APPENDIX A********

APPENDIX A - SAMPLE FORMS

The following pages contain sample forms that may aid your company in compliance with the bloodborne pathogens standard. None of these forms are specifically required by the standard, but it is hoped that your company can benefit from the information.

Sample Forms:

HEALTH CARE PROFESSIONAL'S WRITTEN OPINION FOR HEPATITIS B VACCINATION

Employee Name _____

Date of Office Visit _____

Health Care Facility Address _____

_____

Health Care Facility Telephone _____

As required under the bloodborne pathogen standard:

Hepatitis B vaccination is _____ is not _____ recommended for the employee named above.

The employee named above is scheduled to receive the hepatitis B vaccination on the following dates:

First of three _____

Second of three _____

Third of three _____

_____ _____

(Signature of Health Care Provider) (Printed or typed name of health care provider)

This form is to be returned to the employer, and a copy provided to the employee, within 15 days.

Employer Name: _____

Title: _____

Address: _____

_____

_____

HEALTH CARE PROFESSIONAL'S WRITTEN OPINION FOR POST-EXPOSURE EVALUATION

Employee Name _____

Date of Incident _____

Date of Office Visit _____

Health Care Facility Address _____

_____

Health Care Facility Telephone _____

As required under the bloodborne pathogen standard:

_____ The employee named above has been informed of the results of the post-exposure health evaluation.

_____ The employee named above has been told about any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

_____ Hepatitis B vaccination is _____ is not _____ indicated.

_____
(Printed or typed name of health care provider)

_____ _____
(Signature of Health Care Provider) (Date)

This form is to be returned to the employer and a copy provided to the employee within 15 days. Please label the outside of the envelope "Confidential."

Employer Name: _____

Title: _____

Address: _____

_____

BLOODBORNE PATHOGEN EXPOSURE EVALUATION FORM

(Send with employee at the time a health evaluation is needed. Form to be completed and kept by health care provider only. Information on this form is confidential. Do not send this form to employer.)

Employee Name _____ Today's Date _____

Social Security # _____ Date of Birth _____

Home Phone # _____

Job Title _____

Date of Exposure _____

(See Exposure Report for circumstances under which exposure incident occurred)

Source of exposure: _____

(Circle response and complete explanation as appropriate)

Yes No Blood of source individual has been tested with consent of individual as applicable. If no, please explain and/or indicate if HIV and/or HBV is already known.

_____

_____

Yes No Results of source individual's testing conveyed to employee.
(Explain)_____

Yes No Employee informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source.
(Explain)_____

Yes No Exposed employee's blood collected and tested with obtained consent.
(Explain)_____

Yes No If employee declines HIV testing, blood stored for 90 days from exposed incident.
(Explain)_____

Bloodborne Pathogen Exposure Evaluation

Yes No Post-exposure prophylaxis initiated if medically indicated.
(Explain)_____

Yes No Hepatitis B vaccination is indicated. Elaborate on treatment given:
_____

Status of employee vaccination:

One of three: Date_____ Type_____ Lot #_____ Site_____

Administered by: _____

Two of three: Date_____ Type_____ Lot #_____ Site_____

Administered by: _____

Three of three: Date_____ Type_____ Lot #_____ Site_____
Administered by:_____

Yes No Employee informed of results of evaluation.
(Explain)_____

Yes No Employee has been informed of any health conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.
(Explain)_____

Assessment/Observations/Plan:

_____

_____

Action: _____ Confidential post-exposure evaluation entered into employee's individual health record.

_____ Copy of health care professional's written opinion for post-exposure evaluation completed and sent to employer.

_____ Copy of health care professional's written opinion for post-exposure evaluation given to employee.

Note: All other findings shall remain confidential and shall not be included

EMPLOYEE EDUCATION AND TRAINING RECORD

EMPLOYEE NAME	JOB TITLE

SUBJECT	DATE	TRAINER INITIALS
THE STANDARD		
EPIDEMIOLOGY & SYMPTOMS OF BLOODBORNE DISEASES		
MODES OF TRANSMISSION		
EXPOSURE CONTROL PLAN		
RECOGNIZING POTENTIAL EXPOSURE		
USE & LIMITATIONS OF EXPOSURE CONTROL METHODS		
PERSONAL PROTECTIVE EQUIPMENT (TYPES, USES, DISPOSAL, ETC.)		
SELECTION OF PPE		
HBV VACCINATION PROGRAM		
EMERGENCIES INVOLVING BLOOD OR OPIM		
EXPOSURE FOLLOW-UP PROCEDURES		
POST-EXPOSURE EVALUATION & FOLLOW-UP		
SIGNS AND LABELS		
OPPORTUNITY TO ASK QUESTIONS		
ADDITIONAL EDUCATION: SUBJECTS		

