PROVIDER CHECKLIST

☐ Provide necessary medical care to treat the injury/exposure.

☐ Refer to the BBP Flow Chart and Procedures (enclosed) as a guide for post-exposure care.

☐ Complete the BBP Exposure Notification form (enclosed) and FAX the completed form to The Health Center Downtown at 504-988-3217.

☐ Provide patient education information.

☐ Complete Informed Consent for Prophylaxis form.

☐ Billing instructions for Students’ Off-Campus Exposures
  o Student’s insurance should be billed.
  o After insurance is billed, the balance should be submitted to The Health Center Downtown.
    For assistance, call The Health Center at 504-988-6929.

Reimbursement will be for reasonable and customary charges for authorized or medically necessary tests as noted in enclosed information. Any additional charges will not be reimbursed.
STUDENT CHECKLIST

☐ Wash exposed area immediately.

☐ Notify supervisor immediately (supervisor to assist with obtaining source consent and lab work).
   
   o Have supervisor document in source’s medical record “source of occupational exposure” and that labs were drawn for **HIV, HCV, and HBsAg** (Hepatitis B surface antigen) with source’s consent.

   ***You must report the exposure and have HIV lab testing done within ten (10) days to receive maximum benefits.***

☐ Seek post-exposure care as soon as possible, but within 2 hours of exposure. Students should report to The Health Center Downtown or Emergency Department.

☐ Student On-campus Exposures:

   - **Weekdays, Monday-Friday, 8:30 a.m.-5:00 p.m.**
     - Report to The Health Center Downtown, Phone: 504-988-6929
     - Complete **BBP Exposure Notification** form at The Health Center

   - **After hours, weekends, or holidays**
     - Report to Emergency Department and **follow-up in The Health Center Downtown the next business day**.
     - Complete **BBP Exposure Notification** form at the Emergency Department and FAX the completed form to 504-988-3217 at The Health Center Downtown

☐ Student Off-site Exposures:

   - Follow clinic-specific policy.
     - Obtain packet from campushealth.tulane.edu website for required forms, procedures, and information.
     - Complete **BBP Exposure Notification** form and FAX the completed form to 504-988-3217 at The Health Center Downtown.

The Blood Borne Pathogen (BBP) Exposure Notification form is available:

   - In this packet
   - From The Health Center Downtown
   - Online at https://campushealth.tulane.edu/emergency/bloodborne-pathogen-emergency

Tulane’s Health Center Downtown is open Monday-Friday, 8:30 a.m.-5:00 p.m.
Phone: 504-988-6929 | Fax: 504-988-3217
After Hours Nurse Advice: 855-487-0290

Online at https://campushealth.tulane.edu/emergency/bloodborne-pathogen-emergency
SUPERVISOR / FACULTY CHECKLIST

☐ Please refer student for post exposure care immediately.

☐ Student seek post-exposure care as soon as possible, but within 2 hours of exposure. Students should report to The Health Center Downtown or Emergency Department.

☐ Student On-campus Exposures:

  - Weekdays, Monday-Friday, 8:30 a.m.-5:00 p.m., student should:
    - Report to The Health Center Downtown, Phone: 504-988-6929
    - Complete BBP Exposure Notification form at The Health Center

  - After hours, weekends, or holidays
    - Report to Emergency Department and follow-up in The Health Center Downtown the next business day.
    - Complete BBP Exposure Notification form at the Emergency Department and FAX the completed form to 504-988-3217 at The Health Center Downtown

☐ Student Off-site Exposures:

  - Follow clinic-specific policy.
    - Obtain packet from campushealth.tulane.edu website for required forms, procedures, and information.
    - Complete BBP Exposure Notification form and FAX the completed form to 504-988-3217 at The Health Center Downtown.

☐ Please assist student with obtaining source consent and source lab work.

☐ Document in source’s medical record “source of occupational exposure” and that labs were drawn for: HIV, HCV, and HBsAg with source’s consent.

