Welcome to Virtua Health!

We are very glad that you will be joining us for part of your graduate medical education experience. In order to comply with OSHA Standards, you are required to review our Bloodborne Pathogens and Needlestick Prevention Policy in the pages that follow. This brief orientation, will only take a few minutes of your time and it will help to acquaint you with Virtua Health, our facilities, and our policies.

The OSHA Bloodborne Pathogens Standard seeks to protect workers in occupations that are at risk of exposure to Hepatitis B, Hepatitis C, and HIV/AIDS. This being the case, we want to tool our employees with information and guidelines for how to avoid exposures and reduce risks of infection.

In the event that you are stuck by a needle/other sharp object, or were to get blood or other potentially infectious materials in your eyes, nose, mouth, or on broken skin immediately flood - the exposed area should be flooded with water and the wound should be cleaned with soap and water or a skin disinfectant if that is available. The procedures for seeking immediate medical attention and reporting the incident are contained in the following pages of reading material.

Please remember to submit your name at the end,
to acknowledge that you have successfully read and understand this material.

Thank you for your Time & Cooperation!

STAR Initiative

How to deliver
an outstanding patient experience

Why have we selected STAR?

- To provide a framework and create a culture that drives the way we do our work
- To offer the best quality care and service to our patients
- To transform Virtua into a high performing organization

- To ensure our long-term success as the premier provider of health care in southern New Jersey
- To achieve our full potential and be recognized for our excellence

STAR

What is STAR?

It is creating an outstanding experience for our patients through:

- ★ **Best People**: hiring & keeping the best person for the job
- ★ **Caring Culture**: showing understanding, empathy, compassion
- ★ **Clinical Quality**: doing routine things in a superior way; continually seeking a better way
- ★ **Excellent Service**: consistent, reliable, responsive care
- ★ **Resource Stewardship**: making the most of our resources

STAR

What makes an outstanding patient experience?

- ★ Best People: ***"I was treated by highly competent professionals."***
- ★ Caring Culture: ***"I never expected such personal care & attention…They took my problems seriously."***
- ★ Excellent Service: ***"I wouldn't go anywhere else…They did everything right the first time."***

STAR

What makes an outstanding patient experience?

- ★ Highest Clinical Quality: ***"I had a great result…I came to the right place."***
- ★ Resource Stewardship: ***"There was no waste…I was out of the hospital as soon as I was ready."***

Infection Control and Prevention – Follow standard precautions for all patients.

Protect Yourself

- Wear gown to protect skin and clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood and body fluids. Remove soiled gowns as soon as possible and wash hands.
- Wear masks and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to generate splashes of blood and body fluids (such as, suctioning and emptying catheter bags)
- Use mouthpieces, resuscitation gags, other ventilation devises as an alternative to mouth-to-mouth resuscitation.

Wash hands

- Before and after patient care, regardless of whether gloves are worn or not.
- Immediately after gloves are removed and between patient contacts.

Wear gloves when touching blood, body fluids, secretions, and contaminated items. Put on clean gloves, before touching mucous membranes and non-intact skin.

Take care to prevent injuries when handling needles, scalpels, and other sharp instruments or devices.

Utilize the safety needles/IV catheters as designed by the manufacturers. ALWAYS activate the safety device immediately after use.

Dispose all sharps into puncture resistant containers that are NOT filled beyond indicator.

Place used linen into appropriate receptacles that MUST be kept covered.

Hand Hygiene/Handwashing

The #1 defense against the spread of infection.

- Use soap and running water
- Rub your hands vigorously for 15 seconds
- Dry hands and shut off faucet with a paper towel.

Waterless soap dispensers are located in every patient's room and other designated areas. When using, apply friction for 15 seconds. After 8-10 uses, you MUST wash with soap and running water.

*Nails cannot exceed ¼ inch beyond the end of fingertip. Artificial nails, acrylic nails, wraps and nail jewelry are not permitted by staff that provide direct patient care.

Blood Borne Pathogens
How do blood borne pathogen exposures occur in the workplace?

- Through exposure to blood or body fluids, through contaminated needles and other sharp devices.
- Through splashing or spraying to eyes, nose, or mouth.
- Through direct contact with open skin.

What should I do if I am exposed to body fluids or get a needle stick?

