

**Policy**

- All blood borne pathogen (BBP) exposures and personal injuries are to be treated immediately.
- All BBP exposures and personal injuries are to be reported immediately.

**Procedures**

**Blood Borne Pathogen Exposure – Faculty, Staff, and Students**

1. Blood Borne Pathogen Exposures - Steps for Treatment
  - a. Administer first aid, immediately after exposure. Allow a penetrating injury to bleed. Wash the injury site thoroughly with soap and water or rinse the exposed mucous membrane thoroughly with water. If anyone assists with first aid they should wear gloves and eye protection.
  - b. After first aid has been administered, the individual must report to incident to their supervisor.
  - c. The supervisor will complete the Exposure Report Form (Appendix A), First Report of Injury Form (Appendix B) and Injury/Illness Loss Investigation Report (Appendix C).
  - d. If injury occurs Monday-Friday between 8am-4pm the supervisor will call the University of Delaware Nurse Managed Primary Care Center (“UD NMPCC”) at 302-831-3195 to alert the office that they are referring an individual for treatment for BBP exposure.
  - e. If injury occurs Monday-Friday between 4pm-8pm or Saturday-Sunday between 8am-8pm, the supervisor will call the closest Medical Aid Unit to alert the Medical Aid Unit that they are referring an individual for treatment for BBP exposure. Local Medical Aid Units include:
    - i. Glasgow Medical Aid Unit  
STAR Campus  
550 South College Avenue, Suite 115  
Newark, DE 19713  
302-533-7148
    - ii. Glasgow Medical Aid Unit  
Glasgow Medical Center  
2600 Glasgow Ave., Newark, DE 19702  
302-836-8350
    - iii. Medical Aid Unit at Christiana  
HealthCare Center at Christiana  
200 Hygeia Drive, Newark, DE 19713  
302-623-0444
    - iv. Medical Aid Unit at Middletown  
Middletown Care Center  
124 Sleepy Hollow Drive, Middletown, DE 19709  
302-449-3100
  - f. If injury occurs during any hours not covered above, the supervisor will contact the closest Christiana Care Emergency Room to alert them that they are referring an individual for treatment for BBP exposure.
    - i. Christiana ER (Triage Desk) 302-733-1620
    - ii. Wilmington ER (Triage Desk) 302-428-4180
  - g. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for BBP exposure.
  - h. The supervisor will provide the injured individual with a copy of the Exposure Referral Guideline (Appendix E).

- i. The supervisor will contact the University of Delaware (UD) Nurse Managed Primary Care Center (NMPCC) at 302-831-3195 to notify them that an individual has been referred for treatment for BBP exposure and will require follow-up in the NMPCC.
  2. Blood Borne Pathogen Exposures - Source Evaluation
    - a. The supervisor is responsible for requesting that the source patient's blood be tested for:
      - i. RAPID HIV testing; no consent is needed.
      - ii. Hepatitis B and Hepatitis C testing.
    - b. The supervisor will complete the Source Patient Information Form (Appendix D).
  3. Blood Borne Pathogen Exposures - Immediate Post-Exposure Documentation
    - a. The supervisor is responsible for submitting all the required completed forms:
      - i. Appendix A - Exposure Report Form
      - ii. Appendix B - First Report of Injury Form
      - iii. Appendix C - Injury/Illness/Loss Investigation Report
      - iv. Appendix D - Source Patient Information Form
      - v. For Faculty/Staff only: Appendix F – First Report of Injury Form
    - b. All forms are to be submitted via FAX or hand-delivery within 24 hours of the BBP exposure to the following:
      - i. UD Department of Environmental Health & Safety: 302-831-1528 (only forms A,B,C)
      - ii. UD department director's office: 302-831-2382 (only forms A,B,C)
      - iii. UD NMPCC: fax 302-831-3193 (all forms A,B,C,D)
  4. Blood Borne Pathogen Exposure - Follow-up Care
    - a. The UD NMPCC upon notification and receipt of the above documentation will contact the injured individual to schedule a follow-up office visit for counseling and health care treatment as indicated.

