BLOOD AND BODY FLUID EXPOSURE MANAGEMENT PACKET

In accordance with BAMC MEMO 40-135

Points of Contact:

Occupational Health	**295-2437**
Emergency Department	**916-0808**
Infectious Disease	**916-5554**
Safety Office	**916-1427**

Once complete, place in Preventive Medicine box on the half wall in Emergency Department for Occupational Health pick-up.

BLOOD AND BODY FLUID EXPOSURE CHECKLIST

A. When an exposure happens:

- Initiate first aid immediately. Wash exposed skin with soap and water. Flush mucous membranes or irrigate eyes with water for 10 minutes.
- Report the incident to the immediate supervisor.
- Attempt to identify the source of the exposure, identify the patient's name and location.
- The exposed person must report to the Emergency Department (ED) with all pertinent information regarding the source patient.
- If source patient is known or suspected to be HIV positive, report immediately to the ED for evaluation for post-exposure prophylaxis (PEP).
- Provide necessary information for completion of BAMC Form 1195 (available through WebAEFSS) as part of the ED evaluation.

B. The EP's supervisor will:

- Ensure STEPS 1 through 4 above are completed. If EP refuses treatment, have the EP sign Declination of Treatment Statement (Appendix C), witness and forward to Department of Preventive Medicine, Occupational Health Section (**FAX 295-2456)**
- Send source patient information with injured EP, **OR** call the Emergency Department (**916-3693**) as soon as practical (ASAP) with the above information.
- Complete DA Form 285-AB to send with EP or FAX (6-2297) or tube to ED. Ultimately send completed form to Safety.
- Evaluate the procedure risk, how can this be prevented. Discuss with Safety, and Infection Control.
- For civil service employees, completion of the CA-1 (Federal Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) form is required. This form is available on the BAMC Safety webpage (https://intranet.bamc.amedd.army.mil/SiteDirectory/CommandSuite/CommandSafety/default.aspx). Follow the link to DoDCPMS and then click on "Filing Claims Electronically". For questions regarding this form and/or its completion, contact the Occupational Health Section.

C. The Emergency Department (ED) will—

- Triage EP into emergency category if source is known or suspected to be HIV positive.
- Ensure that first aid was or is performed adequately.
- Obtain information from CHCS/AHLTA and the source patient's physician regarding source patient HIV, hepatitis B, and C status, and risk of these infections if status is unknown. Instruct the source patient's physician to order source patient labs if HIV, HBV, or HCV status is unknown. **(CHCS/AHLTA lab panel= NEEDLESTICK SOURCE**)
- Use exposure type and HIV infection status to determine recommendation of HIV PEP (See Appendix G). IMMEDIATELY consult Infectious Disease fellow on-call if questions arise regarding PEP.
- If HIV PEP is indicated:

- Offer immediate pregnancy testing for all women of childbearing age not known to be pregnant
- Initiate PEP immediately. INITIATION OF PEP SHOULD NOT BE DELAYED. THE OBJECTIVE IS TO BEGIN INDICATED HIV PEP WITHIN ONE HOUR FROM EXPOSURE. HOWEVER, WHEN INDICATED, HIV PEP SHOULD STILL BE INITIATED EVEN WHEN A DELAY

HAS OCCURRED. This can be accomplished through the ER pixis or STAT through the inpatient pharmacy. Provide exposed EP enough antiretroviral medication to last until first follow up in Infectious Disease clinic (usually limited to 3 day supply).

- IMMEDIATELY contact the Infectious Disease fellow on-call to arrange follow up of ALL exposed EP started on HIV PEP.
- Obtain blood from EP for testing. (**CHCS/AHLTA lab panel= NEEDLESTICK EXPOSED)** If antiretroviral medications are indicated, also draw a CBC, LFTs and Chem-7.
- Follow the hepatitis B algorithm (Appendix F) to determine whether HBIG should be administered immediately (source patient is known to be HBV carrier, and the EP is not vaccinated or is known to be a non-responder to vaccine).
- Administer Tetanus diphtheria and Pertussis (Tdap) *if over five years since last vaccination.*
- Refer EP to Department of Preventive Medicine, Occupational Health Section (295-2437) to be seen next business day for lab follow-up.
- Complete BAMC Form 1195
- Place completed packet in Preventive Medicine box on the half wall in ED for OH pick-up.

