ISD 318 - Grand Rapids, MN

Bloodborne Pathogens

Post-Exposure Incident Packet

An Informational Guide

December 2018

ISD 318 - Grand Rapids

Bloodborne Pathogens (BBP)

Post-Exposure Incident Packet

This packet has been developed as an informational guide for what to do when an employee is actually (or potentially) exposed to blood or other potentially infectious materials. This packet contains the following important documents:

1. Employee Self-Assessment of BBP Exposure
2. Post-Exposure Instructions and Response Actions
3. Forms:

   BBP1: Supervisor's Report of Employee's Exposure to Blood or OPIM

   BBP2: Exposed Employee Declination of Medical Evaluation

   BBP3: Transmittal Letter to Healthcare Provider for Exposed Employee

   BBP4: Consent/Declination for Blood Testing of Exposed Employee

   BBP5: Healthcare Provider Written Opinion for Exposed Employee

   BBP6: Consent/Declination for Blood Testing of Source Individual

   BBP7: Transmittal Letter to Healthcare Provider for Source Individual

   BBP8: Healthcare Provider Written Opinion for Source Individual

   BBP9: Cleaning and Disinfection Procedures for Blood and Body Fluids

The injured employee will begin to use this packet by reading and working through the Employee Self-Assessment of BBP Exposure.

For assistance with this packet or process, please seek help from the Building Nurse or District Nurse.

District Nurse: 218-327-5760, ext 41423

ISD 318 - Grand Rapids

EMPLOYEE NAME: _____ **TODAY'S DATE:** _____

Employee Self-Assessment of BBP Exposure

** ATTENTION INJURED EMPLOYEE **

Please follow the steps listed below:

1. Immediately flush the affected area with water and if possible wash with warm water and soap.
2. Seek immediate first aid from health services, if required.
3. Answer the following questions to determine if the incident you've been involved in should be considered an "exposure" to bloodborne pathogens or other potentially infectious material (OPIM). **Any YES answer means an "exposure" has most likely occurred.** Initial your answers. *Make sure to ask for clarification if you're not sure of any answer!*
4. **Questions: Did the contact with blood or other potentially infectious materials include any of the following?**

	YES	NO	Initials
Blood (or body fluid with visible blood) in your eyes, nose, or mouth?			
Blood (or body fluid with visible blood) in contact with your broken skin (less than 24 hours old), including cuts or open skin rashes, or breaking of your skin in a bite?			
Penetration of your skin by a sharp object (needle, lancet, glass, teeth, etc.) contaminated with blood (or body fluid with visible blood)?			

4. **If you answered NO to ALL of the questions above, an exposure did not occur and medical attention for exposure to blood or OPIM is not required. Other medical attention may still be appropriate. You may stop here and give this form to your supervisor. Please report other injuries or concerns involved in this event, as applicable. Please ask for help from health services if you're not sure of this result or what to do next.**
5. **If you answered YES to any of the above questions, do the following:**

    1) Report the incident to your supervisor immediately.

    2) Go to the next page for additional directions and information.

Post-Exposure Instructions and Response Actions

(For exposures identified by a YES answer on the previous Self-Assessment)

ISD 318 employees who experience a work-related exposure to blood or any other potentially infectious material (OPIM) are encouraged to **seek medical care immediately**. The purpose of medical care is to discuss the event with a qualified healthcare provider and to obtain baseline blood antibody levels for Hepatitis B and HIV. In addition, the exposed employee could be offered and provided with a hepatitis vaccine and/or gamma globulin to prevent development of hepatitis. Both the exposed employee and the source individual will be given an opportunity to accept or decline having their blood drawn and tested, or drawn and held for future testing. This testing is done by the healthcare provideer of their choice at no cost to them.

