Washtenaw County Community Mental Health

BLOODBORNE INFECTIOUS DISEASE – (policy)

PURPOSE

- Minimize exposure of staff, clients, students, volunteers and contract agency employees to blood borne infectious diseases.

APPLICATION

- The application of this plan includes all Washtenaw County Community Mental Health (WCCMH), Washtenaw County Health Organization (WCHO), including permanent and temporary staff, Interns, Students and Volunteers.
- All persons are categorized based on their common work activities and potential for exposure to unpredictable circumstances or customer behaviors.
- The following categories determine necessary work practices, protective equipment, and need for pre-exposure immunization with hepatitis B vaccine. (Exhibit A: Category Determination Matrix)
  - **Category I** persons may administer health care, first aid, or have other occupational exposure to bloodborne infectious diseases due to unpredictable circumstances and/or customer behavior. Category I persons are offered pre-exposure hepatitis B vaccine upon employment.
  - **Category II** persons participate in work activities where exposure is unexpected. Category II persons are provided pre-exposure hepatitis B vaccine upon request.
  - **Category III** persons include clients, students, and volunteers. Category III persons must obtain hepatitis B vaccine through other sources.
  - **Category IV** persons are contract agency staff. Category IV persons should follow the Bloodborne Infectious Diseases policy for their agency.

POLICY

All persons will be appropriately trained to protect against and/or respond to a bloodborne infectious diseases incident involving staff, clients, students/interns, volunteers, contract agency and self-employed contractual employees should an exposure occur.

DEFINITIONS

**Bloodborne Infectious Diseases (BID):** Disease caused by pathogenic micro-organisms found in humans, dead or alive, which are present in human blood and can cause disease in humans, but not limited to hepatitis B, hepatitis C, and human immunodeficiency virus (HIV).

**Contaminate:** Presence or reasonably anticipated presence of blood or other potentially infected materials (OPIM) on an item or surface.

**Disinfect:** To inactivate virtually all pathogenic micro-organisms, but not necessarily all microbial forms, on inanimate objects.
Exposure Control Officer (ECO): Washtenaw County Public Health Department Medical Director

**Hepatitis B (HBV):** A bloodborne and sexually transmitted virus that causes a liver infection (hepatitis). Some persons will develop liver disease including chronic hepatitis or cirrhosis, and have an increased risk of liver cancer. Some persons will become chronic carriers of the virus, retaining the ability to infect others.

**Hepatitis C (HBC):** A bloodborne virus that causes an acute liver infection (hepatitis) that is either a very mild illness or has no symptoms at all. However, 60-70% of infected persons will develop chronic liver disease that progresses slowly before developing signs and symptoms. The virus is transmitted primarily through IVDU and contaminated sharps.

**Human Immunodeficiency Virus (HIV):** A bloodborne and sexually transmitted virus that without treatment progresses to Acquired Immune Deficiency Syndrome (AIDS) in some persons. AIDS develops after HIV invades and destroys the body’s immune system. The person is then vulnerable to life threatening and rare forms of cancer, and deterioration of the nervous system. Most HIV carriers have not been tested and are unaware of their infection.

Infection Control Committee: A joint committee made up of staff from Washtenaw County Public Health Department, Community Support and Treatment Services and Washtenaw Community Health Organization.

**Michigan Occupational Safety and Health Administration:** The state regulatory agency responsible for monitoring employee health and safety issues in the workplace (within the State of Michigan). The Department of Consumer and Industry Services Director’s Office issues administrative rules that include the Occupational Health Standards-Bloodborne Infectious Diseases document (MIOSHA BID Standard).

**Occupational Exposure Incident:** Includes eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM that occurs during the performance of an employee’s duties.

**Occupational Safety and Health Administration:** OSHA is the federal agency responsible for monitoring employee health and safety issues in the workplace.

**Other Potentially Infectious Materials (OPIM):** Includes the following body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, or any body fluid, which is contaminated with blood, and all fluids where it is difficult to differentiate between body fluids.

**Personal Protective Equipment (PPE):** Specialized clothing or equipment (e.g. Goggles, masks, gloves) worn by an employee for protection against bloodborne infectious diseases contamination. General work clothes (e.g. Uniforms, pants, shirts, or blouses) are not considered PPE.

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Pre-Exposure Prophylaxis: All employees who have been identified as belonging in Category I (Exhibit A) will be offered 3 doses of hepatitis B vaccine, according to the most current Advisory Committee on Immunization Practices (ACIP) recommendations, at no cost to the employee, upon hire and prior to assignment where exposure is likely to occur. Category II employees are provided the hepatitis B vaccine, at no cost to the employee, upon request.

Public Health Management Team (PHMT): Membership includes administrative and management level representatives, including the Public Health Officer, the Public Health Medical Director and Public Health Program Managers.

Regulated Waste: Liquid, semi-liquid, or dried human blood or OPIM on contaminated items, includes contaminated sharps such as syringes and lancets.

