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Management of Needlestick and Mucous Membrane Exposures to Blood/Body Fluids

Exposure Occurs
- Laceration, Puncture Wound, Splatter or Splash
- To Mucous Membranes, Eyes or Non-intact Skin

Student/Employee
- Stop Procedure
- Apply First Aid
  - Wash Area with Soap and Water
  - Flood Eyes with Water from Eye Wash Station
  - Flush Mucous Membranes with Water
- See Clinic Director Immediately

Clinic Director or Designate
- Assess Exposure using Checklist A
- Assess Source Patient using Checklist B

Low Risk Exposure
- No Referral Required

High Risk Exposure
Clinic Director or Designate
- Provide Counselling to Source Patient and Receive Consent for Bloodwork
- Arrange for Student/Employee and Source Patient to be seen at QE II Health Sciences Centre Emergency Department 1796 Summer Street
- Complete Incident Report
Checklist A
To Assess Exposure for Risk of Infection
(To be completed by Clinic Director or Designate)

Source Material
• Bloody Fluid
• Blood
• Instrument contaminated with one of these substances

No
• No Follow-Up Required

Yes
• Complete Accident Report

Type of Exposure

Intact Skin
• No Follow-Up Required

Mucous Membrane or Non-Intact Skin
• Volume

Small
• Few drops
• Short duration

Large
• Several drops
• Major Splash
• Long Duration >2 minutes

Less Severe
• Solid Needle
• Superficial Scratch

More Severe
• Large Bore Hollow Needle
• Deep Puncture
• Needle used in Source Patients Artery or Vein

Follow-Up
• Assess Source Patient using Checklist B
• Obtain Consent from Source and Provide Counselling Prior to Blood Work
• Arrange for Student/Employee and Source Patient to be Seen at QE II Emergency Department
Checklist B
To Assess Source Patient After Exposure
(To be completed by Clinic Director or Designate)

1. Inform the Source Patient of the reason for the enquiry and allow them time to read Information for Patients.

2. Evaluate the Source Patient’s risk of blood-borne infection by reviewing their medical history for clinical symptoms and asking them for additional information.

Do you know if you are Hepatitis B, Hepatitis C, or HIV positive or have any risk factors for exposure to these viruses?

Hepatitis B  ___ Yes ___ No ______ Date Diagnosed
Hepatitis C  ___ Yes ___ No ______ Date Diagnosed
HIV  ___ Yes ___ No ______ Date Diagnosed

Stage of Illness ___
Antiretroviral medications:___________________________________________

Risk Factors ___ Yes ___ No
Risk Factors may include:
a) IV drug use/shared needles
b) receiving blood products (before 1986 for HIV, before 1986 for HCV)
c) multiple sex partners
d) men having sex with men
e) partner with Hepatitis B, Hepatitis C or HIV or any of the above risk factors

3. Request Source Patient’s consent to obtain blood for testing of their Hepatitis B, Hepatitis C and HIV status.

Physician to whom test results should be sent:
Dr. ___________________________             Telephone Number__________

Address ________________________________________________________

Test results will also be sent to Clinic Director, Faculty of Dentistry.
Sometimes, during the course of treatment, injuries occur to our students/employees which expose them to a patient’s blood. This may lead to an infection. In order to reduce the risk of infection after an injury it is important to know if the patient is infected with certain organisms. These include Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (the virus that causes AIDS).

Such an injury has recently occurred and your blood has come in contact with one of our students/employees. We would appreciate your cooperation in allowing a blood test to be taken so that we can determine if there is a risk of passing on an infection from you to the student/employee. You will receive the test results. The test results will be known by the physician ordering the tests and by your family physician if you wish. The results will be kept confidential.

The Faculty of Dentistry has policies and procedures in place to reduce injuries to students/employees. However, when accidents occur, we want to ensure that our students/employees receive proper care. We appreciate your assistance in helping us to achieve this.

Consent To Give Blood For Hepatitis B, Hepatitis C, and HIV Testing
I have discussed the reasons for these blood tests with the witness to my signature and agree to give blood for Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus testing.

Patient’s Name:_______________________
Patient’s Signature:_____________________ Date: _____________

Witness’s Name:_______________________
Witness’s Signature:_____________________ Date: _____________
Medical Follow-up
Needlestick and Mucous Membrane Exposures

The Following Procedures will be directed by the Attending Physician at QE II Emergency Department:

1. Medical management of the injury.

2. Testing of the Source Patient for Hepatitis B surface antigen, Hepatitis C antibody, and HIV antibodies with appropriate pre and post counselling and informed consent. Testing of the Exposed Individual for Hepatitis B surface antibodies (if vaccinated), Hepatitis C antibodies, and HIV antibodies. Source patient may choose to have blood work through their personal physician and results forwarded to University Health Services.

3. Determine the need for Post-Exposure Prophylaxis. Discuss with the Exposed Individual the benefits and side-effects of HIV prophylaxis. Exposed Individual will go to QE II Emergency Department for HIV starter kit, which contains 5 day supply of additional medications.

4. Documentation of the following information in the Exposed Individual's confidential medical file:
   - date and time of exposure
   - details of the procedure being performed by individual at time of exposure
   - details of exposure including amount of fluid or material, type of fluid or material, and severity of exposure
   - details of exposure source
   - details of counselling, post-exposure management and follow-up.