#### **Faculty and Staff Injury (other than BBP exposure)**

1. Injuries - Steps for Faculty and Staff Treatment
  - a. Administer first aid and/or treatment as indicated.
  - b. After first aid has been administered, the faculty or staff member must notify their supervisor.
  - c. The supervisor will contact the UD NMPCC at 302-831-3195 to alert them of the individual's injuries and in consultation with the UD NMPCC, determine if individual should be treated at the UD NMPCC or referred to the nearest urgent care facility or emergency room.
  - d. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for treatment of the injury.
  - e. The supervisor will complete a First Report of Injury Form (Appendix F) and an Injury/Illness Loss Investigation Report (Appendix C).
  - f. The supervisor is responsible for submitting all the required completed forms:
    - i. Appendix F – First Report of Injury Form
    - ii. Appendix C – Injury/Illness/Loss Investigation Report
  - g. All forms are to be submitted via FAX or hand-delivery within 24 hours of the personal injury to the following:
    - i. UD Department of Environmental Health & Safety: 302-831-1528
    - ii. UD department director's office
    - iii. UD Nurse Managed Primary Care Center: fax 302-831-3193

#### **Student Injury (other than BBP exposure)**

1. Injuries – Steps for Student Treatment
  - a. Administer first aid and/or treatment as indicated.
  - b. After first aid has been administered, the student must notify their supervisor.

- c. The supervisor will contact Student Health Services at 302-831-2226 to alert them of the student's injuries and in consultation with the Student Health representative, determine if student should be treated at the Student Health Services or be referred to the nearest urgent care facility or emergency room.
- d. If injury occurs at a facility out of state or at a significant distance from the above sites, the supervisor will identify the closest urgent care facility or emergency room and contact the identified facility and refer as indicated for treatment of the injury.
- e. The supervisor will complete a First Report of Injury Form (Appendix B) and an Injury/Illness Loss Investigation Report (Appendix C).
- f. The supervisor is responsible for submitting all the required completed forms:
  - i. Appendix B – First Report of Injury Form
  - ii. Appendix C – Injury/Illness/Loss Investigation Report
- g. All forms are to be submitted via FAX or hand-delivery within 24 hours of the personal injury to the following:
  - i. UD Department of Environmental Health & Safety: 302-831-1528
  - ii. UD department director's office
  - iii. UD Student Health Services: 302-831-6407 (only for students)

## **Appendices**

Appendix A - Exposure Report Form

Appendix B - First Report of Injury Form – Student Use Only

Appendix C - Injury/Illness/Loss Investigation Report

Appendix D - Source Patient Information Form

Appendix E - Exposure Referral Guideline

Appendix F – First Report of Injury Form – Employee Use Only

Submit a Copy of This Report to Each of the Following:		
University of Delaware Environmental Health & Safety 132 General Services Bldg.	Nurse Managed Primary Care Center STAR Campus 540 S College Ave, Ste 130	UD Department's Director's Office

Exposed Individual:		
Name:		
Role:	<input type="checkbox"/> Student <input type="checkbox"/> Employee	
Department:		
Phone Numbers:	Cell:	Home:

Exposure:		
Date of exposure:		
Location of exposure:		
Type of exposure: (i.e. needle-stick, mucous membrane, non-intact skin, bite, etc.)	Type of Device: (i.e. type of needle, safety device)	
Body fluid/substance involved:		
Estimated quantity of fluid involved:		
Was fluid actually injected into individual?		
Body part exposed:		

Witness:	
Name:	
Address:	
Phone#:	

Incident Details:	
Explain in detail what occurred:	
Personal protective equipment used:	

First Aid:	
What first aid was performed:	
By whom:	

Hepatitis B:	
Has individual had Hepatitis B vaccine series?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, has series been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date and Signature of Person Recording Report:	
Signature:	Date:
Name Printed:	

**FIRST REPORT OF INJURY** - This form applies to visitors and students who are not employed by the University of Delaware

Student  Visitor

Nature of Business: Educational Institution

**Submit a Copy of This Report to Each of the Following:**

Environmental Health & Safety 132 General Services Bldg. Fax: 302-831-1528	Nurse Managed Primary Care Center 540 South College Ave, Ste 130 Fax: 302-831-3193 (BBP Injuries Only)	UD Department's Director's Office
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**Location and Date/Time of Injury:**

Location Where Accident Occurred: \_\_\_\_\_  
University Property:  Yes  No  
Date of Injury: \_\_\_\_\_  
Day of Week: Su M Tu W Th F Sa  
Time of Injury: \_\_\_\_\_

**Name of Supervisor Reporting Injury:**

First Name, MI: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_  
Job Title: \_\_\_\_\_

**Address of Supervisor Reporting Injury:**

Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

**Name of Injured Person:**

First Name: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_  
Last Name: \_\_\_\_\_

**Address/Phone Number of Injured Person:**

Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Demographic Information of Injured Person:**

Date of Birth: \_\_\_\_\_  
Gender:  Male  Female  
Name of Health Care Insurance Carrier: \_\_\_\_\_

**Injury Details:**

Describe fully how the accident occurred:

Describe the Nature  
and Location of Injury  
(describe fully exact  
location of amputations or  
fractures, right or left):

**Names, Addresses and Phone Numbers of Witnesses:**

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Name, Address and Phone Number of Treating Healthcare Provider:**

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Name, Address and Phone Number of Treating Hospital or Health Care Facility:**

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

**Date and Signature of Person Recording Report:**

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

**Routing:**

Department Director's  
Office  
NMPCC (BBP) or  
Student Health (Non-  
BBP)  
EHS

Rejected: Yes No

Rejected By: \_\_\_\_\_

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

Reason: \_\_\_\_\_

**University of Delaware  
Illness/Injury/Loss Investigation Report (Appendix C)**



<b>Case No:</b>	<b>Date of Injury /Illness /Loss:</b>		<b>Name of Injured:</b>	
<b>Injured Person's Department:</b>			<b>Immediate Supervisor:</b>	
<b>Submit a Copy of This Report to Each of the Following:</b>				
Environmental Health & Safety 132 General Services Bldg. Fax: 302-831-1528	Nurse Managed Primary Care Center 540 S College Ave, Ste 130 Fax: 302-831-3193	Department Director's Office		
<b>Identify the Direct and Contributing Causes of the Illness/Injury</b>				
1. Was this person made aware of hazards and proper safety procedures with the task prior to the accident? (Explain)				
2. What mechanical, physical or environmental conditions contributed to the accident (e.g. broken equipment, poor lighting, noise, material defects, slippery surfaces, lack of warning signs or posted directions, etc.)				
3. What act(s) by the injured and/or others contributed to the accident (e.g. wrong tool or equipment, improper position or placement, work rule violation, failed to follow instructions, etc.)				
4. What personal factors contributed to the accident (e.g. improper attitude, fatigue, inattention, substance abuse, etc.)				
5. Was the accident the result of failing to wear personal protective equipment? (Explain)				
6. What corrective action(s) has been or will be taken to prevent a recurrence of this type of accident? (e.g. repair/modify/replace equipment, counseling, training, policies, procedures, etc.)				
7. Who is responsible for implementing corrective actions?				
<b>Investigated by:</b> Supervisor			<b>Date:</b>	
<b>Reviewed by:</b> Safety Committee Chair			<b>Date:</b>	

**Only submit a copy of this report to:**

Nurse Managed Primary Care Center, 540 South College Ave., Suite 130; Secure Fax: 302-831-3193

**Source Person's Information Form**

**Source Person's HIV Status**

Positive:

Negative:

Verification:  Rapid HIV  Reported  Documented in Chart

Unknown:  Source Not Tested  Source Not Available

**Individual Exposed From Source Person and Reporting Supervisor**

Individual's

Name: \_\_\_\_\_

Supervisor's

Name: \_\_\_\_\_

Date of

Exposure: \_\_\_\_\_

**Location/Facility Where Injury Occurred (e.g. hospital name):**

Location/Facility: \_\_\_\_\_



**Instructions:**

The supervisor is to complete the bottom of the form and supply the completed form to the individual who has the BBP exposure. The individual is to give it to the healthcare facility to which he/she has been referred for treatment.

**Financial Responsibility**

The University of Delaware individual has been referred to your facility for treatment of a Blood Borne Pathogen (BBP) exposure. The individual is financially responsible for this visit. If the individual is not able to provide health insurance information or payment at time of service, the individual should be given a receipt and billed as indicated.

The University of Delaware will assist the student with the health insurance reimbursement process, or navigating mechanisms for payment of services received at your facility, if needed, during their follow-up visit at the UD Nurse Managed Primary Care Center.

**Post-Exposure Treatment**

Individuals presenting at a Medical Aid Unit or Emergency Room should be treated in accordance with the guidelines set forth by the CDC's - National Institute for Occupational Safety and Health (NIOSH).

**Post-Exposure Laboratory Testing Guidelines**

1. ALT/AST, Anti-HIV, Anti-HBs, Anti-HCV
2. If individual to receive Post-Exposure Prophylaxis (PEP) include CBC, CMP, UA, and HCG
3. For questions concerning testing and treatment contact the (24/7) National Clinicians' Post-Exposure Prophylaxis Hotline at 888-448-4911.

**Follow-up Care**

1. Fax copy of all laboratory results to the University of Delaware Nurse Managed Primary Care Center (UD NMPCC) at 302-831-3193.
2. Refer the individual for follow-up care to the UD NMPCC, phone 302-831-3195.
3. Then UD NMPCC will assume responsibility for all subsequent care and treatment of the individual.