TRAINER NAME	INITIALS	TRAINER QUALIFICATIONS

EPINET UNIFORM BLOOD AND BODY FLUID EXPOSURE REPORT

The form found in this appendix was developed by Janine Jagger, director of the Health Care Worker Safety Project, at the University of Virginia Health Sciences Center. It has been adapted for the first time for use in home health care for incorporation in this Model Exposure Control Plan. Dr. Jagger describes the tool below:

"The EPINet (Exposure Prevention Information Network) system consists of:

1. data collection forms to be filled out by employees reporting sharps object injuries or blood and body fluid exposures, and
2. software already programmed for entering data from the report forms, and for accessing and analyzing the data.

"The data entry and analysis program, Epi Info, is a public domain computer program -- it can be copied freely -- for MS-DOS (IBM) compatible computers developed by the Centers for Disease Control. It is ideal for use with EPINet because it was designed for surveillance programs like this one, and it is easy to use, flexible, and is available at nominal cost. The data collection forms, Epi Info, and the EPINet program diskette provide you with a complete surveillance, prevention and evaluation system that can be up and running in the time that it takes you to install the diskettes and photocopy the report forms."

Epi-Info and EPINet can be ordered through USD, Inc. at 404-469-4098. Even agencies who do not utilize computers for tracking employee health and illness may find this tool useful for reporting exposures. You may copy the forms found in this appendix, or request original forms from the Health Care Worker Safety Project, at 804-982-0702.

Please note the box at the bottom right corner of pages two and four, "Is this incident OSHA reportable?" The exposure incident must be recorded on the OSHA No. 200 form, "Log and Summary of Occupational Injuries and Illnesses," if the employee receives medical treatment, or if the incident results in lost workdays, restriction of work or motion, transfer to another job, illness or death. Each reportable injury or illness must be logged on this form within six working days from the time the employer learns of it. In addition, the OSHA No. 101 form, "Supplementary Record of Occupational Injuries and Illnesses," or an equivalent which contains all the required information, must be completed.

EXPOSURE PREVENTION INFORMATION NETWORK

Uniform Needlestick and Sharp Object Injury Report

Name: _____ Hospital ID: [ ][ ][ ][ ]

1. ID: [ ][ ][ ][ ] 2. Date of injury: month [ ][ ] day [ ][ ] year [ ][ ]

3. Job Category: *(check one)*

- [1] M.D. *(attending/staff)*
- [2] M.D. *(intern/resident/fellow)*
- [3] medical student
- [4] nurse RN/LPN
- [5] nursing student
- [6] respiratory therapist
- [7] surgery attendant
- [8] other attendant
- [9] phlebotomist/venipuncture/I.V. team
- [10] clinical laboratory worker
- [11] technologist *(non-lab)*
- [12] dentist
- [13] dental hygienist
- [14] housekeeper/laundry worker
- [15] home health aide
- [16] chore worker/personal care provider
- [99] other, describe _____

4. Where did the injury occur? *(check one)*

- [1] patient room *(in hospital)*
- [2] outside patient room *(hallway, nurses' station, etc.)*
- [3] emergency department
- [4] intensive/critical care unit
- [5] operating room
- [6] outpatient clinic/office *(incl. home health office)*
- [7] blood bank
- [8] venipuncture
- [9] dialysis facility
- [10] procedure room *(X-ray, EMG, etc.)*
- [11] clinical laboratories
- [12] autopsy/pathology
- [13] service/utility area *(laundry, central supply, loading dock, etc.)*
- [14] patient's home *(home health care)*
- [15] transport vehicle *(car, ambulance, helicopter, etc.)*
- [99] other, describe _____

5. Was the source patient known?

[1] yes [2] no [3] unknown [4] not applicable

6. Was the injured worker the original user of the sharp item?

[1] yes [2] no [3] unknown [4] not applicable

7. Was the sharp item: *(check one)*

- [1] contaminated *(known exposure to patient or contaminated equipment)*
- [2] uncontaminated *(no known exposure to pt. or contaminated equipment)*
- [3] unknown

