Kinney College of Nursing and Health Professions

Infection Control Policy

Academic Year 2025-2026

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Introduction

Protecting health care professions students from exposures to pathogenic microorganisms is a critical component of the educational environment. Clinical situations present the possibility for contact with blood, body fluid, or biological agents which pose infectious disease risk, particularly risk associated with the hepatitis B virus, hepatitis C virus, the human immunodeficiency virus, and tuberculosis.

Medical histories and examinations cannot identify all clients infected with pathogens. Therefore, the concept of **STANDARD PRECAUTIONS** is to be practiced with all clients during treatment and post-treatment procedures. Standard precautions encompass the standard of care designed to protect health care providers and clients from pathogens that may be spread by blood or any other body fluid, excretion, or secretion. Clients must be protected from disease transmission which can occur via contaminated hands, instruments, and other items. Use of appropriate infection control procedures will minimize this risk of transmission.

Guidelines for reducing risk of disease transmission have been issued by many health-related organizations. The *Bloodborne Pathogens Standard* issued through the Federal Occupational Safety and Health Administration along with recommendations from the Centers for Disease Control and Prevention, (CDC), provide the basis for the University of Southern Indiana Kinney College of Nursing and Health Professions *Infection Control Policy* developed by the Kinney College of Nursing and Health Professions Infection Control and HIPAA Committee.

The policies and procedures contained in the *Infection Control Policy* are designed to prevent transmission of pathogens. All students and faculty in the Kinney College of Nursing and Health Professions are expected to always adhere to the policies and procedures when participating in educational experiences where the potential for contact with blood or other potentially infectious materials (OPIM) exists. These experiences include practice on peers. The goal of the *Infection Control Policy* is to provide procedures and guidelines to be used by students to prevent transmission of infectious diseases while enrolled as a student in the Kinney College of Nursing and Health Professions.

Exposure to infectious diseases is an integral part of practicing as a health care professional (HCP). All students must recognize and accept this risk to complete their education and participate fully in their chosen career. Students may not refuse to care for a client solely because the client has an infectious disease or is at risk of contracting an infectious disease such as HIV, AIDS, HBV, HCV, or TB. *PROFESSIONAL STANDARDS OF INDIVIDUAL DISCIPLINES MAY NECESSITATE EXCEPTIONS TO THE PRECEDING STATEMENT.*

All information regarding a client's medical status is considered confidential and shall be used for treatment purposes only. No information about the client's medical status will be disclosed or reported without the client's express written consent, except in those cases as stipulated by law.

The curriculum of each program in the Kinney College of Nursing and Health Professions includes information regarding the etiology, symptoms, and transmission of infectious diseases, as well as specific methods of preventing disease transmission to be utilized in various clinical sites. This information will be provided to the student prior to initiation of clinical experiences.

Information contained in the *Infection Control Policy* will be reviewed with students on an annual basis or more often if changes in content occur.

The Kinney College of Nursing and Health Professions Infection Control and HIPAA Committee will review the *Infection Control Policy* annually and will make revisions as needed.

The Committee will also evaluate exposure incidents to determine the need for modification of the *Infection Control Policy*.

Documentation

1. All records related to a student's medical status and program-required documents will be maintained by CastleBranch. Reports related to medical records and other documents will be available to program administrators.
2. The records will be maintained separately from all other student records.
3. The records will be maintained in a secure and confidential manner and will not be disclosed or reported without the student's express written consent.
4. Student workers will not have access to student or faculty medical records.

Medical Evaluation

All students admitted to a clinical program in the Kinney College of Nursing and Health Professions are required to undergo comprehensive medical evaluation prior to enrolling in professional courses. Students should refer to their program (major) for Medical Evaluation forms that must be completed.

Immunizations

All students and faculty involved in clinical education, internships, and fieldwork experiences through the Kinney College of Nursing and Health Professions who have client contact must adhere to vaccination requirements established by affiliated organizations and our contractual agreements. Compliance with the affiliated organizations vaccination policy may entail:

- Laboratory confirmation of disease or immunity against varicella, mumps, measles, and rubella OR two doses of MMR vaccine and varicella vaccine.
- Completed hepatitis B vaccine series and evidence of post-vaccination serologic testing for anti-HBs is required.
- One dose of tetanus, pertussis, and diphtheria vaccine (Tdap); documentation of booster Td every 10 years
- Annual influenza immunization.

The timeframe for obtaining required vaccinations varies by major and must be in compliance with affiliated organizations policies on immunizations prior to participation in clinical education, internships, or fieldwork experiences.

Vaccine & Recommendations in Brief

http://www.immunize.org/catg.d/p2017.pdf

COVID-19 – If not up to date, provide COVID-19 vaccine according to current CDC recommendations (see https://www.cdc.gov/acip-recs/hcp/vaccine-specific/covid-19.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html).

Hepatitis B –Previously unimmunized students must receive an approved two (2) or three (3) dose series of hepatitis B vaccine.

For HCP who perform tasks that may involve exposure to blood or body fluids, obtain antibody serology 1–2 months after final dose.

- Unvaccinated healthcare personnel (HCP) and/ or those who cannot document previous vaccination must receive an approved two (2) or three (3) dose series of hepatitis B vaccine.
- HCP who perform tasks that may involve exposure to blood or body fluids should be tested for hepatitis B surface antibody (anti-HBs) 1–2 months after completion of the two or three-dose series.
- If anti-HBs is at least 10 mIU/mL (positive), the vaccinee is immune. No further serologic testing or vaccination is recommended. • If anti-HBs is less than 10 mIU/mL (negative), the vaccinee is not protected from hepatitis B virus (HBV) infection and should receive another 2-dose or 3-dose series of Hep B vaccine on the routine schedule, followed by anti-HBs testing 1–2 months later.
- A vaccinee whose anti-HBs remains less than 10 mIU/ mL after 2 complete series is considered a "non-responder." For non-responders: HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood or blood with unknown HBsAg status.
- It is also possible that non-responders are people who are HBsAg positive. HBsAg testing is recommended. HCP found to be HBsAg positive should be counseled and medically evaluated. For HCP with documentation of a complete 2-dose or 3-dose vaccine series but no documentation of anti-HBs of at least 10 mIU/mL (e.g., those vaccinated in childhood): HCP who are at risk for occupational blood or body fluid exposure might undergo anti-HBs testing upon hire or matriculation.
- **Students determined to be non-responders must complete and submit a nonresponder form found in CastleBranch.**

Influenza – Give 1 dose of influenza vaccine annually. All students admitted to clinical programs and completing internships must receive annual vaccination against influenza. All clinical faculty must receive annual vaccination against influenza. Students and faculty will follow current influenza recommendations from ACIP for the year in which immunization is administered. All HCP students participating in volunteer assignments should follow the guidelines of the facility.

MMR – For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart.

HCP born in 1957 or later are considered immune to measles, mumps, or rubella only if they have documentation of (a) laboratory confirmation of disease or immunity or (b) appropriate vaccination against measles, mumps, and rubella (i.e., 2 doses of live measles and mumps vaccines given on or after the first birthday and separated by 28 days or more, and at least 1 dose of live rubella vaccine). HCP with 2 documented doses of MMR are not recommended to be serologically tested for immunity; but if they are tested and results are negative or equivocal for measles, mumps, and/or rubella,

these HCP should be considered to have presumptive evidence of immunity to measles, mumps, and/or rubella and are not in need of additional MMR doses.