GENERAL INSTRUCTIONS:

Employee completes the "Supervisor's Report of Employee's Exposure to Blood or OPIM" (form BBP1 found on page 6 of this packet) with supervisor or District Nurse. Complete as soon after the incident as possible, but in every case, it must be done within 24 hours of the incident. Submit original form to District Nurse; copies to employee, Payroll/Benefits Department, and healthcare provider.

Medical Evaluation of Exposed Employee: **Obtain medical care within 24 hours.** Employees may see their usual healthcare provider at no cost to them.

Note: If Employee chooses not to seek medical evaluation, Complete "Exposed Employee Declination of Medical Evaluation" (form BBP2 found on page 7 of this packet) with assistance of supervisor and/or District Nurse. Original to the District Nurse; copy to employee. The process ends here.

1. Complete "Transmittal Letter to Healthcare Provider for Exposed Employee" (form BBP3 found of page 8 of this packet) with assistance of supervisor and/or District Nurse. Employee takes original to healthcare provider; copy to District Nurse.

2. Employee takes "Consent/Declination for Blood Testing of Exposed Employee" (form BBP4 found on pages 9 and 10 of this packet) to healthcare provider. The form may be completed with the District representative or brought to the clinic for completion with healthcare provider. Employee takes original to healthcare provider; copy to District Nurse.

3. Employee takes "Health Care Provider Written Opinion for Exposed Employee" (form BBP5 found on page 11 of this packet) to healthcare provider for completion. The healthcare provider is asked to send completed form back to District Nurse.

4. Employee and supervisor communicate regarding job restrictions, return-to-work date, or other appropriate information.

Medical Evaluation of Source Individual:

1. District Nurse and/or supervisor will pursue information about BBP with source individual (including parents/guardians if source individual is a minor) and begin "Consent/Declination for Blood Testing of Source Individual" (form BBP6 found on pages 12 and 13 of this packet.) The form may be completed with the District representative or bought to the medical facility for completion with the healthcare provider. Source individual takes original to healthcare provider; copy to District Nurse.

2. For subsequent medical evaluation, complete "Transmittal Letter to Healthcare Provider for Source Individual" (form BBP7 found of page 14 of this packet) with assistance of District Nurse and/or supervisor. Source individual takes original to healthcare provider; copy to District Nurse.

3. Source individual also takes "Health Care Provider Written Opinion for Source Individual" (form BBP8 found on page 15 of this packet) to healthcare provider for completion. The healthcare provider is asked to send the completed form back to the District Nurse.

Cleaning & Disinfection:

See "Cleaning and Disinfection Procedures for Blood and Body Fluids" (form BBP9 found on page 16 of this packet.)

Summary of Forms and Routing Directions

- Take the forms as indicated to healthcare provider, along with a copy of the OSHA Regulation 29 CFR 1910.1030 - Occupational Exposure to Bloodborne Pathogens.* **Or simply take this entire booklet to healthcare provider.**

  * For copy of regulation, see Appendix A of *Management Plan for Bloodborne Pathogens* Manual.

- All completed forms will ultimately be submitted to District 318 Nurse, along with any supporting documentation.

Form BBP1

Supervisor's Report of Employee's Exposure to Blood or OPIM

EMPLOYEE INFORMATION

Employee Name:_____ Birth Date:_____

Social Security Number:_____ Job Title:_____

Home Address:_____ Date of Hire:_____

Home Phone:_____ Work Phone:_____

INCIDENT REPORT

Date of Exposure:_____ Time of Exposure:_____ A.M_____P.M.