☐ Remind student to report exposure by completing “BBP Exposure Notification Form”
BBP EXPOSURE NOTIFICATION FORM

Name: ___________________________ Home #: ___________________________

Work #: ___________________________ Cell #: ___________________________

□ I am a student. □ Yes □ No If yes, please provide Splash Card #: __________

Name of School: ___________________________

Date of Exposure (MM / DD / YYYY): ____ / ____ / ____ Time ________ Please circle: a.m. / p.m.

Location where exposure occurred (Please name the Building / Floor / Room): ___________________________

Personal Protective Equipment (PPE) Used:

☐ Gloves ☐ Eye Protection (Goggles, Etc.) ☐ Face Protection (Mask, Face shield, etc.) ☐ Gown ☐ Other: _________

Was a safety device being used? □ Yes □ No If so, did it work? □ Yes □ No

Type & Brand of Safety Device: ___________________________

Body part exposed (Please circle one): Hand Eye Mouth Other (Please identify): ___________________________

Describe how exposure occurred: ___________________________

Type of body substance exposed to:

☐ blood ☐ body fluid contaminated by blood ☐ semen ☐ vaginal secretions ☐ cerebrospinal

☐ synovial ☐ pleural ☐ peritoneal ☐ pericardial ☐ amniotic fluids ☐ unfixed human tissue

Type of exposure (check all that apply):

☐ Needlestick Depth of Injury ___________________________

□ Yes □ No

Hollow Bore ___________________________

□ Yes □ No

☐ Cut Depth of Injury ___________________________

☐ Yes □ No

Fluid Injected ___________________________

□ Yes □ No

Estimated Volume: ___________________________

How long was body fluid in contact with skin/mucous membranes? ___________________________

☐ Mucous membranes

☐ Non-intact skin (e.g., chapped, abraded, or otherwise non-intact)

Did this exposure occur during the student’s normal work activities? □ Yes □ No

Is patient source known? □ Yes □ No Was source consent obtained? □ Yes □ No

Source lab testing done? □ Yes □ No Source on antiretroviral therapy? □ Yes □ No

List Drugs: ___________________________

Was source blood sent to lab? □ Yes □ No

Exposed student lab testing done? □ Yes □ No

Source name: ___________________________ UH# ___________________________ Location ___________________________

For female students: Pregnancy test result: ___________________________

Was prophylaxis initiated? □ Yes □ No Date/Time of 1st dose ____ / ____ / ____ Time ______ a.m. / p.m.

Have you had training on Standard Precautions within the last 12 months? □ Yes □ No

Person completing form ___________________________ Signature ___________________________ Date/Time ___________________________

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Tulane’s Health Center Downtown is open Monday-Friday, 8:30 a.m.-5:00 p.m.
Phone: 504-988-6929

FAX THIS FORM TO: 504-988-3217

Online at https://campushealth.tulane.edu/emergency/bloodborne-pathogen-emergency
OCCUPATIONAL EXPOSURE TO BLOOD BORNE PATHOGENS (BBP)* MANAGEMENT ALGORITHM

**Supervisor / Student Actions**

- **BBP Exposure Occurs** (Sharps injury or contamination of mucous membranes or nonintact skin)
  - Wash Immediately (flush mucous membranes)
  - Notify Supervisor
  - Send student for medical evaluation and/or possible prophylaxis Immediately
  - Supervisor assists with obtaining informed consent from source (Consent for HIV testing, if required)
  - If needed, obtain source patient’s blood for: rapid HIV test (if available)
  - Document in source’s medical record “source of occupational exposure”
  - Required source patient’s labs: HIV Ag/AB, or AB if Ag/AB unavailable, HepCAB with reflex qualitative RNA and HBsAg, HBcAB, HepBsAB
  - Student labs: HIV 1/2 Ag/AB, Hep C antibody, Hep BsAB, HepBsAg, HepBcAB

