _____ Transported By _____

Location Where Exposure Occurred _____

EMS Provider with Significant Blood and Body Fluid (B/BF) Exposure from:

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

Body Part(s) Involved _____

Body Fluid Involved:

- Blood
- Semen/Vaginal secretions
- Spinal/synovial/pleural/peritoneal/pericardial fluid
- Amniotic fluid
- Other with visible blood: _____
- Other without visible blood _____

If the needle involved was *not* engineered with a sharps injury protection component, check if any of the following apply.

- Sharps with injury protection components are not available to the exposed EMS Provider
- The EMS employer determined that use of a sharps with injury protection components during the procedure being performed at the time of the exposure jeopardized patient or worker safety
- Other: _____

By the exposed EMS provider's assessment, could a needle with a sharps injury protection component have prevented the exposure? Yes No

List Why or Why Not _____

EMS Provider Sought a Post-Exposure Medical Evaluation: Yes No

If "Yes," Where? _____ What Time? _____

Medical Screening Done at What Time? * _____ By Whom? _____

***REQUEST FOR NOTIFICATION OF THE INVOLVED EMS PROVIDER OF ANY TEST RESULTS IS IMPLIED IF SCREENING IS REQUESTED AND PERFORMED.**

If "No," Why Not? _____

EMS Supervisor Name _____ Phone # (____) _____

Contacted by EMS Provider on Date _____ Time _____

EMS Infection Control Officer (ICO) Name _____ Phone # (____) _____

Contacted by EMS Provider on Date _____ Time _____

EMS Provider Informed of Test Results on _____ By _____

Additional Information Received from _____ On Date _____

EMS Referral for Counseling Done by _____ On Date _____

ADDITIONAL COMMENTS:

EMS Provider's Signature _____ Date _____

EMS Infectious Exposure Incident Checklist for B/BF Exposure For EMS Providers and Hospitals

These checklists are intended to serve as guidelines in promoting expeditious, consistent, and prudent care of the EMS Provider who sustains a potentially infectious exposure while on-duty in the central Ohio community.

EMS PROCEDURE after Significant B/BF Exposure

- If the exposure involves non-intact skin, wash area with soap & water
- If the exposure involves eyes, irrigate with copious amounts of normal saline
- Report the exposure to ICO immediately
- Report to Occupational Health Clinic or Emergency Department (ED) if significant exposure determination is made by ICO. To have baseline testing done in the ED, the EMS provider must sign in as an ED patient.
- If to hospital, notify emergency department (ED) charge nurse of exposure
- Complete the regional *Request for Notification of Test Results* form
- Submit a written incident report (agency specific) to supervisor within 24 hours

HOSPITAL PROCEDURE after Significant B/BF Exposure

- Triage the EMS provider without delay.
- Obtain source patient consent for testing. If patient is unconscious or refuses, testing can be done under Ohio Revised Code Sec 3701.242.
- Obtain baseline serum HIVAb, HBsAg, & HCVAb screens of source patient
- Obtain EMS baseline testing per agency policy AND at the request of the EMS provider
- If source patient is known to be HIV positive or at high risk for HIV, initiate PEP of the EMS Provider per CDC recommendations

For both EMS and HOSPITALS after Significant B/BF Exposure

- Maintain confidentiality of the source patient and exposed EMS provider at all times.
- If there is not consensus regarding the significance of the exposure or the need for PEP between the exposed EMS provider, the ICO, ICP and/or the treating ED physician, consultation may be held in conjunction with the EMS Medical Director.
- For issues regarding these guidelines, contact the Central Ohio Trauma System (COTS) at (614) 240-7419 ext 6, the respective institution's representative to the COTS Prehospital Committee or nbechtel@goodhealthcolumbus.org.