8. For what purpose was the sharp item originally used: *(check one)*

- [1] unknown/ not applicable
- [2] injection, intramuscular/subcutaneous , or other injection through the skin *(syringe)*
- [3] heparin or saline flush *(syringe)*
- [4] other injection into (or aspiration from) I.V. injection site or I.V. port *(syringe)*
- [5] to connect I.V. line *(intermittent I.V./ piggyback/ I.V. infusion/ other I.V. line connection)*
- [6] to start I.V. or set up heparin lock *(I.V. catheter or Butterfly™ -type needle)*
- [7] to draw a venous blood sample → if used to draw blood, was it a: [1] direct stick
- [8] to draw an arterial blood sample *(ABG)* [2] draw from a line
- [9] to obtain a body fluid or tissue sample *(urine/ CSF/ amniotic fluid/ other fluid, biopsy)*
- [10] fingerstick/ heel stick
- [11] suturing
- [12] cutting *(surgery)*
- [13] electrocautery
- [14] to contain a specimen or pharmaceutical *(glass items)*
- [99] other, describe _____

over——

9. Did the injury occur: *(check one)*

1	before use of item *(item broke or slipped, assembling device, etc.)*
2	during use of item *(item slipped, patient jarred item, etc.)*
3	between steps of a multistep procedure *(between incremental injections, passing instruments, etc.)*
4	disassembling device or equipment
5	in preparation for reuse of reusable instrument *(sorting, disinfecting, sterilizing, etc.)*
6	while recapping a used needle
7	withdrawing a needle from rubber or other resistant material *(rubber stopper, I.V. port, etc.)*
8	other after use, before disposal *(in transit to trash, cleaning up, left on bed, table, floor, or other inappropriate place , etc.)*
9	from item left on or near disposal container
10	while putting the item into the disposal container
11	after disposal, stuck by item protruding from opening of disposal container
12	item pierced side of disposal container
13	after disposal, item protruded from **trash bag** or **inappropriate** waste container
99	other, describe _____

10. What device or item caused the injury?
(refer to the list of items and enter the item code number here): [ ][ ]

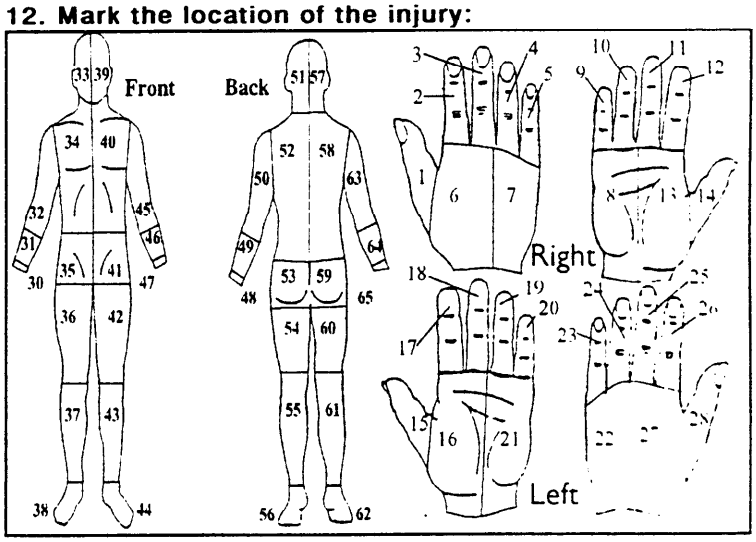
If the item is coded as "other" (29, 59, 79), then please describe the item:

_____

11. If the item causing the injury was a needle, was it a "safety design" with a shielded, recessed, or retractable needle?

[1] yes [2] no / not applicable

12. Mark the location of the injury:



13. Was the injury: *(check one)*

1	superficial *(little or no bleeding)*
2	moderate *(skin punctured, some bleeding)*
3	severe *(deep stick/cut, or profuse bleeding)*

14. Describe the circumstances leading to this injury:

_____

_____

_____

_____

_____

_____

_____

Costs: for office use only *(round to nearest dollar)*

[ ][ ][ ][ ]	laboratory charges for employee and source *(Hb, HIV, other tests)*
[ ][ ][ ][ ]	treatment, prophylaxis *(H-BIG, Hb vaccine, tetanus, AZT, other treatments)*
[ ][ ][ ][ ]	service charges *(Emergency Department, Employee Health, other services)*
[ ][ ][ ][ ]	other costs *(Worker's Compensation, surgery, other)*
[ ][ ][ ][ ]	total

Is this incident OSHA reportable?

