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Bloodborne Pathogens Exposure Response Quick Guide

If an employee is involved in an accident where an exposure to Bloodborne Pathogens (BBP) or exposure to Other Potentially Infectious Material (OPIM) has occurred, the employee should seek consultation and treatment **IMMEDIATELY and as follows:**

1. WASH/FLUSH AREA FOR 15 MINUTES!

- Wash needlesticks, cuts and all skin exposures with soap and water.
- Flush splashes to nose or mouth with water.
- Flush/irrigate eyes with clean water, saline or sterile wash (eye wash).

2. NOTIFY YOUR SUPERVISOR (IF AVAILABLE).

3. SEEK IMMEDIATE MEDICAL ATTENTION AS INDICATED:

OU Employees Working on Main Campus	After Hours and Weekends	OU Employees Working Off Campus
Crittenton Hospital: Occupational Medical Clinic 1101 W. University Drive Rochester, Michigan 48307 Phone: (248) 652-5203	**Crittenton Hospital: Emergency Room** 1101 W. University Drive Rochester, Michigan 48307 Phone: (248) 652-5311	**Go to the NEAREST Hospital Emergency Room!**

4. TAKE WITH YOU:

- A completed and signed Authorization for Employee to Seek Medical Treatment Form
- If possible, a completed Exposure Incident Report Form to present to attending physician.

5. FOLLOW-UP WITH EH&S:

- Provide a copy of the completed Exposure Incident Report Form and a completed Post Exposure Incident Checklist.

Note: All forms are available for download in the Exposure Response Guidance Kit. at www.oakland.edu/ehs/occupational-safety-and-health/bloodborne-pathogens/

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Post-Exposure Incident Checklist

The following steps must be taken, and information provided, in the event of an employee's exposure to blood or other potentially infectious material.

Date of Exposure Incident ______________________________

ACTIVITY	COMPLETION
• Contaminated area was washed with soap and water (or eyewash if the eye) for at least 15 minutes.	____________
• Employee transported to emergency room within 2 hours of incident for anti-viral drugs (following washing/flushing described above).	____________
• Employee furnished with documentation regarding exposure incident.	____________
• The following documentation was forwarded to a Healthcare Professional who is evaluating employee:	
o Bloodborne Pathogens Standard	____________
o Exposure Incident Report	____________
o Employee's medical records	____________
• Source Individual:	
o Identified OR it was determined that ID was not feasible (circle one)	____________
o Authorization to collect blood requested	____________
o Blood tested OR authorization refused (circle one)	____________
• Source individual's blood results given to exposed employee	____________
• Employee informed that any/all follow-up care shall be at no cost to him/her	____________

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Bloodborne Pathogen Exposure Incident Report Form

Name of Employee: ______________________________ Grizzly ID: G__________________

Date of Incident: ______________________________ Time of Incident: __________ am/pm

Job Site/Location: ______________________________ Department: ______________________

Job Description (Description of General Duties): ______________________________

Potentially Infectious Material Involved (e.g. blood, etc.): ______________________________

____

Source of Potentially Infectious Material (e.g. needle-stick, cut, bite, etc.): ______________________________

____

Circumstances Surround Exposure Incident (e.g. work being performed, etc.): ______________________________

____

Route of Exposure (e.g. under the skin, unprotected skin, eyes, mouth, etc.): ______________________________

____

How the Exposure occurred (e.g. equipment malfunction, human error, etc.): ______________________________

____

Personal Protection Equipment work at time of Incident: ______________________________

____

Actions Taken at time of Incident (e.g. soap/water clean-up, reporting to supervisor, etc.): ______________________________

____

Recommendation for avoiding repetition: ______________________________

____

____

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Authorization for Employee To Seek Medical Treatment

THIS EMPLOYEE IS REFERRED TO YOU FOR THE FOLLOWING ILLNESS/INJURY:

Name of Injured ____ Grizzly ID. ____________
(Last) (First) (Middle Initial)

Department ______________________________ Telephone Number ____________________

Date of Illness/Injury ________________________ Time of illness/injury ____________________

Description of illness/injury ____

____

Department chair or supervisor's signature ________________________ Date ______________

Department Name ______________________________________ Phone ______________

In my judgement, the above condition ☐ *did* or ☐ *did not* arise of and in the course of my employment at Oakland University. I understand that medical information regarding this condition will be given to my supervisor and/or the Staff Benefits Office. I agree to be responsible for payment if the condition is determined not to be work-related.

