Policy

- All blood borne pathogen (BBP) exposures and personal injuries are to be treated immediately.
- All BBP exposures and personal injuries are to be reported immediately.

Procedures

Blood Borne Pathogen Exposure – Faculty, Staff, and Students

1. Blood Borne Pathogen Exposures - Steps for Treatment
   a. Administer first aid, immediately after exposure. Allow a penetrating injury to bleed. Wash the injury site thoroughly with soap and water or rinse the exposed mucous membrane thoroughly with water. If anyone assists with first aid they should wear gloves and eye protection.
   b. After first aid has been administered, the individual must report to incident to their supervisor.
   c. The supervisor will complete the Exposure Report Form (Appendix A), First Report of Injury Form (Appendix B) and Injury/Illness Loss Investigation Report (Appendix C).
   d. If injury occurs Monday-Friday between 8am-4pm the supervisor will call the University of Delaware Nurse Managed Health Center (“UD NMHC”) at 302-831-3195 to alert the office that they are referring an individual for treatment for BBP exposure.
   e. If injury occurs Monday-Friday between 4pm-8pm or Saturday-Sunday between 8am-8pm, the supervisor will call the closest Medical Aid Unit to alert the Medical Aid Unit that they are referring an individual for treatment for BBP exposure. Local Medical Aid Units include:
      i. Glasgow Medical Aid Unit
         STAR Campus
         550 South College Avenue, Suite 115
         Newark, DE 19713
         302-533-7148
      ii. Glasgow Medical Aid Unit
         Glasgow Medical Center
         2600 Glasgow Ave., Newark, DE 19702
         302-836-8350
      iii. Medical Aid Unit at Christiana
         HealthCare Center at Christiana
         200 Hygeia Drive, Newark, DE 19713
         302-623-0444
      iv. Medical Aid Unit at Middletown
         Middletown Care Center
         124 Sleepy Hollow Drive, Middletown, DE 19709
         302-449-3100
   f. If injury occurs during any hours not covered above, the supervisor will contact the closest Christiana Care Emergency Room to alert them that they are referring an individual for treatment for BBP exposure.
      i. Christiana ER (Triage Desk) 302-733-1620
      ii. Wilmington ER (Triage Desk) 302-428-4180
   g. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for BBP exposure.
   h. The supervisor will provide the injured individual with a copy of the Exposure Referral Guideline (Appendix E).

        i. The supervisor will contact the University of Delaware (UD) Nurse Managed Health Center (NMHC) at 302-831-3195 to notify them that an individual has been referred for treatment for BBP exposure and will require follow-up in the NMHC.
2. Blood Borne Pathogen Exposures - Source Evaluation
    a. The supervisor is responsible for requesting that the source patient's blood be tested for:
        i. RAPID HIV testing; no consent is needed.
        ii. Hepatitis B and Hepatitis C testing.
    b. The supervisor will complete the Source Patient Information Form (Appendix D).
3. Blood Borne Pathogen Exposures - Immediate Post-Exposure Documentation
    a. The supervisor is responsible for submitting all the required completed forms:
        i. Appendix A - Exposure Report Form
        ii. Appendix B - First Report of Injury Form
        iii. Appendix C - Injury/Illness/Loss Investigation Report
        iv. Appendix D - Source Patient Information Form
        v. For Faculty/Staff only: Appendix F – First Report of Injury Form
    b. All forms are to be submitted via FAX or hand-delivery within 24 hours of the BBP exposure to the following:
        i. UD Department of Environmental Health & Safety: 302-831-1528 (only forms A,B,C)
        ii. UD department director's office: 302-831-2382 (only forms A,B,C)
        iii. UD NMHC: fax 302-831-3193 (all forms A,B,C,D)
4. Blood Borne Pathogen Exposure - Follow-up Care
    a. The UD NMHC upon notification and receipt of the above documentation will contact the injured individual to schedule a follow-up office visit for counseling and health care treatment as indicated.