- *Medical treatment (H-BIG, Hepatitis vaccine, gamma globulin, AZT, etc.; Not first aid, not tetanus)*
- *Restricted/lost work time; transferred*
- *Illness/death*

[1] yes [2] no

If yes, enter: days away from work [ ][ ][ ]
days restricted work activity [ ][ ][ ]

EXPOSURE PREVENTION INFORMATION NETWORK

Items Causing Needlestick and Sharp Object Injuries

NEEDLE

(for suture needle see "surgical instruments")

Item Codes

(1) disposable syringe *(includes standard syringes, insulin, tuberculin syringes)*
(2) prefilled cartridge syringe *(includes Tubex™*/Carpuject™* -type syringes)*
(3) blood gas syringe *(ABG)*
(4) syringe, other type or not sure what kind
(5) needle on I.V. line *(includes piggybacks and I.V. line connections)*
(6) winged steel needle I.V. set *(includes Butterfly™* -type devices)*
(7) I.V. catheter *(stylet)*
(8) vacuum tube blood collection holder/needle *(includes VACUTAINER™* -type devices)*
(9) spinal or epidural needle
(10) unattached hypodermic needle

(28) needle, not sure what kind
(29) other needle *(please describe device on the report form)*

SURGICAL INSTRUMENT OR OTHER SHARP ITEM

(For glass items see below)

(30) lancet *(finger or heel sticks)*
(31) suture needle
(32) scalpel blade
(33) razor
(34) pipette *(plastic)*
(35) scissors
(36) bovie electrocautery device
(37) bone cutter
(38) bone chip
(39) towel clip
(40) microtome blade
(41) trocar
(42) vacuum tube *(plastic)*
(43) specimen/test tube *(plastic)*
(44) fingernails/teeth

(58) sharp item, not sure what kind
(59) other item *(please describe item on the report form)*

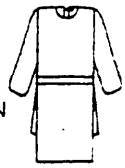
GLASS

(60) medication ampule
(61) medication vial *(small volume with rubber stopper)*
(62) medication/I.V. bottle *(large volume)*
(63) pipette *(glass)*
(64) vacuum tube *(glass)*
(65) specimen/test tube *(glass)*
(66) capillary tube

(78) glass item, not sure what kind
(79) other glass item *(please describe item on the report form)*

*Tubex™ is a trademark of Wyeth Ayerst; Carpuject™ is a trademark of Sanofi Winthrop; Butterfly™ is a trademark of Abbott Laboratories; VACUTAINER™ is a trademark of Becton Dickinson. Identification of these product categories does not imply involvement of these specific brands.

EXPOSURE PREVENTION INFORMATION NETWORK



Uniform Blood and Body Fluid Exposure Report

1193

Name: _____ Hospital ID: ☐☐☐☐

1. ID: ☐☐☐☐ **2. Date of injury:** month ☐☐ day ☐☐ year ☐☐

3. Job Category: *(check one)*

- ☐ 1 M.D. *(attending/staff)*
- ☐ 2 M.D. *(intern/resident/fellow)*
- ☐ 3 medical student
- ☐ 4 nurse RN/LPN
- ☐ 5 nursing student
- ☐ 6 respiratory therapist
- ☐ 7 surgery attendant
- ☐ 8 other attendant
- ☐ 9 phlebotomist/venipuncture/I.
- ☐ 10 clinical laboratory worker
- ☐ 11 technologist *(non-lab)*
- ☐ 12 dentist
- ☐ 13 dental hygienist
- ☐ 14 housekeeper/laundry worker
- ☐ 15 home health aide
- ☐ 16 chore worker/personal care provider
- ☐ 99 other, describe _____

4. Where did the exposure occur? *(check one)*

- ☐ 1 patient room
- ☐ 2 outside patient room *(hallway, nurses' station, etc.)*
- ☐ 3 emergency department
- ☐ 4 intensive/critical care unit
- ☐ 5 operating room
- ☐ 6 outpatient clinic/office
- ☐ 7 blood bank
- ☐ 8 venipuncture
- ☐ 9 dialysis facility
- ☐ 10 procedure room *(X-ray, EMG, etc.)*
- ☐ 11 clinical laboratories
- ☐ 12 autopsy/pathology
- ☐ 13 service/utility area *(laundry, central supply, loading dock, etc.)*
- ☐ 14 patient's home *(home health care)*
- ☐ 15 transport vehicle *(car, ambulance, helicopter, etc.)*
- ☐ 99 other, describe _____