Employee Signature ______________________________________ Date ______________

ATTENDING PHYSICIAN'S REPORT

Date ________Time-In ___________ Time-Out __________

1. When did you first see this employee? ____
2. Do you believe this illness/injury to be job-related? ☐ YES ☐ NO ☐ UNCERTAIN (explain) __________

   ____
3. What is the diagnosis? ____
4. Does this illness/injury cause disability from work? ☐ YES ☐ NO
5. If disabled, can work restrictions be applied to allow employee to return to work immediately?

   ☐ YES ☐ NO If yes, identify restrictions

   ☐ One-hand job (☐ Left or ☐ Right) ☐ Dry work ☐ Clean atmosphere ☐ No lifting over _____pounds

   ☐ No pushing or pulling ☐ Cool atmosphere ☐ Other ______________________________
6. How long should these restrictions exist? ____
7. If the employee is unable to immediately return to work in any capacity, when do you expect him/her to return?

   ____
8. Should employee return for follow-up examination/treatment? ☐ YES ☐ NO When? ______________
9. What type and frequency of treatment have you provided? ____________________________________
10. Did the illness/injury require hospitalization? ☐ YES ☐ NO
11. Refer to Crittenton Medical Center? ☐ YES ☐ NO
12. Additional remarks ____

    ____

Physician's Signature ____________________________________ Date ____________________

Please forward this completed form to: Staff Benefits Office • 403 Wilson Hall

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Sharps Injury Incident Report

Please complete a log for each exposure incident involving a sharp.

Name: ______________________ **Phone**: ______________________

Address: ____________ **City**: ____________ **State**: ________ **Zip**: ________

Classification (check one): ___ Faculty ___ Post Doc ___ Grad Student ___ Undergrad Student ___ Other (explain): ______________________

Department: ______________________ **Laboratory Supervisor**: ______________________

Date filled out: ____________ **Date of Injury**: ____________ **Time of Injury**: ____________

Where did the injury take place? Building: ______________________ **Room Number**: ________

Description of the exposure incident:

____

____

____

____

____

Procedure:

___ Draw venous blood
___ Draw arterial blood
___ Injection
___ Other: ______________________
___ Not Applicable
___ Unknown

When did the exposure occur: (check all that apply)

During the use of sharp ____ Disassembling ____
Between steps of a multistep procedure ____
After use and before the disposal of sharp ____
While putting sharp into disposal container ____
Sharp left in an inappropriate place ____
Other: ______________________

Body Part (check all that apply):

____ Finger ____ Face/Head
____ Hand ____ Torso
____ Arm ____ Leg
____ Other: ______________________

Identify Sharp Involved:

Type: ______________________
Brand: ______________________
Model: ______________________

e.g., 18g needle/ABC Medical/ “No Stick” Syringe

Did this device being used have engineering sharps injury protection?
Yes ___ No___ Don’t know___

Was the protective mechanism activated?
Yes-Fully ___ Yes-Partially ___ No ___

Did the exposure incident occur:
Before ____ During ____ After ____ activation

Question 1: If the sharp did not have an “engineered sharps injury” device on the sharp, do you have an opinion on whether this mechanism would have prevented this injury?

____ Yes ____ No

Explain:

____

____

____

Question 2: Do you have an opinion that other engineering, administrative, or work practice controls could have prevented this injury?

___ Yes ____ No

Explain:

____

____

____

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Authorization to Have Blood Drawn and Analyzed for Presence of Viral Infection Source Individual Consent Form

1. Individual's Name ____

   Date of Birth ____

2. I authorize _________________________ (Name of Health Care Facility to draw and analyze my blood for the presence of viral (i.e., HBV or HIV) infection.

3. I understand that the results of this analysis shall be made available to the individual who has been exposed to my blood (in addition to his/her health care provider) and maintained in that individual's CONFIDENTIAL medical records on file at OU.

4. I agree that a photocopy or facsimile of this authorization shall be valid as the original.

____ ___________________

Signed (source individual) Date

____ ___________________

Parent or guardian (if individual is under 18 years of age) Date