Location / Building:_____ Room # (or location):_____

Describe what happened:_____

_____

_____

Was a needle, lancet, glass or other sharp object involved? ☐ Yes ☐ No

Type of body fluid involved: _____Blood _____Other body fluid

What part of employee's body was involved: _____ Eyes _____ Nose_____ Mouth_____ Cut less than 24 hours old

The following information was obtained to assist in a medical evaluation of the incident:

Severity of exposure:

- Percutaneous (skin piercing): Depth of injury:_____ Was source fluid present at site of injury? ☐Yes ☐No
- Mucous Membranes: Area Affected:_____ Length of time of exposure:_____
- Condition of non Intact skin: ☐Fresh Cuts (<24 hours) ☐ Dermatitis ☐Chapped ☐ Other _____

_____

Was personal protective equipment utilized? (If so, what type, e.g. gloves, face shield, etc.)	☐ Yes	☐ No
Was the integrity of the personal protective equipment compromised (e.g. gloves pierced)?	☐ Yes	☐ No
Was clothing contaminated? Did appropriate disposal/laundering procedures occur?	☐ Yes	☐ No
Did hand-washing and/or flushing of mucous membrane occur as soon as possible?	☐ Yes	☐ No
Employee has been referred to a healthcare provider for medical evaluation and follow-up.	☐ Yes	☐ No

Name and Location of clinic or hospital:_____

SOURCE INFORMATION

(Person whose blood contacted employee)

Name:_____ Student:_____ Staff:_____ Other:_____

It was explained to the employee that he/she was involved in an incident that could place him/her at risk for HBV (Hepatitis B Virus) or HIV (Human Immunodeficiency Virus).

The employee was informed of his/her rights to obtain post-exposure medical care including an examination and blood testing for HBV and HIV. The employee was also offered the opportunity to have a blood sample drawn and preserved for 90 days in the event that he/she might choose to have that sample tested.

It was explained to the employee that this examination may be obtained at no cost to the employee.

Signature:_____ Date:_____
(Supervisor)

Signature:_____ Date:_____
(Employee)

Original to District Nurse; copies to employee, Payroll/Benefits, healthcare provider

Form BBP2

Post Exposure
Exposed Employee Declination of Medical Evaluation

The exposed employee must complete this form if she/he chooses not to receive medical care for a work-related exposure involving blood or OPIM.

Employee Name	Job Title
Date of Exposure	School or Building

I understand that I have been involved in a workplace encounter with blood or body fluids that may place me at risk for HBV (Hepatitis B Virus - a virus which causes liver disease) or HIV (Human Immunodeficiency Virus - the virus which causes AIDS).

I have been given the opportunity for a post-exposure follow-up examination, including testing of my blood for HBV and HIV.

I understand that I may obtain this examination through the healthcare provider of my choice.

Medical services will be provided at no cost to me for work-related incidents involving exposure to blood or other potentially infectious material. I understand that I am eligible for this examination even if I have been previously vaccinated against HBV.

I have been offered the opportunity to have a sample of my blood drawn and preserved for 90 days in the event that I might choose to have that sample tested at some point within the 90 days.

Understanding the information written above, I decline any post-exposure medical evaluation, blood sampling, blood testing, or follow-up examination at this time.

Employee Signature	Date
Witness	Date

Original to District Nurse; copy to employee

Form BBP3

Post Exposure
Transmittal Letter to Healthcare Provider for Exposed Employee

Today's Date: _____ Date of Exposure Incident: _____

Exposed Employee: _____ Social Security Number: _____

The identified employee has been exposed to blood or other potentially infectious body fluids, and requires a medical evaluation, as determined in OSHA Regulation 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens.

To assist in conducting the medical evaluation, we have attached the following information and forms:

- ☐ Copy of the OSHA standard 29 CFR 1910.1030
- ☐ Supervisor's Report of Employee's Exposure to Blood or OPIMs (BBP1)
- ☐ Consent/Declination for Blood Testing of Exposed Employee (BBP4)
- ☐ Healthcare Provider Written Opinion for Exposed Employee (BBP5)

We request that you complete a confidential medical evaluation for the employee, including all appropriate treatments, counseling, and evaluation of illnesses. Your written opinion must be provided to the District Nurse, including the limited information requested on the attached form BBP 5 (or an alternative form which contains the required information.) All other medical information is maintained by your facility. Please return the written opinion within 12 days.

Thank you for your assistance. Should you have any questions, please contact the employer's representative at the location listed below.