CHCS/AHLTA LABORATORY PANEL	INCLUDES
NEEDLESTICK SOURCE	Rapid HIV, Hep B surface ag, Hep C ab
NEEDLESTICK EXPOSED	HIV 1-2 ab, Hep B surface ab, Hep C ab

D. The BAMC Occupational Health Section (OH) will—

- Ensure documentation of the route and circumstances of the incident, including the source individual, unless identification is prohibited by state or local laws or deemed not feasible.
- If testing of source patient was, for some reason, not done at the time of the incident, arrange to test the source individual's blood as soon as feasible and with his/her consent to determine HBV/HCV status. Source individuals known to be HIV infected need not be retested. The exposed employee shall be informed of the source individual's test results and of the applicable laws and regulations concerning disclosure of the identity and status of the source patient.
- If testing of EP was, for some reason, not done at the time of the injury, collect and test the potentially exposed employee's blood, with consent, as soon as feasible. If the employee consents to blood baseline but not to HIV serologic testing, the sample shall be preserved for at least 90 days, and tested as soon as feasible if the employee subsequently consents to HIV testing
- Provide the exposed employee with confidential counseling, treatment, and evaluation of reported illnesses
- Provide the health care professional who is treating or evaluating the employee with a description of the employee's duties, the circumstances of the exposure, and all relevant medical records
- Provide the employee a written opinion from the health care provider within 15 days of the evaluation. The opinion shall address whether HBV vaccination is recommended and whether it has been administered to the employee. The remainder of the opinion is limited to a statement that the employee has been informed of the results of the evaluation, and that the employee has been told about any medical conditions resulting from the exposure. All other findings shall remain confidential and not be included in the report.

BLOOD AND BODY FLUID EXPOSURE ALGORITHM

This algorithm is designed to guide the evaluation of blood and body fluid exposures and prevent transmission of infectious diseases. ***To effectively prevent transmission of HIV from High Risk Sources, antiretroviral therapy must be started as soon as possible after the exposure.*** *Our goal is to complete the evaluation and initiate therapy in less than 1 hour when therapy is indicated. Only exposures from High Risk Sources require immediate consultation with an Infectious Disease staff member (916-4355/5554).*

Exposed Person (EP) sustains Contaminated Fluid Exposure or Needlestick/Sharps Injury (NSI)

Exposed Person (EP)

1. Wash site of injury with soap and water
2. Report injury to Supervisor *immediately*
3. Report to point of care immediately (BAMC ED)
4. MUST see BAMC Occupational Health for follow-up (dial 295-2437 for appointment)

EP Supervisor

1. Prepare documentation
2. Send EP for medical care

Point of care

1. Clean wound; give tetanus prophylaxis as indicated.
2. Determine source patient's sero-status for HIV/HBV/HCV by review of CHCS, medical records, and/or by contacting source patient's physician. **With source patient's consent, order CHCS LAB ORDER = NEEDLESTICK SOURCE**
3. If source is at High Risk or known positive for HIV, consult Infectious Disease on-call staff ***IMMEDIATELY***
4. Order laboratory evaluation of EP **(CHCS LAB ORDER = NEEDLESTICK EXPOSED)**
5. Refer EP *by* ***WRITTEN CONSULT to Occupational Health.*** FAX information to **295-2456.**

Infectious Disease Clinic

1. Provide clinical evaluation
2. Discuss risks/benefits/alternatives to treatment
3. Recommend course of treatment

Occupational Health Clinic

1. See injured EP and assess risk for HIV, HBV, and HCV.
2. Review treatment provided/planned.
3. Follow-up on labs ordered on EP and source patient.
4. Maintain database on injury; submit reports to Infection Control, BAMC Safety, Environment of Care (EOC), other agencies as required.
5. Follow EP as indicated

A "High Risk Source" is a Source with a history of any of the following:

1. **HIV Infection**
2. **IV Drug Abuse**
3. **Multiple Sexually Transmitted Diseases**
4. **Multiple Sex Partners**

A "High Risk Exposure" is one involving a large, hollow-bore needle that is contaminated with visible blood.

