



Blood Borne Pathogens (BBP) Exposure Packet

Tulane University, The Health Center – Uptown 504-865-5255, Downtown 504-988-6169
Campus Health Website: campushealth.tulane.edu



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.

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>

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.
 - o Report to The Health Center Downtown, Phone: 504-988-6929
 - o Complete **BBP Exposure Notification** form at The Health Center
After hours, weekends, or holidays
 - o Report to Emergency Department and **follow-up in The Health Center Downtown the next business day**.
 - o 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.
 - o Obtain packet from campushealth.tulane.edu website for required forms, procedures, and information.
 - o 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:

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

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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:
 - o Report to The Health Center Downtown, Phone: 504-988-6929
 - o Complete **BBP Exposure Notification** form at The Health Center
 - After hours, weekends, or holidays
 - o Report to Emergency Department and **follow-up in The Health Center Downtown the next business day.**
 - o 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.
 - o Obtain packet from campushealth.tulane.edu website for required forms, procedures, and information.
 - o 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”

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Campus Health Website: campushealth.tulane.edu



BBP EXPOSURE NOTIFICATION FORM

Name: _____

Home #: _____ Work #: _____ Cell #: _____

I am a student. Yes No If yes, please provide Splash Card #: _____-oo-_____
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 _____
Hollow Bore Yes No
 Cut Depth of Injury _____
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 _____

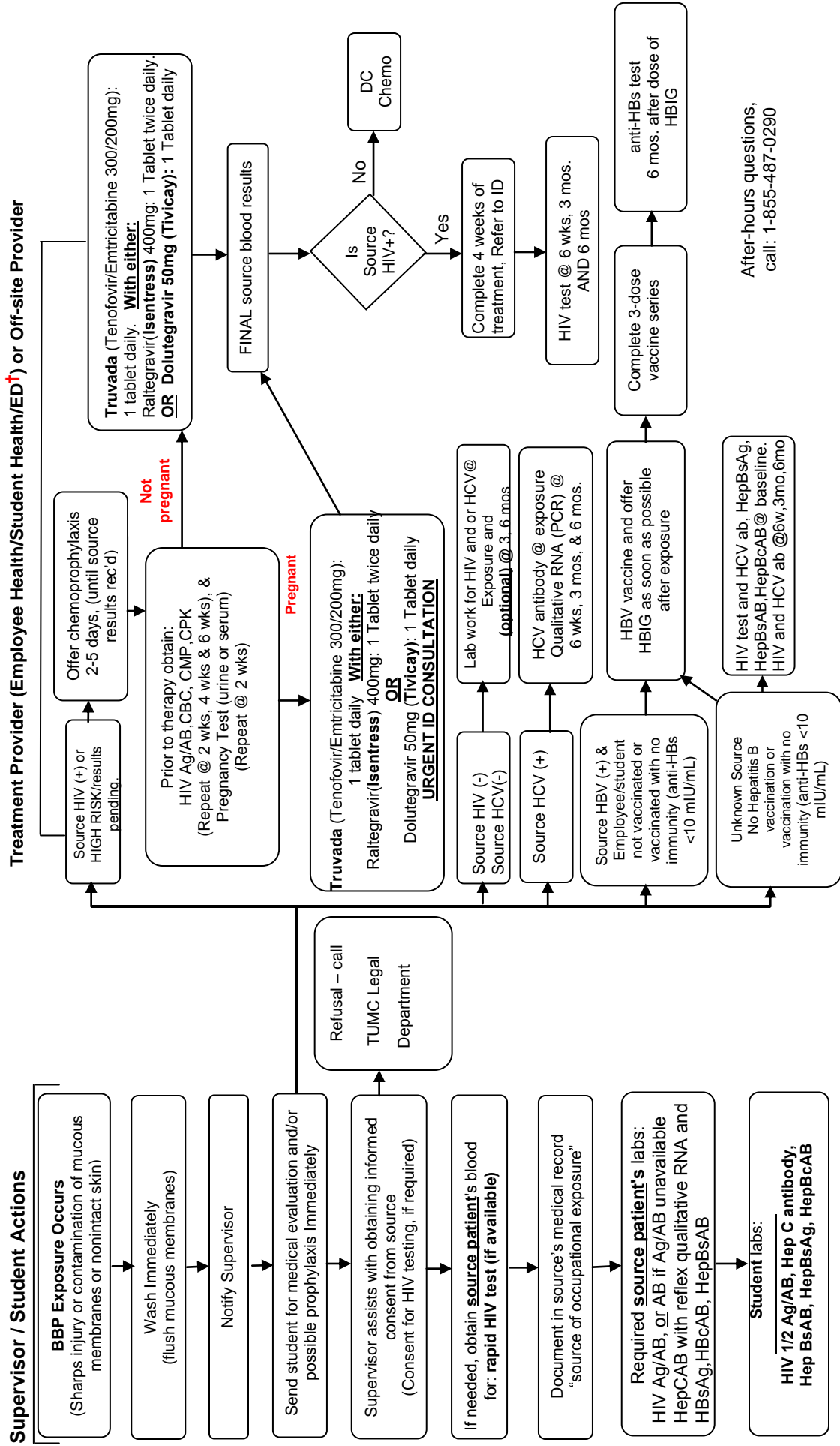
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FAX THIS FORM TO: 504-988-3217

