Assessing the Ability of Hospitals to Report Details of Blood and Body Fluid Exposures in Accordance with Senate Bill 718

Gillian Tarr
Preceptor: Brenda Roup, PhD, RN, CIC
57 cases of HIV in the U.S. were caused by occupational exposures since the epidemic began.

138 additional cases were potentially contracted due to an occupational exposure.

Nurses and clinical laboratory technicians have experienced the majority of occupationally-acquired HIV in the healthcare industry.
Occupational exposure legislation

- Concern for healthcare worker (HCW) safety has prompted legislation in 33 states
- Maryland has been cautious in balancing calls for patient confidentiality and HCW safety
History of occupational exposures in Maryland

• 1991: House Bill 194- Consent required prior to the testing of source blood
• 1996: AIDS Administration “Occupational Exposure Survey”- 6% of source patients refused testing
• 2003: House Bill 343- First responders included in legislation and testing allowed if no substitute consent was available
• 2003: Legislative workgroup report- Only 1% of source patients refused consent
Senate Bill 718

• Effective as of October 2005
• Joined 12 other states in allowing blood testing if a source or substitute refuses consent
• Tasked state agencies to “develop regulations establishing procedures to collect information by county on exposures… and refusals to consent by a patient…”
The Workgroup

- Department of Health and Mental Hygiene
- Maryland Institute for Emergency Medical Services Systems
- AIDS Administration
The Questionnaire

• Questionnaire sent to 51 acute care hospitals in Maryland
• Information requested on both HCW and first responders (FR)
• Hospitals were requested to send policies and procedures regarding occupational exposures to blood and body fluids
• Summary statistics were calculated
Returned questionnaires

• 26 of 51 hospitals returned the questionnaire

• 20 of 26 included policies and procedures
Question 1: Type of information collected

The majority of information collected by hospitals would be irrelevant to the interests of SB 718

- Less than half report recording information on whether labs are done

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of affirmative responses (%)</th>
<th>N = 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCW: Source labs</td>
<td>11 (42%)</td>
<td></td>
</tr>
<tr>
<td>FR: Source labs</td>
<td>6 (23%)</td>
<td></td>
</tr>
<tr>
<td>HCW: Employee labs</td>
<td>13 (50%)</td>
<td></td>
</tr>
<tr>
<td>FR: Employee labs</td>
<td>4 (15%)</td>
<td></td>
</tr>
</tbody>
</table>
Question 2: Recordkeeping tools

- Individual files: 88%
- Logs
  - Physical: 23%
  - Computerized: 69%
  - OSHA: 35%
Question 3: Aggregation and trending

- Almost all hospitals (96%) reported aggregating and/or trending their data on occupational exposures.
- The most common variables to trend by, however, were type of object or sharp involved and other details of the exposure.
- Consent approvals and denials were not listed as variables by which data were trended.
Question 4: Reports

- Again, reporting was generally not specific to matters of consent
- Despite being required by law, only a small percent reported making OSHA reports

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of affirmative responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal board report</td>
<td>19 (73%)</td>
</tr>
<tr>
<td>OSHA report</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>Regular report</td>
<td>20 (77%)</td>
</tr>
<tr>
<td>Report as needed</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>Other reporting</td>
<td>1 (4%)</td>
</tr>
</tbody>
</table>

N = 26
## Question 5: Policies and procedures

<table>
<thead>
<tr>
<th>Steps in occupational exposure procedure</th>
<th>Affirmative responses from all hospitals (%), N = 26</th>
<th>Affirmative responses from hospitals returning policies and procedures (%), N = 20</th>
<th>Affirmative responses from hospitals not returning policies and procedures (%), N = 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent requested</td>
<td>22 (85%)</td>
<td>20 (100%)</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>Substitute consent sought if necessary</td>
<td>11 (42%)</td>
<td>11 (55%)</td>
<td>0</td>
</tr>
<tr>
<td>HIV testing</td>
<td>25 (96%)</td>
<td>20 (100%)</td>
<td>5 (83%)</td>
</tr>
<tr>
<td>Post-testing counseling</td>
<td>19 (73%)</td>
<td>17 (85%)</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>PEP evaluation</td>
<td>21 (81%)</td>
<td>17 (85%)</td>
<td>4 (67%)</td>
</tr>
<tr>
<td>Specified follow-up</td>
<td>19 (73%)</td>
<td>15 (75%)</td>
<td>4 (67%)</td>
</tr>
</tbody>
</table>
Question 5 interpreted

• The results of question 5 as observed in the group that returned policies and procedures indicate that most hospitals follow recommended procedures.

• The difference in those hospitals that only answered the question and did not return policies and procedures suggests that unconfirmed answers to the questionnaire may not be complete.
Recommendation 1

- Policies and procedures would suggest that most of the sought information is contained in employee health files but not tracked in an easily extractable format.
- To decrease the burden on the hospitals, the state could offer to assist with a chart review to extract the needed information from files.
Recommendation 1, cont.

- Considerable privacy and confidentiality assurances would have to be made
- Would require hospitals to set aside large blocks of time
Recommendation 2

• Develop a prospective data collection tool for use by hospitals
• Select a cross-section of hospitals for piloting the tool
• Dual purpose
  – Gather information requested by SB 718
  – Recommend for/against a specific tool for future data collection
Recommendation 2, cont.

- Use a simple paper form to database format that does not require new software
- Do not replicate data hospitals are already collecting, i.e. sharps type, exposure details, etc.
- Develop in cooperation with hospital groups
First responders

- Standards of practice differ among hospitals
- Special effort should be made to partner with emergency departments or others responsible for FR
- Additional data collection for standardization of practices would be advisable but difficult
References


2. Final Report: Workgroup to study the issue of HIV testing of individuals who refuse to consent to HIV testing in the event of an occupational exposure involving a health care worker or first responder HB343. Baltimore: Maryland Department of Health and Mental Hygiene; 2003.


Acknowledgements

• Brenda Roup, Joey Scaletta, and the Workgroup
• Dr. Ibrahim, Dipti Shah, and the PHASE Program
• The hospitals of Maryland