Safer Sharp: Non-needle sharp. A needle device which is used for withdrawing body fluids, accessing a vein or artery, or administering medications or vaccines that has a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Safety Committee: Each building site safety committee includes representation from both employees and employer or management.

Self-Management: Source individual personally manages their own injury/incident, cleans and disinfects contaminated surfaces and disposes of contaminated articles.

Sharp: Any object that can penetrate the skin, including any of the following: needles, lancets, broken capillary tubes, scalpels, broken glass, or exposed ends of dental wires.

Sharps Container: Leak-proof and puncture resistant container with locking lid and biohazard label for disposal of sharps and safer sharps.

Source Individual: Any individual whose blood or OPIM may be a source of occupational exposure to a staff, student, volunteer, or contract agency employee.

Universal Precautions: An approach to infection control whereby all human blood and body fluids are considered infectious for hepatitis B, hepatitis C, HIV and other bloodborne pathogens. Since there is no way to know if a person has hepatitis B, C or HIV, universal precautions is the action of treating all body fluids as infectious and protecting oneself as appropriate.

Washtenaw County Medical Provider: St. Joseph Mercy Health System Business Health Services/Urgent Care/Emergency Room

Work Practices: Practices/procedures performed in a manner that shall reduce the likelihood of exposure to blood and OPIM, including proper use of PPE, hand hygiene, and safety equipment.
PROCEDURES

See procedures manual

REFERENCES


Amendments to MIOSHA BID Standard published April 15, 2001, as amended June 28, 2001

Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program, CDC Division of Healthcare Quality Promotion, February 12, 2004


Safety Devices (on-line listing) - International Healthcare Worker Safety Center, University of Virginia Website: www.healthsystem.virginia.edu/internet/epinet/

Needlestick Safety (on-line resource list) – Immunization Action Coalition Website: www.immunize.org


Washtenaw County Bloodborne Infectious Diseases Training Curriculum- 2007 Version

Washtenaw County Sharps Disposal Fact Sheet: http://www.ewashtenaw.org/government/departments/environmental_health/recycling_home_toxics/hhw/sharps_html

This document is based on the OSHA Standard regulations, Part 1910 of Title 29 of the Code of Federal Regulations and the Department of Community Health Occupational Health Standards Commission, Bloodborne Infectious Diseases, Section 24 of Act No. 154 of the Public Acts of 1974, as amended, 408.1024 of the Michigan Compiled Laws.

Washtenaw County Medical Waste and Sharps Disposal Fact Sheet web site

EXHIBITS

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A. Hepatitis B Category Determination Chart
B. Training Matrix
C. BID Training Curriculum
D. Hepatitis B Vaccine Waiver
E. BID Exposure Incident Quick Reference Guide
F. BID Post Exposure Checklist (Supervisor)
G. Source Individual Information Form
H. Release of Medical Information (HBV, HCV and HIV Antibody Test Results)
I. BID Exposure Incident Report
J. Supervisor’s Report of Accident (Employee involvement)
K. Washtenaw County Incident Report (Client involvement)
L. Incident Report DMH 2550 (CMH Client involvement)
M. Sharps Injury Log
N. Safety Device Selection Process
O. Safety Feature Evaluation Form – Vacuum Tube Collection System
P. Safety Feature Evaluation Form – Safety Syringes
Q. Safety Feature Evaluation Form – Sharps Containers
R. Authorization for Examination or Treatment (Business Health Services)
<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>ACTIVITIES</th>
<th>WORK PRACTICES</th>
<th>PROTECTIVE EQUIPMENT</th>
<th>PRE-EXPOSURE VACCINE</th>
</tr>
</thead>
</table>
| Director Of Nursing & Nurse Supervisor | - Drawing up and injection vaccines or skin tests  
- Performing hematoctrit, lead PKU, sickle cell, or other blood tests  
- Drawing venous blood Samples  
- Applying band-aids, or first aid to stop bleeding  
- Administering CPR  
- Occasional assistance to persons with equipment such as tracheostomy or G-tube  
- Transporting medical waste from field clinics  
- Performing Physical Exams | - Follow hand washing procedures  
- Wear disposable gloves as needed  
- Use CPR mask if CPR trained  
- Use personal protective equipment based on situation requirements  
- Dispose of contaminated articles using appropriate containers | - Gloves  
- Lab Coat Availability  
- CPR Mask (if trained)  
- Sharps containers  
- Biohazard disposal container | - Hepatitis B vaccine offered |
| Adult Nurse Practitioner | - Blood draws  
- Performing gynecological or physical Exams  
- Performing tasks associated with preparing or evaluating collected specimens including microscopic exams, centrifuging and pouring off serum from blood samples, handling samples and culture plates  
- Urine collection | - SAME AS ABOVE | - SAME AS ABOVE | - Hepatitis B vaccine offered |
| Medical Technologist/Technician | - Drawing Blood Samples  
- Performing tasks associated with preparing or evaluating collected specimens including microscopic exams, centrifuging and pouring off serum from blood samples, labeling tubes, culture plates and containers | - SAME AS ABOVE | - SAME AS ABOVE | - Hepatitis B vaccine offered |
<table>
<thead>
<tr>
<th>Disease Intervention Specialist</th>
<th>Performing tasks associated with preparing or evaluating collected specimens including microscopic exams, centrifuging and pouring off serum, labeling tubes, culture plates and containers</th>
<th>SAME AS ABOVE</th>
<th>SAME AS ABOVE</th>
<th>Hepatitis B vaccine offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Program Supervisor (WIC)</td>
<td>Performing hematocrit test via capillary method</td>
<td>SAME AS ABOVE</td>
<td>SAME AS ABOVE</td>
<td>Hepatitis B vaccine offered</td>
</tr>
</tbody>
</table>
| Nutrition specialist            | - Administering injectable medications and skin tests. Applying Band-Aids or first aid to stop bleeding, or administering CPR.  
| Registered Dietician             | - Occasional assistance to persons requiring assistance with tracheostomies, suctioning or G-tube care.  
| WIC Associate                   | - One on one contact with customers                                                                               | SAME AS ABOVE | SAME AS ABOVE | Hepatitis B vaccine offered |
| Mental Health Nurse Service Coordinator | - Assists with toileting, diapering, feeding, and positioning.  
|                                  | - Applying band-aids, or first aid to stop bleeding, administering CPR.  
|                                  | - Urine collection                                                                                               | SAME AS ABOVE | SAME AS ABOVE | Hepatitis B vaccine offered |
| Mental Health Attendant Mental Health Worker | - One on one contact with customers                                                                                 | SAME AS ABOVE | SAME AS ABOVE | Hepatitis B vaccine offered |
| All PES, Court Services, Inpatient Services to persons with developmental disabilities |                                                                      | SAME AS ABOVE | SAME AS ABOVE | Hepatitis B vaccine offered |
### Category II

