Texas Liver Institute

Employee Needlestick/Blood or Body Fluid Exposure Policy and Procedures

1. **GENERAL PROCEDURE STATEMENT:** This procedure is intended to guide the management of an employee injury from needle sticks or any contact of broken skin, subcutaneous tissue or mucous membranes with blood, body fluids or tissue. Following these procedures will minimize the risk of infection, ensure appropriate documentation, and minimize the likelihood of future exposure incidents.

2. **AFFECTED DEPARTMENT(S):** All staff

3. **PROCEDURE:**
   A. **The steps of the plan include:**
      I. Immediate wound treatment and supervisor notification.
      II. Exposure evaluation and follow up
      III. Counseling and retraining
   B. **Immediate Wound Treatment and Notification.** When a staff member is exposed to a patient’s blood, bodily fluids, tissue, or other potentially infectious material, or stuck with a contaminated sharp instrument used on a clinic patient:
      I. As soon as it is safe to do so, the staff member will wash exposed skin thoroughly with soapy water and exposed mucous membranes (eye or mouth) will be flushed with copious amounts of water.
      II. The staff member will immediately inform his/her supervisor or designated person.
      III. The supervisor and affected staff member will fill out Needle Stick Injury/Body Fluid Exposure Report Form within 7 days of incident (Appendix A)
   C. **Exposure Action Plan**
      I. The supervisor or staff member will notify the QA/Compliance Director of the exposure incident.
      II. Staff member will be offered testing for infectious diseases. Affected staff members are not required to undergo testing for infectious diseases but may forfeit a future workman’s compensation claim if baseline testing was not obtained. Employee Consent Form attached as Appendix B.
      III. If the source (patient) is known, the supervisor will:
         1. Inform the patient of the staff members’ injury
         2. Review the patient’s health history and will ask the patient to consent to infectious disease testing
         3. Advise the patient that testing is voluntary and free of charge
4. Advise the patient that they may be informed of test results if they would like to know
5. Obtain informed consent and patient signature (Appendix C)
6. Send the patient to the appropriate lab so that a blood sample can be drawn
7. Action plan documented on the Needle Stick Injury/Body Fluid Exposure Report Form (Appendix A)

IV. Supervisor and staff member will complete the Needlestick and Sharp Object Injury Checklist (Appendix D) or Blood and Body Fluid Exposure Checklist (Appendix E).

D. Counseling and Retraining
   I. Counseling and retraining of the staff member and/or any coworker whose actions or omissions may have contributed to the exposure will be performed.
   II. Retraining will be completed within 10 days of the incident.
Needle Stick Injury/ Body Fluid Exposure Report Form

I. Employee Information:
Full Name ___________________________ □ Male □ Female Date of Birth ___ / ___ / ______
Address: Street ___________________________ City ___________________ State _____ Zip _________
Date Hired: ___ / ___ / _______ Job Title: ____________________
Status: □ Employee, □ Contract Employee, □ Volunteer, □ Student, Other: ________________
Phone No: (            )______-
Hepatitis B vaccine: 1st ___ / ___ / _____ 2nd ___ / ___ / _____ 3rd ___ / ___ / ______
Date of completion ___ / ___ / ______
Last Tetanus vaccine: ___ / ___ / ______

II. Exposure
Work area of Exposure: ____________________________
Date of Injury: _______________ Time of Injury: ___________ (am/pm)
Needle stick ______ Eye/mucous membrane splash ________ Sharp object __________
Other _________________________________________

III. Patient (source) Information:
Identification No. ___________________________ Date of Birth ____________
Social Security No. _____-_____-_______
Department or place where injury/exposure happened: ________________________________
Diagnosis ___________________________ Provider _______________________
Does the patient now have or has she/he ever had any of the following diseases:
If yes, give Date: Syphilis ________Hepatitis A ________Hepatitis B _____________
HIV/AIDS _____________ Hepatitis C_______

IV. Description of Incident (Complete Needle Stick and Sharp Object Injury Checklist, Attachment D or Blood & Body Fluid Exposure Checklist, Attachment E)
V. Treatment at Time of Incident __________________________
VI. Lab: □ HIV-1&2(*run stat if source is positive) □ HBsAg □ HBsAb □ HBcAb □ HCVAb □ HCV RNA PCR
Baseline labs to monitor for adverse reaction:
□ BHeg □ CBC, Diff, Plts □ UA □ BUN/Cr □ ALT/AST/AlkPhos/T.Bili
(HIV status immediately after exposure...then 1 month, 2 months, 3 months, and 6 months)
VII. Follow-up Service Chosen (circle one):
   a. Evaluation by TLI Medical Staff
   b. See own private physician.
   c. Go to Emergency Room.
   d. Obtain appropriate testing at County Health Agency
   e. Decline Further Evaluation
   f. Name of health care professional: ________________________________
   g. If treated away from worksite, where was it given?
      Facility: ____________________________
      Street: ____________________________
      City: ____________________________ State: _____ Zip: ____________