**Treatment Provider (Employee Health/Student Health/ED†) or Off-site Provider**

- **Source HIV (+) or HIGH RISK/results pending.**
  - Offer chemoprophylaxis 2–5 days, (until source results rec’d)
  - Prior to therapy obtain:
    - HIV Ag/AB, CBC, CMP, CPK (Repeat @ 2 wks, 4 wks & 6 wks), & Pregnancy Test (urine or serum) (Repeat @ 2 wks)
    - Truvada (Tenofovir/Emtricitabine 300/200mg): 1 tablet daily. **With either:**
      - Raltegravir (Isentress) 400mg: 1 Tablet twice daily
      - Dolutegravir 50mg (Tivicay): 1 Tablet daily

- **Source HIV (-) Source HCV(-)**
  - Lab work for HIV and or HCV @ Exposure and (optional) @ 3, 6 mos.
  - HCV antibody @ exposure Qualitative RNA (PCR) @ 6 wks, 3 mos, & 6 mos.

- **Source HBV (+) & Employee/student not vaccinated or vaccinated with no immunity (anti-HBs <10 mIU/mL)**
  - HBV vaccine and offer HBIG as soon as possible after exposure

- **Unknown Source No Hepatitis B vaccination or vaccination with no immunity (anti-HBs <10 mIU/mL)**
  - HIV test and HCV ab, HepBsAg, HepBsAB, HepBcAB @ baseline, HIV and HCV ab @ 6w, 3mo, 6mo

- **Anti-HBs test 6 mos. after dose of HBIG**

**Final source blood results**

- **Is Source HIV+?**
  - **No**
    - DC Chemo
  - **Yes**
    - Complete 4 weeks of treatment, Refer to ID
    - HIV test @ 6 wks, 3 mos. AND 6 mos.

- **Complete 3-dose vaccine series**

**After-hours questions, call: 1-855-487-0290**

*Off-site clinics refer to your agency specific policy
†Emergency Department

From the Centers for Disease Control and Prevention, U.S Department of Health and Human Services: "Updated Guidelines for Antiretroviral Postexposure Prophylaxis", 2016 (Revised 4.17.17 by V.V, M.D)
Needlestick & Sharp Object Injury Report

Last Name: ____________________________ First Name: ________________________

Injury ID: (for office use only) S _____ Facility ID: (for office use only) _____ Completed By: ______

1) Date of Injury: ___ ___ ___  2) Time of Injury: ___ ___

3) Department where Incident Occurred: ____________________________

4) Home Department: ____________________________

5) What is the Job Category of the Injured Worker? (check one box only)

☐ 1 Doctor (attending/staff); specify specialty ____________
☐ 2 Doctor (intern/resident/fellow) specify specialty ____________
☐ 3 Medical Student
☐ 4 Nurse: specify ➔ ☐ 1 RN
☐ 5 Nursing Student ☐ 2 LPN
☐ 18 CNA/HHA ☐ 3 NP
☐ 6 Respiratory Therapist ☐ 4 CRNA
☐ 7 Surgery Attendant ☐ 5 Midwife
☐ 8 Other Attendant ☐ 6 Other
☐ 9 Phlebotomist/Venipuncture/IV Team

6) Where Did the Injury Occur? (check one box only)

☐ 1 Patient Room
☐ 2 Outside Patient Room (hallway, nurses station, etc.)
☐ 3 Emergency Department
☐ 4 Intensive/Critical Care: specify type: ____________________________
☐ 5 Operating Room/Recovery
☐ 6 Outpatient Clinic/Office
☐ 7 Blood Bank
☐ 8 Venipuncture Center

7) Was the Source Patient Identifiable? (check one box only)

☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

8) Was the Injured Worker the Original User of the Sharp Item? (check one box only)

☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

9) The Sharp Item was: (check one box only)