SIGNATURES OF ENDORSEMENT OF REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES

Adena Regional Medical Center _____ / Date _____
Chillicothe, Ohio
Mark H. Shuter
President & Chief Executive Officer

Berger Health System _____ / Date _____
Circleville, Ohio
Larry Thornville
Chief Executive Officer

Nationwide Children's Hospital _____ / Date _____
Columbus, Ohio
Rick Miller
Chief Operating Officer

Central Ohio Fire Chiefs Association _____ / Date _____
Columbus, Ohio
Thomas S. Stewart, Jr., Fire Department Chief
President

Central Ohio Trauma System _____ / Date _____
Columbus, Ohio
Philip H. Cass, PhD
CEO

Coshocton County Memorial Hospital _____ / Date _____
Coshocton, Ohio
Gregory M. Nowak
Chief Executive Officer

Doctors Hospital _____ / Date _____
Columbus, Ohio
Mark Brazitis
President

Fairfield Medical Center _____ / Date _____
Lancaster, Ohio
Mina H. Ubbing
President & Chief Executive Officer

**Franklin County Fire
Chiefs Association**
Columbus, Ohio

_____ / Date _____
*L. James DeConnick, Fire Department Chief
President*

**Franklin County
Coroner's Office**
Columbus, Ohio

_____ / Date _____
*Bradley Lewis, MD
Franklin County Coroner*

**Genesis HealthCare
System**
Zanesville, Ohio

_____ / Date _____
*Thomas Sieber
President & Chief Executive Officer*

Grady Memorial Hospital
Delaware, Ohio

_____ / Date _____
*Steve Garlock
President*

Grant Medical Center
Columbus, Ohio

_____ / Date _____
*Karen H. Connors
Chief Operating Officer*

Knox Community Hospital
Mt. Vernon, Ohio

_____ / Date _____
*Bruce White
Chief Executive Officer*

Madison County Hospital
London, Ohio

_____ / Date _____
*Fred L. Kolb
President & Chief Executive Officer*

Marion General Hospital
Marion, Ohio

_____ / Date _____
*Ronald J. Bachman
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**Memorial Hospital of
Union County**
Marysville, Ohio

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*Olas A. Hubbs, III
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Morrow County Hospital _____ / Date _____
Mt. Gilead, Ohio
Diana Fisher
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Mount Carmel East _____ / Date _____
Columbus, Ohio
Paula Autry
Chief Operating Officer

Mount Carmel New Albany _____ / Date _____
Columbus, Ohio
Richard D'Enbeau
Chief Operating Officer

Mount Carmel St. Ann's _____ / Date _____
Westerville, Ohio
Janet Meeks
Chief Operating Officer

Mount Carmel West _____ / Date _____
Columbus, Ohio
Alan Papa
Chief Operating Officer

**The Ohio State University
Hospitals East** _____ / Date _____
Columbus, Ohio
Elizabeth Seely
Chief Executive Officer

**The Ohio State University
Medical Center** _____ / Date _____
Columbus, Ohio
Larry Anstine
Chief Executive Officer

Pike Community Hospital _____ / Date _____
Columbus, Ohio
Craig Solle
President & Chief Executive Officer