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>ACTIVITIES</th>
<th>WORK PRACTICES</th>
<th>PROTECTIVE EQUIPMENT</th>
<th>PRE-EXPOSURE VACCINE</th>
</tr>
</thead>
</table>
| Any employee NOT designated Category I | First aid to stop bleeding | - Follow hand washing procedures  
- Wear disposable gloves as needed  
- Dispose of contaminated materials using appropriate containers | Gloves  
Disposable biohazard container | Hepatitis B vaccine offered in case of exposure incident |

### Category III

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>ACTIVITIES</th>
<th>WORK PRACTICES</th>
<th>PROTECTIVE EQUIPMENT</th>
<th>PRE-EXPOSURE VACCINE</th>
</tr>
</thead>
</table>
| Clients  
- Customers | Receiving Service | None | Gloves  
Sharps containers  
Biohazard disposal containers | Hepatitis B status must be provided to supervisor prior to assignment  
- If desired, Hepatitis B vaccine should be obtained by the student/intern from their health care provider |
| Inmates  
- Students  
- Volunteers | Observation of or assisting  
Health Services Employees  
- Service to clients, customers | - Follow hand washing procedures  
- Wear disposable gloves as needed  
- Use protective wear based on the situation  
- Dispose of contaminated materials using appropriate containers | Gloves  
Sharps containers  
Biohazard disposal containers | |

### Category IV

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>ACTIVITIES</th>
<th>WORK PRACTICES</th>
<th>PROTECTIVE EQUIPMENT</th>
<th>PRE-EXPOSURE VACCINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual Agency Staff</td>
<td>Service to Washington County Health Services clients and customers</td>
<td>As covered by contract agency policy</td>
<td>As provided by contract agency</td>
<td>Hepatitis B vaccine status of all contractual employees must be provided yearly to Washington County Health Services. It is expected that all contract agencies will follow the OSHA standard in providing protections for their employees.</td>
</tr>
</tbody>
</table>
## Training Matrix

<table>
<thead>
<tr>
<th>Employee Type</th>
<th>Training Provided By</th>
<th>Time Frame:</th>
<th>Hepatitis B Provided By</th>
<th>Training and IMMS. Status Confirmed By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hire</td>
<td>Washtenaw County at the LLRC</td>
<td>Within 10 days of hire or prior to initial assignment where exposure might occur</td>
<td>Washtenaw County based on categorical representation</td>
<td>Chief Clerk/responsible Supervisor</td>
</tr>
<tr>
<td>Current Employees</td>
<td>Washtenaw County at the LLRC</td>
<td>Yearly update</td>
<td>Washtenaw County (post-exposure for category II employees)</td>
<td>Chief Clerk/responsible Supervisor</td>
</tr>
<tr>
<td>Contractual Employees</td>
<td>Contractor or for self-employed, Washtenaw County at the LLRC</td>
<td>Initial training and yearly update</td>
<td>Contractor</td>
<td>Contract Process &amp; Program Coordinator</td>
</tr>
<tr>
<td>Students/Interns (Paid or Unpaid)</td>
<td>Educational sponsor or Washtenaw County at the LLRC</td>
<td>Proof provided prior to internship</td>
<td>Other sources</td>
<td>Supervisor or Program Coordinator sponsoring student/intern</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Other source or Washtenaw County at the LLRC</td>
<td>Prior to beginning assignment and yearly update</td>
<td>Other sources</td>
<td>Supervisor or Program Coordinator sponsoring volunteer</td>
</tr>
</tbody>
</table>
Bloodborne Infectious Diseases Training Curriculum