☐ 1 Contaminated (known exposure to patient or contaminated equipment) ➔ was there blood on the device? ☐ 1 Yes
☐ 2 Uncontaminated (no known exposure to patient or contaminated equipment) ☐ 2 No
☐ 3 Unknown

10) For What Purpose was the Sharp Item Originally Used? (check one box only)

☐ 1 Unknown/Not Applicable
☐ 2 Injection, Intra-muscular/Subcutaneous, or Other Injection through the Skin (syringe)
☐ 3 Heparin or Saline Flush (syringe)
☐ 4 Other Injection into (or aspiration from) IV injection site or IV Port (syringe)
☐ 5 To Connect IV line (intermittent IV/piggyback/IV infusion/other IV line connection)
☐ 6 To Start IV or Set up Heparin Lock (IV catheter or winged set-type needle)
☐ 7 To Draw Venous Blood Sample ➔ if used to draw blood was it? ☐ Direct stick?  ☐ Draw from a Line?
☐ 8 To Draw Arterial Blood Sample

11) Did the Injury Occur? (check one box only)

☐ 1 Before Use of Item (item broke/slipped, assembling device, etc.)
☐ 2 During Use of Item (item slipped, patient jarred item, etc)
☐ 5 Restraining patient
☐ 3 Between Steps of a Multi-step Procedure (between incremental injections, passing instruments, etc.)
☐ 4 Disassembling Device or Equipment
☐ 5 In Preparation for Reuse ofReusable Instrument (sorting, disinfecting, sterilizing, etc.)
☐ 6 While Recapping Used Needle
☐ 7 Withdrawing a Needle from Rubber or Other Resistant Material (rubber stopper, IV port, etc.)

☐ 10 Device Left on Floor, Table, Bed or Other Inappropriate Place
☐ 8 Other After Use—Before Disposal (in transit to trash, cleaning, sorting, etc.)
☐ 9 From Item Left On or Near Disposal Container
☐ 10 While putting Item into Disposal Container
☐ 11 After Disposal, Stuck by Item Protruding from Opening of Disposal Container
☐ 12 Item Pierced Side of Disposal Container
☐ 13 After Disposal, Item Protruded from Trash Bag or Inappropriate Waste Container

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12) What Type of Device Caused the Injury? (check one box only)  □ Needle-Hollow Bore  □ Surgical  □ Glass

Which Device Caused the Injury? (check one box from one of the three sections only)

Needles (for suture needles see “surgical instruments”)

□ 1 Disposable Syringe
   □ a Insulin
   □ b Tuberculin
   □ c 24/25-gauge needle
   □ d 23-gauge needle
   □ e 22-gauge needle
   □ f 21-gauge needle

□ 2 Pre-filled cartridge syringe (includes Tubex™ *, Carpuject™ * -type syringes)

□ 3 Blood gas syringe (ABG)

□ 4 Syringe, other type

□ 5 Needle on IV line (includes piggybacks & IV line connectors)

□ 6 Winged steel needle (includes winged-set type devices)

□ 7 IV catheter stylet

Surgical Instrument or Other Sharp Items (for glass items see “glass”)

□ 30 Lancet (finger or heel sticks)

□ 31 Suture needle

□ 32 Scalpel, reusable (scalpel, disposable code is 45)

□ 33 Razor

□ 34 Pipette (plastic)

□ 35 Scissors

□ 36 Electro-cautery device

□ 37 Bone cutter

□ 38 Bone chip

□ 39 Towel clip

□ 40 Microtome blade

□ 41 Trocar

□ 42 Vacuum tube (plastic)

Glass

□ 60 Medication ampule

□ 61 Medication vial (small volume with rubber stopper)

□ 62 Medication/IV bottle (large volume)

□ 63 Pipette (glass)

□ 64 Vacuum tube (glass)

□ 65 Specimen/Test tube (glass)

□ 8 Vacuum tube blood collection holder/needle (includes Vacutainer™ *-type device)

□ 9 Spinal or Epidural Needle

□ 10 Unattached hypodermic needle

□ 11 Arterial catheter introducer needle

□ 12 Central line catheter needle (cardiac, etc.)