One dose of MMR vaccine should be considered for HCP with no laboratory evidence of disease or immunity to rubella. For these same HCP who do not have evidence of immunity, two doses of MMR vaccine are recommended during an outbreak of measles or mumps and one dose during an outbreak of rubella.

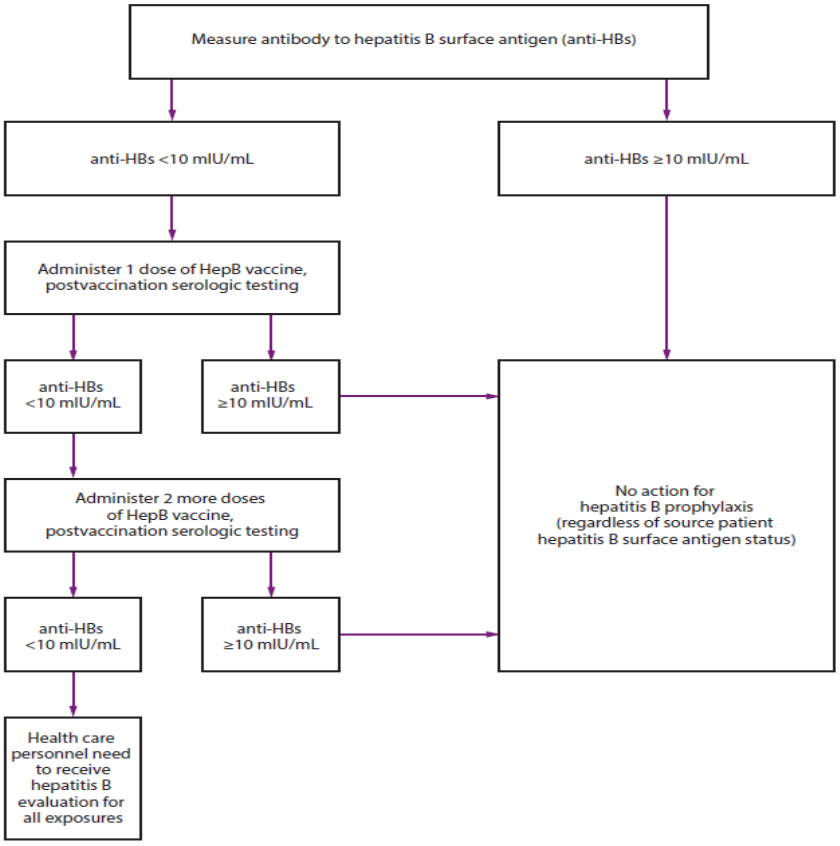
Varicella (chickenpox) – For HCP who have no serologic proof of immunity, prior vaccination, or diagnosis or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider, give 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella containing vaccine, regardless of whether U.S.-born before 1980.

Tetanus, diphtheria, pertussis – Give 1 dose of Tdap as soon as feasible to all HCP who have not received Tdap previously and to pregnant HCP with each pregnancy (see below). Give Td or Tdap boosters every 10 years thereafter.

Meningococcal – Give both MenACWY and MenB to microbiologists who are routinely exposed to isolates of Neisseria meningitidis. As long as risk continues boost with MenB after 1 year, then every 2–3 years thereafter; boost with MenACWY every 5 years.

Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material.

Pre-exposure evaluation for health care personnel previously vaccinated with complete, ≥3-dose HepB vaccine series who have not had postvaccination serologic testing*



Source: *Adapted from CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP). Part II: immunization of adults. MMWR 2006;55(No. RR-16). * Should be performed 1–2 months after the last dose of vaccine using a quantitative method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL) (e.g., enzyme-linked immunosorbent assay [ELISA]).*

Testing anti-HBs for health care personnel (HCP) vaccinated in the past:

The issue: An increasing number of HCP have received routine hepatitis B (Hep B) vaccination during childhood. No postvaccination serologic testing is recommended after routine infant or adolescent Hep B vaccination. Because vaccine-induced antibody to hepatitis B surface antigen (anti-HBs) wanes over time, testing HCP for anti-HBs years after vaccination might not distinguish vaccine non-responders from responders.

Guidance for health care institutions: Health care institutions may measure anti-HBs upon hire or matriculation for HCP who have documentation of a complete Hep B vaccine series in the past (e.g., as part of routine infant or adolescent vaccination). HCP with anti-HBs <10 mIU/mL should receive one or more additional doses of Hep B vaccine and retesting (Figure 3). Institutions that decide to not measure anti-HBs upon hire or matriculation for HCP who have documentation of a complete Hep B vaccine series in the past should ensure timely assessment and postexposure prophylaxis following an exposure (Table 5).

Considerations: The risk for occupational HBV infection for vaccinated HCP might be low enough in certain settings so that assessment of anti-HBs status and appropriate follow-up should be done at the time of exposure to potentially infectious blood or body fluids. This approach relies on HCP recognizing and reporting blood and body fluid exposures and therefore may be applied on the basis of documented low risk, implementation, and cost considerations. Certain HCP occupations have lower risk for occupational blood and body fluid exposures (e.g., occupations involving counseling versus performing procedures), and non-trainees have lower risks for blood and body fluid exposures than trainees. Some settings also will have a lower prevalence of HBV infection in the patient population served than in other settings, which will influence the risk for HCP exposure to HBsAg-positive blood and body fluids.

Tuberculosis Screening

All students admitted to a clinical program in the Kinney College of Nursing and Health Professions will receive baseline TB screening within 12 months prior to admission, using two-step TST, a single BAMT to test for infection with *M. tuberculosis, t-Spot, or* QuantiFERON Blood Gold Test.

A student or faculty who is exposed to tuberculosis or whose negative PPD test converts to positive, will be referred to the County Public Health Department for evaluation.

https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w

TB Screening, Testing and Treatment of Healthcare Personnel (CDC, 2019) summary of recommendations:

https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w

Baseline (preplacement) screening and testing TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI; individual TB risk assessment.

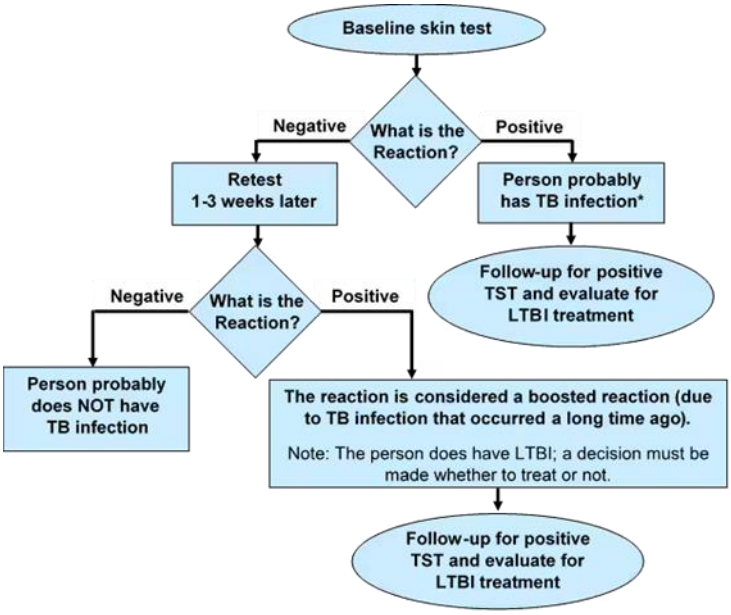
Postexposure screening and testing Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8–10 weeks after the last exposure.

Serial screening and testing for HCP without LTBI Not routinely recommended; can consider for selected HCP groups; recommend annual TB education for all HCP, including information about TB exposure risks for all HCP.