**Riverside Methodist
Hospital** _____ / Date _____
Columbus, Ohio
Bruce Hagen
President

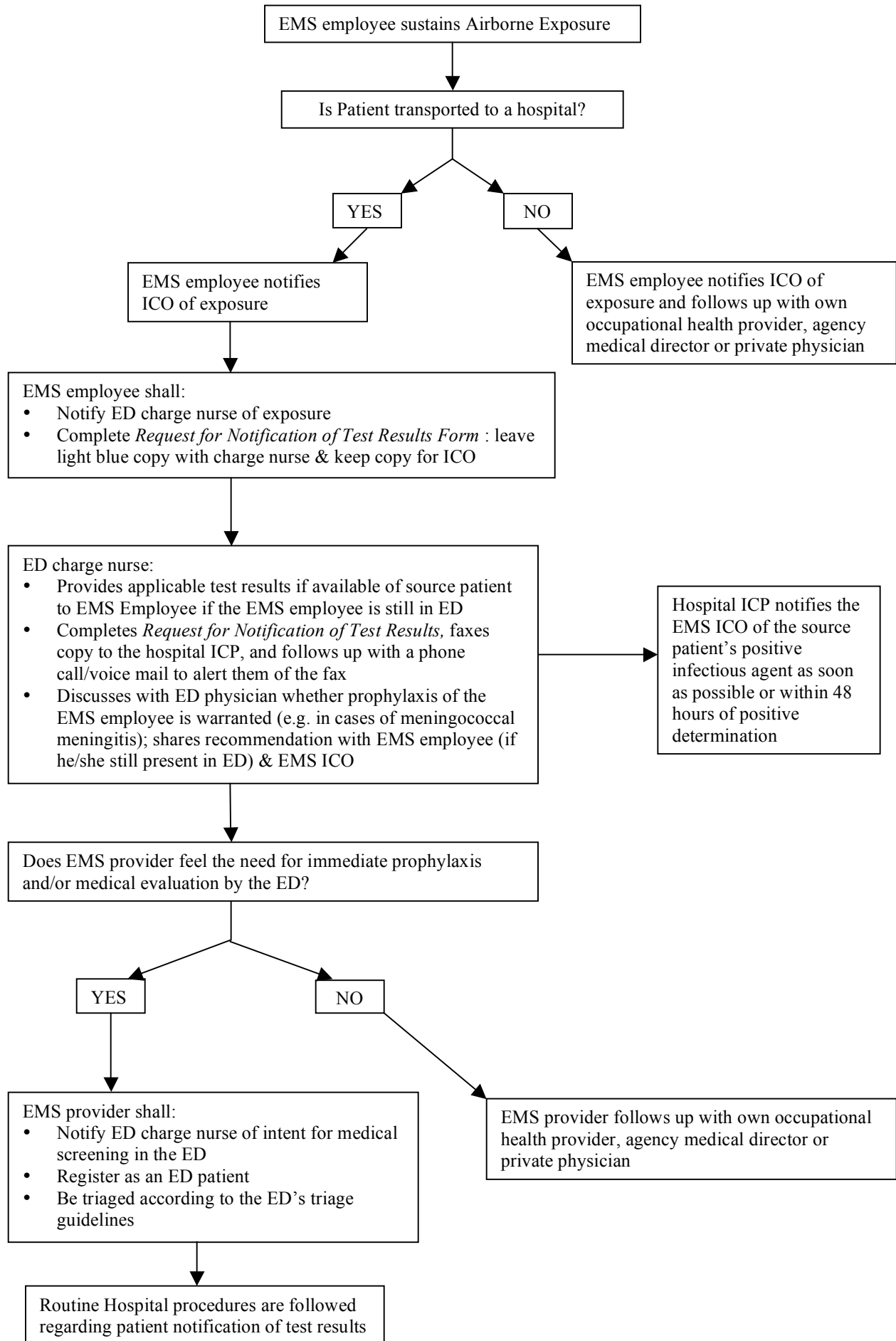
**Southeastern Ohio
Regional Medical Center**
Cambridge, Ohio

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Ray Chorey
President & Chief Executive Officer