All training sessions will include an explanation of the following topics per MIOHSA guidelines, an opportunity for discussion and the answering of questions by a knowledgeable trainer:

1. The MIOHSA Standard for Bloodborne Infectious Diseases
2. Descriptions, signs, symptoms, and mode of transmission of bloodborne infectious diseases.
3. The Exposure Control Plan with particular attention to:
   a. Points of the plan
   b. Lines of responsibility
   c. Implementation of the plan
   d. Location of written plan on Employee website
4. Attention to procedures, which might cause exposure to blood or other potentially infectious materials (OPIM).
5. Control methods, including work practices, used to prevent or reduce exposure to blood or OPIM.
6. Types of Personal Protective Equipment (PPE) available, their location, limitations, and proper use (removal, handling, decontamination and disposal).
7. Summary of selection process for protective clothing, equipment and safety devices.
8. Post exposure evaluation and follow-up procedure, including resource staff contact information and where to access medical care.
9. Signs and labels used at Washtenaw County Health Services Facilities.
10. Hepatitis B vaccine information and availability to staff.
11. Type and location of reports required in case of exposure.
12. Resource list for additional information
13. Post Test
14. Evaluation of the session

04/07
WAIVER FOR 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.

______________________________
Employee Signature                    Date

______________________________
Witness Signature                    Date

(Waiver04/07)
BLOODBORNE INFECTIOUS DISEASES

EXPOSURE INCIDENT
QUICK REFERENCE

1. Immediately wash and flush exposed area with water.

2. Gently express blood from the cut or puncture. **DO NOT SCRUB OR SQUEEZE.**

3. Take steps to minimize exposure of other persons to blood or OPIM. Instruct them to take protective measures.

4. If blood or OPIM penetrates garments, remove as soon as possible. Place in a plastic bag.

5. Contact a supervisor immediately.

Revised 4/07
SUPERVISOR’S
BID POST-EXPOSURE CHECKLIST

Check off the following when completed or indicate NA when not applicable to situation

1. _____ Care at the Scene:
   a) ____ Immediately wash and flush exposed area with water
   b) ____ Gently express blood from the cut or puncture. Do not scrub or squeeze
   c) ____ Take steps to minimize exposure of other persons to blood or OPIM. Instruct individuals to take protective measures.
   d) ____ If blood or OPIM penetrates garments, remove as soon as possible. Place in plastic bag.

2. _____ Obtain information regarding exposure incidents:
   a) ____ Source Individual Information Form (EXHIBIT G)
   b) ____ BID Exposure Incident Report (EXHIBIT I)
   c) ____ Washtenaw County Supervisor’s Report of Accident (EXHIBIT J)
   d) ____ Washtenaw County Incident Report Form (EXHIBIT K)
      (if public or visitor involved)
   e) ____ DMH-2550 Incident Report (if Mental Health customer is involved, employee completes top section of form) (EXHIBIT L)

3. _____ If exposure source is known, explain need for HBV, HCV and HIV testing, and obtain signature on Release of Medical Information (Exhibit H)
   _____ Yes _____ No

4. _____ Direct employee to Washtenaw County approved Medical Provider with the following forms:
   a) ____ Employer Authorization For Treatment and Billing (EXHIBIT R)
      Note check box “Injury” and specify “Exposure to Body Fluid”
   b) ____ Exposure Incident Report (EXHIBIT I)
   c) ____ All relevant medical information about employee including Hepatitis B Vaccine status, e.g. copy of vaccination dates or waiver for Hepatitis B Vaccination
   d) ____ Source Individual Information Form (EXHIBIT G)
f) _____ Copy of Release of Medical Information form (Exhibit H)

1. _____ Send Supervisor’s Report of Accident (EXHIBIT J) to Human Resources

2. _____ Send Washtenaw County Incident Report form (EXHIBIT K) to Risk Management

3. _____ Send DMH-2550 Incident Report form (EXHIBIT L) to Program Manager

4. _____ Look for written report to Employer regarding any work limitations from Medical Provider related to medical visit

5. _____ Send any medical information received to Human Resources to be placed in employee’s confidential medical file

10. _____ Send a copy of BID Exposure Incident Report (EXHIBIT I) to Infection Control Committee Exposure Control Officer

COMMENTS:

SIGNATURE OF SUPERVISOR/DESIGNEE COMPLETING FORM:

__________________________________________________________________________
(Name)                                                                 (Date)