Evaluation and treatment of positive test results Treatment is encouraged for all HCP with untreated LTBI, unless medically contraindicated.

Abbreviations: IGRA = interferon-gamma release assay; LTBI = latent tuberculosis infection; TST = tuberculin skin test.

Two-Step TST Testing



https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/?CDC_AAref_Val=https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm

Updated December 15, 2023

Indicators of risk* for tuberculosis (TB) at baseline health care personnel assessment†
Health care personnel should be considered to be at increased risk for TB if they answer "yes" to any of the following statements.

1. Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)

Or

2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication

Or

3. Close contact with someone who has had infectious TB disease since the last TB test

Abbreviation: TNF = tumor necrosis factor.

* Individual risk assessment information can be useful in interpreting TB test results. (Lewinsohn DM, Leonard MK, LoBue PA, et al. Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention clinical practice guidelines: diagnosis of tuberculosis in adults and children. Clin Infec Dis 2017;64:111–5). https://academic.oup.com/cid/article/64/2/111/2811357external icon

† Adapted from a tuberculosis risk assessment form developed by the California Department of Public Health.

Infection Prevention and Control: COVID-19

COVID-19 (SARS CO-V-2) was first declared a global pandemic by the World Health Organization on March 11, 2020. Since this is a new pathogen, information regarding infection control practices is continually evolving. The Centers for Disease Control and Prevention (CDC) is the repository for most current evidence-based recommendations and practices. Policies for the USI Kinney College of Nursing and Health Professions, and for the general USI community, align with CDC, so the CDC websites will be cited for specific information.

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

https://www.cdc.gov/covid/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

COVID-19 Immunization

All students and employees are strongly encouraged to receive the primary series of immunization against COVID-19 with any available vaccine and receive a booster when eligible.

Indiana Department of Health https://www.coronavirus.in.gov/vaccine/

Center for Disease Control: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html

Communicable Diseases/Infections and Immunocompromised Status

Students and faculty with a communicable disease/infection, or who are considered to be immunocompromised, should consult with their health care provider to assess the risks to their health and to others. The health care provider should make written recommendations related to the student's educational experience.

Exposure Potential

A. All HCP participating in clinical activities have the potential for skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (contained in the following list) and will adhere to policies and procedures contained in the *Infection Control Policy.* Adherence is required without regard to the use of personal protective equipment.

B. Other Potentially Infectious Materials (OPIM)
   - semen
   - vaginal secretions
   - cerebrospinal fluid
   - synovial fluid
   - pleural fluid
   - pericardial fluid
   - peritoneal fluid
   - amniotic fluid
   - breast milk
   - saliva/sputum
   - airborne infections
   - body fluids visibly contaminated with blood.
   - any unfixed tissue or organ (other than intact skin) from a human (living or dead)
   - HIV containing cells or tissues cultures.
   - HIV, HBV, or HCV containing culture medium or other solutions.
   - blood, organs, or other tissues from experimental animals infected with HIV, HBV, or HCV

Percutaneous/Mucous Membrane Exposure to Blood or Other Potentially Infectious Materials (Exposure Incident)

A. An exposure that might place HCP at risk for HIV infection is defined as a percutaneous injury (e.g., a needlestick or cut with a sharp object) or contact of mucous membrane or non-intact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious. In addition to blood and visibly bloody body fluids, semen and vaginal secretions are also considered potentially infectious. Although semen and vaginal secretions have been implicated in the sexual transmission of HIV, they have not been implicated in occupational transmission from patients to HCP. The following fluids are also considered potentially infectious: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid.

   Exposures are to be reported ***immediately,*** (within 2 hours of the incident), by the student to the clinical instructor so that appropriate post-exposure procedures can be initiated. An exposure is considered an urgent medical concern. A delay in reporting/treatment of the incident may render recommended HIV post-exposure prophylaxis, (PEP), ineffective. If a delay occurs, (defined as later than 24-36 hours after the incident), it is advised that expert consultation for HIV/PEP be sought. **The clinical instructor will complete the agency incident report, the University Injury or Illness Report, and the Kinney College of Nursing and Health Professions Student Exposure Incident Report, and Acknowledgement of Refusal if applicable**. The completed college report and the university report will be submitted to the Kinney College of Nursing and Health Professions Infection Control and HIPAA Committee for review. The University report will be forwarded by the Kinney College of Nursing and Health Professions Infection Control and HIPAA Committee to appropriate University personnel. The clinical instructor will also notify the course coordinator and program administrator of the exposure incident.

B. After a percutaneous or mucous membrane exposure to blood or body fluids, the student is to follow USPHS and clinical site policy for immediate post-exposure wound cleansing/infection prophylaxis such as cleansing the affected area with antimicrobial soap, irrigation of the eyes or mouth with large amounts of tap water or saline.

C. The source client, if known, should be tested serologically for evidence of HIV, HbsAg and anti-HCV. HIV consent must be obtained from the source client prior to testing. Testing should be within 2 hours if at all possible.

D. The exposed HCP will be referred for medical attention and counseling by a physician immediately. **Any expenses that are incurred for medical care are the responsibility of the student.**

   Most current recommendations include:

- If source is unknown, the use of Post Exposure Prophylaxis (PEP) is to be decided on a case-by-case basis taking into consideration of exposure.
- If the source patient from whom the practitioner was exposed has a reasonable suspicion of HIV infection or is HIV positive and the practitioner anticipates that hours or day may be required, antiretroviral medications should be started immediately.
- Severity of the exposure to determine the number of drugs to be offered should no longer be used.
- PEP should be stopped if source patient is determined HIV negative.
- The HCP should receive baseline testing for the HIV virus.
- Follow-up counseling should be within 72 hours of exposure with additional follow up in 6 and 12 weeks and again at 6 months.
- The full article: *Updated US Public Health Service Guidelines for the management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Post-exposure Prophylaxis* can be read at: https://stacks.cdc.gov/view/cdc/20711

Hepatitis B Postexposure Prophylaxis
https://www.cdc.gov/mmwr/volumes/67/rr/rr6701a1.htm#T5_down

Vaccinated HCP

- For vaccinated HCP (who have written documentation of a complete HepB vaccine series) with subsequent documented anti-HBs ≥10 mIU/mL, testing the source patient for HBsAg is unnecessary.
- No postexposure prophylaxis for HBV is necessary, regardless of the source patient's HBsAg status (Table 5).
- Postexposure management of health care personnel after occupational percutaneous or mucosal exposure to blood or body fluids, by health care personnel HepB vaccination and response status.
- For vaccinated HCP (who have written documentation of a complete HepB vaccine series) without previous anti-HBs testing, the HCP should be tested for anti-HBs, and the source patient (if known) should be tested for HBsAg as soon as possible after the exposure. Anti-HBs testing should be performed using a method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL).
- Testing the source patient and the HCP should occur simultaneously; testing the source patient should not be delayed while waiting for the HCP anti-HBs test results, and likewise, testing the HCP should not be delayed while waiting for the source patient's HBsAg results (Table 5).
    - If the HCP has anti-HBs <10 mIU/mL and the source patient is HBsAg-positive or has an unknown HBsAg status, the HCP should receive 1 dose of HBIG and be revaccinated as soon as possible after the exposure. HepB vaccine may be administered simultaneously with HBIG at a separate anatomical injection site (e.g., separate limb). The HCP should then receive the second 2 doses of HepB vaccine to complete the second series (likely 6 doses total when accounting for the original series) according to the vaccination schedule. So that the HCP's vaccine response status can be documented for future exposures, anti-HBs testing should be performed 1–2 months after the final vaccine dose.
    - If the HCP has anti-HBs <10 mIU/mL and the source patient is HBsAg-negative, the HCP should receive an additional single HepB vaccine dose, followed by repeat anti-HBs testing 1–2 months later. HCP whose anti-HBs remains <10 mIU/mL should undergo revaccination with two more doses (likely 6 doses total when accounting for the original series). So, the HCP's vaccine response status can be documented for future exposures, anti-HBs testing should be performed 1–2 months after the final dose of vaccine.
    - If the HCP has anti-HBs ≥10 mIU/mL at the time of the exposure, no postexposure HBV management is necessary, regardless of the source patient's HBsAg status.
- For vaccinated HCP with anti-HBs <10 mIU/mL after two complete HepB vaccine series, the source patient should be tested for HBsAg as soon as possible after the exposure. If the source patient is HBsAg-positive or has unknown HBsAg status, the HCP should receive 2 doses of HBIG (*1*,*10*). The first dose should be administered as soon as possible after the exposure, and the second dose should be administered 1 month later. HepB vaccine is not recommended for the exposed HCP who has previously completed two HepB vaccine series. If the source patient is HBsAg-negative, neither HBIG nor HepB vaccine is necessary (Table 5).

