Section 1: **Healthy Workplace**

Policy number: **1.4**

Subject: **Management of Occupational Accidental Exposure to Infectious Diseases**

Issued: **September 2015**

Revised:

Distribution: **All FNIHB Staff**

1 PURPOSE

1.1 The purpose of this policy is to protect the personal health and well-being of employees; to prevent the inadvertent transmission of infectious diseases while providing care to clients; and to ensure workplace safety in compliance with the Ontario Occupational Health and Safety Act and Canada Labour Code.

2 POLICY

2.1 Prevention of transmission of infection and the accidental exposure to infectious diseases in a health care facility or home setting is an important component of client care. The most important airborne transmitted infections are tuberculosis, measles, and varicella. Droplet-spread diseases that may be encountered in health facilities may include pertussis, mumps, rubella, influenza, meningitis, and other acute respiratory infections (ARIs). Common diseases transmitted by contact include conjunctivitis, impetigo, scabies, norovirus and MRSA.

2.2 HCP adherence to immunization requirements and recommendations are the most effective methods of controlling vaccine preventable diseases (Refer to Policy 1.1 Staff Immunization). Where HCPs are not immunized, post exposure prophylaxis may be required, which may include treatment or immunization for: rabies, varicella/zoster, HIV, influenza (outbreaks), diphtheria, hepatitis A, hepatitis B, meningococcal disease, pertussis or scabies.

2.3 HCPs must practice hand hygiene, respiratory hygiene and cough etiquette as part of Routine Practices in all health care settings.

2.4 HCPs have a responsibility to their clients and colleagues to not report to work when ill with symptoms that are likely attributable to an infectious disease. HCPs must report any acute infectious disease and/or possible accidental exposure to an infectious disease as it could impact their work activities within the community. HCPs must comply with any such recommendations regarding work restrictions and/or modifications that may result.

3 PROCEDURE

For Occupational Exposures to Blood and Body Fluids refer to Policy 1.3

3.1 Prevention

3.1.1 All FNIHB - OR HCPs are expected to meet current immunization recommendations and to maintain up-to-date immunization status as outlined in Policy 1.1 Staff Immunization.

3.1.2 All FNIHB - OR HCPs should not report to work if they are ill and experiencing any of the following (but not limited to) symptoms:

3.1.2.1 A fever

3.1.2.2 An undiagnosed rash

3.1.2.3 Flu-like symptoms

3.1.2.4 Diarrhea and/or vomiting

3.1.2.5 Eye infection

3.1.2.6 Other infectious illness as recommended by a physician

3.1.3 All FNIHB – OR HCPs must consistently use Routine Practices, including hand hygiene, application of PPE based on a risk assessment (which may include applying mask, eye protection, gown, gloves) and adhere to Additional Practices when indicated. (Refer to Section 3.0: Routine Practices and Section 4.0: Additional Precautions)

3.1.4 Staff must practice Respiratory Hygiene and Cough Etiquette which refers to measures designed to minimize the transmission of respiratory pathogens via the droplet route in all health care settings using source containment beginning at the point of initial client encounter. (Refer to Policy 3.2 Risk Assessments Including Acute Respiratory Infection).

3.2 Asymptomatic HCPs as Carriers of Blood-Borne Pathogens (as per OMA/OHA Communicable Disease Surveillance Protocol)

3.2.1 Most HCPs carrying HBV, HCV or HIV can work safely with clients without risk of transmission of the virus, as long as reasonable precautions are taken and Routine Practices are observed at all times. Therefore, routine screening of staff is not required after screening at employment.

3.2.2 Asymptomatic infected HCPs who perform “exposure–prone” procedures (e.g. repair of major traumatic injuries) have an ethical obligation to know their serology status for HBV, HCV and HIV and to seek guidance from their professional regulatory body, or for those with no regulatory body, the Regional Community Medicine Specialist with respect to the potential for transmission of infection to their clients.

NOTE: Some professional colleges have specific policies with regard to blood-borne pathogen infected health care professionals licensed by the college; health care professionals must be aware of and follow the requirements of their college.