**CENTRAL OHIO TRAUMA SYSTEM
REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES
ALGORITHM FOR
AIRBORNE EXPOSURE**

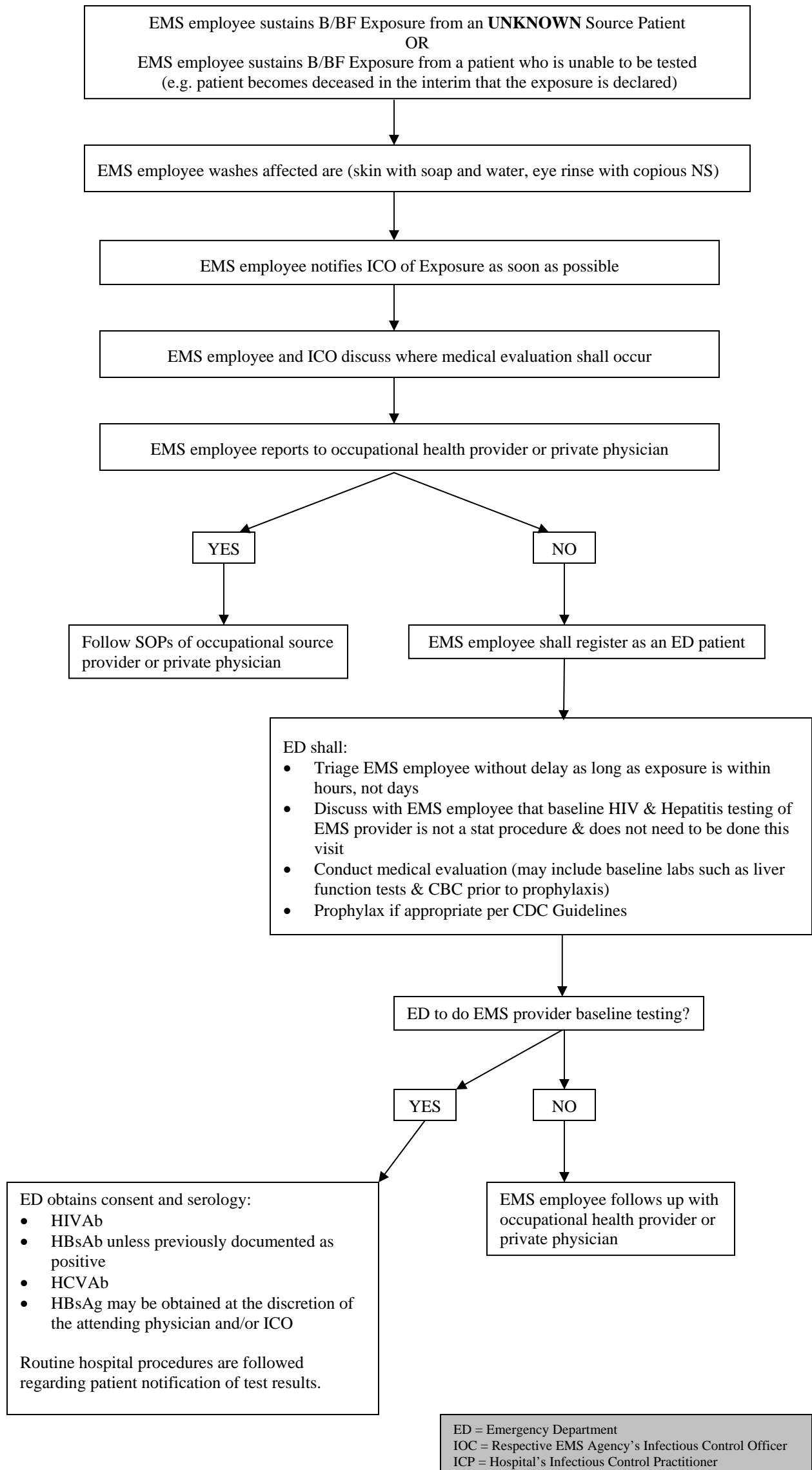
Note: If an airborne infectious agent is suspected based on the nature of the call:

- PPE includes donning a mask upon arrival to the scene (for SARS, an N-95 mask & face shield are recommended)
- EMS personnel should minimize the number of potential exposures to others (crowd control) if possible
- Patient should don a mask if possible