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OCCUPATIONAL EXPOSURE TO BLOOD BORNE PATHOGENS (BBP)* MANAGEMENT ALGORITHM



* Off-site clinics refer to your agency specific policy

† Emergency Department

Updated September 2017

Needlestick & Sharp Object Injury Report

EPINet™

FOR MICROSOFT® ACCESS

EXPOSURE PREVENTION ►
INFORMATION NETWORK ►

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Operates in Windows 95 and Windows 98 Environments.
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V1.2/US 3/2001

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)

- | | |
|---|---|
| <input type="checkbox"/> 1 Doctor (<i>attending/staff</i>); specify specialty _____ | <input type="checkbox"/> 10 Clinical Laboratory Worker |
| <input type="checkbox"/> 2 Doctor (<i>intern/resident/fellow</i>) specify specialty _____ | <input type="checkbox"/> 11 Technologist (<i>non-lab</i>) |
| <input type="checkbox"/> 3 Medical Student | <input type="checkbox"/> 12 Dentist |
| <input type="checkbox"/> 4 Nurse: specify <input type="checkbox"/> 1 RN | <input type="checkbox"/> 13 Dental Hygienist |
| <input type="checkbox"/> 5 Nursing Student <input type="checkbox"/> 2 LPN | <input type="checkbox"/> 14 Housekeeper |
| <input type="checkbox"/> 18 CNA/HHA <input type="checkbox"/> 3 NP | <input type="checkbox"/> 19 Laundry Worker |
| <input type="checkbox"/> 6 Respiratory Therapist <input type="checkbox"/> 4 CRNA | <input type="checkbox"/> 20 Security |
| <input type="checkbox"/> 7 Surgery Attendant <input type="checkbox"/> 5 Midwife | <input type="checkbox"/> 16 Paramedic |
| <input type="checkbox"/> 8 Other Attendant | <input type="checkbox"/> 17 Other Student |
| <input type="checkbox"/> 9 Phlebotomist/Venipuncture/IV Team | <input type="checkbox"/> 15 Other, describe: _____ |

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

- | | |
|--|---|
| <input type="checkbox"/> 1 Patient Room | <input type="checkbox"/> 9 Dialysis Facility (<i>hemodialysis and peritoneal dialysis</i>) |
| <input type="checkbox"/> 2 Outside Patient Room (<i>hallway, nurses station, etc.</i>) | <input type="checkbox"/> 10 Procedure Room (<i>x-ray, EKG, etc</i>) |
| <input type="checkbox"/> 3 Emergency Department | <input type="checkbox"/> 11 Clinical Laboratories |
| <input type="checkbox"/> 4 Intensive/Critical Care unit: specify type: _____ | <input type="checkbox"/> 12 Autopsy/Pathology |
| <input type="checkbox"/> 5 Operating Room/Recovery | <input type="checkbox"/> 13 Service/Utility (<i>laundry, central supply, loading dock, etc</i>) |
| <input type="checkbox"/> 6 Outpatient Clinic/Office | <input type="checkbox"/> 16 Labor and Delivery Room |
| <input type="checkbox"/> 7 Blood Bank | <input type="checkbox"/> 17 Home-care |
| <input type="checkbox"/> 8 Venipuncture Center | <input type="checkbox"/> 14 Other, describe: _____ |

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)

- | | | |
|--|---------------------------------------|--------------------------------|
| <input type="checkbox"/> 1 Contaminated (known exposure to patient or contaminated equipment) <input type="checkbox"/> 1 Yes | was there blood on the device? | <input type="checkbox"/> 1 Yes |
| <input type="checkbox"/> 2 Uncontaminated (no known exposure to patient or contaminated equipment) <input type="checkbox"/> 2 No | | <input type="checkbox"/> 2 No |
| <input type="checkbox"/> 3 Unknown | | |