REPORT OF EXPOSURE TO BLOOD/BODY FLUID

For use of this form, see BAMC Memo 40-169; the proponent is Dept of Prev Med

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.

This form is to be completed by the injured health care worker (HCW) in conjunction with his/her supervisor, provided to the ED to assist with their evaluation and then forwarded to Department of Preventive Medicine, Occupational Health Section (MCHE-DHO) for final review and disposition.

PERSON EXPOSED

NAME	RANK	POSITION	TITLE

DATE/TIME OF EXPOSURE		WHERE DID EXPOSURE OCCUR	DATE/TIME OF THIS REPORT	
DATE	TIME		DATE	TIME

ACCIDENT FIRST REPORTED TO

NAME	POSITION	TITLE

DESCRIBE THE CIRCUMSTANCES SURROUNDING THE EXPOSURE

_____

_____

SOURCE PATIENT INFORMATION

NAME	LAST 4 SSN	DATE OF BIRTH	LOCATION

DETAILS OF EXPOSURE

1. Is the source patient known to be infected with HIV, hepatitis B or C, or suspected to be at risk for those infections? ☐ Yes ☐ No
2. Injury was: ☐ Superficial/Topical ☐ Moderate ☐ Severe/Deep
3. If a sharp injury occurred, was the item contaminated with blood? ☐ Yes ☐ No
4. Did the injury result in puncture to the skin? ☐ Yes ☐ No
5. If puncture occurred, did the injury occur through gloves or protective barrier? ☐ Yes ☐ No
6. Was there visible blood produced at the site of injury? ☐ Yes ☐ No
7. Type of body fluid involved *(please check any and all that apply)*:

☐ Blood	☐ Pericardial Fluid	☐ Body Fluid with Visible Blood
☐ Urine	☐ Peritoneal Fluid	☐ Cerebrospinal Fluid
☐ Saliva	☐ Pleural Fluid	☐ Gastric Contents or Vomitus
☐ Sputum	☐ Synovial Fluid	☐ Endotracheal Secretions
☐ Open Sores	☐ Seminal Fluid	☐ Vaginal Secretions
☐ Feces	☐ Amniotic Fluid	☐ Other *(describe)*: _____

8. Type of instrument or device that caused injury *(please check all that apply)*:

☐ Needle, Open Bore	☐ Needle, Closed Bore *(E.G., Suture)*	☐ Scalpel or Blade	☐ Scissors
☐ Lancet	☐ Glass	☐ Plastic	☐ Trocar
☐ Bone Cutter	☐ Bone Chips	☐ Safety Designed Device	
☐ Splash Injury *(describe)*: _____		☐ Other *(describe)*: _____	
☐ Unknown			

9. If exposure was percutaneous, provide the following information about the device involved:
   Name of device: _____ ☐ Unknown/Unable to determine
   Brand/Manufacturer: _____ ☐ Unknown/Unable to determine
10. Activity leading to exposure:

☐ Drawing Blood	☐ Starting IV, Venous or Arterial Line	☐ Controlling Bleeding
☐ Giving Injection	☐ Handling Sharps Disposal Container	☐ Handling Laboratory Specimens
☐ Recapping Needle	☐ Discarding Needle or Sharp Object	☐ Handling Urinary Catheter
☐ Handling IV Lines	☐ Item Protruding Through Trash or Linen	☐ Surgical/Invasive Procedure
☐ Handling N-G Tube	☐ Disassembling Device or Equipment	☐ Cleaning Blood/Body Fluid Spill