5. Was the source patient known? *(check one)*

☐ 1 yes ☐ 2 no ☐ 3 unknown ☐ 4 not applicable

6. Which body fluids were involved in the exposure? *(check all that apply)*

- ☐ blood or blood product
- ☐ vomit/gastric contents
- ☐ CSF
- ☐ peritoneal fluid
- ☐ pleural fluid
- ☐ amniotic fluid
- ☐ urine
- ☐ saliva
- ☐ sputum
- ☐ feces
- ☐ other, describe _____

7. Was the exposed part: *(check all that apply)*

- ☐ intact skin
- ☐ non-intact skin
- ☐ eye(s)
- ☐ nose
- ☐ mouth
- ☐ other, describe _____

8. Did the blood or body fluid: *(check all that apply)*

- ☐ touch unprotected skin
- ☐ touch skin through gap between protective garments
- ☐ soak through protective garment
- ☐ soak through clothing

9. Which items were worn at the time of the exposure? *(check all that apply)*

- ☐ single pair latex/vinyl gloves
- ☐ double pair latex/vinyl gloves
- ☐ goggles
- ☐ eyeglasses
- ☐ faceshield
- ☐ surgical mask
- ☐ surgical mask with attached eyeshield
- ☐ surgical gown
- ☐ plastic apron
- ☐ lab coat, cloth
- ☐ lab coat, other, _____
- ☐ other, describe _____

over

10. Was the exposure the result of: *(check one)*

1	direct patient exposure	6	other body fluid container spilled/leaked
2	specimen container leaked/spilled	7	touched contaminated equipment
3	specimen container broke	8	touched contaminated drapes/sheets/gowns, etc.
4	IV tubing/bag/pump leaked	9	unknown
5	trach/NG tubing broke/sprayed, etc.	99	other, describe _____

specify tubing: _____

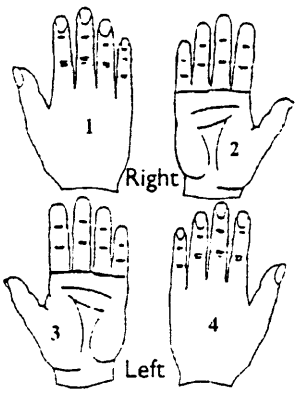
11. For how long was the blood or body fluid in contact with your skin or mucous membranes? *(check one)*

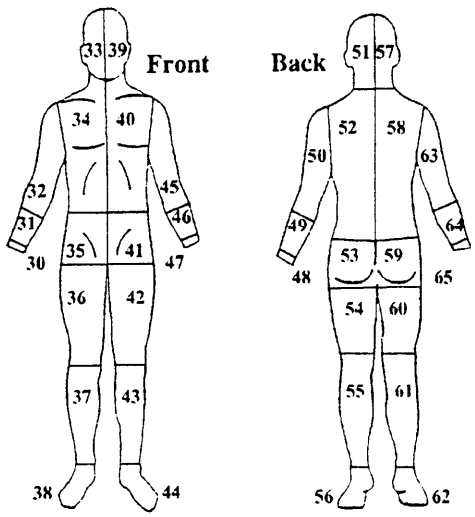
1	less than 5 minutes
2	5-14 minutes
3	15 minutes to 1 hour
4	more than 1 hour

12. Estimate the quantity of blood/body fluid that came in contact with your skin or mucous membranes: *(check one)*

1	small amount *(up to 5 cc, or up to a teaspoon)*
2	moderate amount *(up to 50 cc, or up to a quarter cup)*
3	large amount *(more than 50 cc)*

13. Mark the size and location of the exposure:





14. Describe the circumstances leading to this exposure:

_____

_____

_____

_____

_____

_____

_____

Costs: for office use only *(round to nearest dollar)*

	laboratory charges for employee and source *(Hb, HIV, other tests)*
	treatment, prophylaxis *(H-BIG, Hb vaccine, tetanus, AZT, other treatments)*
	service charges *(Emergency Department, Employee Health, other services)*
	other costs *(Worker's Compensation, surgery, other)*
	total

Is this incident OSHA reportable?

- *Medical treatment (H-BIG, Hepatitis vaccine, gamma globulin, AZT, etc.; Not first aid, not tetanus)*
- *Restricted/lost work time; transferred*
- *Illness/death*

1 yes
2 no

If yes, enter: days away from work ___
days restricted work activity ___