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

- | | |
|--|--|
| <input type="checkbox"/> 1 Unknown/Not Applicable | <input type="checkbox"/> 16 To Place an Arterial /Central Line |
| <input type="checkbox"/> 2 Injection, Intra-muscular/Subcutaneous, or Other Injection through the Skin (<i>syringe</i>) | <input type="checkbox"/> 9 To Obtain a Body Fluid or Tissue Sample (<i>urine/CSF/amniotic fluid/other fluid, biopsy</i>) |
| <input type="checkbox"/> 3 Heparin or Saline Flush (<i>syringe</i>) | <input type="checkbox"/> 10 Finger stick/Heel Stick |
| <input type="checkbox"/> 4 Other Injection into (<i>or aspiration from</i>) IV injection site or IV Port (<i>syringe</i>) | <input type="checkbox"/> 11 Suturing |
| <input type="checkbox"/> 5 To Connect IV line (<i>intermittent IV/piggyback/IV infusion/other IV line connection</i>) | <input type="checkbox"/> 12 Cutting |
| <input type="checkbox"/> 6 To Start IV or Set up Heparin Lock (<i>IV catheter or winged set-type needle</i>) | <input type="checkbox"/> 17 Drilling |
| <input type="checkbox"/> 7 To Draw Venous Blood Sample  | <input type="checkbox"/> 13 Electrocautery |
| <input type="checkbox"/> 8 To Draw Arterial Blood Sample  | <input type="checkbox"/> 14 To Contain a Specimen or Pharmaceutical (<i>glass item</i>) |

if used to draw blood was it? Direct stick? Draw from a Line?

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

- | | |
|---|--|
| <input type="checkbox"/> 1 Before Use of Item (<i>item broke/slipped, assembling device, etc.</i>) | <input type="checkbox"/> 16 Device Left on Floor, Table, Bed or Other Inappropriate Place |
| <input type="checkbox"/> 2 During Use of Item (<i>item slipped, patient jarred item, etc</i>) | <input type="checkbox"/> 8 Other After Use-Before Disposal (<i>in transit to trash, cleaning, sorting, etc.</i>) |
| <input type="checkbox"/> 15 Restraining patient | <input type="checkbox"/> 9 From Item Left On or Near Disposal Container |
| <input type="checkbox"/> 3 Between Steps of a Multi-step Procedure (<i>between incremental injections, passing instruments, etc.</i>) | <input type="checkbox"/> 10 While putting Item into Disposal Container |
| <input type="checkbox"/> 4 Disassembling Device or Equipment | <input type="checkbox"/> 11 After Disposal, Stuck by Item Protruding from Opening of Disposal Container |
| <input type="checkbox"/> 5 In Preparation for Reuse of Reusable Instrument (<i>sorting, disinfecting, sterilizing, etc.</i>) | <input type="checkbox"/> 12 Item Pierced Side of Disposal Container |
| <input type="checkbox"/> 6 While Recapping Used Needle | <input type="checkbox"/> 13 After Disposal, Item Protruded from Trash Bag or Inappropriate Waste Container |
| <input type="checkbox"/> 7 Withdrawing a Needle from Rubber or Other Resistant Material (<i>rubber stopper, IV port, etc.</i>) | <input type="checkbox"/> 14 Other: Describe: _____ |

- 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")