☐ Other *(describe)*: _____

BAMC FORM 1195, FEB 2005 PREVIOUS EDITION IS OBSOLETE. PE V1.00

HEPATITIS B IMMUNIZATION CONSENT OR DECLINE FORM

Brooke Army Medical Center
Occupational Medicine Service
Fort Sam Houston, TX 78234

_____ _____ - ____ - _____
Employee's Name (please print) Social Security Number

_____ _____ _____
Department Worksite Building Worksite Room or Area

CONSENT TO HEPATITIS B VACCINATION

I have read the information about hepatitis B and the hepatitis B vaccine. I have had an opportunity to ask questions of a qualified nurse or physician and understand the benefits and risks of hepatitis B vaccination. I understand that **I must have 3 doses of the vaccine to obtain immunity.** However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience side effects from the vaccine.

_____ _____
Signature of Employee Date Signed

If you will not be at BAMC for the third dose, please let us know your address and telephone number so we can notify you.

_____ _____ _____ _____ _____
Street City State Zip Phone Number

DECLINE OF HEPATITIS B VACCINATION

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 vaccination 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 or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____
Signature of Employee Date Signed

If the employee declines the hepatitis B vaccination, this form must be filed in the employee's department.

U.S. ARMY ABBREVIATED GROUND ACCIDENT REPORT *(AGAR)*

For use of this form, see and DA Pamphlet 385-40; the proponent agency is OCSA

REQUIREMENTS CONTROL SYMBOL
CSOCS-308

1. TIME & DATE OF ACCIDENT	a. Yr	b. Mth	c. Day	d. Time	2. PERIOD OF DAY ☐ Day ☐ Night ☐ Dusk ☐ Dawn	3. ACDT CLASS	4. COMBAT STATUS ☐ Combat ☐ Non-Combat

5. UNIT IDENTIFICATION	a. UIC *(6-digit Code)*	b.Unit Address	c. Unit's Branch	5d. Army HQ's

6. LOCATION OF ACCIDENT	a. Exact Location	b. Type Location	6c. Grid Coordinates/Lat-Long

d. State/Country	e. ☐ Off Post ☐ On Post Name:	7. EXPLOSIVES/AMMO INVOLVED? ☐ Yes ☐ No

8. MISSION	a. Briefly describe the mission.	b. METL Task? ☐ Yes ☐ No

9. VEHICLE/EQUIPMENT/MATERIEL INVOLVED

	a. Type of Item *(Nomenclature)*	b. Make/Model #	c. Serial #	d. Ownership	e. Estimated Cost of Damage	f. Vehicle Collision
#1						

Materiel Failure/Malfunction Information *(Blks 9g-9l)*

g. Failure Mode	h. Part Nomenclature	i. Part #	j. Part NSN	k. Part Manufacturer Code	l. EIR/QDR Submitted
					☐ Yes ☐ No

	a. Type of Item *(Nomenclature)*	b. Make/Model #	c. Serial #	d. Ownership	e. Estimated Cost of Damage	f. Vehicle Collision
#2						

Materiel Failure/Malfunction Information *(Blks 9g-9l)*

g. Failure Mode	h. Part Nomenclature	i. Part #	j. Part NSN	k. Part Manufacturer Code	l. EIR/QDR Submitted
					☐ Yes ☐ No

10. WHY DID THE MATERIEL FAIL/MALFUNCTION? *(Check the root causes(s) in Blk 10a. In Blk 10b., explain how the root causes(s) led to the materiel failure/malfunction.)*

a.	LEADER *(Not ready, willing, or able to enforce standards)*	STDS/PROCEDURES *(Not clear, Not practical)*				SUPPORT *(Short comings in type, capability, amount or condition of equip/supplies/ services/facilities)*			
☐	Direct Supervision	☐	AR	☐	SOP	☐	Equip/Materiel Improperly Designed	☐	Inadequate Manufacture
☐	Unit Command Supervision	☐	TM	☐	Other	☐	Equip/Materiel Not Provided	☐	Inadequate Maintenance
☐	Higher Command Supervision	☐	FM	☐	None Exists	☐	Inadequate Facilities/Services	☐	Other

b. Describe how the materiel failed/malfunctioned and explain why *(root cause)*.

