Blood and Body Fluid Exposure Report

EXPOSURE PREVENTION ▶
INFORMATION NETWORK ▶

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Last Name: ____________________________ First Name: ________________________

Exposure ID: *(for office use only)* **B**_________ Facility ID: *(for office use only)* ___________

1) Date of Exposure: ☐☐ ☐☐ ☐☐☐☐ **2) Time of Exposure:** ☐☐ ☐☐

3) Ward/Department where Incident Occurred: _________________________

4) Employing Department: ____________________________

5) What is the Job Category of the Injured Worker: (tick one box only)

☐ 1 Doctor *(Consultant/Registrar)*; specify specialty ______________
☐ 2 Doctor *(SHO/HO)* specify specialty __________
☐ 3 Medical Student
☐ 4 Nurse--**TICK ONE**══▶ ☐ 1 Staff/Enrolled ☐ 2 Sister/Charge ☐ 3 Specialist ☐ 4 Consultant ☐ 5 Midwife ☐ 6 Agency *(temporary staff only)*
☐ 5 Nursing Student
☐ 18 HCA/NA
☐ 7 ODA/ODP
☐ 8 Other Attendant
☐ 9 Phlebotomist/IV Team
☐ 22 Professions Allied to Medicine (*PAMS*)
☐ 10 Clinical Laboratory Worker
☐ 11 Technician *(non-lab)*
☐ 12 Dentist
☐ 13 Dental Hygienist/Dental Nurse
☐ 14 Domestic/Porter
☐ 19 Laundry Worker
☐ 16 Ambulance/Paramedic
☐ 21 Sterile Services
☐ 15 Other, describe: ___________

6) Where Did the Exposure Occur? (tick one box only)

☐ 1 Patient Room
☐ 2 Outside Patient Room *(hallway, nurses station, etc.)*
☐ 10 Treatment/Procedure Room
☐ 3 Emergency Department (*A and E*)
☐ 4 Intensive/Critical Care unit: specify type: _______________
☐ 5 Operating Theatre/Recovery
☐ 6 Outpatient Clinic/Office
☐ 7 Blood Bank
☐ 8 Venepuncture Center
☐ 9 Dialysis Facility *(haemodialysis & peritoneal dialysis)*
☐ 11 Clinical Laboratories
☐ 12 Mortuary/Pathology
☐ 13 Service/Utility *(sluice,laundry,sterile supply,estates,etc)*
☐ 16 Labour and Delivery Room
☐ 17 Home Care
☐ 18 Day Centre
☐ 14 Other, describe: __________________

7) Was the Source Patient Identifiable? (tick one box only)

☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

8) Which Body Fluids were Involved in the Exposure? (tick all that apply)

☐ Blood or Blood Products
☐ Vomit
☐ Sputum
☐ Saliva
☐ CSF
☐ Peritoneal Fluid
☐ Pleural Fluid
☐ Amniotic Fluid
☐ Urine
☐ Other, Describe: _____________________

Was the body fluid visibly contaminated with blood? ☐ Yes ☐ No ☐ Unknown

9) Was the Exposed Part: (tick all that apply)

☐ Intact Skin
☐ Non-Intact Skin
☐ Eyes (*conjunctiva*)
☐ Nose (*mucosa*)
☐ Mouth (*mucosa*)
☐ Other, Describe: _____________________

10) Did the Blood or Body Fluid: (tick all that apply)

☐ Touch Unprotected Skin
☐ Touch Skin Between Gap in Protective Garments
☐ Soak through Barrier Garment or Protective Garment
☐ Soak through Clothing

11) Which Barrier Garments were Worn at the Time of Exposure: (tick all that apply)

☐ Single Pair Latex/Vinyl Gloves
☐ Double pair Latex/Vinyl Gloves
☐ Goggles
☐ Eyeglasses *(not a protective item)*
☐ Eyeglasses with Side shields
☐ Face shield
☐ Surgical Mask
☐ Surgical Gown
☐ Plastic Apron
☐ Lab Coat, Cloth *(not a protective garment)*
☐ Lab Coat, Other
☐ Other, Describe: ______________________