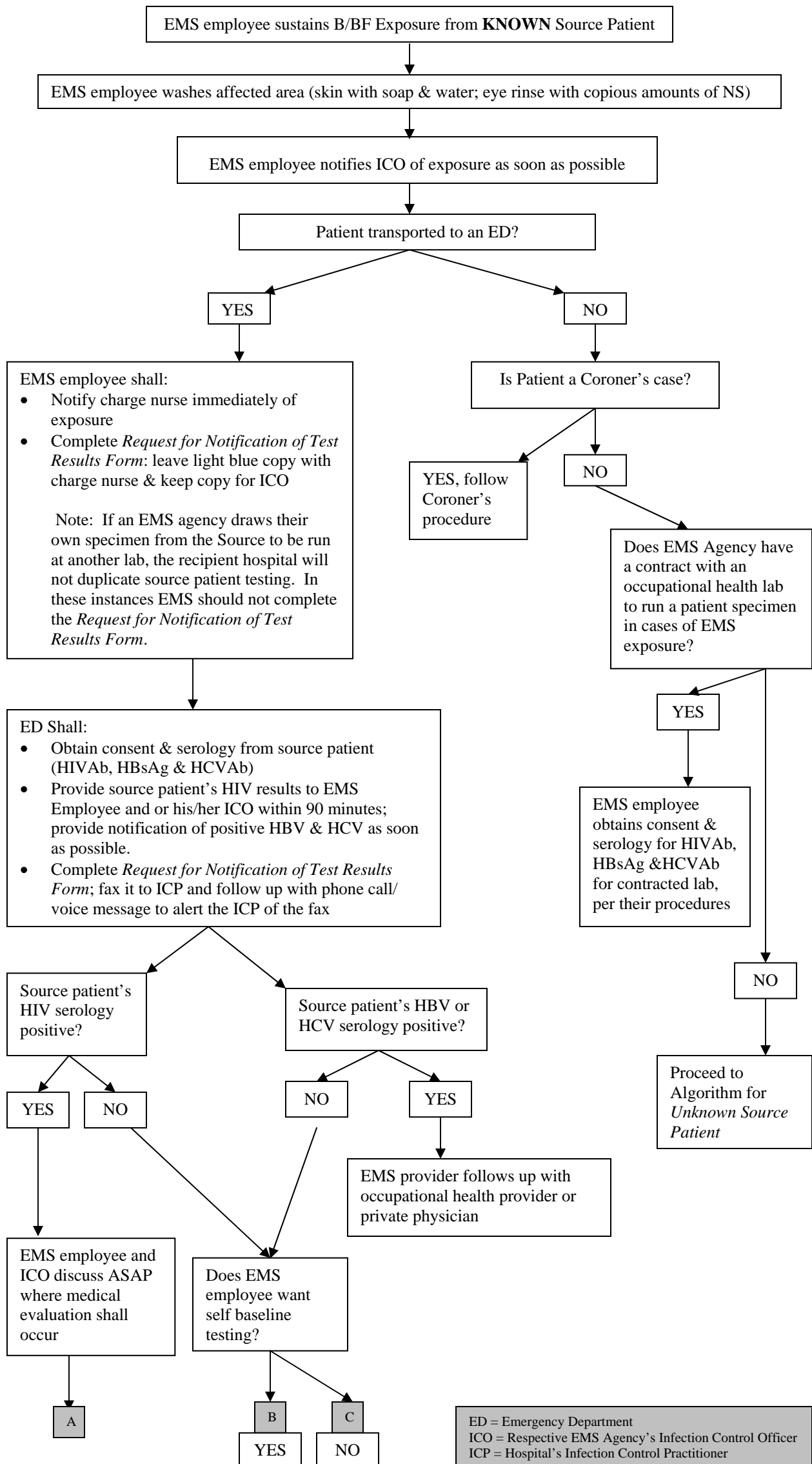
ED = Emergency Department
 ICO = Respective EMS Agency's Infection Control Officer
 ICP = Hospital's Infection Control Practitioner

**CENTRAL OHIO TRAUMA SYSTEM
 REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES
 ALGORITHM FOR
 B/BF EXPOSURE FROM AN UNKNOWN SOURCE PATIENT**