Sincerely,

_____ Telephone Number: _____

ISD 318 - Grand Rapids Representative (printed name)

_____

ISD 318 - Grand Rapids Representative (signature)

Independent School District 318
820 NW 1st Ave
Grand Rapids, MN 55744-2687

Original to healthcare provider; copy to District Nurse

Post Exposure
Consent/Declination for Blood Testing of Exposed Employee

Today's Date: _____ Date of Exposure Incident: _____

Name of Exposed Employee: _____

While performing your duties as an employee, on the above date you were involved in an exposure incident as defined by the Federal and Minnesota State Bloodborne Pathogen Regulations. According to these regulations, a sample of blood is to be drawn as soon as possible from the source of the exposure as well as the exposed employee to determine if any infectious diseases (Hepatitis B and HIV) are present.

We are requesting to have your blood drawn and tested for HBV and HIV in order to provide appropriate medical direction. If you are a minor, consent to have your blood drawn and tested must be given by your parent or guardian. You are not legally required to consent to having your blood drawn and tested. In the event that you decline to have your blood drawn and tested, however, we will not be able to determine whether you have been infected by either the Hepatitis B Virus (HBV) or the Human Immunodeficiency Virus (HIV) or advise or counsel you on appropriate steps to take as a result of such infection.

Please read the following and, if you consent, sign and date the form. You may choose your own healthcare provider and the cost, if not covered, will be paid by ISD 318. You will be provided with the test results as soon as possible.

If you know that you are infected with HBV or HIV and can provide medical records or documentation, no blood test is necessary.

1. I authorize and consent to testing of a sample of my blood for the following (check only one):
   - ☐ Human Immunodeficiency Virus (HIV)
   - ☐ Hepatitis B Virus (HBV)
   - ☐ Both the Human Immunodeficiency Virus (HIV) and the Hepatitis B Virus (HBV)

2. I understand that a positive HIV test does not necessarily mean that a person has AIDS; testing can assist healthcare personnel in medical management and infectious disease control of the virus.

3. I understand that I should rely on my physician for information regarding the nature and purpose of the HIV/HBV test and the meaning and significance of the result of the test.

4. I understand that HIV/HBV testing is not always 100% accurate and that results may be "false negative" (negative results when the virus is actually present) or "false positive" (positive results when the virus is not present). If a positive result is obtained, additional tests will be done to attempt to confirm the test results.

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5. I understand that the results of the test will be confidential and will not be disclosed unless necessary for ISD 318 to comply with the provisions of OSHA's Bloodborne Pathogen Regulation (29 CFR 1910.1030).

6. I understand that I can personally make arrangements to have my blood drawn, as authorized, or that arrangements will be made for me, with the assistance of District personnel or other designated parties.

7. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give this informed consent/declination.

CONSENT

☐ I consent to have my blood drawn and tested at this time.

☐ I consent to have my blood drawn and stored for up to 90 days for possible future testing upon my written consent.

Print Name _____ Date _____

Signature _____ Time _____

DECLINE

☐ I decline to have my blood drawn and tested or drawn and stored for up to 90 days for future testing. I have read the information contained in this form and have had a chance to ask questions.

Print Name _____ Date _____

Signature _____ Time _____

Original to healthcare provider; copy to District Nurse

Form BBP5

Post Exposure
Healthcare Provider Written Opinion for Exposed Employee

Date: _____ Name of Exposed Employee: _____

The above individual received a medical evaluation on _____ for an occupational exposure to blood or other potentially infectious material.

Please indicate the following:

☐ Hepatitis B vaccine was provided

☐ Hepatitis B vaccine was not provided

Notes: _____

_____

☐ The above individual was informed of the results of the evaluation.

☐ The individual was informed about medical conditions resulting from the exposure which may require further evaluation or treatment.

Notes: _____

_____

All other medical information is maintained at the healthcare provider's facility.