Unvaccinated HCP

- For unvaccinated or incompletely vaccinated HCP, the source patient should be tested for HBsAg as soon as possible after the exposure. Testing unvaccinated or incompletely vaccinated HCP for anti-HBs is not necessary and is potentially misleading, because anti-HBs ≥10 mIU/mL as a correlate of vaccine-induced protection has only been determined for persons who have completed an approved vaccination series (Table 5).

- If the source patient is HBsAg-positive or has an unknown HBsAg status, the HCP should receive 1 dose of HBIG and 1 dose of HepB vaccine administered as soon as possible after the exposure. HepB vaccine may be administered simultaneously with HBIG at a separate anatomical injection site (e.g., separate limb). The HCP

should complete the HepB vaccine series according to the vaccination schedule. To document the HCP's vaccine response status for future exposures, anti-HBs testing should be performed approximately 1–2 months after the final vaccine dose. Anti-HBs testing should be performed using a method that allows detection of the protective concentration of anti-HBs (≥10 mIU/mL). Because anti-HBs testing of HCP who received HBIG should be performed after anti-HBs from HBIG is no longer detectable (6 months after administration), it might be necessary to defer anti-HBs testing for a period longer than 1–2 months after the last vaccine dose in these situations (Table 5).
    - HCP with anti-HBs ≥10 mIU/mL after receipt of the primary vaccine series are considered immune. Immunocompetent persons have long-term protection and do not need further periodic testing to assess anti-HBs levels.
    - HCP with anti-HBs <10 mIU/mL after receipt of the primary series should be revaccinated. For these HCP, administration of a second complete series on an appropriate schedule, followed by anti-HBs testing 1–2 months after the final dose, is usually more practical than conducting serologic testing after each additional dose of vaccine. So the HCP's vaccine response status can be documented for future exposures, anti-HBs testing should be performed 1–2 months after the final vaccine dose.
- If the source patient is HBsAg-negative, the HCP should complete the HepB vaccine series according to the vaccination schedule. So the HCP's vaccine response status can be documented for future exposures, anti-HBs testing should be performed approximately 1–2 months after the final vaccine dose (Table 5).
    - HCP with anti-HBs ≥10 mIU/mL after receipt of the primary vaccine series are considered immune. Immunocompetent persons have long-term protection and do not need further periodic testing to assess anti-HBs levels.
    - HCP with anti-HBs <10 mIU/mL after receipt of the primary series should be revaccinated. For these HCP, administration of a second complete series on an appropriate schedule, followed by anti-HBs testing 1–2 months after the final dose, is usually more practical than conducting serologic testing after each additional dose of vaccine. So the HCP's vaccine response status can be documented for future exposures, anti-HBs testing should be performed 1–2 months after the final vaccine dose.

Clinical Management of Exposed HCP

- HCP who have anti-HBs <10 mIU/mL (or who are unvaccinated or incompletely vaccinated) and sustain an exposure to a source patient who is HBsAg-positive or has an unknown HBsAg status should undergo baseline testing for HBV infection as soon as possible after the exposure, and follow-up testing approximately 6 months later. Testing immediately after the exposure should consist of total anti-HBc, and follow-up testing approximately 6 months later should consist of HBsAg and total anti-HBc (Table 5).
- HCP exposed to a source patient who is HBsAg-positive or has an unknown HBsAg status do not need to take special precautions to prevent secondary transmission during the follow-up period; however, they should refrain from donating blood, plasma, organs, tissue, or semen (*10*). The exposed HCP does not need to modify sexual practices or refrain from becoming pregnant (*10*). If an exposed HCP is breastfeeding, she does not need to discontinue (*7,10*). No modifications to an exposed HCP's patient-care responsibilities are necessary to prevent transmission to patients based solely on exposure to a source patient who is HBsAg-positive or has an unknown HBsAg status.

Previously Vaccinated HCP

- Providers should only accept written, dated records as evidence of HepB vaccination (*151*).
- An increasing number of HCP have received routine HepB vaccination during childhood. No postvaccination serologic testing is recommended after routine infant or adolescent HepB vaccination. Because vaccine-induced anti-HBs wanes over time, testing HCP for anti-HBs years after vaccination might not distinguish vaccine nonresponders from responders. Pre-exposure assessment of current or past anti-HBs results upon hire or

matriculation, followed by one or more additional doses of HepB vaccine for HCP with anti-HBs <10 mIU/mL and retesting anti-HBs, if necessary, helps to ensure that HCP will be protected if they have an exposure to HBV-containing blood or body fluids (Box 5; Figure 3).

- HCP who cannot provide documentation of 3 doses of HepB vaccine should be considered unvaccinated and should complete the vaccine series. Postvaccination serologic testing for anti-HBs is recommended 1–2 months after the third vaccine dose. HCP who are inadvertently tested before receiving 3 documented doses of HepB vaccine and have anti-HBs ≥10 mIU/mL should not be considered immune because anti-HBs ≥10 mIU/mL is a known correlate of protection only when testing follows a documented 3-dose series. Health care facilities are encouraged to try to locate vaccine records for HCP and to enter all vaccine doses in their state immunization information system.

Kinney College of Nursing and Health Profession students should complete the Hepatitis B Non-responder Acknowledgement Form in CastleBranch.

Postexposure management of health care personnel after occupational percutaneous or mucosal exposure to blood or body fluids, by health care personnel Hep B vaccination and response status.

		Postexposure testing		Postexposure prophylaxis	
HCP status	**Source patient (HBsAg)**	**HCP testing (anti-HBs)**	**HBIG**	**Vaccination**	**Postvaccination Serologic testing**
Documented responder after complete series			No action needed		
Documented nonresponder after two complete series	Positive/unknown	__*	HBIG x2 separated by 1 month	--	N/A
	Negative		No action needed		
Response unknown after complete series	Positive/unknown	<10 mIU/mL	HBIG x1	Initiate revaccination	Yes
	Negative	<10 mIU/mL	None	Initiate revaccination	Yes
	Any result	≥10 mIU/mL	No action needed		
Unvaccinated/incompletely vaccinated or vaccine refusers	Positive/unknown	--	HBIG x1	Complete vaccination	Yes
	Negative	--	None	Complete vaccination	yes

Abbreviations: anti HBs = antibody to hepatitis B surface antigen; HBIG = hepatitis B immune globulin; HBsAg = hepatitis B surface antigen; HCP = health care personnel; N/A = not applicable.