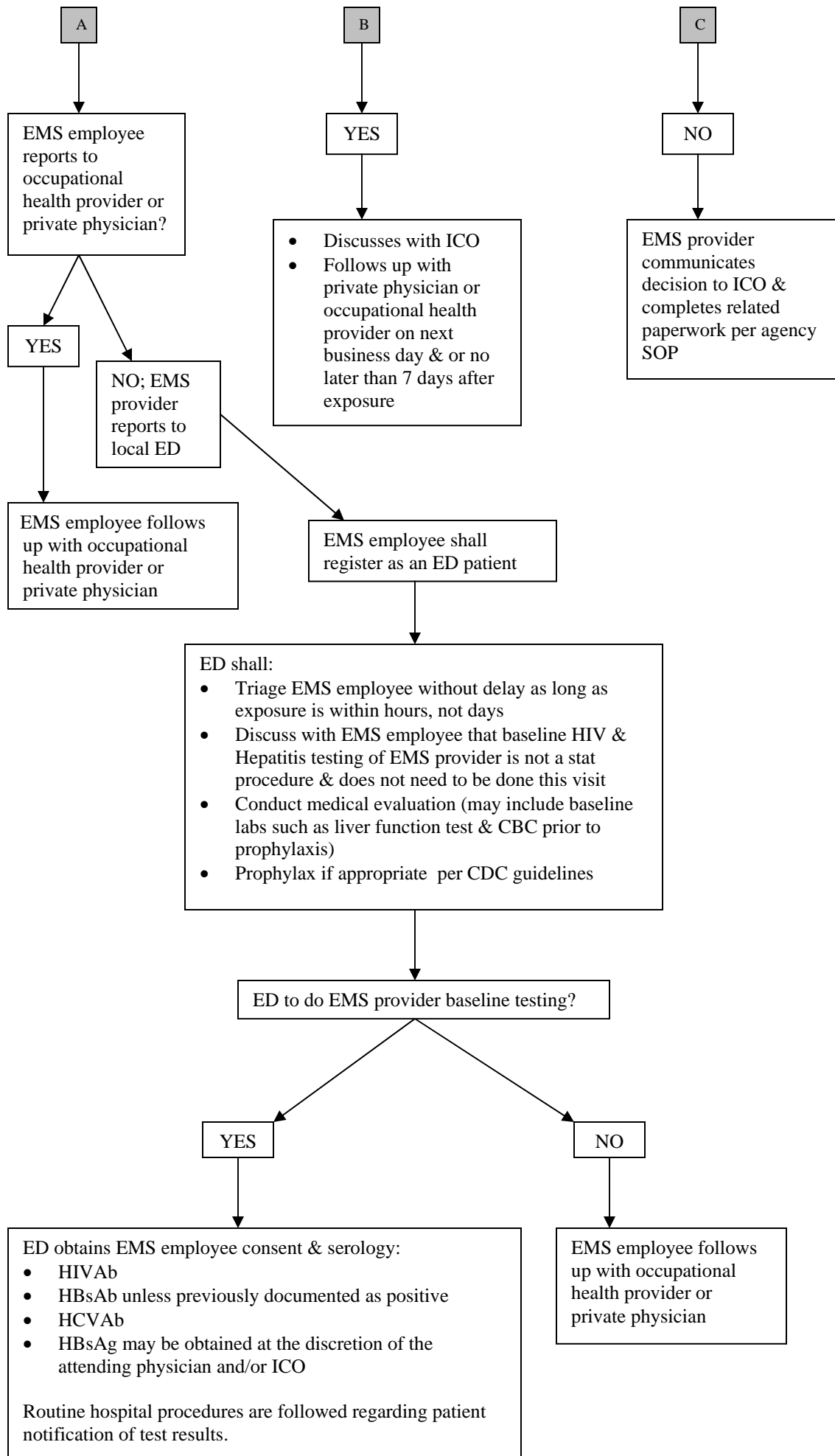


ED = Emergency Department
 IOC = Respective EMS Agency's Infectious Control Officer
 ICP = Hospital's Infectious Control Practitioner

**CENTRAL OHIO TRAUMA SYSTEM
REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES
ALGORITHM FOR
B/BF EXPOSURE FROM KNOWN SOURCE PATIENT**