Please fax this (or similar) completed form along with BBP 4 ("Consent/Declination for Blood Testing of Exposed Employee") to the District Nurse as soon as possible at (218) 327-5865.

_____
Name of Healthcare Provider

_____
Signature of Healthcare Provider

_____
Name of Healthcare Clinic / Hospital

_____
Phone Number

Post Exposure
Consent/Declination for Blood Testing of Source Individual

Today's Date: _____ Date of Exposure Incident: _____

Name of Source Individual: _____

On the above date, an exposure incident as defined by the Federal and Minnesota State Bloodborne Pathogen Regulations occurred involving an employee performing his/her duties. According to these regulations, a sample of blood is to be drawn as soon as possible from the source of the exposure as well as the exposed employee to determine if any infectious diseases (Hepatitis B and HIV) are present.

We are requesting to have your blood drawn and tested for HBV and HIV in order to provide appropriate medical direction. If you are a minor, consent to have your blood drawn and tested must be given by your parent or guardian. You are not legally required to consent to having your blood drawn and tested.

Please read the following and, if you consent, sign and date the form. You may choose your own healthcare provider and the cost, if not covered, will be paid by ISD 318.

If you know you are infected with HBV or HIV and can provide medical records or documentation, no blood test is necessary.

1. I authorize and consent to testing of a sample of my blood for the following (check only one):

   ☐ Human Immunodeficiency Virus (HIV)
   ☐ Hepatitis B Virus (HBV)
   ☐ Both the Human Immunodeficiency Virus (HIV) and the Hepatitis B Virus (HBV)

2. I understand that a positive HIV test does not necessarily mean that a person has AIDS; testing can assist healthcare personnel in medical management and infectious disease control of the virus.

3. I understand that I should rely on my physician for information regarding the nature and purpose of the HIV/HBV test and the meaning and significance of the result of the test.

4. I understand that HIV/HBV testing is not always 100% accurate and that results may be "false negative" (negative results when the virus is actually present) or "false positive" (positive results when the virus is not present). If a positive result is obtained, additional tests will be done to attempt to confirm the test results.

5. I understand that the results of the test will be confidential and will not be disclosed unless necessary for ISD 318 - Grand Rapids to comply with the provisions of OSHA's Bloodborne Pathogen Regulation (29 CFR 1910.1030).

6. I understand that I can personally make arrangements to have my blood drawn, as authorized, or that arrangements will be made for me, with the assistance of District personnel or other designated parties.

Continued on next page

7. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents. I have been given an opportunity to ask questions about the test and I believe that I have sufficient information to give this informed consent/declination.

CONSENT

☐ I consent to have my blood drawn and tested at this time.

☐ I consent to have my blood drawn and stored for up to 90 days for possible future testing upon my written consent.

Print Name _____ Date _____

Signature _____ Time _____

DECLINE

☐ I decline to have my blood drawn and tested or drawn and stored for up to 90 days for future testing. I have read the information contained in this form and have had a chance to ask questions.

Print Name _____ Date _____

Signature _____ Time _____

Original to healthcare provider; copy to District Nurse

Form BBP7

Post Exposure
Transmittal Letter to Healthcare Provider for Source Individual

Today's Date: _____ Date of Exposure Incident: _____

Source Individual: _____

An employee of Independent School District 318 has been exposed to blood or other potentially infectious body fluids from the above source individual. OSHA Regulation 29 CFR 1910.1030, Occupational Exposure to Bloodborne Pathogens, provides for testing of the source individual's blood with their consent in order to determine HBV and HIV infectivity.

To assist in conducting the medical evaluation, we have attached the following information and forms:

- ☐ Copy of the OSHA standard 29 CFR 1910.1030.
- ☐ Consent/Declination for Blood Testing of Source Individual (BBP6)
- ☐ Healthcare Provider Written Opinion for Source Individual (BBP8)

We request that you provide a confidential evaluation of this individual. Your written opinion must be provided to the District Nurse, including the limited information requested on the attached form BBP 8 (or an alternative form which contains the required information.) All other medical information is maintained by your facility. Please return the written opinion within 12 days.