* Not indicated.

Hepatitis C Postexposure Actions

https://www.cdc.gov/mmwr/volumes/69/rr/rr6906a1.htm?s_cid=rr6906a1_w

Test the Source Patient as soon as possible (preferably within 48 hours) after the exposure. This guidance provides two options for initial source patient testing: 1) option A (preferred), to test for HCV RNA, or 2) option B, to test for anti-HCV and then if positive, test for HCV RNA (Figure 1).
All source patients who are anti-HCV positive should be tested by a nucleic acid test (NAT) for HCV RNA, preferably with a reflex test by using the same specimen if cross-contamination is not a concern or by using a fresh aliquot of the same sample if stored correctly.
If HCV RNA tests are positive but the RNA level is less than the lower limit of quantitation of the assay, the results are reported as <XX IU/mL (e.g., <15 IU/mL if the lower limit of quantitation of the assay is 15 IU/mL). This means that HCV RNA was detected in the sample but is not quantifiable and that the person from whom the sample was collected should be considered to have current HCV infection.

If the source patient is known or suspected to have recent behavior risks for HCV acquisition (e.g., injection drug use within the previous 4 months) or if risk cannot be reliably assessed, initial testing should include a NAT for HCV RNA. Persons with recently acquired acute infection typically have detectable HCV RNA levels as early as 1–2 weeks after exposure. Source patients determined to be positive for anti-HCV or HCV RNA should be reported to the state or local health department and referred for clinical management, as recommended. False-positive anti-HCV results are known to occur among populations at low risk.

HCV RNA testing is preferred for source patient testing. However, if anti-HCV testing is performed, a sufficient blood sample should be obtained for simultaneous or reflex (if anti-HCV positive) HCV RNA testing. This can minimize the need to redraw blood and reduce delays in establishing the status of the source patient. Testing of the source patient and baseline testing of the HCP might be either concurrent or sequential; follow-up testing of the HCP should be determined by the source patient's status.
If the source patient is HCV RNA or anti-HCV positive with unavailable NAT or if the HCV infection status is unknown (e.g., when the HCP sustains a percutaneous injury from a needle in the trash), follow-up testing of the exposed HCP should be initiated. Follow-up testing for an HCP exposed to blood or body fluids from a source patient who tests anti-HCV positive, but HCV RNA negative is not recommended because this status can indicate a previously cleared or cured infection. However, instances might occur when follow-up testing is warranted (e.g., when specimen integrity concerns exist, including handling and storage conditions, that might have compromised test results) or if the HCP exhibits any clinical signs of HCV infection.

Test the HCP

Baseline Testing

HCP should have an initial baseline test for anti-HCV with testing for HCV RNA if positive (i.e., either reflex or follow-up NAT) as soon as possible (preferably within 48 hours) after the exposure to rule out a pre-existing chronic infection. HCP testing positive for HCV RNA at baseline should be referred to care for pre-existing current HCV infection. If HCP are anti-HCV positive and HCV RNA negative at baseline, this likely indicates a previously cleared infection; therefore, if test results for the source patient warrant follow-up testing for HCP in context of a current exposure, HCP should be tested for HCV RNA instead of retesting for anti-HCV, which usually will remain positive regardless of current infection status.

HCV PEP (postexposure prophylaxis) Not Recommended

HCV PEP with DAA therapy is not routinely recommended. The risk for transmission of HCV from percutaneous exposures (0.2%) and mucocutaneous exposures (0%) is low and in most situations does not justify giving DAAs to several hundred exposed HCP because of potential side effects; furthermore, efficient duration of PEP has not been established. DAA therapy is highly efficacious in eradicating acute and chronic infections; therefore, new HCV infections should be identified early and treated, and the strategy of testing and treating if transmission occurs is recommended.

<u>Testing 3–6 Weeks Postexposure</u>

If the source patient is HCV RNA positive or source-patient testing is not performed or not available, HCP baseline testing should be followed by a NAT for HCV RNA at 3–6 weeks after exposure. This test also should be performed if a source

patient is anti-HCV positive and no source patient HCV RNA testing is available. A NAT performed at 6 weeks postexposure has the advantage of coinciding with HIV postexposure testing schedules, if recommended.

Testing 4–6 Months Postexposure

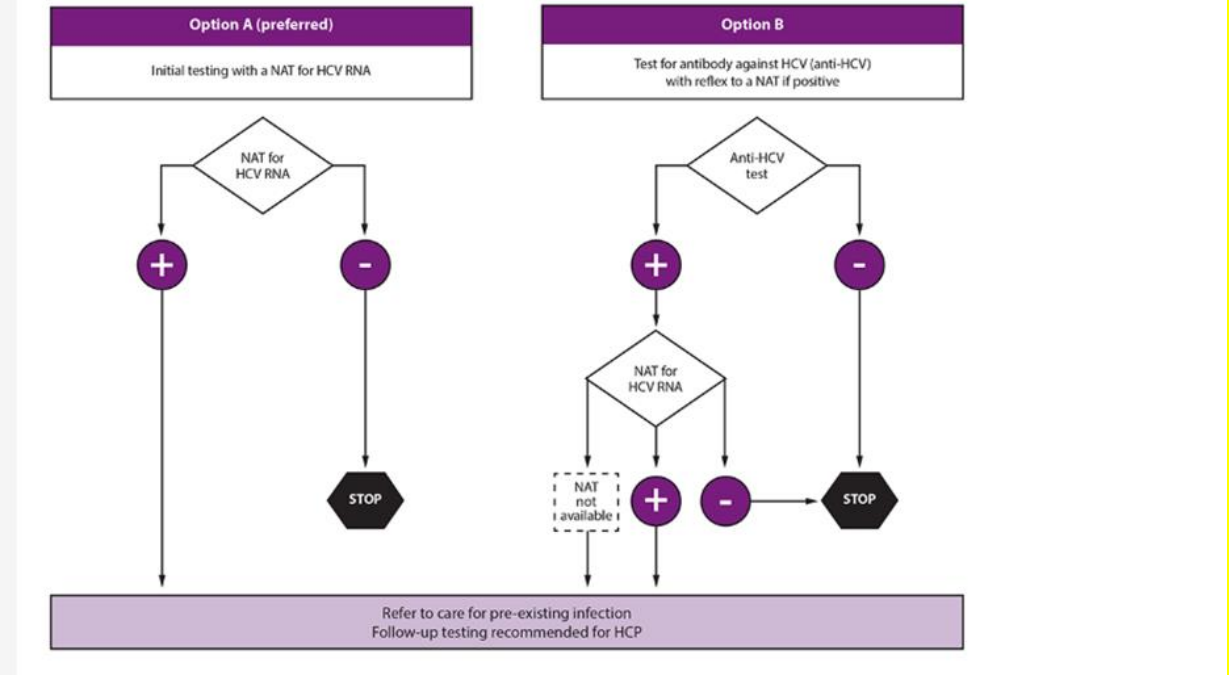
For all HCP for whom follow-up testing is recommended, a final test for anti-HCV at 4–6 months with testing for HCV RNA if positive (i.e., either reflex to or follow-up NAT) should be conducted. Testing performed at 6 months postexposure has the advantage of coinciding with hepatitis B virus (HBV) postexposure testing schedules, if recommended. Exposed HCP who develop illness with symptoms indicative of acute HCV infection at any point should be tested for HCV RNA.