3.3 Risk Assessment of Disease/Exposure Incident:

3.3.1 The HCP must report the exposure/disease incurred to their manager or designate who will facilitate the affected staff member to be immediately assessed at the local medical care facility (medical clinic, hospital emergency). If the exposure occurs in a remote or isolated community, the employee will contact the community physician for assessment. In the event that the community physician is not available, the employee may contact the Regional Community Medicine Specialist. It may be necessary for the worker to obtain further assessment outside of the community. The employee should be advised of the support available to them through the Employee Assistance Program (EAP).

3.3.2 If the exposure was to a disease that is vaccine preventable, and their immune status is not known, serology should be completed to verify immunity to diseases such as: measles, mumps, rubella, varicella, pertussis, hepatitis A or B.

3.3.3 If staff is susceptible, the staff may require **post exposure prophylaxis OR immunization** which in some situations may prevent them from acquiring the disease; e.g. measles, mumps, rubella, varicella/zoster, diphtheria, pertussis, hepatitis A, hepatitis B, meningitis, rabies, influenza, diphtheria, meningococcal disease, pertussis.

3.3.4 If the results of the investigation determine a staff member had a significant exposure, and is found to be susceptible to the infectious disease, or becomes sick with the illness, they may need to be excluded from work during the period of time when they may be at risk of transmitting the disease. Refer to the OHA/OMA communicable disease surveillance protocols for periods of communicability, and periods of time when staff should be furloughed. Also refer to NACI Canadian Immunization Guide current edition, and the PHAC Routine Practices and Additional Precautions (2013), Table 10 Transmission Characteristics and Precautions by Specific Etiology.

3.3.5 The risk assessment/evaluation should include the circumstances around the actual or potential exposure, which may include, but is not limited to proximity of staff to ill client, length of exposure, medical device that led to exposure, and the type of Personal Protective Equipment (PPE) being worn at the time of the potential exposure and/or if the employee is exhibiting any signs or symptoms of an infectious disease.

3.3.6 Following a report from the medical assessment, the appropriate manager, will facilitate any need for work restrictions during incubation or active disease. Human Resources Department should be included in these discussions.

3.4 Reporting:

3.4.1 The employee must report the incident/injury/exposure to their manager or designate who will facilitate the affected employee to be immediately assessed at the local medical care facility (medical clinic, hospital emergency). If the injury or exposure occurs in a remote or isolated community, the employee will contact the community physician for assessment to determine if immunity screening, post-exposure prophylaxis or immunization is required. In the event that the community physician is not available, the employee may contact the Regional Community Medicine Officer. It may be necessary for the worker to obtain further assessment outside of the community.

3.4.2 The employee should be advised of the support available to them through the Employee Assistance Program (EAP).

3.4.3 Process for Reporting Injuries/Incidents/Exposures: (Refer to http://www.esdc.gc.ca/en/reports/health_safety/hazardous_occurrence.page

3.4.4 Minor Injury/Incident/Exposure with no medical follow-up: Following a minor injury/incident/exposure that **requires first-aid treatment** only i.e. no professional medical attention sought and no time lost, the manager will complete a Hazardous Occurrence Investigation Report (HOIR) electronically using the Accident Incident Reporting System (AIRS) database **within 14 days** of the incident. It will automatically be submitted to Human Resources and Skills Development Canada (HRSDC). A copy is to be given to the employee.

3.4.5 Minor Injury/Incident/Exposure with medical follow-up: If an injury/exposure/incident **requires professional medical treatment resulting in no time lost** i.e. does not prevent an employee from reporting for work or from effectively performing all the duties connected with their regular work, the manager will complete a HOIR electronically using the Accident Incident Reporting System (AIRS) database **within 14 days** of the incident. The manager **must** complete the relevant provincial Workplace Safety Insurance Board (WSIB) Claim – Form 7. (available at http://www.wsib.on.ca/wsib/wsibsite.nsf/public/home_e) and fax it **within 3 days** to the HRSDC – Injury Compensation Program at (819) 934-6590 and also fax one copy to the Corporate Occupational Health and Safety Unit, at 613-960-1528. Please note: Forms are **not** to be sent directly to the WSIB. A copy of the form 7 is to be given to the employee.

