OR Blood and Body Fluid Exposure Report

INTERNATIONAL SAFETY CENTER

EPINet®

EXPOSURE PREVENTION► INFORMATION NETWORK►

(Non-Sharps Exposures)

Last name: _____ First name: _____

Email address: _____

Injury ID: *(for office use only)* **S**_____ Facility ID*: (for office use only)* _____ Completed by: _____

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1. Date of exposure: ☐☐ ☐☐ ☐☐☐☐ **2. Time of exposure:** ☐☐ ☐☐

3. Surgical service:

☐ 1 General ☐ 6 ENT ☐ 11 Transplants
☐ 2 Cardiovascular ☐ 7 Neurosurgery ☐ 12 Ophthalmology
☐ 3 OB/C-section ☐ 8 Plastic ☐ 13 Thoracic
☐ 4 Gynecology ☐ 9 Urology
☐ 5 Orthopedic ☐ 10 Oral/Dental ☐ 99 Other service, describe: _____

3a. Surgical procedure being performed: _____

3b. Was it an endoscopic/laparascopic procedure?

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

4. What is the job category of the exposed worker? (check one box only)

☐ 1 Surgeon *(attending)* specify specialty _____
☐ 2 Surgeon *(resident)* specify specialty _____
☐ 16 Surgeon *(fellow)* specify specialty _____
☐ 3 Ob/Gyn *(attending)*
☐ 4 Ob/Gyn *(resident)*
☐ 5 Anesthesiologist *(attending)*
☐ 6 Anesthesiologist *(resident)*
☐ 7 Nurse anesthetist
☐ 8 Med student, mark rotation→ ☐ surg ☐ anesth ☐ ob-gyn
☐ 9 Circulating nurse at time of incident → ☐ 1 RN ☐ 2 ORT ☐ 3 UAP
☐ 10 Scrub nurse at time of incident → ☐ 1 RN ☐ 2 ORT ☐ 3 UAP
☐ 11 Other Nurse
☐ 12 Nursing student
☐ 13 OR assistant/attendant
☐ 14 Housekeeper
☐ 15 Physician assistant
☐ 99 Other, describe: _____

4a. If the exposure was sustained by an anesthesia team member, what anesthesia task was being performed at the time of exposure?
describe: _____

5. Where did the exposure occur? (check one box only)

☐ 1 Pre-operative area
☐ 2 At the mayo *(instrument)* stand
☐ 3 At the back table
☐ 4 In the operative site/wound
☐ 5 On the surgical field *(near operative site)*
☐ 6 On anesthesia machine
☐ 7 On anesthesia cart
☐ 8 At patient's puncture site *(intro of vascular cath/injection,etc)*
☐ 9 At site of injection into IV equipment
☐ 10 On OR floor
☐ 11 In the OR utility room
☐ 12 Post anesthesia care unit *(PACU/recovery room*)
☐ 13 In trash
☐ 14 Accessing airway
☐ 99 Other, describe: _____

6. Was the source patient's identity known? (check one box only)

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

7. Which of the patient's body fluids were involved in the exposure? (check all that apply)

☐ Blood or blood products
☐ Vomit/gastric contents
☐ Sputum
☐ Saliva
☐ CSF
☐ Peritoneal fluid
☐ Pleural fluid
☐ Amniotic fluid
☐ Urine
☐ Other, describe: _____

7a, Was the body fluid visibly contaminated with blood? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

8 Was the worker's exposed part? (check all that apply)

☐ Intact skin
☐ Non-intact skin
☐ Eyes (*conjunctiva*)
☐ Nose (*mucosa*)
☐ Mouth (*mucosa*)
☐ Other, describe: _____

9. Did the blood or body fluid? (check all that apply)

☐ Touch unprotected skin
☐ Touch skin between gap in protective garments
☐ Touch skin through tear in glove
☐ Soak through barrier garment or protective garment
☐ Soak through clothing/uniform

9a. Did the exposure result in the need to remove a garment and obtain a replacement? ☐ 1 Yes ☐ 2 No

10. Which barrier garments and/or personal protective equipment were worn at the time of exposure? (check all that apply)

- ☐ Single pair latex/vinyl/nitrile gloves
- ☐ Double pair latex/vinyl/nitrile gloves
- ☐ Eyeglasses *(not a protective item)*
- ☐ Eyeglasses with side shields
- ☐ Protective eyewear/Goggles
- ☐ Face shield
- ☐ Surgical mask
- ☐ Surgical mask with attached eye shield
- ☐ Surgical,gown, disposable
- ☐ Surgical,gown, reusable
- ☐ Plastic apron
- ☐ Scrubs/Uniform *(not protective garments)*
- ☐ Other specialized garment worn as protection
- ☐ Other, describe: _____

10a. If surgical gown, was it?

