Bloodborne Pathogens

Post-Exposure Incident Packet

Hastings Public Schools

An Informational Guide

Hastings Public Schools

Bloodborne Pathogens

Post-Exposure Incident Packet

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

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

1. BBP Exposure Self-Assessment

2. Post-Exposure Instructions and Response Actions

3. Post-Exposure Forms Routing Process

4. Forms:

- BBP1: Employee Self-Assessment and Immediate Response Process
- BBP2: Supervisor's Report of Employee's Exposure to Blood or OPIMS
- BBP3: Exposed Employee Declination of Medical Evaluation
- BBP4: Transmittal Letter to Healthcare Professional
- BBP5: Exposed Employees Consent/Declination for Blood Testing
- BBP6: Source Individual Consent/Declination for Blood Testing
- BBP7: Healthcare Professional Written Opinion

For assistance with this packet or process, please seek help from your supervisor, school's health services or the district safety consultant. If they are not available report directly to the Allina Clinic.

Contact numbers are as follows:

Health Services Coordinator:	Mary Ellen Fox –651-480-7353
District Safety Consultant:	Denise Jorgensen, Health & Safety Consultant 612-978-2504
Allina Clinic	651-438-1824

Hastings Public Schools

Employee Name: _____ Today's Date:_____

Form BBP1

BBP Exposure Self-Assessment

** ATTENTION INJURED EMPLOYEE **

Please follow the steps listed below:

1. Seek immediate first aid, if required.
2. 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 materials (OPIMs). **Any YES answer means an "exposure" has occurred.** Initial your answers. *Make sure to ask for clarification if you're not sure of any answer!*
3. **Questions: Did the contact with blood OR other potentially infectious materials (OPIMs) include any of the following:**

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

4. **If you answered NO to ALL of the questions above.**
An exposure did not occur and medical attention for exposure to blood or OPIMs is not required. Other medical attention may still be appropriate. You may stop here and give this page to your supervisor. Please report other injuries or concerns involved in this event, as applicable. Please ask for help or 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) Complete a "Supervisor Report of Employee's Exposure To Blood or OPIMS" (Page 6 of this packet) form with your supervisor. Supervisor will send completed form to Mary Ellen Fox at the Tilden Community Center.
   3) Complete a "Supervisor's Report of Accident" (on SMARTeR) with your supervisor or building nurse. The form can be found online.
   4) **You are encouraged to obtain medical care within 24 hours of the exposure.** Take all forms indicated in the routing directions on page 5 of this booklet (or bring the entire packet if you're not sure).
   5) The nurse or supervisor will notify the Allina Clinic, 1210 First Street (651 438 1824).
      - Indicate it is a Blood Exposure, need a blood test.
      - Indicate it is School District employee
      - Need immediate appointment.
      - Ask for directions to clinic and where to report
   6) If you choose to decline medical services at this time, you must sign the Exposed Employee Declination of Medical Services (Form BBP3), found on page 7 of this packet. Send the signed form to Mary Ellen Fox at the Tilden Community Center. Keep a copy for your records.

Additional Post-Exposure Instructions and Response Actions

Hastings Public School District employees who experience a work-related exposure to blood or any other potentially infectious agent (OPIM) are encouraged to seek medical care immediately. The purpose of medical care is to discuss the event with a qualified health care provider and obtain baseline blood antibody levels for Hepatitis B and HIV. Both the exposed employee and source individual will be given an opportunity to accept or decline having their blood drawn and tested, or drawn and held for future testing. In addition, the exposed employee could be offered and provided with a hepatitis vaccine and/or gamma globulin to prevent development of hepatitis.

Hastings Public Schools has identified Allina Clinic as an optional, primary provider for post-exposure health care services. Alternatively, exposed employees are allowed to seek a medical evaluation through a provider of their choice, at no cost to that employee.

General Instructions:

1) Complete the "Transmittal Letter to Healthcare Professional" form (BBP4 – found on page 8 of this packet) with the assistance of your supervisor, district health services and/or the district safety consultant. Take this form to the medical care provider of your choice. Give the form directly to the doctor or nurse and ask that they process the form, as indicated.

2) Complete the "Exposed Individual – Consent or Declination for Blood Testing" form (BBP5 – found on page 9 for this packet) with the assistance of your supervisor, building health services, district safety consultant – OR TAKE TO CLINIC TO COMPLETE THERE.