12) Was the Exposure the Result of: (tick one box only)

☐ 1 Direct Patient Contact
☐ 2 Specimen Container Leaked/Spilled
☐ 3 Specimen Container Broke
☐ 4 IV Tubing/Bag/Pump Leaked/Broke
☐ 10 Feeding/Ventilator/other Tube Separated/Leaked/Splashed. Specify Tubing: ______________________________
☐ 5 Other Body Fluid Container Spilled/Leaked
☐ 6 Touched Contaminated Equipment/Surface
☐ 7 Touched Contaminated Drapes/Sheets/Gowns, etc.
☐ 8 Unknown
☐ 9 Other, Describe: ___________________________

If Equipment Failure, Please Specify: **Equipment Type**: ______________________________________

Manufacturer: ____

13) For How Long Was the Blood or Body Fluid In Contact with Your Skin or Mucous Membranes? (tick one)

- ☐ 1 Less than 5 Minutes
- ☐ 2 5-14 Minutes
- ☐ 3 15 Minutes to 1 Hour
- ☐ 4 More than 1 Hour

14) How Much Blood/Body Fluid Came in Contact with Your Skin or Mucous Membranes? (tick one)

- ☐ 1 Small Amount (up to 5 cc, or up to 1 teaspoon)
- ☐ 2 Moderate Amount (up to 50 cc, or up to quarter cup)
- ☐ 3 Large Amount (More than 50 cc)

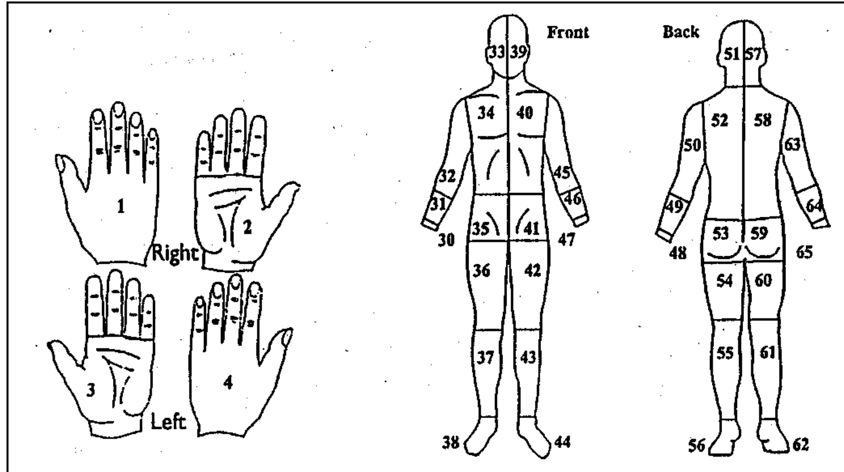
15) Location of the Exposure:

Write the number of the location of up to three exposed body parts in the blanks below.

Largest area of exposure: _____

Middle area of exposure: _____

Smallest area of exposure: _____



16) Describe the Circumstances Leading to this Exposure *(please note if a device malfunction was involved)***:**

____
____
____
____
____

17) For Injured Worker: Do you have an Opinion that any other Engineering Control, Administrative or Work Practice could have Prevented the Injury? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

Describe: ____
____
____
____

Cost:

Lab charges *(Hb, HCV, HIV, other tests)*

_____________ Healthcare Worker
_____________ Source

Treatment Prophylaxis *(HBIG, Hb vaccine, tetanus, other)*

_____________ Healthcare Worker
_____________ Source
_____________ **Service Charges** *(Emergency Dept, Employee Health, other)*
_____________ **Other Costs** *(Worker's Comp, surgery, other)*
_____________ **TOTAL** *(round to nearest dollar)*

Is this Incident RIDDOR reportable? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If Yes, Days Away from Work? _____
Days of Restricted Work Activity? _____

Was medical or surgical intervention required, or did death occur, within 10 days? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown