

Document Name: Bloodborne Pathogen ECP
Document Number: 5460.1 v.2
FMC Division: Risk Management

Approval Date: 4/30/11
Review Date: 1/28/15
Approved By: AVP, FMC

Exposure Incident Procedure Summary

The following is a summary of the required procedures when an employee or student has an “exposure incident” (a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee’s duties or as part of a student’s education). For complete instructions, refer to the [Post Exposure Evaluation and Follow-Up section of the TWU Bloodborne Pathogen Exposure Control Plan](#).

Following an exposure incident **all of the following must be completed:**

1. **Cleanse the wound and surrounding area** with soap and water (for a puncture, cut or similar incident), and/or flush eyes, nose or mouth with copious amounts of tap water (for a splash to the face).
2. **Report the incident to exposed individual’s supervisor immediately.**
3. **Exposure incidents are to be considered urgent medical concerns.** The supervisor of the exposed individual must ensure that he/she **receive medical attention promptly** The CDC states that post exposure preventive medications are most likely to be effective if administered as soon as possible after the exposure (within hours of the incident, ***not days***). The exposed individual **must immediately** be sent to a nearby hospital or clinic to receive the post-exposure evaluation described below. Students may be sent to Student Health Services in Denton, or to a local clinic or hospital. Employees must be sent to a clinic or hospital within the [IMO Med-Select Network](#) if available in the area (call 888-466-6381 or visit www.injurymanagement.com to find a provider).
 - a. The exposed individual **must receive a confidential medical evaluation and follow up** including identification and documentation of source individual, collection and testing of blood, post-exposure prophylaxis when medically indicated, and appropriate counseling regarding infection status/results of tests/necessary precautions.
 - b. The information on the [Exposure Incident Reporting Form](#) must be provided to the healthcare professional providing the medical evaluation as soon as possible (but **do not delay sending the exposed individual for treatment**). This may be accomplished verbally or by using the form, but all information on the form must be provided.
4. The exposed individual’s supervisor must **obtain and provide the individual with a copy of the medical provider’s written opinion within 15 days** of completion of the evaluation. This opinion must be limited to the items listed on the [Medical Provider’s Written Opinion Form](#).
5. The exposed individual and his/her supervisor must complete the [“Employee’s Report of Injury” form](#) (SORM-29) and the [“Supervisor’s Report of Incident, Injury or Illness” form](#) (SORM-703) and submit them to TWU Human Resources as soon as possible **after** the employee receives medical care.
6. If the incident involved a percutaneous injury from contaminated sharps, the [DSHS “Contaminated Sharps Injury Reporting Form”](#) must be completed by the supervisor and mailed to the local health department and a copy provided to Risk Management **within 10 days** of the incident.

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Exposure Incident Reporting Form – Exposed Individual Information

This information must be provided to the evaluating healthcare professional as soon as possible. A copy must also be provided to Risk Management if Student Health Services is not conducting the evaluation.

Name of **Exposed** Individual: _____

Address: _____

Telephone: (work) _____ (home) _____ (cell) _____

Date of Incident: _____ Time: _____ Location of Incident: _____

Description of individual’s duties as they relate to the exposure incident: _____

Description of the incident which exposed an employee or student to blood or other potentially infectious materials; including the route of exposure and the circumstances in which the incident occurred:

- Hepatitis B vaccinations received (circle response): 0 / 1 / 2 / 3 / not known
- Hepatitis B titer (HBsAb) results (circle response): negative / positive / not known
- HIV infection status (circle response): negative / positive / not known
- Hepatitis C infection status (circle response): negative / positive / not known

Other relevant medical information for **exposed** individual:

Forward exposed individual’s relevant medical records (including vaccination records) to evaluating health care professional as soon as possible.

Preparer’s Name: _____ Phone: _____

Preparer’s Signature: _____ Date: _____

Clinical Consultation Center Post-Exposure Prophylaxis Hotline (PEPline): 888-448-4911

Applicable regulatory references required to be provided to the healthcare professional:

The US Occupational Safety and Health Administration (OSHA) [bloodborne pathogens standard](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) and the Texas Department of State Health Services (DSHS) [bloodborne pathogen control standard](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y) ([http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y)).

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Exposure Incident Reporting Form – Source Individual Information

This information must be provided to the evaluating healthcare professional as soon as possible. This information should be forwarded directly to the healthcare professional, and should not be sent with the exposed individual in compliance with privacy requirements. A copy must also be provided to Risk Management if Student Health Services is not conducting the evaluation.

Name of **Source** Individual (if available): _____

Address: _____

Telephone: (work) _____ (home) _____ (cell) _____

- Hepatitis B vaccinations received (circle response): 0 / 1 / 2 / 3 / not known
- Hepatitis B surface antigen (HBsAg) results (circle response): negative / positive / not known
- HIV infection status (circle response): negative / positive / not known
- Hepatitis C infection status (circle response): negative / positive / not known

Other relevant information regarding **source** individual:

Preparer's Name: _____ Phone: _____

Preparer's Signature: _____ Date: _____

Clinical Consultation Center Post-Exposure Prophylaxis Hotline (PEpline): 888-448-4911

Applicable regulatory references required to be provided to the healthcare professional:

The US Occupational Safety and Health Administration (OSHA) [bloodborne pathogens standard](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) and the Texas Department of State Health Services (DSHS) [bloodborne pathogen control standard](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y) ([http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=96&rl=Y)).

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Medical Provider's Written Opinion Form

*The written opinion provided to the exposed individual's supervisor must be limited to those items on this form; all other findings or diagnoses must remain confidential. This information must be provided to the supervisor and exposed individual within **15 days** of completion of the post-exposure evaluation. Please also provide a copy of this form to TWU Risk Management at the address below.*

Name of **Exposed** Individual: _____

Date of exposure incident: _____ Date of initial post-exposure evaluation: _____

Check the following statements as appropriate:

___ The exposed individual **has been informed** of the results of the post-exposure evaluation.

___ The exposed individual **has been informed** of any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

Description of any follow up that is required, including due dates:

Licensed physician/healthcare professional conducting post-exposure evaluation and follow-up:

Name: _____ Telephone: _____

Signature: _____ Date: _____

Address: _____

Please forward a copy of this form to the following address:

Texas Woman's University
Risk Management
Director of Environmental, Safety & Health
PO Box 425619
Denton, TX 76204-5619
940-898-2924