No further follow-up is indicated for HCP who remain anti-HCV negative at 4–6 months. However, for those who had a negative anti-HCV result at 4–6 months and are immunocompromised or have liver disease, an additional test for HCV RNA can be considered. Seroconversion from anti-HCV negative to anti-HCV positive with undetectable HCV RNA can indicate resolved infection or acute infection during a period of aviremia. In addition, false-positive anti-HCV tests have been reported to occur. For HCP with a positive anti-HCV result and confirmed undetectable HCV RNA after 4–6 months, a NAT for HCV RNA should be repeated if clinical evidence of HCV infection is present. Tests should be repeated if concerns exist about results being compromised because of storage and handling errors or other issues that might affect specimen integrity.

Management of HCP Who Acquire HCV

HCP with detectable HCV RNA or anti-HCV seroconversion as a result of an occupational exposure should be referred for further care and evaluation for treatment as indicated in AASLD-IDSA guidelines (10). Because DAA therapy is highly efficacious in eradicating acute and chronic infections, new HCV infections should be identified early and treated. Additional recommendations are available to facilitate provision of occupational infection prevention and control services to HCP.

FIGURE 1. Testing of source patients after potential exposure of health care personnel to hepatitis C virus — CDC guidance, United States 2020*



Additional Information

For additional information related to management of exposure incidents refer to:

https://www.cdc.gov/dental-infection-control/hcp/dental-ipc-faqs/index.html

National Clinicians' Post-Exposure Prophylaxis Hotline:
http://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/

Needlestick Reference:
https://www.cdc.gov/niosh/docs/2000-108/default.html

Immunization Action Coalition:
http://immunize.org/

Healthcare Worker Immunization Recommendations
https://www.cdc.gov/vaccines-adults/recommended-vaccines/

Methods of Reducing Potential for Exposure to Pathogens

Standard Precautions

Standard precautions refer to the prevention of contact with blood, all body fluids, secretions, and excretions except sweat, and must be used with every client. Exposure of non-intact skin and mucous membranes to these fluids must be avoided. All body fluids shall be considered potentially infectious materials.

Engineering and Work Practice Controls

Engineering and work practice controls shall be used to eliminate or minimize exposure to blood or OPIM (Other Potentially Infectious Materials). An example of an engineering control would include the use of safer medical devices, such as sharps with engineered sharps injury protection and needleless systems. Where potential exposure remains after institution of these controls, personal protective equipment shall also be used.

The following engineering controls will be utilized:

1. Hand washing is a " foundational component of infection prevention in all healthcare settings" (Glowicz, 2023, p. 4). Students will wash their hands before donning gloves and immediately or as soon as feasible after removal of gloves or other personal protective equipment. Students will wash hands and any other skin with soap and water or flush mucous membranes with water immediately or as soon as feasible following contact with blood or OPIM**. No nail polish or artificial fingernails are allowed during clinical activities**. Jewelry has the potential to harbor microorganisms. Refer to individual program handbooks for specific guidelines regarding wearing jewelry during clinical activities.

    - **Alcohol-based hand sanitizers (with at least 60% alcohol) are the most effective products and are the preferred method of hand hygiene in most clinical settings.**
    - Antiseptic soaps and detergents are the next most effective and non-antimicrobial soaps are the least effective.

When using alcohol-based hand sanitizer:

- Put a "palmful" of product (with at least 60% alcohol) on hands and rub hands together.
- Cover all surfaces until hands feel dry.
- This should take around 15-20 seconds.
- When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting.

Soap and water are recommended for cleaning visibly dirty hands.

  - When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for **at least 15 seconds**, covering all surfaces of the hands and fingers.
  - Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet.
  - Avoid using hot water, to prevent drying of skin.
- Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html

Use an Alcohol-Based Hand Sanitizer	Wash with Soap and Water
Immediately before touching a patient	When hands are visibly soiled
Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	After caring for a person with known or suspected infectious diarrhea
Before moving from work on a soiled body site to a clean body site on the same patient	After known or suspected exposure to spores (e.g. *B. anthracis, C difficile* outbreaks)
After touching a patient or the patient's immediate environment	
After contact with blood, body fluids or contaminated surfaces	
Immediately after glove removal	

https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/sheaidsaapic-practice-recommendation-strategies-to-prevent-healthcareassociated-infections-through-hand-hygiene-2022-update/FCD05235C79DC57F0E7F54D7EC314C2C#tbl3

2. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in treatment areas or any other area where there is a reasonable likelihood of exposure to blood or OPIM.

3. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on counter tops or bench tops where blood or OPIM are present.

4. All procedures involving blood or OPIM shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

5. Mouth pipetting/suctioning of blood or OPIM is prohibited.

6. Sharps Management

Sharps are items that can penetrate skin and include injection needles, scalpel blades, suture needles, irrigation cannulas, instruments, and broken glass. It is recommended that the clinician select the safest medical device and/or technique available to help reduce needlesticks and other sharps injuries. The use of needles should be avoided where safe and effective alternatives are available.

- All disposable contaminated sharps shall be disposed of immediately or as soon as feasible in closable, puncture resistant, leak proof on sides and bottom, and labeled containers. The container must be maintained in an upright position and must not be overfilled.
- Sharps disposal containers must be readily accessible and located in reasonable proximity to the use of sharps.
- Containers containing disposable contaminated sharps are not to be opened, emptied, or cleaned manually or in any other manner which could create a risk of percutaneous injury.
- Contaminated needles and other contaminated sharps shall not be bent, sheared, recapped, or removed unless no alternative is feasible or is required by a specific procedure. If recapping is necessary, a one-handed technique or mechanical recapping device must be used.
- Reusable contaminated sharps shall be placed in leak proof, puncture resistant, labeled containers while waiting to be processed.
- Sharps containers must be closed before they are moved.
- HCP are not to reach by hand into containers of contaminated sharps.
- Contaminated broken glass should be picked up using mechanical means such as a brush and dustpan, tongs, or forceps.
- Whenever possible, sharps with engineered sharps injury protection or needleless systems should be used.

7. Specimens of blood or OPIM shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. The container must be closed before being stored, transported, or shipped. If outside contamination of the primary container occurs, or if the specimen could puncture the primary container, the primary container shall be placed within a secondary container which prevents leakage, and/or resists puncture during handling, processing, storage, transport, or shipping.

8. Equipment Sterilization
    a. Reusable heat stable instruments are to be sterilized by acceptable methods.
    b. Heat sterilization equipment will be monitored for effectiveness and records will be maintained.

9. Equipment which may be contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary. Equipment which has not been fully decontaminated must have a label attached with information about which parts remain contaminated.

Personal Protective Equipment

1. Personal protective equipment including gloves, gowns, laboratory coats, face masks, eye protection or face shields, resuscitation bags, pocket masks or other ventilation devices shall be used whenever there is the potential for exposure to blood or OPIM.

2. Personal protective equipment must not permit blood or OPIM to pass through to or reach the student's clothes, skin, eyes, mouth, or other mucous membranes.

3. All personal protective equipment must be removed prior to leaving the treatment area. When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage, washing, decontamination, or disposal.

Gloves

Gloves shall be worn in the following situations:

- when it can be reasonably anticipated that hands may contact blood, OPIM, mucous membranes, or non-intact skin.
- when performing vascular access.
- when handling or touching contaminated items or surfaces.