- | | | |
|--|--|--|
| <input type="checkbox"/> 1 Disposable Syringe | <input type="checkbox"/> e 22-gauge needle | <input type="checkbox"/> 8 Vacuum tube blood collection holder/needle (includes Vacutainer™ *-type device) |
| <input type="checkbox"/> a Insulin | <input type="checkbox"/> f 21-gauge needle | <input type="checkbox"/> 9 Spinal or Epidural Needle |
| <input type="checkbox"/> b Tuberculin | <input type="checkbox"/> g 20-gauge needle | <input type="checkbox"/> 10 Unattached hypodermic needle |
| <input type="checkbox"/> c 24/25-gauge needle | <input type="checkbox"/> h "Other" | <input type="checkbox"/> 11 Arterial catheter introducer needle |
| <input type="checkbox"/> d 23-gauge needle | | <input type="checkbox"/> 12 Central line catheter needle (cardiac, etc.) |
| <input type="checkbox"/> 2 Pre-filled cartridge syringe (includes Tubex™ *, Carpuject™* - type syringes) | | <input type="checkbox"/> 13 Drum catheter needle |
| <input type="checkbox"/> 3 Blood gas syringe (ABG) | | <input type="checkbox"/> 14 Other vascular catheter needle (cardiac, etc.) |
| <input type="checkbox"/> 4 Syringe, other type | | <input type="checkbox"/> 15 Other non-vascular catheter needle (ophthalmology, etc.) |
| <input type="checkbox"/> 5 Needle on IV line (includes piggybacks & IV line connectors) | | |
| <input type="checkbox"/> 6 Winged steel needle (includes winged-set type devices) | <input type="checkbox"/> 28 Needle, not sure what kind | |
| <input type="checkbox"/> 7 IV catheter stylet | <input type="checkbox"/> 29 Other needle, please describe: _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> 30 Lancet (finger or heel sticks) | <input type="checkbox"/> 43 Specimen/Test tube (plastic) |
| <input type="checkbox"/> 31 Suture needle | <input type="checkbox"/> 44 Fingernails/Teeth |
| <input type="checkbox"/> 32 Scalpel, reusable (scalpel, disposable code is 45) | <input type="checkbox"/> 45 Scalpel, disposable |
| <input type="checkbox"/> 33 Razor | <input type="checkbox"/> 46 Retractors, skin/bone hooks |
| <input type="checkbox"/> 34 Pipette (plastic) | <input type="checkbox"/> 47 Staples/Steel sutures |
| <input type="checkbox"/> 35 Scissors | <input type="checkbox"/> 48 Wire (suture/fixation/guide wire) |
| <input type="checkbox"/> 36 Electro-cautery device | <input type="checkbox"/> 49 Pin (fixation, guide pin) |
| <input type="checkbox"/> 37 Bone cutter | <input type="checkbox"/> 50 Drill bit/bur |
| <input type="checkbox"/> 38 Bone chip | <input type="checkbox"/> 51 Pickups/Forceps/Hemostats/Clamps |
| <input type="checkbox"/> 39 Towel clip | |
| <input type="checkbox"/> 40 Microtome blade | <input type="checkbox"/> 58 Sharp item, not sure what kind |
| <input type="checkbox"/> 41 Trocar | <input type="checkbox"/> 59 Other sharp item: Describe: _____ |
| <input type="checkbox"/> 42 Vacuum tube (plastic) | |

Glass

- | | |
|--|---|
| <input type="checkbox"/> 60 Medication ampule | <input type="checkbox"/> 66 Capillary tube |
| <input type="checkbox"/> 61 Medication vial (small volume with rubber stopper) | <input type="checkbox"/> 67 Glass slide |
| <input type="checkbox"/> 62 Medication/IV bottle (large volume) | |
| <input type="checkbox"/> 63 Pipette (glass) | <input type="checkbox"/> 78 Glass item, not sure what kind |
| <input type="checkbox"/> 64 Vacuum tube (glass) | <input type="checkbox"/> 79 Other glass item: Describe: _____ |
| <input type="checkbox"/> 65 Specimen/Test tube (glass) | |

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

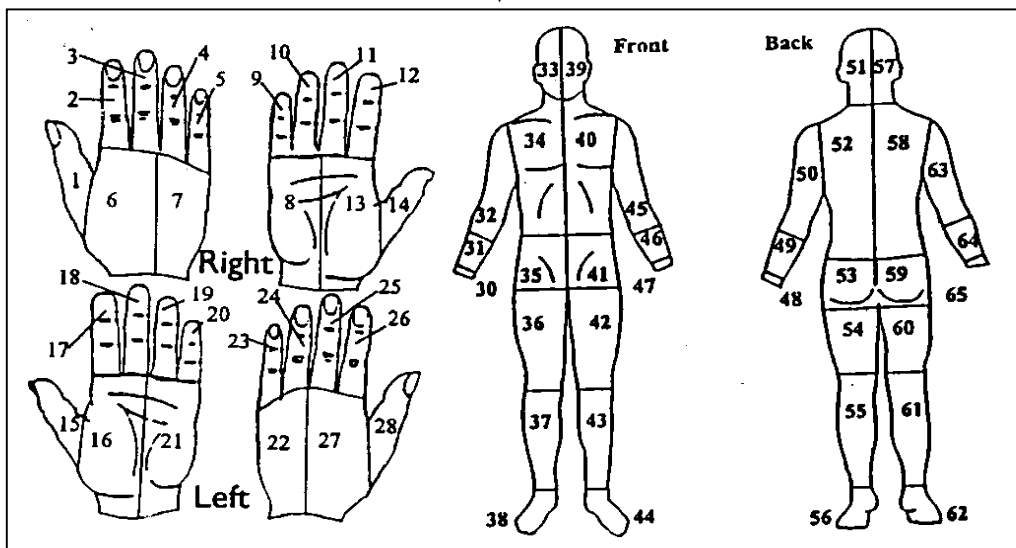
12b) **Model:**
 98 Please Specify: _____ 99 Unknown

- 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 3 No
 2 Yes, partially 4 Unknown

- 13b) **Did Exposure Incident Happen?**
- 1 Before activation 3 After activation
 2 During activation 4 Unknown

14) **Mark the Location of the Injury:** _____



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)
_____	Other Costs (Worker's Comp, surgery, other)
_____	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

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