Original: Human Resources Confidential Medical File
Copy: Infection Control Committee Exposure Control Officer

Revised 4/07DN
SOURCE INDIVIDUAL INFORMATION FORM

Name: __________________________________________________________

Address: _______________________________________________________

Phone #: ________________________________________________________

Alternate phone #: _____________________________________________
Alternate address: _______________________________________________

Release of Medical Information obtained?  ____Yes  ____ No

Source Individual’s blood drawn?  ____ Yes  ____ No
Date blood work drawn:  ___________
Location blood drawn: __________________________________________

Comments: _____________________________________________________
______________________________________________________________
_________________________________________________________________
_________________________________________________________________

Employee notified that source individual had blood drawn?  ____ Yes  ____ No
WASHTENAW COUNTY PUBLIC HEALTH DEPARTMENT
555 Towner, Ypsilanti, MI 48197

RELEASE OF MEDICAL INFORMATION
HBV, HCV AND HIV ANTIBODY TEST RESULTS

I, _____________________________________, hereby authorize
(Name of Source Individual)
____________________________________________________
(Name of Source’s Medical Provider)
to release the results of my
HBV, HCV and HIV Antibody tests to Business Health Services, associated with Saint Joseph
Mercy Health System, who is treating the employee exposed to my blood:

Business Health Services
3131 S. State St.
Ann Arbor, MI 48108
Phone: 734-213-6285
Hours: M-F: 800am-6:00pm

After Hours or for severe emergencies:
St Joseph Mercy Hospital
Emergency and Trauma Center
5301 E. Huron River Dr., Ypsilanti, MI
Phone: 734-712-3000

________________________________________________
(Signature of Exposure Source, or parent/guardian)
(Date)

________________________________________________
(Witness)
(Date)

Original: Medical Provider of Employee
Copy: Customer
Copy: Customer’s Record
BID EXPOSURE INCIDENT REPORT

Date of Incident: ____________ Time: ____________ Location: ________________

Employee Exposed: Name: ____________________________
Address: _________________________________________

Source Individual: Name: ______________________________________________________
Primary Address: ____________________________________________________________
Alternate Address: ____________________________________________________________
Phone #: _________________________________________________________________
Alternate Phone #: _________________________________________________________

Potentially Infectious Material: _________________________________________________

Description of Employee’s duties as they relate to exposure incident: ________________

Description of Incident: _________________________________________________________

Cause of Exposure, i.e. accident, equipment malfunction, etc: _________________________

Safety / PPE utilized (include name and manufacturer): ______________________________

First Aid administered to exposed employee: ______________________________________

Recommendations for changes in Exposure Control Plan and/or work practices to avoid repetition of incident:

________________________________________________

________________________________________________

Signature: ________________________________ Date: __________________

Original: Infection Control Committee Exposure Control Officer

04/07
EXHIBIT J

Washoe County
Workers' Comp Accident Report for Work-Related Injury or Illness &
Authorization for Treatment

Section 1: Employee Information (to be completed by the employee, if possible)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Middle Name</td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single</td>
</tr>
<tr>
<td></td>
<td>Married</td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
<tr>
<td># of Dependents</td>
<td></td>
</tr>
<tr>
<td>Employee Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Home Phone</td>
<td></td>
</tr>
<tr>
<td>Department/Division</td>
<td></td>
</tr>
<tr>
<td>Physical Work Location</td>
<td></td>
</tr>
<tr>
<td>Employee #</td>
<td></td>
</tr>
<tr>
<td>Work Phone</td>
<td></td>
</tr>
<tr>
<td>Position/Occupation</td>
<td></td>
</tr>
<tr>
<td>Date of Hire</td>
<td></td>
</tr>
<tr>
<td>Date in Position</td>
<td></td>
</tr>
<tr>
<td>Wage</td>
<td></td>
</tr>
<tr>
<td>Circle</td>
<td></td>
</tr>
<tr>
<td>Hours worked/Day</td>
<td></td>
</tr>
<tr>
<td>Hours/week</td>
<td></td>
</tr>
<tr>
<td>Schedule</td>
<td>Full-time</td>
</tr>
<tr>
<td></td>
<td>Part-time</td>
</tr>
<tr>
<td>Days Worn per week</td>
<td></td>
</tr>
</tbody>
</table>

Section 2: Alleged Work-Related Injury or Illness Information (to be completed by the employee, if possible)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occur Date</td>
<td></td>
</tr>
<tr>
<td>Occur Time</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Type of Accident</td>
<td></td>
</tr>
<tr>
<td>Injured on Regular Job?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Employee's Premise?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Injury Description</td>
<td></td>
</tr>
<tr>
<td>1) Physical stress (i.e., climbing, lifting):</td>
<td></td>
</tr>
<tr>
<td>2) Source of injury (i.e., type of machinery):</td>
<td></td>
</tr>
<tr>
<td>3) Type of injury (i.e., contusion, laceration):</td>
<td></td>
</tr>
<tr>
<td>4) Specific body part(s) injured:</td>
<td>Left</td>
</tr>
<tr>
<td></td>
<td>Right</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Describe the Events Which Caused the Injury/Illness (Details or Comments):</td>
<td></td>
</tr>
</tbody>
</table>