Disposable gloves

- shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.
- shall be replaced if excessive moisture develops beneath the glove.
- shall not be washed or decontaminated for re-use.
- if contaminated, must be covered by over gloves when handling non-contaminated items (e.g., client charts)

Utility gloves

- may be decontaminated for re-use if the integrity of the glove is not compromised.
- must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

Masks

https://www.cdc.gov/respiratory-viruses/prevention/masks.html

Eye Protection

https://www.cdc.gov/covid/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Face or eye protection (goggles or face shields) should be worn in addition to a mask or respirator, particularly when caring for patients who are unable to reliably use a mask and when performing aerosol-generating procedures. HCP who use a full-face shield should be reminded that face shields alone do not provide adequate respiratory protection or source control (i.e., they should still wear a medical mask under the face shield).

Protective Body Clothing

https://www.cdc.gov/niosh/learning/safetyculturehc/module-3/7.html

Appropriate protective clothing such as gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in potential exposure situations.

- Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated.
- Protective body clothing must be changed when visibly contaminated with blood or OPIM or if they become torn or punctured.

Housekeeping

Equipment and Environmental and Working Surfaces

- Contaminated work surfaces shall be decontaminated after completion of procedures using a tuberculocidal chemical disinfectant having an Environmental Protection Agency (EPA) registration number. Decontamination must occur between clients, immediately or as soon as feasible when surfaces are contaminated, or after any spill of blood or OPIM.

- Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and surfaces are to be removed and replaced as soon as feasible when they become contaminated. Protective coverings do not replace decontamination with tuberculocidal chemical disinfectant.

- Reusable bins, pails, cans, and similar receptacles are to be regularly inspected for contamination with blood or OPIM and decontaminated as needed.

Infectious Waste Management

1. Infectious waste is defined as:
    - contaminated disposable sharps or contaminated objects that could potentially become contaminated sharps
    - infectious biological cultures, infectious associated biologicals, and infectious agent stock
    - pathological waste
    - blood and blood products in liquid and semi-liquid form
    - carcasses, body parts, blood and body fluids in liquid and semi-liquid form, and bedding of laboratory animals
    - other waste that has been intermingled with infectious waste

2. Infectious waste must be placed in labeled containers which are closable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping.

3. Containers must be closed prior to moving/removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. If the outside of the container becomes contaminated it is to be placed in a second container which must have the same characteristics as the primary container.

Definitions of Terms/Abbreviations

AIDS

- Acquired Immune Deficiency Syndrome
- A disabling or life-threatening illness caused by HIV (human immunodeficiency virus). It is the last stage on the long continuum of HIV infection and is characterized by opportunistic infections and/or cancers.

Anti-HBs - Hepatitis B Surface Antibody

- The presence of anti-HBs (hepatitis B surface antibodies) in an individual's blood indicates immunity to hepatitis B disease. This is the test used to indicate that a person has had a serologic response to hepatitis B immunization and has developed antibodies to the infection.

Anti-HCV – Hepatitis C antibody virus

- Indicates past or present infection with hepatitis C.

CDC

- Centers for Disease Control and Prevention
- The branch of the U.S. Public Health Service whose primary responsibility is to propose, coordinate and evaluate changes in the surveillance of disease in the United States.

COVID-19

- The coronavirus SARS-CoV-2, responsible for the pandemic that began in 2020.

Delayed Report

- Not reporting an exposure incident until 24 hours or more hours following the exposure.

Exposure Incident

- 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.

HBIG Hepatitis B Immune Globulin

- A type of vaccine administered in the event of an exposure to hepatitis B disease. The administration of this preparation confers a temporary (passive) immunity or raises the person's resistance to hepatitis B disease.

HBsAg - Hepatitis B Surface Antigen

- A surface antigen of the hepatitis B virus. Indicates potential infectivity.

HCP

- Health Care Personnel / Professional

HIV - Human Immunodeficiency Virus

- The organism that causes AIDS.

LTBI

- Latent Tuberculosis Infection

OPIM - Other Potentially Infectious Materials

- Materials other than human blood that carry the potential for transmitting pathogens.

PEP

- Post Exposure Prophylaxis

Standard Precautions

- Treating all clients as if they are infected with a transmissible disease.

Universal Precautions

- Treating all clients as if they are infected with a transmissible bloodborne disease.

Kinney College of Nursing and Health Professions Management of Exposure or Injury Incidents

Any percutaneous (needle stick, cut, human bite, splash to non-intact skin, etc.) or mucous membrane (splash to eyes, lips, or mouth) exposure to blood, blood products, other body fluids, airborne exposures or injury must be reported immediately by the student to clinical faculty so that appropriate procedures can be initiated. Please see the Kinney College of Nursing and Health Profession's Infection Control Manual for further information.

Management of Exposure Incidents Checklist

☐ For exposures other than air-borne exposures: The affected area was cleansed with antimicrobial soap. Water was run through the glove if a puncture was suspected. Eyes: The eyes were irrigated for one minute. Mouth: The mouth cleansed with tap water for fifteen minutes.

☐ Accident/ Injury Investigation Report completed. This form is to be completed when a student has had an accident, injury, or exposure incident during clinical ("clinical" includes activities labeled as fieldwork or internships). The injured should complete the entire first page, and sign and date the form. Both pages are given to the clinical preceptor/supervisor, who should fill out the top section of the second page. Both pages are given to the program designee, who should make sure all portions of the form are filled out. Finally, the form is given to the Chair of the Infection Control Committee in the Kinney College of Nursing and Health Professions by the program designee. This form is also used to document when a student is involved in a patient care incident. The "Injured person section" should record the name of the student involved in the incident if they are the injured party. If they are not the injured party, they are listed as the witness.

☐ Student Exposure Incident Report completed. This form is to be completed when a student has had an exposure incident. This form is not used when there is no exposure. (Ex: A clean needle stick is not an exposure and only the accident/injury form is filled out). The first page of the form and the top section of the second page can be filled out by a student or in conjunction with a clinical preceptor. The second portion on the second page is to be filled out by a provider if the student seeks treatment. Otherwise, the clinical preceptor should note that the student refused treatment and make sure the student fills out the **Acknowledgement of Refusal to Seek Management of Exposure Incident** form. The student needs to sign and date the third section of the second page. This form (and if applicable **Acknowledgement of Refusal to Seek Management of Exposure Incident** form) is given to the program designee, who makes sure all portions of the form are filled out. Finally, all forms are given to the Chair of the Infection Control Committee in the Kinney College of Nursing and Health Professions by the program designee.

☐ Exposed student is provided a copy of the Student Exposure Incident Report and sent for treatment as recommended by primary HCP. The student takes the form for treatment and has the provider seen fill out the top portion of the second page. The student should then turn in the completed form to the program designee who makes sure all portions of the form are filled out. Finally, all forms are given to the Chair of the Infection Control Committee in the Kinney College of Nursing and Health Professions. (*For TB exposures, students will receive notice of exposure to suspected or active cases of TB through either the clinical facility's employee health department where they were exposed or, in cases of active TB, through the county health department. Instructions for follow-up are provided by the notifying department.)*

- ☐ Source Patient Management: The source client, if known, should be serologically tested for evidence of HIV, HbsAg, and anti-HCV. Please circle one:

Source patient known and tested Source patient known and refused testing Source patient unknown Not applicable

☐ Clinical Facility's Incident Report completed. The student should notify the clinical preceptor/supervisor of the incident to make sure the appropriate clinical facility form is completed. This is a clinical affiliate form and does not get turned into the University.

Clinical Affiliate Preceptor Signature: _____Date: _____

Program _____ Course Name and Number _____

☐ The completed Accident/Injury Investigation Report, Student Exposure Incident Report and Management of Exposure Check List returned to the program designee within 24 hours or as soon as possible.