3) "Source Individual – Consent or Declination for Blood Testing" form (BBP6 – found on page 12 of this packet) completed by the source employee with assistance of your supervisor, building health services, district safety consultant – OR TAKE TO CLINIC TO COMPLETE. The Source individual may go to their own medical provider or to Allina Clinic to provide a blood sample. The consent form should go with the source individual and be given to the medical provider administering the test. A copy should be sent to Mary Ellen Fox. If the source employee declines, the form should be sent to Mary Ellen Fox. *If a minor child is involved or you are unable to get the adult source individual to sign this form, involve the school principal or assistant principal.*

4) Obtain medical care within 24 hours. You may go to your usual provider of health care for this exam or to an occupational health clinic, as indicated above. Take this booklet with you when seeking care from any medical provider other than Allina Clinic.

   - Give the medical provider a copy of the "Health Care Professional Written Opinion" form (BBP7 – found on page 14 of this packet) to complete, as appropriate. The provider is asked to send the completed form back to the district.

5) Communicate with your supervisor regarding job restrictions, return-to-work date or other appropriate information.

(Employee bring copy to Clinic. Supervisor send original to Mary Ellen Fox)

Summary of Bloodborne Pathogens Post Exposure Program
Forms and Routing Direction

- All forms will be ultimately submitted to Mary Ellen Fox at the Tilden Community Center.
- Exposed employee should take the forms indicated, in the grid below, with them to the clinic.
- Supervisor or nurse: If the exposed employee **consents** to a medical evaluation send copies of completed forms, BBP1, BBP2, BBP4, BBP5, and BBP6 to Mary Ellen Fox at the Tilden Community Center. If the employee **declines** medical evaluation send forms BBP1, BBP2, and BBP3 to Mary Ellen Fox.
- Exposed employee should complete Form BBP3 only if the employee does not want medical attention. Forward the form to Mary Ellen Fox at the Tilden Community Center.

Form #	Page #	Routing				Form Title
		Exposed Employee Take with you to the medical provider (as indicated)		Supervisor or Nurse Send to Mary Ellen Fox at the Tilden Community Center ASAP	Healthcare Provider Send to Mary Ellen Fox	
BBP1	3	copy		original		BBP Exposure Self-Assessment
BBP2	6			original		Supervisor's Report of Employee's Exposure to Blood or OPIMS
BBP3	7			Original (complete only if employee refuses medical services)		Exposed Employee Declination of Medical Evaluation
BBP4	8	original		copy		Transmittal Letter to Healthcare Professional
BBP5	9-10	original		copy		Exposed Individual – Consent for Blood Testing
BBP6	11-13			Original or copy		Source Individual – Consent or Declination for Blood Testing
BBP7	14				original	Health Care Professional Written Opinion

* Health Services Coordinator retains the completed original incident paperwork and sends a copy to HR.

Please contact a building nurse or Safety Consultant for additional information or assistance.

Comments:

Form BBP2

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

EMPLOYEE INFORMATION

Employee Name:_____ Birth Date: _____

Social Security Number:_____ Job Title: _____

Work Location:_____ 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:
  - Precutaneous (skin piercing): Depth of injury: _____ Was source fluid present at site of injury? ☐ Yes ☐ No
  - Mucous Membranes: Area Affected: _____ Length of time of exposure: _____
  - Non-Intact Skin: Condition of 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 handwashing and/or flushing of mucous membrane occur as soon as possible? ☐ Yes ☐ No

- Employee has been referred to a healthcare professional for medical evaluation and follow-up. ☐ Yes ☐ No
- Name and Location of Professional Clinic: _____

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)

(Supervisor send original to Mary Ellen Fox)

Form BBP3

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 OPIMs

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 physician of my choice or at:

Allina Clinic
1210 First Street West
Hastings, MN 55033 - 1056
651 438 1824

Medical services will be provided at no cost to me for work-related incidents involving exposure to blood or other potentially infectious materials. 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

(Supervisor send original to Mary Ellen Fox only if employee refuses medical services)

Form BBP4

Post Exposure
Transmittal Letter to Healthcare Professional

Completed by supervisor or school nurse

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:

- ☐ Exposed Individual – Consent for Blood Testing (BBP5)
  (results to be transmitted directly to employee)
- ☐ Source Individual – Name:_____
  (results to be transmitted directly to employee)
- ☐ Healthcare Professional Written Opinion Form (BBP7)

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 Hastings Public School District, including the limited information requested on the attached form (BBP7). All other medical information is maintained by your facility. You may utilize the attached form BBP7 or an alternative form that contains the required information. Please return the written opinion within 12 days for timely distribution to the employee.