11a. NAME *(Last, First, MI) (include Address and UIC if different than Blks 5a and 5b.)*	12. SSN	13a. PERSONNEL CLASSIFICATION	13b. DATE ASSIGNED/HIRED *(YYYYMMDD)*

11b. HOME ADDRESS	13c. DATE OF REDEPLOYMENT FROM COMBAT ZONE, IF APPLICABLE *(YYYYMMDD)*	14. MOS/JOB SERIES	15a. DUTY STATUS	15b. IF OFF DUTY *(if on leave/pass)*	
			☐ On-duty ☐ Off-duty	☐ Leave ☐ Pass	Date from *(YYYYMMDD)* Date to *(YYYYMMDD)*

16. DOB *(YYYYMMDD)*	17. GENDER	18. PAY GRADE	19. FLIGHT STATUS
			☐ Yes ☐ No

20. MOST SEVERE INJURY *(See Instructions)*	a. Degree ____ Date of Death *(YYYYMMDD)* ____	b. Type ____	c. Body Part ____	d. Cause ____
21. LOST TIME	ACTIVITY OF INDIVIDUAL *Provide code (from list in instructions) and describe in space below.*			

a. Days Hospitalized ____ b. Days lost not Hospitalized ____ c. Days Restricted ____ d. Treated in ER ☐ Yes ☐ No	23. ACTIVITY CODE *(If activity is parachuting, complete Blk 38)*	24. SPECIFIC DESCRIPTION OF ACTIVITY/TASK
22a. OSHA Log 300 Case No. b. Name of Physician c. Name and Address of Treatment Facility		

25. PERSONAL PROTECTIVE EQUIPMENT		AVAILABLE?		USED?		N/A
CHECK APPROPRIATE BLOCK*(S)*		Yes	No	Yes	No	
☐	a. Seat Belt	☐	☐	☐	☐	☐
☐	b. Restraint System	☐	☐	☐	☐	☐
☐	c. Goggles/glasses/visor	☐	☐	☐	☐	☐
☐	d. Gloves	☐	☐	☐	☐	☐
☐	e. Ear Plugs	☐	☐	☐	☐	☐
☐	f. IBA	☐	☐	☐	☐	☐
☐	g. Other *(Specify)*	☐	☐	☐	☐	☐
☐	h. Helmet	☐	☐	☐	☐	☐
	DOT Approved (if Motorcycle) ? Yes ☐ No ☐					

26. ALCOHOL/DRUGS CAUSE/CONT	27. EQUIP THIS PERSON WAS ASSOCIATED WITH? *(Enter Item No. from Blk 9)*
☐ Yes BAC % ____ ☐ No ☐ Unknown	
28a. LICENSED TO OPERATE EQUIPMENT ☐ Yes ☐ No ☐ N/A	28b. MANDATORY 4hr TRAFFIC SAFETY TRAINING ☐ Yes ☐ No If Yes, Date: ____
28c. MSF CERTIFIED ☐ Yes ☐ No If Yes, Date: ____	29. DUTY HOURS a. Time work began (e.g., 0645): ____ b. Continuous hours: ____

30. HRS SLEEP LAST 24	31. TACTICAL TRAINING	32. TYPE TRAINING FACILITY	33. LAST TRAINING
	☐ Yes ☐ No		

34. FIELD EXERCISE/NAMED OPERATION	35. NIGHT VISION SYSTEM USED
☐ Yes ☐ No If Yes, provide name: ____	☐ Yes ☐ No If Yes, provide type: ____

36. DID INDIVIDUAL MAKE A MISTAKE THAT CAUSED/CONTRIBUTED TO ACCIDENT OR SEVERITY OF INJURY/DAMAGE? *In Blk a, indicate if individual made a mistake. If yes, provide the code (from instructions) in Blk b and describe in Blk c.*

a. Mistake ☐ Yes ☐ No b. Code	c. Tell what the mistake was and how it caused/contributed to the accident or serverity of injury/damage.