Unsafe Acts/Conditions:   Yes   No   (Explain):
Safety Equipment Provided:   Yes   No   (Explain):
Safety Equipment Used:   Yes   No   (Explain):
Witness Information:   Name:   Address:
City, State, Zip:
Phone:

Section 3: Supervisor Information (to be completed by Supervisor)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Name</td>
<td></td>
</tr>
<tr>
<td>Date Notified by Employee</td>
<td></td>
</tr>
<tr>
<td>If died, date</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>FAX</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>Supervisor's Comments</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hereby authorize treatment for this employee at Business Health Services:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|                                      |                              |
|                                      |                              |
|                                      |                              |
|                                      |                              |

Washoe County agrees to pay for any medical treatment provided to the above named individual to address this alleged work-related injury/Illness. If this case is disputed, we agree to pay for services up to the point the case is settled in writing of a dispute.

Email a copy of this form to Human Resources within 24 hours following accident or injury.
**I. Incident Reporting - Injury to Public**

This form should be used for the reporting of all types of injury to the public
(NOT for Employee Injuries)

* Indicates required fields

**II. General Incident Information**

Report prepared by: *

Department: *

If your department is not listed you must enter it in the "Other Department" field.

Other Department:

Division:

Phone Number: *

E-mail: *

Date of Incident: *

04/09/2010

Time of Incident: *

Incident Location: *

If the incident location is not listed above, you must enter it in the "Other Incident Location" field.

Other Incident Location:

THIS FORM SHOULD BE SUBMITTED WITHIN 24 HOURS OF INCIDENT

If you have questions about the reporting of an incident, contact Risk Management at 222-6755.
## INCIDENT REPORT

<table>
<thead>
<tr>
<th>INCIDENT REPORT</th>
<th>RECIPIENT NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>TIME</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>NAME</td>
<td></td>
</tr>
<tr>
<td>MEAN OF VICTIM NAME</td>
<td></td>
</tr>
<tr>
<td>NAME OF HOSPITAL</td>
<td></td>
</tr>
<tr>
<td>DATE OF OCCURRANCE</td>
<td></td>
</tr>
<tr>
<td>TIME OF OCCURRANCE</td>
<td></td>
</tr>
<tr>
<td>WHERE DID INCIDENT OCCUR?</td>
<td></td>
</tr>
<tr>
<td>LOCATION</td>
<td></td>
</tr>
<tr>
<td>EMPLOYER INVOLVED</td>
<td></td>
</tr>
<tr>
<td>EMPLOYER INVOLVED ADJACENT PRESENT</td>
<td></td>
</tr>
<tr>
<td>EXPLAIN WHAT HAPPENED</td>
<td></td>
</tr>
<tr>
<td>ACTION TAKEN BY STAFF</td>
<td></td>
</tr>
<tr>
<td>LOCAL INJURY APPOINT</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>INJURY OCCURRENCE OF INJURY BY PHYSICIAN OR RN</td>
<td></td>
</tr>
<tr>
<td>DESCRIPTION OF INJURY OCCURRENCE OF INJURY</td>
<td></td>
</tr>
<tr>
<td>TREATMENT OF INJURY</td>
<td></td>
</tr>
<tr>
<td>DATE OF INJURY</td>
<td></td>
</tr>
<tr>
<td>TIME OF INJURY</td>
<td></td>
</tr>
<tr>
<td>EXTENT OF INJURY AT TIME OF INJURY</td>
<td></td>
</tr>
<tr>
<td>PHYSICIAN SIGNATURE</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>EMPLOYEE NOTIFIED</td>
<td></td>
</tr>
<tr>
<td>STM SUPERVISOR/STAFF</td>
<td></td>
</tr>
<tr>
<td>ADMINISTRATIVE ACTION TO REMEDY AND PREVENT REoccurrence OF INCIDENT</td>
<td></td>
</tr>
<tr>
<td>ADMINISTRATOR SIGNATURE</td>
<td></td>
</tr>
</tbody>
</table>

**EXHIBIT L**

**NOTE TO SUPERVISOR: DISTRIBUTION TO DIRECTOR, ADMINISTRATIVE OFFICE, AND ADVICE TO EMPLOYEE REGARDING POTENTIAL RESPONSES.**

- Copy to Director
- Copy to Administrator
- Copy to Employee
- Copy to Agency
### WCPHD Sharps Injury Log

**Record all injuries that occur from contaminated sharps**

<table>
<thead>
<tr>
<th>Date</th>
<th>Employee ID #</th>
<th>Type and Brand of Device</th>
<th>Incident Description</th>
<th>Dept. or Work Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Protect confidentiality</td>
<td></td>
<td></td>
<td>Where incident occurred</td>
</tr>
</tbody>
</table>