Faculty and Staff Injury (other than BBP exposure)

1. Injuries - Steps for Faculty and Staff Treatment
    a. Administer first aid and/or treatment as indicated.
    b. After first aid has been administered, the faculty or staff member must notify their supervisor.
    c. The supervisor will contact the UD NMHC at 302-831-3195 to alert them of the individual's injuries and in consultation with the UD NMHC, determine if individual should be treated at the UD NMHC or referred to the nearest urgent care facility or emergency room.
    d. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for treatment of the injury.
    e. The supervisor will complete a First Report of Injury Form (Appendix F) and an Injury/Illness Loss Investigation Report (Appendix C).
    f. The supervisor is responsible for submitting all the required completed forms:
        i. Appendix F – First Report of Injury Form
        ii. Appendix C – Injury/Illness/Loss Investigation Report
    g. All forms are to be submitted via FAX or hand-delivery within 24 hours of the personal injury to the following:
        i. UD Department of Environmental Health & Safety: 302-831-1528
        ii. UD department director's office
        iii. UD Nurse Managed Health Center: fax 302-831-3193

Student Injury (other than BBP exposure)

1. Injuries – Steps for Student Treatment
    a. Administer first aid and/or treatment as indicated.
    b. After first aid has been administered, the student must notify their supervisor.

c. The supervisor will contact Student Health Services at 302-831-2226 to alert them of the student's injuries and in consultation with the Student Health representative, determine if student should be treated at the Student Health Services or be referred to the nearest urgent care facility or emergency room.
d. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for treatment of the injury.
e. The supervisor will complete a First Report of Injury Form (Appendix B) and an Injury/Illness Loss Investigation Report (Appendix C).
f. The supervisor is responsible for submitting all the required completed forms:
    i. Appendix B – First Report of Injury Form
    ii. Appendix C – Injury/Illness/Loss Investigation Report
g. All forms are to be submitted via FAX or hand-delivery within 24 hours of the personal injury to the following:
    i. UD Department of Environmental Health & Safety: 302-831-1528
    ii. UD department director's office
    iii. UD Student Health Services: 302-831-6407 (only for students)

Appendices

Appendix A - Exposure Report Form
Appendix B - First Report of Injury Form – Student Use Only
Appendix C - Injury/Illness/Loss Investigation Report
Appendix D - Source Patient Information Form
Appendix E - Exposure Referral Guideline
Appendix F – First Report of Injury Form – Employee Use Only

Submit a Copy of This Report to Each of the Following:		
University of Delaware Environmental Health & Safety 132 General Services Bldg.	Nurse Managed Health Center STAR Campus 540 S College Ave, Ste 130	UD Department's Director's Office

Exposed Individual:		
Name:		
Role:	☐ Student ☐ Employee	
Department:		
Phone Numbers:	Cell:	Home:
Exposure:		
Date of exposure:		
Location of exposure:		
Type of exposure: (i.e. needle-stick, mucous membrane, non-intact skin, bite, etc.)		Type of Device: (i.e. type of needle, safety device)
Body fluid/substance involved:		
Estimated quantity of fluid involved:		
Was fluid actually injected into individual?		
Body part exposed:		
Witness:		
Name:		
Address:		
Phone#:		
Incident Details:		
Explain in detail what occurred:		
Personal protective equipment used:		
First Aid:		
What first aid was performed:		
By whom:		
Hepatitis B:		
Has individual had Hepatitis B vaccine series? ☐ Yes ☐ No		
If yes, has series been completed? ☐ Yes ☐ No		
Date and Signature of Person Recording Report:		
Signature:		Date:
Name Printed:		

FIRST REPORT OF INJURY *- This form applies to visitors and students who are not employed by the University of Delaware*

☐ Student ☐ Visitor

Nature of Business: Educational Institution

Submit a Copy of This Report to Each of the Following:

Environmental Health & Safety 132 General Services Bldg. Fax: 302-831-1528	Nurse Managed Health Center 540 South College Ave, Ste 130 Fax: 302-831-3193 (BBP Injuries Only)	UD Department's Director's Office

Location and Date/Time of Injury:

Location Where Accident Occurred: ______

University Property: ☐Yes ☐No

Date of Injury: ______

Day of Week: Su M Tu W Th F Sa

Time of Injury: ______

Name of Supervisor Reporting Injury:

First Name, MI: ______

Middle Initial: ______

Job Title: ______

Address of Supervisor Reporting Injury:

Street Address: ______

City/State/Zip: ______

Name of Injured Person:

First Name: ______

Middle Initial: ______

Last Name: ______

Address/Phone Number of Injured Person:

Street Address: ______

City/State/Zip: ______

Phone Number: ______

Demographic Information of Injured Person:

Date of Birth: ______

Gender: ☐Male ☐ Female

Name of Health Care Insurance Carrier: ______

Injury Details:

Describe fully how the accident occurred:

Describe the Nature and Location of Injury (describe fully exact location of amputations or fractures, right or left):	

Names, Addresses and Phone Numbers of Witnesses:

Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone Number: ____________________
Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone Number: ____________________
Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone Number: ____________________

Name, Address and Phone Number of Treating Healthcare Provider:

Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone Number: ____________________

Name, Address and Phone Number of Treating Hospital or Health Care Facility:

Name: ____________________
Street Address: ____________________
City/State/Zip: ____________________
Phone Number: ____________________

Date and Signature of Person Recording Report:

Date: ____________________
Signature: ____________________

Routing:

Department Director's Office
NMHC (BBP) or Student Health (Non-BBP)
EHS

Rejected: ☐Yes ☐No

Rejected By: ____________________

Date: ____________________

Reason: ____________________

University of Delaware
Illness/Injury/Loss Investigation Report (Appendix C)

Case No:	*Date of Injury /Illness /Loss:*		*Name of Injured:*	
Injured Person's Department:			*Immediate Supervisor:*	

Submit a Copy of This Report to Each of the Following:		
Environmental Health & Safety 132 General Services Bldg. Fax: 302-831-1528	Nurse Managed Health Center 540 S College Ave, Ste 130 Fax: 302-831-3193	Department Director's Office

Identify the Direct and Contributing Causes of the Illness/Injury
1. Was this person made aware of hazards and proper safety procedures with the task prior to the accident? (Explain)
2. What mechanical, physical or environmental conditions contributed to the accident (e.g. broken equipment, poor lighting, noise, material defects, slippery surfaces, lack of warning signs or posted directions, etc.)
3. What act(s) by the injured and/or others contributed to the accident (e.g. wrong tool or equipment, improper position or placement, work rule violation, failed to follow instructions, etc.)
4. What personal factors contributed to the accident (e.g. improper attitude, fatigue, inattention, substance abuse, etc.)
5. Was the accident the result of failing to wear personal protective equipment? (Explain)
6. What corrective action(s) has been or will be taken to prevent a recurrence of this type of accident? (e.g. repair/modify/replace equipment, counseling, training, policies, procedures, etc.)
7. Who is responsible for implementing corrective actions?

Investigated by: Supervisor	**Date:**
Reviewed by: Safety Committee Chair	**Date:**

UNIVERSITY OF DELAWARE

<u>Only submit a copy of this report to:</u>
Nurse Managed Health Center, 540 South College Ave., Suite 130; Secure Fax: 302-831-3193

Source Person's Information Form

Source Person's HIV Status	
Positive:	☐
Negative:	☐
Verification:	☐ Rapid HIV ☐ Reported ☐ Documented in Chart
Unknown:	☐ Source Not Tested ☐ Source Not Available
Individual Exposed From Source Person and Reporting Supervisor	
Individual's Name:	
Supervisor's Name:	
Date of Exposure:	
Location/Facility Where Injury Occurred (e.g. hospital name):	
Location/Facility:	

UNIVERSITY OF DELAWARE

Instructions:
The supervisor is to complete the bottom of the form and supply the completed form to the individual who has the BBP exposure. The individual is to give it to the healthcare facility to which he/she has been referred for treatment.