37. WHY WAS THE MISTAKE MADE? *(ROOT CAUSE) (Check the root cause(s) in Blk a. In Blk b, tell how the root cause(s) led to the mistake.)*

a.	LEADER *(Not ready, willing, or able to enforce standards)*	TRAINING *(Insufficient in Content/Amount*		STDS/PROCEDURES *(Not clear/Not practical)*				SUPPORT *(Shortcomings in type, capability, amount or condition of equip/supplies/services/facilities)*				INDIVIDUAL *(Mistake due to own personal factors)*			
☐	Direct Supervision	☐	School	☐	AR	☐	SOP	☐	Equip/Materiel Improperly Designed	☐	Inadequate Manufacture	☐	Poor/Bad Attitude	☐	Fatigue
☐	Unit Command Supervision	☐	Unit	☐	TM	☐	Other	☐	Equip/Materiel Not Provided	☐	Inadequate Maintenance	☐	Overconfident	☐	Alcohol, Drugs
☐	Higher Command Supervision	☐	Experience, OJT	☐	FM	☐	None exists	☐	Inadequate Facilities/Services	☐	Other	☐	In a Hurry	☐	Fear/Excitement

37b. Describe root cause(s) *(reason)* and tell how it/they caused the mistake.

38. PARACHUTE INFORMATION FOR PERSON LISTED IN Blk 11.

a. Jumper Height	g. Wind Direction/Speed at Jump Height / Drop Zone	m. Type of Last Jump	39. ENVIRONMENTAL CONDITIONS a. Present: #1 ____ ☐ Yes ☐ No ☐ Unk #2 ____ ☐ Yes ☐ No ☐ Unk #3 ____ ☐ Yes ☐ No ☐ Unk b. Caused/Contributed: #1 ____ ☐ Yes ☐ No ☐ Unk #2 ____ ☐ Yes ☐ No ☐ Unk #3 ____ ☐ Yes ☐ No ☐ Unk
b. Jumper Weight		n. Number of Previous Jumps	
c. Type of Jump	h. Jump Altitude	o. Date Graduated Basic Airborne Training *(YYYYMMDD)*	
d. Parachute Type/Model	i. Position in Stick		
e. Equipment	j. Door Exited	p. Type Aircraft	
	k. Time Pre-jump Conducted	q. Accident Factors (parachute): *(Explain as necessary)*	
f. Wt. of Equipment	l. Date of Last Jump		

40. PROVIDE BRIEF SYNOPSIS OF ACDT *(Use additional sheets if required)(Explain sequence of events, tell how acdt happened.)*

41. CORRECTIVE ACTION(S) TAKEN OR PLANNED

42. EXPLOSIVE/AMMUNITION INFORMATION	ITEM 1	ITEM 2	ITEM 3	ITEM 4
a. Lot#				
b. Quantity				
c. Net Explosive Weight *(NEW)*				
d. DoDIC/DoDAC				

43. POINT OF CONTACT INFORMATION ON THE ACCIDENT

a. Name *(Last, First, MI),* Rank Position/Title		b. Telephone No. DSN: ____ COM: ____	
		c. Email Address:	
44. COMMAND REVIEW a. Name	b. Signature	c. Rank	d. Date *(YYYYMMDD)*
45. SAFTETY OFFICE REVIEW a. Name, Rank & Title			b. Phone Number
c. Email Address	d. Date Reviewed *(YYYYMMDD)*	e. Local Report No. *(Safety Office use only)*	

DA FORM 285-AB, FEB 2009

PAGE 3 of 3

APD PE v1.00