*Note: This log applies to any employer who is required to maintain a log of occupational injuries and illnesses under R 408.22101 Part 11 Recording and Reporting of Occupational Injuries and Illnesses. It shall be maintained for the period required by Part 11.*

Michigan Department of Consumer and Industry Services  
Bureau of Safety and Regulation  
BSR-CET-824 (7/01)  
Revised by WCPHD (4/07)
Safety Device Selection Process

1. Review of the devices causing or involved in the most exposure incidents

2. Identify type of device with greatest risk of exposure (i.e. blood filled hollow-bore needles)

3. Review of safety/efficacy data on currently available safety devices

4. Screen and select devices appropriate for meeting basic programmatic criteria

5. Conduct simulated procedure evaluations and review data

6. Select most effective safety device(s) that meet programmatic criteria

7. Provide training in use of the device and safety features; include hands-on practicum to demonstrate skills/identify preferences between devices

8. Distribute new safety devices; remove all conventional devices from worksites

9. Continue to monitor safety and efficacy data

10. Conduct annual utilization review, including any newly commercially available equipment
EXHIBITS O- Q: Please continue to scroll down to view these scanned documents
SAFETY FEATURE EVALUATION FORM
VACUUM TUBE BLOOD COLLECTION SYSTEMS

Date: ___________ Department: ____________________ Occupation: ____________

Product: ____________________________________________________________ Number of times used: ___________

Please circle the most appropriate answer for each question. Not applicable (N/A) may be used if the question does not apply to this particular product.

1. The safety feature can be activated using a one-handed technique.............. 1 2 3 4 5 N/A
2. The safety feature does not interfere with normal use of this product........... 1 2 3 4 5 N/A
3. Use of this product requires you to use the safety feature........................... 1 2 3 4 5 N/A
4. This product does not require more time to use than a non-safety device........ 1 2 3 4 5 N/A
5. The safety feature works well with a wide variety of hand sizes..................... 1 2 3 4 5 N/A
6. The safety feature works with a butterfly.............................................. 1 2 3 4 5 N/A
7. A clear and unmistakable change (either audible or visible) occurs when the safety feature is activated.................................................. 1 2 3 4 5 N/A
8. The safety feature operates reliably........................................................ 1 2 3 4 5 N/A
9. The exposed sharp is blunted or covered after use and prior to disposal......... 1 2 3 4 5 N/A
10. The inner vacuum tube needle (rubber sleeved needle) does not present a danger of exposure................................................................. 1 2 3 4 5 N/A
11. The product does not need extensive training to be operated correctly......... 1 2 3 4 5 N/A

Of the above questions, which three are the most important to your safety when using this product?

Are there other questions which you feel should be asked regarding the safety/ utility of this product?
SAFETY FEATURE EVALUATION FORM

SAFETY SYRINGES

Date: ___________ Department: __________________ Occupation: __________________

Product: ___________________________ Number of times used: ___________

Please circle the most appropriate answer for each question. Not applicable (N/A) may be used if the question does not apply to this particular product.

DURING USE:

1. The safety feature can be activated using a one-handed technique .................. 1 2 3 4 5 N/A
2. The safety feature does not obstruct vision of the tip of the sharp .................. 1 2 3 4 5 N/A
3. Use of this product requires you to use the safety feature .................. 1 2 3 4 5 N/A
4. This product does not require more time to use than a non-safety device ........ 1 2 3 4 5 N/A
5. The safety feature works well with a wide variety of hand sizes .................. 1 2 3 4 5 N/A
6. The device is easy to handle while wearing gloves .................. 1 2 3 4 5 N/A
7. This device does not interfere with uses that do not require a needle ........ 1 2 3 4 5 N/A
8. This device offers a good view of any aspirated fluid .................. 1 2 3 4 5 N/A
9. This device will work with all required syringe and needle sizes ........ 1 2 3 4 5 N/A
10. This device provides a better alternative to traditional recapping .......... 1 2 3 4 5 N/A

AFTER USE:

11. There is a clear and unmistakeable change (audible or visible) that occurs when the safety feature is activated .................. 1 2 3 4 5 N/A
12. The safety feature operates reliably .................. 1 2 3 4 5 N/A
13. The exposed sharp is permanently blunted or covered after use and prior to disposal .................. 1 2 3 4 5 N/A
14. This device is no more difficult to process after use than non-safety devices ...... 1 2 3 4 5 N/A

TRAINING:

15. The user does not need extensive training for correct operation .................. 1 2 3 4 5 N/A
16. The design of the device suggests proper use .................. 1 2 3 4 5 N/A
17. It is not easy to skip a crucial step in proper use of the device .................. 1 2 3 4 5 N/A

Of the above questions, which three are the most important to your safety when using this product?

Are there other questions which you feel should be asked regarding the safety/ utility of this product?
SAFETY FEATURE EVALUATION FORM
SHARPS DISPOSAL CONTAINERS

Date: ___________________ Department: ______________________ Occupation: ______________________

Product: ___________________________ Number of times used: ______________________

Please circle the most appropriate answer for each question. Not applicable (N/A) may be used if the question does not apply to this particular product.