□ 13 Drum catheter needle

□ 14 Other vascular catheter needle (cardiac, etc.)

□ 15 Other non-vascular catheter needle (ophthalmology, etc.)

□ 28 Needle, not sure what kind

□ 29 Other needle, please describe: ______________________

□ 43 Specimen/Test tube (plastic)

□ 44 Fingernails/Teeth

□ 45 Scalpel, disposable

□ 46 Retractors, skin/bone hooks

□ 47 Staples/Steel sutures

□ 48 Wire (suture/fixation/guide wire)

□ 49 Pin (fixation, guide pin)

□ 50 Drill bit/bur

□ 51 Pickups/Forceps/Hemostats/Clamps

□ 58 Sharp item, not sure what kind

□ 59 Other sharp item: Describe: ______________________

12a) Brand/Manufacturer of Product: (e.g. ABC Medical Company) ______________________

12b) Model:

□ 98 Please Specify: ______________________  □ 99 Unknown

13) If the Item Causing the Injury was a Needle or Sharp Medical Device, Was it a “Safety Design” with a Shielded, Recessed, Retractable, or Blunted Needle or Blade?

□ 1 Yes

□ 2 No

□ 3 Unknown

13a) Was the Protective Mechanism Activated?

□ 1 Yes, fully

□ 2 Yes, partially

□ 3 No

□ 4 Unknown

13b) Did Exposure Incident Happen?

□ 1 Before activation

□ 2 During activation

□ 3 After activation

□ 4 Unknown

14) Mark the Location of the Injury: ______________________

> Return to Table of Contents <
15) Was the Injury?
☐ 1 Superficial (little or no bleeding)
☐ 2 Moderate (skin punctured, some bleeding)
☐ 3 Severe (deep stick/cut, or profuse bleeding)

16) If Injury was to the hand, did the Sharp Item Penetrate?
☐ 1 Single pair of gloves
☐ 2 Double pair of gloves
☐ 3 No gloves

17) Dominant Hand of the Injured Worker:
☐ 1 Right-handed
☐ 2 Left-handed

18) Describe the Circumstances Leading to this Injury (please note if a device malfunction was involved):
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

19) For Injured Healthcare Worker: If the Sharp had no Integral Safety Feature, Do you have an Opinion that such a Feature could have prevented the Injury?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown
Describe: __________________________________________________________________________________________
___________________________________________________________________________________________________

20) For Injured Healthcare Worker: Do you have an Opinion that any other Engineering Control, Administrative or Work Practice could have prevented the Injury?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown
Describe: __________________________________________________________________________________________
___________________________________________________________________________________________________

Cost:
Lab charges (Hb, HCV, HIV, other)
Healthcare Worker __________
Source __________

Treatment Prophylaxis (HBIG, Hb vaccine, tetanus, other)
Healthcare Worker __________
Source __________

Service Charges (Emergency Dept, Employee Health, other)
Healthcare Worker __________
Source __________

Other Costs (Worker’s Comp, surgery, other)
Healthcare Worker __________
Source __________

TOTAL (round to nearest dollar) __________

Is this Incident OSHA reportable?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown
If Yes, Days Away from Work? ____
Days of Restricted Work Activity? ____

Does this incident meet the FDA medical device reporting criteria? (Yes if a device defect caused serious injury necessitating medical or surgical intervention, or death occurred within 10 works days of incident.)
☐ 1 Yes (If Yes, follow FDA reporting protocol.) ☐ 2 No

* Tubex™ is a trademark of Wyeth Ayers; Carpuject™ is a trademark of Sanofi Winthrop; VACUTAINER™ is a trademark of Becton Dickinson. Identification of these products does not imply endorsement of these specific brands.