Employee Signature: ________________________________ Date ___________

Provider Signature: ________________________________ Date: ____________

Follow-up dates:
   1 Month: __________________________________
   2 Month: __________________________________
   3 Month: __________________________________
   6 Month: ____________________________
ATTACHMENT B

HIV, HBV, and HCV Testing Employee Consent Form

As an employee/volunteer of Texas Liver Institute (TLI), I have been exposed to blood or other potentially infectious blood/body fluid. I agree to a blood draw for detection of antibodies to the Human Immunodeficiency Virus (HIV), Hepatitis B antigens and antibodies, and Hepatitis C performed by an outside laboratory. I understand that these tests may not be conclusive because a positive result means additional tests may be needed and a negative result does not necessarily eliminate consideration of AIDS. I have also been informed that the results of this blood test will only be released to those health care personnel and insurance companies providing medical care and coverage to me as allowed by federal and state law. I understand that these test results will be part of my medical record and will not be released unless I have signed an authorization for release of medical information.

I consent to the release of all medical records, information, results for evaluation to the following persons or organizations:
   a. TLI is required by law to keep the above information for the length of my employment plus thirty years.
   b. Supervisors and managers who may also need to be informed of any work or duty restrictions.
   c. Any hospital, clinic, physician, nurse, or other health care professional to whom the results of any medical treatment may be needed to provide care or treatment to me, including any physician or health care provider to whom I may be referred.

I voluntarily agree to these tests and understand that I will not be charged for any of the costs incurred by TLI for these lab tests. I agree not to hold TLI authorized personnel or referral physicians and their authorized representatives responsible for any action that may be taken because of this release of information.

This consent may be revoked by me when received in writing to TLI authorized representative.

1. I hereby give my consent for the performance of the HIV, HEP B, and HEP C blood tests and to the release of results as outlined above.

   (Print Name of TLI Employee/Volunteer) __________________________
   (Signature) __________________________________________________
   (Date) _______________________________________________________

   (Print Name of Witness) __________________________
   (Witness Signature) _________________________
   (Date) _______________________________________

2. I decline the opportunity for the HIV, HEP B, and HEP C blood tests at this time.

   (Print Name of TLI Employee/Volunteer) __________________________
   (Signature) __________________________________________________
   (Date) _______________________________________________________

   (Print Name of Witness) __________________________
   (Witness Signature) _________________________
   (Date) _______________________________________
ATTACHMENT C

SOURCE CONSENT

Initials: _______ 1. I understand that an employee of this facility has been contaminated with my blood or other potentially infectious blood product or body fluid. I authorize a representative for this facility to draw blood for the following tests: Hepatitis B surface antigen, Hepatitis B surface antibody, Hepatitis C antibody, HIV.

Initials: _______ 2. I consent to the release of all medical records, information, results for evaluation to the following persons or organizations:
   a. This facility’s officials that are required by law to keep the above information for the length of the exposed employee’s employment plus thirty years.
   b. Supervisors and managers of this facility who may also need to be informed of any work or duty restrictions for the employee.
   c. Any hospital, clinic, physician, nurse, or other health care professional to whom the results of any medical treatment may be needed in order to provide care or treatment to me, including any physician or health care provider to whom the employee or myself may be referred.

Initials: _______ 3. I voluntarily agree to these tests and understand that I will not be charged for any of the costs incurred by this facility for these lab tests.

Initials: _______ 4. I agree not to hold this facility’s authorized personnel or referral physicians and their authorized representatives responsible for any action that may be taken as a result of this release of information.

Initials: _______ 5. This consent may be revoked by me when received in writing by the TLI authorized representative.

____________________________________________  ____________________
Patient Signature  Date

____________________________________________  ____________________
Witness Signature  Date
ATTACHMENT D

NEEDLESTICK AND SHARP OBJECT INJURY CHECKLIST

Employee Name: ____________________________________________

1. Type and brand of sharp involved (☑ as appropriate)

   Needle  Other Sharp
   ☐ Insulin syringe with needle  ☐ Lancet
   ☐ Tuberculin syringe with needle  ☐ Suture Needle  ☐ Scalpel
   ☐ Other syringe with needle  ☐ Other surgical instrument (nonglass)
   ☐ Needle connected to IV line  ☐ GLASS
   ☐ Winged steel needle (butterfly)  ☐ Blood Tube
   ☐ IV catheter, loose  ☐ Other tube
   ☐ Vacuum tube collection  ☐ Slide
   ☐ Other: _______________________  ☐ Ampule,  ☐ Other glass: ____________

2. Brand name (or ☐ unknown): ______________________________________

3. Intended use of sharp? (☑ as appropriate)

   ☐ Injection, IM  ☐ Incision
   ☐ Obtain body fluid/tissue sample
   ☐ Injection, SC/ID  ☐ Start IV/hep lock  ☐ Suturing, skin
   ☐ Other Injection  ☐ Aspiration IV  ☐ Contain specimen/pharmaceutical
   ☐ Draw venous sample  ☐ Heparin/saline flush  ☐ Unknown/NA  ☐ Other