**Communication:**

1. Fax the individual's complete medical report to the NMPCC at 302-831-3193.
2. All labs ordered will be copied to Carolyn Haines, FNP-C (Nurse Practitioner) at the UD NMPCC.

**Contact Information:**

1. Nurse Managed Primary Care Center – 302-831-3195

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Supervisor Name

Phone #

**ALL COPIES OF FIRST REPORT MUST BE TYPED OR PRINTED**

Department of Labor  
Office of Workers' Compensation  
P.O. Box 8902  
Wilmington DE 19899-8902  
Telephone 302-761-8200

**STATE OF DELAWARE  
FIRST REPORT OF OCCUPATIONAL  
INJURY OR DISEASE  
(Appendix F)**

\_\_\_\_\_ CASE OR FILE NO.

\_\_\_\_\_ LOCATION/DEPT. CODE

\_\_\_\_\_ EMPLOYER'S UC REPORTING NUMBER

1.. EMPLOYEE: FIRST MIDDLE LAST			2. EMPLOYEE SOCIAL SECURITY NO.			
3. ADDRESS – INCLUDE COUNTY AND ZIP CODE			4. MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	5. EMPLOYEE TELEPHONE NUMBER (INCLUDE AREA CODE)		
6. DATE OF BIRTH	7. AGE	8. WAGE		9. WEEKLY HOURS WORKED		
10. OCCUPATION (REGULAR)		11. DEPARTMENT OF DIVISION REGULARLY EMPLOYED		12. HOW LONG EMPLOYED		
13.. EMPLOYER <b>University of Delaware</b>			14. PERSON MAKING OUT THIS REPORT			
15. ADDRESS – INCLUDE COUNTY AND ZIP CODE <b>413 Academy St. Newark DE 19716</b>			16. EMPLOYER TELEPHONE NUMBER (INCLUDE AREA CODE) <b>302-831-8305</b>			
17. MAILING ADDRESS – IF DIFFERENT THAN ABOVE			18. NATURE OF BUSINESS – TYPE OF MFG., TRADE, CONSTRUCTION, SERVICE, ETC. <b>Educational Institute</b>			
20. DATE OF INJURY AND TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	21. NORMAL STARTING TIME <input type="checkbox"/> AM <input type="checkbox"/> PM.	22. IF EMPLOYEE BACK TO WORK GIVE DATE		23. AT SAME WAGE YES <input type="checkbox"/> NO <input type="checkbox"/>		
24. IF FATAL INJURY, GIVE DATE OF DEATH.	25. DATE EMPLOYER KNEW OF INJURY	26. DATE DISABILITY BEGAN		27. LAST FULL DAY PAID – DATE		
28. DESCRIBE THE INJURY/ILLNESS AND PART OF BODY AFFECTED.						
29. SPECIFY THE DEPARTMENT WHERE INCIDENT OCCURRED AND THE WORK PROCESS INVOLVED.						
30.. LIST THE EQUIPMENT, MATERIALS, AND CHEMICALS EMPLOYEE WAS USING WHEN THE INCIDENT OCCURRED, E.G. ACETYLENE.						
31. DESCRIBE THE EMPLOYEE'S ACTIVITY AT THE TIME OF INJURY OR ILLNESS, I.E.						
32. DESCRIBE HOW THE INJURY/ILLNESS OCCURRED						
33. NAME OF PHYSICIAN			34. PHYSICIAN'S ADDRESS			
35. HOSPITAL (IF APPLICABLE)			36. HOSPITAL ADDRESS			

**WORKER'S COMPENSATION INSURANCE COMPANY AND COMPLETE ADDRESS (PREPRINT OR STAMP INCLUDE IAB CODE)  
37. (THIS SECTION MUST BE COMPLETED IN ORDER TO PROCESS.)**

**PMA Management Corp  
P O Box 25250 Lehigh Valley, PA 18002**

I.A.B. CODE \_\_\_\_\_

**POLICY NO.** \_\_\_\_\_

DISTRIBUTION OF THIS REPORT DOC. NO. #60-07-01-90-10-04

1. ORIGINAL MUST BE SENT IMMEDIATELY TO WORKER'S COMPENSATION INSURANCE CARRIER.
2. COPY TO INDUSTRIAL ACCIDENT BOARD
3. EMPLOYER'S COPY – RETAIN AS RECORD
4. EMPLOYEE'S COPY

\_\_\_\_\_  
SIGNATURE OF PERSON IN 14 ABOVE

\_\_\_\_\_  
OFFICIAL POSITION

Last updated: 5/12/2017