Financial Responsibility
The University of Delaware individual has been referred to your facility for treatment of a Blood Borne Pathogen (BBP) exposure. The individual is financially responsible for this visit. If the individual is not able to provide health insurance information or payment at time of service, the individual should be given a receipt and billed as indicated.

The University of Delaware will assist the student with the health insurance reimbursement process, or navigating mechanisms for payment of services received at your facility, if needed, during their follow-up visit at the UD Nurse Managed Health Center.

Post-Exposure Treatment
Individuals presenting at a Medical Aid Unit or Emergency Room should be treated in accordance with the guidelines set forth by the CDC's - National Institute for Occupational Safety and Health (NIOSH).

Post-Exposure Laboratory Testing Guidelines
1. ALT/AST, Anti-HIV, Anti-HBs, Anti-HCV
2. If individual to receive Post-Exposure Prophylaxis (PEP) include CBC, CMP, UA, and HCG
3. For questions concerning testing and treatment contact the (24/7) National Clinicians' Post-Exposure Prophylaxis Hotline at 888-448-4911.

Follow-up Care
1. Fax copy of all laboratory results to the University of Delaware Nurse Managed Health Center (UD NMHC) at 302-831-3193.
2. Refer the individual for follow-up care to the UD NMHC, phone 302-831-3195.
3. Then UD NMHC will assume responsibility for all subsequent care and treatment of the individual.

Communication:
1. Fax the individual's complete medical report to the NMHC at 302-831-3193.
2. All labs ordered will be copied to Carolyn Haines, FNP-C (Nurse Practitioner) at the UD NMHC.

Contact Information:
1. Nurse Managed Health Center – 302-831-3195

____

Supervisor Name Phone #

Last updated: 12/08/2015

ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED

Department of Labor
Office of Workers' Compensation
P.O. Box 8902
Wilmington DE 19899-8902
Telephone 302-761-8200

STATE OF DELAWARE
FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE
(Appendix F)

_______________ CASE OR FILE NO.

_______________ LOCATION/DEPT. CODE /

_______________ EMPLOYER'S UC REPORTING NUMBER

1.. EMPLOYEE: FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO.
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE	4. MALE ❑ FEMALE ❑		5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE)
6. DATE OF BIRTH	7. AGE	8. WAGE	9. WEEKLY HOURS WORKED
10. OCCUPATION (REGULAR)	11. DEPARTMENT OF DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED
13.. EMPLOYER **University of Delaware**		14. PERSON MAKING OUT THIS REPORT	
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE **413 Academy St. Newark DE 19716**			16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE) **302-831-8305**
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE		18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC. **Educational Institute**	
20. DATE OF INJURY AND TIME ❑ AM ❑ PM	21. NORMAL STARTING TIME ❑ AM ❑ PM,	22. IF EMPLOYEE BACK TO WORK GIVE DATE	23. AT SAME WAGE YES ❑ NO ❑
24. IF FATAL INJURY, GIVE DATE OF DEATH.	25. DATE EMPLOYER KNEW OF INJURY	26. DATE DISABILITY BEGAN	27. LAST FULL DAY PAID – DATE
28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.			
29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.			
30.. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.			
31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.			
32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED			
33. NAME OF PHYSICIAN		34. PHYSICIAN'S ADDRESS	
35. HOSPITAL (IF APPLICABLE)		36. HOSPITAL ADDRESS	

WORKER'S COMPENSATION INSURANCE COMPANY AND COMPLETE ADDRESS (PREPRINT OR STAMP INCLUDE IAB CODE)
37. (THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS.)

PMA Management Corp
P O Box 25250 Lehigh Valley, PA 18002

I.A.B. CODE _________ **POLICY NO. ________________**

DISTRIBUTION OF THIS REPORT DOC. NO. #60-07-01-90-10-04

1. **ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.**
2. **COPY TO INDUSTRIAL ACCIDENT BOARD**
3. **EMPLOYER'S COPY – RETAIN AS RECORD**
4. **EMPLOYEE'S COPY**

_______________ SIGNATURE OF PERSON IN 14 ABOVE

_______________ OFFICIAL POSITION

Last updated: 12/08/2015