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

Sincerely,

_____

Mary Ellen Fox
Health Services Coordinator

Tilden Community Center
310 River St.
Hastings, MN 55033
651-480-7353 or 651-480-7286

(Employee bring original to Clinic. Supervisor send copy to Mary Ellen Fox)

Form BBP5

Post Exposure
Exposed Individual
Consent for Blood Testing

(Review instructions prior to using this form)

Employee Name: _____ Today's Date: _____

Date of Incident: _____

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.

The regulation requires that a sample of blood be drawn as soon as possible from the source of the exposure and 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. Directions will be provided on the location for the test and the cost, if not covered, will be paid by the district. You will be provided with the test results as soon as possible.

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 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.

(continued on next page)

Form BBP5 = Continued

5. I understand the results of the test will be confidential and will not be disclosed unless necessary for Hastings Public Schools to comply with the provisions of OSHA's Bloodborne Pathogen Regulation (29 CFR 1910.1030). If you are a source individual, disclosure will be made to the exposed employee and their healthcare professional.

6. I understand 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.

6. 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.

NAME		WITNESS	
Print Name/Other Legally Responsible Person		Print Name/Witness	
Signature		Signature	
Date	Time	Date	Time

(Employee bring original to Clinic. Supervisor send copy to Mary Ellen Fox)

FORM BBP6

"SOURCE INDIVIDUAL CONSENT OR DECLINATION FOR BLOOD TESTING"

Form BBP6 asks for permission to test the source individual's blood. The source individual may have their blood drawn and tested by Allina Clinic or a medical provider of their choice. Form BBP6 should go with the source individual and be given to the medical provider administering the test.

If the source individual declines to sign permission to have their blood tested, send form BBP6 to Mary Ellen Fox incomplete. The district will review and assist in obtaining permission, as appropriate.

Form BBP6

Post Exposure
Source Individual
Consent or Declination for Blood Testing

(Read form completely prior to completing)

Name of Source Individual: _____ Today's Date:_____

Date of Incident: _____

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.

The regulation requires that a sample of blood be drawn as soon as possible from the source of the exposure and the exposed employee to determine if any infectious diseases (hepatitis B and HIV - Human Immunodeficiency Virus) 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. Directions will be provided on the location for the test and the cost, if not covered, will be paid by the district. You will be provided with the test results as soon as possible.

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 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.

Continued on next page

Form BBP6 = continued

5. I understand the results of the test will be confidential and will not be disclosed unless necessary for Hastings Public Schools to comply with the provisions of OSHA's Bloodborne Pathogen Regulations (29 CFR 1910.1030). ***I understand, disclosure will be made to the exposed employee and their healthcare professional.***

6. 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.

NAME		WITNESS	
_____		_____	
Print Name/Other Legally Responsible Person		Print Name/Witness	
_____		_____	
Signature		Signature	
_____	_____	_____	_____
Date	Time	Date	Time

I HAVE READ ALL INFORMATION CONTAINED ON THIS FORM, HAVE ASKED QUESTIONS WHERE ADDITIONAL INFORMATION WAS NECESSARY AND FULLY UNDERSTAND THE ISSUES INVOLVED IN THIS MATTER.

I REFUSE TO HAVE MY BLOOD DRAWN AND TESTED AT THIS TIME OR DRAWN AND STORED FOR UP TO 90 DAYS FOR POSSIBLE FUTURE TESTING, UPON MY WRITTEN CONSENT

_____

Signature

_____

Date Time

(Employee bring original to Clinic. Supervisor send copy to Mary Ellen Fox)

Form BBP7

Post Exposure
Healthcare Professional Written Opinion

Date: _____

Exposed Employee: _____

Social Security Number: _____

The above individual received a medical evaluation on _____ (date):

- ☐ For an occupational exposure to blood or other potentially infectious material
- ☐ As source individual involved in a potential BBP exposure incident

The Hastings Public School District provided the required information necessary for the evaluation. Please indicate the following:

- ☐ Hepatitis B vaccine was provided
- ☐ Hepatitis B vaccine was not provided

Notes _____

_____

- ☐ The above individual was informed as to the results of the evaluation.
- ☐ The individual was informed about medical conditions resulting from the exposure that may require further evaluation or treatment.

Notes _____

_____

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

_____
Name of Healthcare Professional

_____

_____
Phone No.

_____ _____
Signature of Healthcare Professional Date Sent to Hastings Public Schools

_____
Signature of Parent/Guardian (if applicable)

Please forward this completed form or similar form to the attention of Mary Ellen Fox (651-480-7353) at the Tilden Community Center as soon as possible or within 12 days at most. 310 River St, Hastings, MN 55033 or fax (651-480-7680).