3.4.5.1 Once the provincial Workplace Safety Insurance Board (WSIB) receives the Form 7, they may contact the employee directly for more information and request the employee to complete a Workplace Safety and Insurance Board (WSIB) Worker's Report of Injury/Disease (Form 6) available athttp://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdey/~edisp/wsib012386.pdf.

NOTE: If a Form 7 was submitted, the employee has an option of voluntarily completing a Workplace Safety and Insurance Board (WSIB) Worker's Report of Injury/Disease (Form 6) available athttp://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdex/~edisp/wsib011595.pdf. The employee should contact WSIB as soon as possible for detailed instructions for submission. The employee will give a copy of the completed form 6 to the employer /HR.

3.4.6 Disabling Injury / occupationally acquired illness: If an injury/incident/exposure requires medical attention and results in lost time **(**day of injury is not counted as day/time lost, even if the employee left work early) i.e. injury, incident, exposure or furlough prevents an employee from reporting for work or from effectively performing all the duties connected with their regular work, the manager will complete a HOIR electronically using the Accident Incident Reporting System (AIRS) database **within 14 days** of the incident. The manager must also:

3.4.6.1 Complete the relevant provincial Workplace Safety Insurance Board (WSIB) Claim – Form 7 available at http://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdey/~edisp/wsib012386.pdf

3.4.6.2 Fax it **within 3 days** to the HRSDC – Injury Compensation Program at 819-934-6590 and also

3.4.6.3 Fax one copy to the Corporate Occupational Health and Safety Unit, at 613-960-1528. Note: Forms are **not** to be sent directly to the WSIB. A copy of the form 7 is to be given to the employee.

3.4.6.4 Once the employee returns to work, a WSIB Form 9 must be sent to HRSDC.

3.4.7 The employee can voluntarily report an incident to WSIB through the "Program for Exposure Incident Reporting"(PEIR). In this voluntary program, an exposure incident is defined as "an unplanned exposure to a chemical, physical or biological hazard resulting from a leak, spill, escape, explosion or direct physical contact". The purpose of the program is to collect information while it is readily available, in the event an illness occurs in the future. The employer can also report non-significant exposures to this program, but should discuss this first with the appropriate federal Labour Program regional injury compensation office.

3.4.8 For assistance in completing reporting forms contact HRSDC – Injury Compensation Program.

3.4.9 All reports of the injury/incident/exposure are to be kept by the employer for a period of 10 years. Where there has been an exposure to designated substances (e.g. asbestos), the report must be kept indefinitely, or for 40 years.

4 REFERENCES

Canada Occupational Health and Safety Regulations, Part 15 Hazardous Occurrence Investigation Recording and Reporting. Retrieved from: http://laws-lois.justice.gc.ca/eng/regulations/sor-86-304/

Canadian Paediatric Society. (2008). Position Statement on Infection Control in Paediatric Office Settings: *Paediatric Child Health.* 13(5), 408-419.

Friedman, C., Petersen, K.H. (2004). Infection Control in Ambulatory Care. Sudbury, MA: Jones and Barlett Publishers

Health Canada. (2012). Occupational Health Assessment Guide. Retrieved from: http://publiservice.gc.ca/services/rapb-dgrp/psohp-pstfp/assets/pdf/ohag-gest/ohag-gest_e.pdf

Health Canada. (2002). Prevention and Control of Occupational Infections in Health Care. An Infection Control Guideline. CCDR 2002; 28S1:1-264

Ontario Hospital Association. (2014). Communicable Disease Surveillance Protocols. Retrieved from:http://www.oha.com/Services/HealthSafety/Pages/CommunicableDiseasesSurveillanceProtocols.aspx

PHAC. (2013). Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care. Table 10.

Workplace Safety & Insurance Board. (2012). Construction Exposure Incident Reporting. http://www.wsib.on.ca

Government of Ontario. (1990). Occupational Health Safety Act: Designated Substance. Retrieved from *http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_090490_e.htm#BK35*