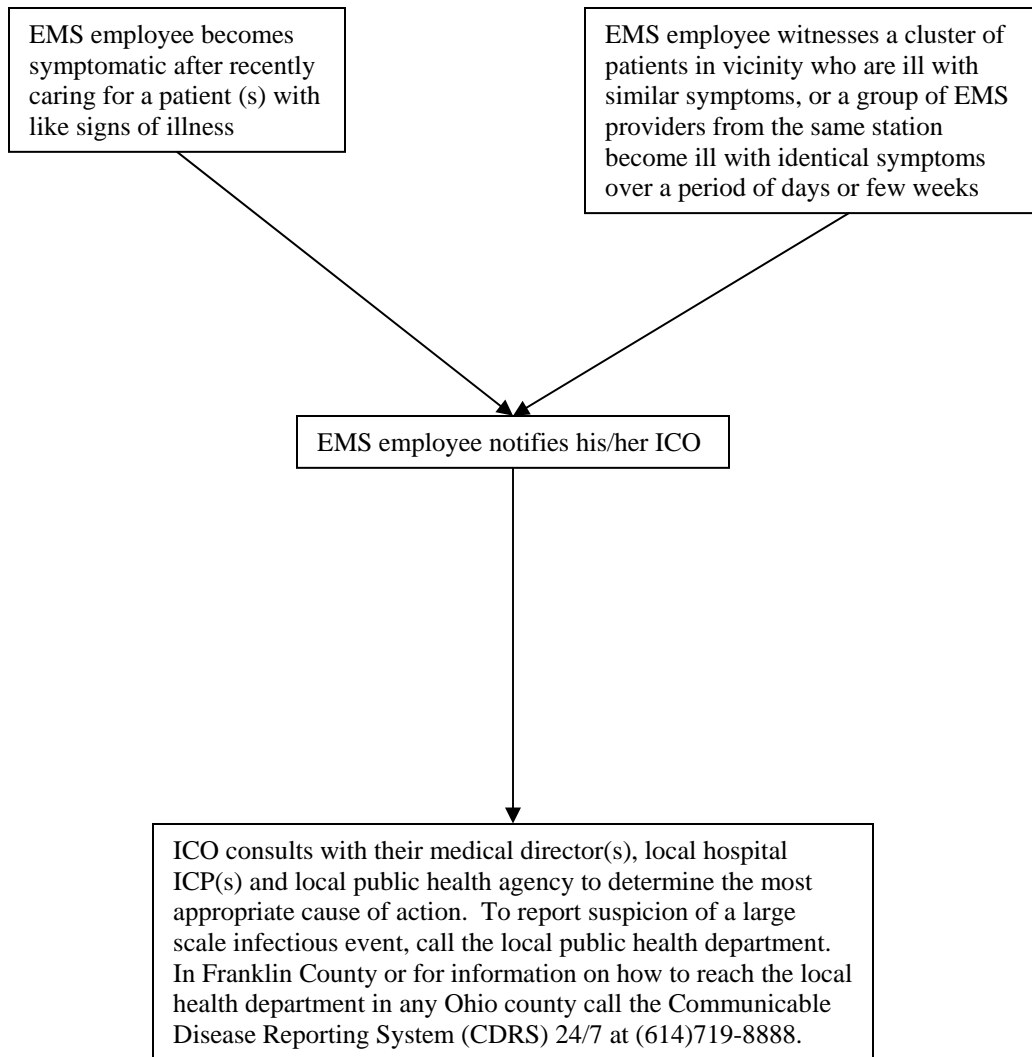


ED = Emergency Department
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ED = Emergency Department
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**CENTRAL OHIO TRAUMA SYSTEM
REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES
ALGORITHM FOR
SUSPECTED “OTHER” EXPOSURE**



ED = Emergency Department
ICO = Respective EMS Agency's Infection Control Officer
ICP = Hospital's Infection Control Practitioner



**CENTRAL OHIO TRAUMA SYSTEM
PRE-HOSPITAL COMMITTEE**

REGIONAL EMS INFECTIOUS EXPOSURE GUIDELINES

ADDENDUM FOR EXPOSED BYSTANDERS WHO CONTACT EMS

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

This addendum document to the Central Ohio Trauma System (COTS) *Regional EMS Infectious Exposure Guidelines* is intended to promote consistency among Central Ohio emergency medical service (EMS) providers for bystanders who call or present wanting follow up for a potential exposure.

ASSESSMENT. Bystanders who contact EMS shall be assessed via oral history and/or physical exam for the likelihood of an exposure. See guidelines for assessing exposures in the COTS *Regional EMS Infectious Exposure Guidelines*.