- ☐ 1 Fabric, standard single layer
- ☐ 2 Fabric, reinforced
- ☐ 3 Plastic, reinforced/coated
- ☐ 4 Composite construction *(multi-layer laminate)*

11. Was the exposure the result of? (check one box only)

- ☐ 1 Direct patient contact
- ☐ 2 Touched contaminated equipment/surface
- ☐ 3 Touched contaminated drapes/sheets/gowns, etc.
- ☐ 4 Specimen container leaked/spilled/broke
- ☐ 5 Tubing *(blood,suction,drain,etc.)* leaked/disconnected/broke
- ☐ 6 Bag/pump leaked/spilled/broke
- ☐ 7 Trach/NG tubing broke/sprayed
- ☐ 8 Suction canister spilled/leaked/broke
- ☐ 9 Other irrigation/fluid container spilled/leaked/broke
- ☐ 10 Other equipment/operator failure
- ☐ 11 Unknown
- ☐ 99 Other, describe: _____

11a. Did the incident result in an exposure to a hazardous drug (e.g. chemotherapy, antineoplastic)? ☐ 1. Yes ☐ 2. No ☐ 3. Unknown

12 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? (check one box only)

- ☐ 1 Less than 5 minutes
- ☐ 2 5-14 minutes
- ☐ 3 15 minutes to 1 hour
- ☐ 4 More than 1 hour
- ☐ 5 Unknown

14. How much blood/body fluid came in contact with your skin or mucous membranes? (check one box only)

- ☐ 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)

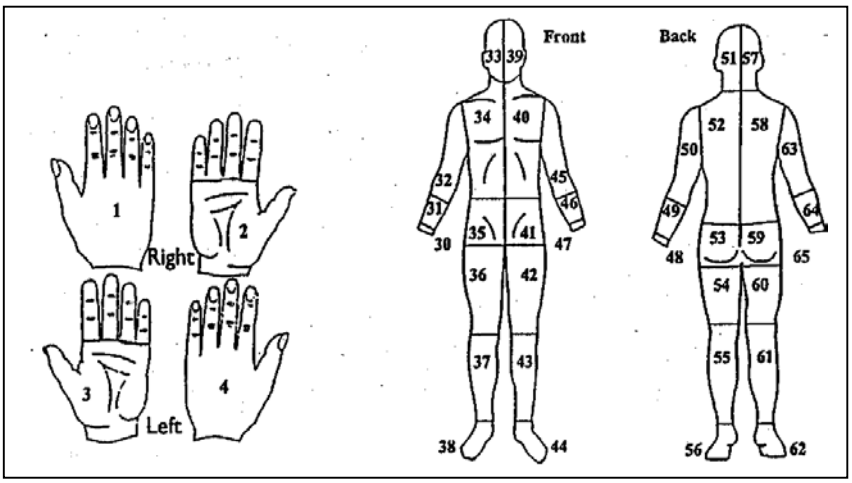
15. Location of the exposure:

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

Largest area of exposure: _____

Middle area of exposure: _____

Smallest area of exposure: _____



16 Employment status of injured worker:

- ☐ 1 Employee
- ☐ 2 Temp/Contract
- ☐ 3 Student
- ☐ 4 Volunteer
- ☐ 5 Non-employee practitioner
- ☐ 6 Other

17. Describe the circumstances leading to this exposure: *(please note if a device malfunction was involved)***:**

_____
_____
_____
_____
_____

Is this incident OSHA recordable? *(for office use only)*

☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If yes:
Days away from work: _____
Days of restricted work activity: _____

Was prophylaxis provided? *(for office use only)* ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

Does this incident meet the FDA medical device reporting criteria? (Yes if a device defect caused serious injury necessitating medical or surgical intervention, or death occurred within 10 works days of incident.) ? *(for office use only)*

☐ 1 Yes *(If yes, follow FDA reporting protocol.)* ☐ 2 No ☐ 3 Unknown

Cost: *(optional, for office use only)*

	Lab charges (HBV, HCV, HIV, other)
_____	Healthcare worker
_____	Source
	Treatment/Prophylaxis (HBIG, HBV vaccine, tetanus, other)
_____	Healthcare worker
_____	Source
_____	Service charges (Emergency Dept, Employee Health, other)
_____	Other costs (Worker's Comp, surgery, other)
_____	Paid Time Off
_____	TOTAL