4. Injury occurred: ☐ Before intended use  ☐ During intended use  ☐ After intended use

5. If exposure occurred “During” or “After” intended use, was it (☑ one)

   ☐ Because patient moved during procedure  ☐ While dissembling
   ☐ While recapping
   ☐ While putting into sharp container
   ☐ Found in inappropriate place
   ☐ Other: ______________________

6. Did device used have engineered sharps injury protection?  ☐ Yes  ☐ No  ☐ Don’t Know

7. Was the protective mechanism activated?  ☐ Yes  ☐ Yes, Partially  ☐ No  ☐ Don’t Know  ☐ N/A

8. When, during activation of the protective mechanism did exposure occur?

   ☐ Before  ☐ During  ☐ After  ☐ N/A

9. Was the injured person wearing gloves?  ☐ Yes  ☐ No  ☐ Don’t Know

10. Had the injured person completed a Hep B vaccination series?  ☐ Yes  ☐ No  ☐ Don’t Know

11. Was there a sharps container readily available for sharps disposal?  ☐ Yes  ☐ No  ☐ Don’t Know
12. Was the injury? (✓ one)  
  □ Superficial (little or no bleeding)  
  □ Moderate (skin punctured, some bleeding)  
  □ Severe (deep stick/cut or profuse bleeding)  

13. What body part was involved? □ Finger  
    □ Hand  
    □ Arm  
    □ Leg/foot  
    □ Face/head/neck  
    □ Torso  

14. Where was the work area of the exposure incident?  
    □ Patient Rm  
    □ Procedure Rm  
    □ Lab  
    □ Other:________  

15. What is the job classification of the injured person?  
    □ MD  
    □ PA/FNP  
    □ MA  
    □ Lab Tech  
    □ Other:________  

16. What is the employment status of the injured person? □ Employee  
    □ Volunteer  
    □ Other:________  

Employee Signature: ____________________________  
Date: ________________  

Employer Signature: ____________________________  
Date: ________________
ATTACHMENT E

BLOOD AND BODY FLUID EXPOSURE CHECKLIST

1. Where was the work area of the exposure incident? □ Patient Rm □ Procedure Rm □ Lab □ Other:________

2. What is the job classification of the exposed person? □ MD □ PA/FNP □ MA □ Lab Tech □ Other:_______

3. Employment status of the injured person? □ Employee □ Volunteer □ Other:_____________________

4. Was the identity of the fluid source (patient) known? (✓ one) □ Yes □ No □ Unknown □ N/A

5. Which body fluids were involved in the exposure? (✓ all that apply)
   □ Blood □ Gastric contents □ Sputum □ Mucous □ Saliva □ Urine □ Other:________
   Was the body fluid visibly contaminated with blood? (✓ one) □ Yes □ No □ Unknown

6. What body part was involved? □ Finger □ Hand □ Arm □ Leg/foot □ Face/head/neck □ Torso

7. Was the body part? (✓ all that apply) □ Intact skin, □ Non-intact skin, □ Eyes (conjunctiva),
   □ Nose (mucosa), □ Mouth (mucosa), □ Other:__________________

8. Did the blood or body fluid? (✓ all that apply) □ Touch unprotected skin, □ Touch skin in gap between barrier garments,
   □ Touch skin through tear in glove, □ Soak through barrier garment, □ Soak through clothing

9. Which barrier garments were worn at time of exposure? (✓ all that apply)
   □ Single pair latex/vinyl gloves □ Double pair latex/vinyl gloves
   □ Goggles □ Eyeglasses (not protective equipment)
   □ Eyeglasses with side shields □ Face Shield
   □ Surgical Mask □ Surgical Gown

10. Was the exposure the result of
    □ Direct patient contact □ Needle stick
    □ Touched contaminated equipment/surface □ Touched contaminated drape/sheet/gown, etc
    □ Specimen container leaked/spilled/broke □ Tubing leaked/disconnected/broke
    □ Bag/pump leaked/spilled/broke □ Equipment/operator failure □ Other:________________________

    If equipment failure: Type/Manufacturer:______________________________

11. How long was the blood/body fluid in contact with the skin/mucous membrane? (✓ one)
    □ < 5 minutes □ 5-14 minutes □ 15 minutes □ > 1 hour

12. How much blood/body fluid came in contact with skin/mucous membrane? (✓ one)
    □ Small amount (up to 5cc, or 1 tsp) □ Moderate amount (up to 50cc, or 1/4th cup) □ Large amount (> 50cc)

13. Describe the circumstances leading to this exposure? (Note if a device malfunction was involved)

___________________________________________________________________________________________
___________________________________________________________________________________________

Employee Signature: ____________________________ Date: __________________

Employer Signature: ____________________________ Date: __________________