ACTIONS. If a bystander's exposure history is deemed credible:

- The bystander's exposed areas (i.e. mucous membranes/skin) should be washed immediately as described in the COTS *Regional EMS Infectious Exposure Guidelines* if prior decontamination has not occurred.
- The Bystander should be instructed to follow up with a primary care physician or urgent care for further assessment unless they are within the first few hours of exposure. If within the first few hours of exposure, EMS should encourage the bystander to seek medical evaluation in the emergency department that the source patient was transported to.
- If the bystander desires EMS transport to an area hospital emergency department for further care:
 - ♦ EMS shall transport per Agency protocol.
 - ♦ If possible, consideration should be given to transferring the bystander to the same hospital destination as the source patient.
 - ♦ EMS shall anticipate that the bystander will be assessed by emergency department personnel but that the bystander---now a patient---may be directed to the triage area upon arrival.
 - ♦ EMS is aware that HIPAA precludes disclosure of private information, and shall anticipate that the bystander may be considered as an exposure to an unknown patient by the receiving emergency department.

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

Approved by the COTS Prehospital Committee on November 17, 2009
Approved by the COTS Board of Trustees on December 1, 2009

[OWN EMS AGENCY NAME INSERTED HERE]

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

NOTE to EMS Agency: This TWO-SIDED form is to be printed by the EMS Agency on LIGHT BLUE PAPER to promote form recognition by hospital & EMS stakeholders in the region. TWO COPIES should be completed: one to be left in the emergency department and one to be retained by the EMS agency.

EXPOSED EMS EMPLOYEE INFORMATION: *This box is to be filled out by the exposed person.*
PLEASE PRINT.

EMS Employee Name	[REDACTED]	
EMS Employee Phone(s)	[REDACTED]	
EMS Employee Address	[REDACTED]	
Medic / Unit Number	[REDACTED]	or Incident Number [REDACTED]
Agency Address	[REDACTED]	
Agency Phone	[REDACTED]	Agency Fax [REDACTED]
ICO Name	[REDACTED]	ICO Phone Number [REDACTED]
Type of Exposure:	<input type="checkbox"/> Blood/Body Fluid	<input type="checkbox"/> Airborne <input type="checkbox"/> Other _____
Exposure Date	[REDACTED]	Time [REDACTED] Location [REDACTED]
Explain how exposure occurred	[REDACTED]	
Source Patient Name	[REDACTED]	DOB [REDACTED]
Other Info	[REDACTED]	
Exposed Provider Signature & Date	[REDACTED]	

ED Charge Nurse Signature Upon Receipt	Date	Hospital
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SOURCE PATIENT TEST RESULTS: *This box is to be filled out by the hospital staff person providing results to the EMS Employee/EMS Infection Control Officer.* PLEASE PRINT.

Name & Credentials of Person Providing Results:

Testing Results:

HIV _____ HepBsAG _____ HepCAb _____ Other _____

Source Patient Results provided to:

EMS Provider Name: _____

EMS Infection Control Office Name: _____

Signature & Date of Person Providing Results:

HOSPITAL EMERGENCY DEPARTMENT STAFF: Please FAX this form to your hospital's Infection Control Practitioner (ICP) at the number listed below. A phone call to your hospital ICP should accompany the fax so the ICP can be on the "lookout" for this form. Thank you.

Hospital Name	ICP Fax #	ICP Phone #
Children's Hospital	(614) 722-6337	(614) 722-4990
Doctors West Hospital	(614) 544-1749	(614) 544-2076
Grant Medical Center	(614) 566-8006	(614) 566-9127
Grady Memorial Hospital	(740) 368-5773	(740) 368-5229
Mount Carmel East	(614) 234-6589	(614) 234-6750
Mount Carmel St. Ann's	(614) 898-4168	(614) 898-4321
Mount Carmel West	(614) 234-2384	(614) 234-1313
The OSU East Hospital	(614) 293-8018	(614) 293-8146
The OSU Medical Center (Employee Health)	(614) 293-8018	(614) 293-8146
Riverside Methodist Hospital	(614) 566-5794	(614) 566-6685