

<b>PLAN REVIEW</b>	
<i>Reviewer</i>	<i>Date</i>
Eileen Carlson	9/21/2015
Brian Parrie	2/21/2017
Shane Carlson	2/16/2018
Shane Carlson	9/19/2019

Contact: Sue Wear  
(507) 232-3411 ext. 3108

## **BLOODBORNE PATHOGENS**

**Sue Wear is the contact person for this program. Sue maintains a copy of the of the program plan and training outlines at her office.**

### **TRAINING OUTLINES**

#### **AWAIR**

- \*Safety Committee (Members, chain of command)
- \*OSHA 300 Log (Federal Govt. requirement)
- \*First Report of Injury (Fill out of injury if beyond first aid)
- \*Concerns (Safety)

#### **BLOODBORNE PATHOGENS**

- \*Introduction
- \*At-Risk Employees (By job description)
- \*Exposure Control Plan
- \*Cleanup Procedures (Universal precautions)
- \*Disposal Procedures (Policy of school, red bag if saturated with blood - Biohazard)
- \*HBV Vaccination Policy (At risk- Paid by school district) District may offer to all
- \*Engineering Controls
- \*Post Exposure Procedures

#### **HAZARD COMMUNICATION/RTK**

- \*Introduction
- \*OSHA (Occupational Safety and Health Admin.)
- \*Routes of Entry (Dermal, inhalation, ingestion, etc.)
- \*PPE (Personal Protective Equipment)-Gloves, etc.
- \*Labeling (All containers should be labeled)

- \*MSDS's (Have one for each chemical, also have an inventory of chemicals)
- \*Disposal (Properly store and dispose of)

### I.A.Q.

- \*IAQ Committee (Know who is on committee)
- \*Record keeping (Forms and procedures for addressing concerns)
- \*Management Plan
- \*IAQ issues/concerns (Know who the contact is)

## Sharps Injury Log

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Engineering controls in use at the time of the incident: \_\_\_\_\_

Work practices followed: \_\_\_\_\_

Description and brand name of the device in use: \_\_\_\_\_

Protective equipment or clothing that was used at the time of the exposure incident:

—

Procedure being performed when the incident occurred: \_\_\_\_\_

Employee training: \_\_\_\_\_

The injured employee's opinion about whether any other engineering, administrative, or work practice controls could have prevented the injury and the basis for that opinion. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Form B**  
**BLOOD EXPOSSURE INCIDENT REPORT**

Complete items 1-9. Items 10-14 should be filled out by the employer (school district representative).

Employee's Full Name: \_\_\_\_\_

Employee's Social Security Number: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Date of Incident: \_\_\_\_\_

Time of Incident: \_\_\_\_\_

Date and Time Incident Report: \_\_\_\_\_

Incident Reported by: \_\_\_\_\_

The employee named above was involved in an exposure incident consisting of blood or other potentially infectious material (OPIM) involving the employee's mouth, eyes, or other mucous membranes, open cuts, non-intact skin, or piercing of mucous membranes or skin.

The following exposure incident information was obtained to help assist the Healthcare Professional in completing the medical evaluation of the employee.

1. Exposure route to blood or OPIM. Check the following:  
A.  Eyes  Mouth  Nose  Other mucous membrane  
(list): \_\_\_\_\_  
B.  Needlestick  Puncture  Bite  Scratch  
C.  Non-intact skin  
D.  Other (list): \_\_\_\_\_

Comments: \_\_\_\_\_

2. Type of body fluid or material  
 Blood  
 Other potentially infectious material (List): \_\_\_\_\_

Comments: \_\_\_\_\_

3. Estimated amount of body fluid or description of amount:

\_\_\_\_\_

4. Severity of Exposure:

A.  Mucous Membranes  Area covered  
 Exposure length (time)

Comments: \_\_\_\_\_

B.  Percutaneous (skin piercing)  Injury depth  
 Yes  No, was source fluid present at injury site:

Comments: \_\_\_\_\_

C.  Non-intact skin  
 Skin condition:  Fresh cuts (<24 hrs)  chapped  
 Dermatitis  Other

Comments: \_\_\_\_\_

5. Job duties being performed during exposure: \_\_\_\_\_

6. Did employee wash hands and/or flush the mucous membrane as soon as possible:

Yes  No

Comments: \_\_\_\_\_

7. Was employee using Person Protective Equipment (PPE)?

Yes  No If yes, what types: \_\_\_\_\_

Comments: \_\_\_\_\_

8. Was the Personal Protective Equipment (PPE) adversely affected:  
(examples: gloves torn or pierced)  Yes  No

If yes, list: \_\_\_\_\_

Comments: \_\_\_\_\_

9. Was clothing contaminated:  Yes  No  
If yes, were procedures for disposal/laundrying of contaminated materials adhered to:  
 Yes  No

Comments: \_\_\_\_\_

If employee does not want his/her blood tested or a medical follow-up, then Form E should be completed by signing the Declination section for blood testing, and also Form G "Post-Exposure Declination of Medical Evaluation".

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TO BE COMPLETED BY EMPLOYER-

10. Has employee been referred to a healthcare professional for medical evaluation and follow-up?  Yes  No

Name and location of professional/clinic (unless employee has made arrangements with his/her own physician. If this is the case, obtain the name and address of the employee's physician):

\_\_\_\_\_  
\_\_\_\_\_

11. Was the source's blood tested?  Yes  No  
If yes, are results being directly forwarded to Healthcare Professional?  
 Yes  No

If no, record the date of consent for testing source was declined:

\_\_\_\_\_  
If no, was source known?  Yes  NO

Source is known to be infected with:  
 HIV  HBV  Not applicable

12. Employee's consent for blood collection (See Form E):

\_\_\_\_\_ Employee consented to baseline blood collection

Employee consented to the serologic testing for HBV:

\_\_\_\_\_ Yes    \_\_\_\_\_ No

Employee consented to serologic testing for HIV:

\_\_\_\_\_ Yes

\_\_\_\_\_ No, sample is preserved for 90 days. Employee may elect to have test

conducted within 90 days.

Date: \_\_\_\_\_

13. All required documents were provided to professional/clinic on the following date (See Form C):

\_\_\_\_\_

14. Has employee had Hepatitis B vaccination? \_\_\_\_\_ Yes    \_\_\_\_\_ No

If the employee has indicated that no medical follow-up is to be done, please make sure that Form G is filled out and signed.

Signature \_\_\_\_\_

Date

\_\_\_\_\_

## Hepatitis B Vaccination Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself.

However, I decline hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood and/or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I may receive the vaccination series at no charge to me.

**Please Print:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security or Visa # \_\_\_\_\_ Employee # \_\_\_\_\_

Department and Lab room # \_\_\_\_\_

Principal Investigator \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Contact your BBP Contact Person if you have questions filling out this form