1. The container's shape, its markings, or its color, imply danger. 1 2 3 4 5 N/A
2. The implied warning of danger can be seen from the angle at which people commonly view it. (very short people, people in wheelchairs, children, etc.) 1 2 3 4 5 N/A
3. The implied warning can be universally understood by visitors, children, and patients. 1 2 3 4 5 N/A
4. The container's purpose is self-explanatory and easily understood by a worker who may be pressed for time or unfamiliar with the hospital setting 1 2 3 4 5 N/A
5. The container can accept sharps from any direction desired. 1 2 3 4 5 N/A
6. The container can accept all sizes and shapes of sharps. 1 2 3 4 5 N/A
7. The container allows single handed operation. (Only the hand holding the sharp should be near the container opening.) 1 2 3 4 5 N/A
8. It is difficult to reach in and remove a sharp. 1 2 3 4 5 N/A
9. Sharps can go into the container without getting caught on the opening. 1 2 3 4 5 N/A
10. Sharps can go into the container without getting caught on any molded shapes in the interior. 1 2 3 4 5 N/A
11. The container is puncture resistant. 1 2 3 4 5 N/A
12. When the container is dropped or turned upside down (even before it is permanently closed) sharps stay inside 1 2 3 4 5 N/A
13. The user can determine easily, from various viewing angles, when the container is full. 1 2 3 4 5 N/A
14. When the container is to be used free-standing (no mounting bracket), it is stable and unlikely to tip over. 1 2 3 4 5 N/A
15. It is safe to close the container. (Sharps should not protrude into the path of hands attempting to close the container.) 1 2 3 4 5 N/A
16. The container closes securely. (e.g. if the closure requires glue, it may not work if the surfaces are soiled or wet.) 1 2 3 4 5 N/A
17. The product has handles which allow you to safely transport a full container. 1 2 3 4 5 N/A
18. The product does not require extensive training to operate correctly. 1 2 3 4 5 N/A

Of the above questions, which three are the most important to your safety when using this product?

Are there other questions which you feel should be asked regarding the safety/utility of this product?
### Section 1: Employee Information (to be completed by the employee, if possible)

- **Employee Last Name:**
- **First Name:**
- **Middle Name:**
- **Social Security Number:**
- **Gender:** Male/Female
- **Marital Status:** Single/Married/Divorced/Widowed
- **Birth Date:**
- **# of Dependents:**
- **Employee Address:**
- **City:**
- **State:**
- **Zip:**
- **Home Phone:**
- **Department/Division:**
- **Physical Work Location:**
- **Employee #:**
- **Work Phone:**
- **Position/Occupation:**
- **Date of Hire:**
- **Date in Position:**
- **Viage:**
- **O/Hours: Per Hour / Day / Week / Month**
- **Schedule:** (Circle) Full-time or Part-time or Temporary
- **Days Worked per week:**
- **Hours worked/day:**
- **Hourly Week:**

### Section 2: Alleged Work-Related Injury or Illness Information (to be completed by the employee, if possible)

- **Occur Date:**
- **Occur Time:**
- **Location:**
- **Type of Accident:**
- **Injured on Regular Job?** Yes/No/Unknown
- **Employee & Premises?** Yes/No/Unknown

#### Injury Description:
1. Physical action (e.g., climbing, lifting): ___
2. Source of injury (i.e., type of machinery): ___
3. Type of injury (i.e., contusion, laceration): ___
4. Specific body part(s) injured: ___
   - Right: ___
   - Left: ___
   - Other: ___

#### Describe the Events Which Caused the Injury/Illness (Details or Comments):

### Section 3: Supervisor Information (to be completed by Supervisor)

- **Supervisor Name:**
- **Telephone:**
- **Fax:**
- **Email:**
- **Date Notified by Employee:**
- **If died, date:**
- **Supervisor’s Comments:**

### Medical Information

- **Unsafe Acts/Conditions:** Yes/No/Unknown
- **Safety Equipment Provided:** Yes/No/Unknown
- **Safety Equipment Used:** Yes/No/Unknown
- **Witness Information:** Yes/No/Unknown
  - **Name:**
  - **Address:**
  - **City, State, Zip:**
  - **Phone:**

### Treatment

- **Treatment to be obtained at:**
  - Business Health
  - Emergency Room

### Supervisor’s Information

- **Last Work Date:**
- **Disability Start Date:**
- **Returned to Work?** Yes/No/Unknown
- **Date Returned to Work:**

---

I hereby authorize treatment for this employee at Business Health Services:

- **Supervisor Signature:**
- **Date:**

Washoe County agrees to pay for any medical treatment provided to the above named individual to address this alleged work-related injury/illness. If this case is disputed, we agree to pay for services up to the point of no contest in writing of a dispute.

Email a copy of this form to Human Resources within 24 hours following accident or injury.