Thank you for your assistance. Should you have any questions, please contact the employer's representative identified below.

Sincerely,

_____ Telephone Number: _____

ISD 318 - Grand Rapids Representative (printed name)

_____

ISD 318 - Grand Rapids Representative (signature)

District Nurse
Independent School District 318
820 NW 1st Ave
Grand Rapids, MN 55744-2687

Bill to:

Independent School District 318
Attn: Accounts Payable
820 NW 1st Ave
Grand Rapids, MN 55744-2687

Note: Grand Itasca please use
Vendor Account 80003180

Original to healthcare provider; copy to District Nurse

Form BBP8

Post Exposure
Healthcare Provider Written Opinion for Source Individual

Date: _____ Name of Individual Evaluated: _____

The above individual received a medical evaluation on _____ after a School District 318 employee was exposed to blood or other potentially infectious material.

Please indicate the following:

☐ Hepatitis B positive

☐ HIV positive

Notes: _____

All other medical information is maintained at the healthcare provider's facility.

Please fax this (or similar) completed form along with BBP 6 ("Consent/Declination for Blood Testing of Source Individual") to the District Nurse as soon as possible at (218) 327-5865.

_____
Name of Healthcare Provider

_____
Signature of Healthcare Provider

_____
Name of Healthcare Clinic / Hospital

_____
Phone Number

Form BBP9

Cleaning & Disinfection Procedures for Blood and Body Fluids

Materials Needed

- ☐ "Caution Wet Floor" or "Do Not Enter" signs.
- ☐ Disposable vinyl or nitrile gloves.
- ☐ Disposable cloth or paper towels or absorbent granules and disposable cardboard pieces.
- ☐ Pail containing soap & water (or spray bottle of general cleaner).
- ☐ Pail (or spray bottle) of rinse water.
- ☐ EPA approved disinfectant (tuberculocidal disinfectant) or fresh bleach & water solution.
- ☐ Plastic trash bag.

1 PROTECT YOURSELF AND THE AREA

- ✓ Secure the area with "Wet Floor" or "Do Not Enter" signs.
- ✓ Put on the disposable gloves.

2 REMOVE BODY FLUIDS SAFELY

- ✓ Soak up liquids with absorbent, disposable towels.
- ✓ If there is a large volume, use absorbing granules. Pick up debris with cardboard pieces.
- ✓ For carpet, vacuum granular remains if necessary.
- ✓ Place debris and disposable materials used in plastic bag.

3 CLEAN AND DISINFECT THE AREA

☐ **CLEAN** the area with soap and water or general cleaning agent. Use disposable towels.
☐ **RINSE** with clear water. Use disposable towels.
☐ **APPLY DISINFECTANT**** and allow to air dry (at least 10 minutes).
☐ **CARPET** Use the same process as above. Extra agitation, cleaning agent, and water may be necessary. Repeat wash until blood or body fluids are gone. Rinse and apply disinfectant. Allow to air dry.

** **AN APPROPRIATE DISINFECTANT IS:**

- EPA approved (Environmental Protection Agency Approved as "sterilant") or
- Tuberculocidal (lists on the bottle that it is capable of killing tuberculosis) or
- Bleach & Water Solution

To prepare bleach solution, mix 2 teaspoons of bleach to one-quart water.

BLEACH SOLUTION MUST BE MIXED DAILY.
DO NOT MIX BLEACH WITH ANY OTHER CHEMICALS OR PRODUCTS.
LABEL BLEACH SOLUTIONS AND KEEP OUT OF REACH OF CHILDREN.

4 FINISHING

Clean and disinfect any mops, brooms, brushes, dust pans, etc. used in the cleaning process.
Remove your gloves and dispose of in plastic trash bag and seal. Discard in regular trash.

WASH YOUR HANDS COMPLETELY.