Program Designee* Signature: _____ Date: _____

☐ Postexposure management/counseling completed. Students have the right to be counseled about exposure by university faculty if desired.

Please circle one: Counseling completed Counseling declined

University Faculty* Signature: _____ Date: _____

*Program Designee: the individual in your specific program who is responsible for receiving and processing the exposure incident form **before** it is submitted to the Infection Control Committee Chair

*University Faculty: The individual responsible for performing **post-exposure management and counseling**

(Rev. 04/30/25)

Kinney College of Nursing and Health Professions

Acknowledgement of Refusal to Seek Management of Exposure Incident

Any percutaneous (needlestick, cut, human bite, splash to non-intact skin, etc.) or mucous membrane (splash to eye, lips, or mouth) exposure to blood, blood products, body fluids, or airborne pathogens is to be reported immediately by the student to the clinical faculty so that appropriate post-exposure procedures can be initiated. The Public Health Services, (PHS), recommends that treatment should be recommended to healthcare workers who experience occupational high-risk exposures. Please refer to the Kinney College of Nursing and Health Professions Infection Control Policy.

I understand that I have been advised to seek prompt management of an exposure incident. At this time, I am refusing referral to a healthcare professional for recommendation regarding the need for evaluation and the need for chemoprophylaxis.

Date of Exposure Incident: _____ Time of Exposure Incident: _____

Institution where the incident took place: _____

Summary of incident: _____

_____

_____

_____

_____

Student Name: _____

Student Signature: _____Date/Time:_____

Advising Faculty:_____Date:_____

Kinney College of Nursing and Health Professions

Student Exposure Incident Report

Exposed Student Information:

Program: _____

Student Name: _____DOB:_____

Date Incident Occurred: _____ Time Incident Occurred: _____ Time Reported: _____ Does the student have a positive hepatitis B titer? [ ] yes [ ] no

Post-vaccination HBV antibody status, if known: [ ] positive [ ] negative [ ] unknown

Date of Last Tetanus Vaccination: _____ Date of Last Tuberculin Test: _____

Exposure Incident Information:

Agency/site where incident occurred (include specific unit): _____

Type of incident:

- [ ] needle stick
- [ ] instrument puncture
- [ ] bur laceration
- [ ] injury from other sharp object: _____
- [ ] blood/other body fluid splash or spray
- [ ] human bite
- [ ] other _____

Area of body exposed: _____

Type of body fluid/tissue/airborne pathogen exposed to: _____

Describe incident in detail: _____

_____

_____

What barriers were being used by the student when the incident occurred?

[ ] gloves [ ] mask [ ] eye wear [ ] gown [ ] other _____

Source Patient Information:

Access to source patient information is known/available [ ] yes [ ] no

If the answer is **yes**, complete the following information about the source patient:

Review of source patient medical history: [ ] yes [ ] no

Verbally questioned regarding:

History of hepatitis B, hepatitis C, or HIV infection [ ] yes [ ] no

High risk history associated with these diseases [ ] yes [ ] no

Patient consents to be tested for HBV, HCV, and HIV [ ] yes [ ] no

Referred to (name of evaluating healthcare professional/facility): _____

Incident report completed by: _____

Post-exposure management/counseling (to be completed by evaluating health care provider):

Date: _____ Time: _____

Comments: _____

_____

_____

_____

Counselor Signature: _____

I have reviewed and confirm the accuracy of the information contained in this report. I acknowledge that I have been referred for medical evaluation and may need to receive additional medical evaluation as prescribed by the physician, *at my own expense.* I authorize the release of the information related to this exposure incident for treatment, payment activities, and healthcare operations.

Student Signature: _____ Date: _____

TO BE COMPLETED BY THE KINNEY COLLEGE OF NURSING AND HEALTH PROFESSIONS INFECTION CONTROL COMMITTEE CHAIR

Corrective action needed: _____

_____

Has this action been taken? [ ] yes [ ] no

Is further investigation needed? [ ] yes [ ] no

Comments: _____

_____

Signature: _____Date _____

Updated August 2025

ACCIDENT / INJURY INVESTIGATION REPORT
INSTRUCTIONS

The attached form must be completed for injuries to employees, students, visitors or volunteers that occur on the job or during USI activities/events on or off campus.

Form should be completed within 24 hours of an incident.

CLAIMANT/INJURED (Employee, Student Worker, Student, Visitor, or Volunteer)

1. Complete entire 1st page, sign and date form.
2. Give both pages of Accident/Injury form to your supervisor or program director for completion.

SUPERVISOR OR PROGRAM DIRECTOR OF CLAIMAINT/INJURED

1. Complete top section of page 2, sign and date form.
2. Return completed Accident/Injury Investigation Form to:
   - Human Resources – for injured employee or student worker.
   - Department of Risk Management – for injured student, visitor, or volunteer.

ACCIDENT / INJURY INVESTIGATION REPORT

UNIVERSITY OF SOUTHERN INDIANA

Form revised 5/1/15

MUST BE COMPLETED AND RETURNED WITHIN 24 HOURS OF ACCIDENT

☐ Employee ☐ Student Worker ☐ Student ☐ Visitor ☐ Volunteer

Date of Report _____ Time of Report _____ ☐ A.M. ☐ P.M.

INJURED PERSON INFORMATION

Name of Injured _____ ☐ Male ☐ Female

Permanent Address _____

City _____ State _____ Zip _____

Date of Birth _____ USI Employee ID # _____

Telephone: Home / Cell _____ Telephone: Work _____

Department _____ Job Title _____

Number of hours scheduled to work per week _____

WITNESS INFORMATION

Name(s) of Witness _____

Telephone: Home / Cell _____ Telephone: Work _____

STATEMENT OF INJURED PERSON OR WITNESS

Date of Accident _____ Time of Accident _____ ☐ A.M. ☐ P.M.

Location of Accident _____ Type of Injury (e.g., strain, laceration) _____

Cause of Injury (e.g., slip/fall , lifting) _____ Part of Body Affected (e.g., arm, leg, back) _____

Description of Accident _____

Is Treatment being sought? If so, where? _____

I authorize the release of any medical information relating to this injury / illness to the University's relevant insurers for review of this claim.

Signature of Injured Person _____ Date _____

SECOND PAGE MUST BE COMPLETED BY SUPERVISOR OR PROGRAM DIRECTOR

1 of 2

TO BE COMPLETED BY THE SUPERVISOR OF THE ACTIVITY OR PROGRAM DIRECTOR
(attach additional information if necessary)

Name of Injured Person _____ **Time employee's work day began (if employee)** _____ ☐ **A.M.** ☐ **P.M.**

Evaluation of how accident occurred / contributing factors _____

Possible Preventative Actions (actions that have been / will be taken to prevent recurrence) _____

Work Phone of Supervisor or Program Director _____ **Date signed** _____

Signature of Supervisor or Program Director _____

Printed Name of Supervisor or Program Director _____

FOR HUMAN RESOURCES USE ONLY

Lost Time ☐ **Yes** ☐ **No**

Number of Days _____ **Anticipated Release Date** _____

Work Restrictions _____

Medical Treatment _____

EMPLOYEE OR STUDENT WORKER:
FILL IN FORM, FORWARD TO SUPERVISOR FOR COMPLETION. SUPERVISOR FORWARD TO HUMAN RESOURCES.

STUDENT, VISITOR OR VOLUNTEER: FILL IN FORM, FORWARD TO SUPERVISOR OR PROGRAM DIRECTOR.
SUPERVISOR OR PROGRAM DIRECTOR PLEASE FORWARD TO THE DEPARTMENT OF RISK MANAGEMENT.