

Occupational Exposures

December, 2014

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An occupational exposure is an exposure to human immunodeficiency virus (HIV) contaminated blood or body fluids, or concentrated virus in an occupational setting including health care, corrections and policing, sanitation workers and other workplaces. This involves any non-intact skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious material that may result from the performance of employees' duties.

For these guidelines, the following occupational groups have been identified:

- Regional Health Authority employees.
- Employees of other organizations – this may include civic, provincial or federal employees (sanitation workers, corrections workers, Royal Canadian Mounted Police, Health Canada employees working in facilities, or private industry).
- Self-Employed.

Assumption: An occupational exposure is where the source is the patient/client and the exposed is the care provider/worker.

The [Exposure Incident Report Form \(Appendix 3\)](#) should be completed by the attending physician/RN(NP) and submitted to the Regional Public Health Office. Public Health will redirect the Incident Report Form to the appropriate health department or jurisdiction responsible for follow-up for the client (for example, Employee Health Services for Health Region Staff or to First Nations and Inuit Health Branch/Northern Inter-Tribal Health Authority for First Nations clients living on reserve).

Step 1 – History of the Incident

Take a history of the incident – Complete [Exposure Incident Report Form \(Appendix 3\)](#) and refer to [Appendix 15 – Collection Use and Disclosure of Information](#). Determine the time elapsed since the exposure. Human immunodeficiency virus post-exposure prophylaxis (PEP) is most beneficial if started within 2 hours. If the exposure occurred greater than 72 hours from presentation, HIV PEP is not recommended.

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Step 2 – Risk Assessment – Refer to [Section 2 – Risk Assessment](#).

- a. Exposure Fluid.
- b. Type of Exposure.
- c. Source Assessment – a tool for completing a risk assessment is included in [Appendix 14 – Source Patient Risk Assessment](#). Refer to [Appendix 15 – Collection Use and Disclosure of Information](#) and [Appendix 16 – Consent for Source Patient Testing Following a Blood/Body Fluid Exposure](#).

Step 3 – Classify the level of risk for HIV – Refer to [Section 2 – Risk Assessment](#).

- High-risk.
Low-risk.

Step 4 – Management of Exposure

- a. Wound/exposure site management.
- b. Tetanus vaccination or tetanus immune globulin should be provided based on the assessment of the injury and immunization history.
- c. Baseline laboratory evaluation of exposed person. [See Appendix 10 – Monitoring Recommendations Following Exposures](#).
 - HIV testing;
 - serologic testing for hepatitis B and hepatitis C.
- d. Testing of source if available.

HIV Management – Refer to [Section 3 – Antiretroviral Therapy \(ART\) for HIV Post-Exposure Prophylaxis](#).

Hepatitis B Management

I. Review Hepatitis B Immunization History and Immune Status.

Health Region Employees

Upon notification of exposure of an employee, the occupational/employee health nurse should determine if documentation for hepatitis B immune status is available. In the absence of the data, the employee should be asked to confirm hepatitis B immune status. Ideally, hepatitis B immune globulin (HBIG) should be provided within 48 hours therefore if immune status cannot be obtained within this timeframe, refer to [II – Arrange for Administration of appropriate Hepatitis Immunological Agents](#).

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Non-Health Region Employees

The employee should provide consent before any attempts are made to contact their employing agency to obtain hepatitis B immunization records. Alternatively, during office hours Monday to Friday, the local public health office¹² may be contacted to review immunization history.

NOTE: If the immunizations were provided by the employer, Public Health's records may not be current.

- II. Arrange for Administration of Appropriate Hepatitis Immunological Agents. Hepatitis B vaccine and/or HBIG should be provided as per the algorithm in [Appendix 8 – Management of Potential Exposures to Hepatitis B](#).

If indicated, HBIG should be provided within 48 hours after an exposure. The efficacy of HBIG decreases significantly after 48 hours but may be given up to 7 days after exposure. This allows time to review the necessity for the immune globulin and to access it from Canadian Blood Services (if it is not already available in the facility/region).

Individuals requiring immunization may be referred to Occupational/Employee Health or Public Health (if time allows) or be given the first dose of hepatitis B immunization in the ER and referred to Occupational/Employee Health or Public Health for completion of immunization series.

Hepatitis C Management

There is no PEP for exposure to hepatitis C.

Seek expert consultation in situations where source testing is positive for hepatitis B or C. Refer to [Appendix 9 – Management of Potential Exposures to Hepatitis C](#) and [Appendix 10 – Monitoring Recommendations Following Exposures](#).

Step 5 – Counselling

Refer to [Section 6 – Counselling and Follow-Up](#) for guidelines and topics to discuss with the exposed. This includes routine counselling as well as additional recommendations for

¹² <http://www.saskatchewan.ca/residents/health/understanding-the-health-care-system/saskatchewan-health-regions/health-region-contact-information-and-websites>

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those engaging in behaviours with ongoing risks. [Appendix 6a – Patient Information Following an Exposure](#) should be provided and reviewed with the client. When HIV PEP is provided, [Appendix 6b – Patient Information for HIV PEP Kits](#) that is found in the PEP Kits should be provided to the individual.

Regardless of HIV status, assess and assist with access to medical care, social support services, and risk-reduction counselling. Refer to [Appendix 13 – Expert Consultation Resources](#) for contact information of various services and care providers.

Step 6 – Follow-up Testing

The client should be advised to follow-up with their family physician or the health region occupational/employee health department for follow-up assessment and testing as outlined in [Appendix 10 – Monitoring Recommendations Following Exposures](#).

NOTE: Public Health will also follow-up with all non-health region staff that have experienced an occupational exposure to ensure they are aware of the follow-up required with their primary care provider.

Step 7 – Reporting Requirements

- Refer to [Appendix 12 – Reporting Requirements](#).
- Ensure the [Exposure Incident Report Form \(Appendix 3\)](#) is completed and submitted to the Regional Public Health Office (the Medical Health Officer or Communicable Disease Coordinator) who will submit necessary reporting elements to the Ministry.
- The [HIV PEP Kit Replacement Form \(Appendix 4\)](#) must be completed and Page 1 must be sent to Ministry of Health. Page 2 must be sent to Royal University Hospital (RUH) Pharmacy to have another kit dispensed to the HIV PEP Kit location.
- Workers Compensation Board Forms¹³ that must be completed include:
 - the employers report of injury (E1);
 - the physician's report to WCB.
- Employees should follow their employing agencies incident reporting protocols.

¹³ <http://www.wcbask.com/WCBPortalWeb/appmanager/WCBPortalWeb/WCBPortalWeb>.