5. Follow-up care of the Exposed Individual including counselling, medical evaluation and blood tests at 3 months, 6 months, and 12 months. Instruct the Exposed Individual to contact physician if they experience acute febrile illness.
## Capital Health
### Out-patient Microbiology Requisition

Queen Elizabeth II Health Sciences Centre  
5788 University Avenue, Halifax, NS  B3H 1V8

Laboratory Reports  
Ph: 473-2266  Fax: 473-5566

Microbiology Processing Area  
Ph: 473-2120  Fax: 473-4120

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### ONE REQUISITION PER SPECIMEN TYPE

LABEL SPECIMEN WITH PATIENT’S FULL NAME AND HEALTH CARD NUMBER

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### RELEVANT CLINICAL INFORMATION

- **Collection date:** MM / DD
- **Collection time:**
  - Pregnant
  - Prenatal
  - Current Antibiotics: ___________
  - Current Antibiotics (source person): ___________
  - Pre transplant screen
  - Pathology
- **Travelled to/immigrated from outside North America:**
- **Culture:**
  - C. difficile cytotoxin
- **Examination Requested:**
  - Microscopic Exam
  - Culture
  - Gram Stain
  - KOH (for fungi)
  - Virus (specify) ___________ (transport media required)
  - Mycobacteria
  - Helicobacter pylori
  - Lyme disease
  - Syphilis
  - Syphilis screen (RPR)
- **Hepatitis:**
  - Immune Status
  - Hepatitis A
  - Hepatitis B (Anti-HBs)
  - Disease Diagnosis
  - Hepatitis A
  - Hepatitis B (HBsAg)
  - Hepatitis C screening (lgG)
  - Previously HCV positive
  - Other ___________
  - Measles (Rubeola)
    - Immune status (lgG)
    - Diagnosis (lgM)
  - Rubella
    - Immune status (lgG)
    - Diagnosis (lgM)
  - Parvovirus B19
    - Immune status (lgG)
    - Diagnosis (lgM)
  - Varicella-Zoster
    - Immune status (lgG)
- **Other Serology:**
  - Toxoplasmosis
    - Immune status (lgG)
    - Diagnosis (lgM)
  - Infectious mononucleosis
    - Monoscreen
  - Retroviruses
    - HIV 1&2
- **Indication for Testing:**
  - Post immunization
  - Specimen from needlestick injury (exposed person)
  - Specimen from needlestick injury (source person)
  - Pre transplant screen
  - Vaginosis/yeast/trichomonas gram stain
  - Urethral swab for Neisseria gonorrhoeae culture
  - Urethral swab for Chlamydia (transport media required)
  - Cervical swab for Neisseria gonorrhoeae culture
  - Cervical swab for Chlamydia (transport media required)
  - Urine for Chlamydia by PCR (males only – first void urine)
  - Vag/rectal Group B Strep prenatal screen
- **Examination Requested:**
  - Microscopic Exam
  - Culture
  - Gram Stain
  - KOH (for fungi)
  - Virus (specify) ___________ (transport media required)
  - Mycobacteria
  - Helicobacter pylori
  - Lyme disease
  - Syphilis
  - Syphilis screen (RPR)
- **Other Tests Not Specified Above**
  - Request:
  - Clinically relevant information:

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### ADDITIONAL COPY TO PHYSICIAN:

- **Name:**
- **Address:**
- **PMB #:**

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### FINANCIAL RESPONSIBILITY (IF NOT ROUTINE):

- **Research Acct #**
- **WCB**
- **Other**

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### MOST COMMONLY REQUESTED (IF NOT IN THIS SECTION, MOVE TO NEXT)

- **Sputum**
- **Skin scrapings (specify site):**
- **Other (specify site):**
- **Vagina**
- **Eye swab**

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<table>
<thead>
<tr>
<th><strong>INFORMATION</strong></th>
<th><strong>DATE, TIME &amp; LOCATION OF INCIDENT (IN DETAIL)</strong></th>
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<tbody>
<tr>
<td>Last Name</td>
<td>First Name &amp; Initial</td>
</tr>
<tr>
<td>Dalhousie ID #</td>
<td>Dalhousie Phone #</td>
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<tr>
<td>Home Address</td>
<td>Home Phone #</td>
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<tr>
<td>Faculty/Department</td>
<td>Classification</td>
</tr>
<tr>
<td></td>
<td>Name &amp; Phone of Witnesses</td>
</tr>
<tr>
<td></td>
<td>Date, Time &amp; Location of Incident (In Detail)</td>
</tr>
</tbody>
</table>

**INCIDENT**

Describe the incident in detail. (Include sequence of events leading to the incident, what the person was doing, and what conditions contributed to the incident.)

When and to whom was the incident reported?

Did the incident result in an early departure from the University? Yes [ ] No [ ]

Time

**INJURY**

Describe Injuries:

Briefly describe medical treatment. (Include name of doctor & hospital) None needed [ ]

**FOLLOWUP**

Date [ ]

Person involved in Incident [ ]

Describe previous similar incidents.

Based on the supervisor's knowledge of the job and work conditions, what steps should be taken to prevent a recurrence?

Date [ ]

Supervisor/Director/Department Head [ ]

Please return the completed form to the Director of Safety within 48 hours of the incident. Use additional pages if necessary. Report fires and serious personal injuries immediately to Security from Dalhousie phones - 4109, from external phones - 494-4109.