- Wash the affected area immediately-obtain medical treatment immediately. (CDC recommends evaluation and intervention within 2 hours of exposure.)
- Notify your manager/supervisor.
- Fill out an Employee Incident Report. List the source patient's name, medical record number, and room number.
- Go to the Emergency Department when Virtua at Work is not open.
- Virtua at Work has hours at:
    - Voorhees, Memorial and Marlton; M-F, 8:00am – 4:00pm, 856-325-5310.
    - Camden and Berlin obtain treatment in Emergency Dept.

Standard Precautions
Prevent exposure to HIV, Hepatitis B & C, by using standard precautions.

Standard Precautions makes us aware that organisms can be transmitted through all body fluids, secretions and excretions. Standard Precautions apply to all patients, regardless of their diagnosis. Personal protective equipment, such as masks, gowns, gloves, and face-shields, are available for all employees to decrease transmission.

The combination of Standard Precautions and Isolation Categories are needed to reduce the risk of transmission of organisms from both recognized and unrecognized sources in hospitals. All body fluids may contain infectious organisms.

ISOLATION – for all types of isolation visitors must check with the nurse before entering.

A- Airborne Precautions

- Private room.
- Must wear a surgical mask when entering the room.
- Negative air pressure room or HEPA filter.
- Doors are to remain closed at all times.
- Transport: Place mask on patient when possible. Notify treatment/diagnostic department of precaution type.
- Wash hands before and after patient contact.

C – Contact Precautions

- Private room preferred but can be placed in a semi-private room.
- Gloves and gowns must be worn for contact with patient or environmental surfaces.
- Equipment: single use/disposable when available. Multi-use MUST be cleaned before use on another patient.
- Wash hands with antimicrobial soap after leaving the room.

All patients admitted with presumed c-diff and all patients with laboratory positive c-diff toxin analysis:

- Will be placed in contact isolation
- Private Room preferred
- Cohort only if both patients have positive test results
- Utilization of personal protective equipment and hand-washing **must** be adhered to.
- Daily cleaning, using a 1:10 bleach solution, of all c-diff positive rooms is required. EVS will maintain log for documentation of room cleaning.
- Daily cleaning of patient care equipment, using disinfectant wipes, by assigned Nurse/MST. Documentation logs will be posted outside the patient room on a clipboard.
- Cleaning of all discharge beds is performed, using a 1:10 bleach solution, to prevent spread of spores..

Note: Always wear gloves when cleaning rooms and equipment

D – Droplet Precautions

- Private room Call infection control if cohorting of patient is needed.
- Surgical masks MUST be worn by ALL persons entering the room.
- Transport: Place a mask on patient with possible.
- Wash hands before and after patient contact.

AFB – Tuberculosis Precautions

- Private Room
- Respirators are to be worn by ALL persons entering the room.
- Negative Pressure Room or HEPA Filter.
- Doors are to remain closed at ALL times.
- Notify treatment diagnostic department or precaution type.
- Wash hands before and after patient contact.

Tuberculosis (TB)

How is TB spread? Tiny droplets spread TB. The droplets travel through the air from one person to another. The signs and symptoms of TB:

- Cough
- Weakness
- Weight loss
- Fever
- Loss of appetite
- Night sweats
- Coughing up blood

How can I protect myself?

- Get an annual PPD skin test to screen for TB. (Twice a year if you work in a high risk area.)
- Learn more about TB if your PPD skin test is positive.

How can I protect myself if a patient is suspected of having active tuberculosis?

- Look for AFB isolation signs on doors of negative pressure rooms.
- Keep the door closed.
- Fit testing for the TB respirator is required annually for designated employees.
- Wear a TB respirator if you are entering this room.

If you have a rash or think you or a family member may have a communicable disease, check with your supervisor before coming to work.

Quarantine Precautions:

Notify Infection Control immediately of Admission

Only authorized persons may enter room

- Negative Pressure Room (Notify Plant Operations)
- Doors are to remain closed at ALL times (Patient registration by telephone)
- Gowns, Gloves, Goggles or Face Shield
- Head Cover Required.
- N-95 Respirators are to be worn by ALL persons entering the room.
- Transport: Patient may not leave the room without the approval of ID physician.
- **Maintain Standard Precautions at all times.**

Note: Persons with active or suspected SARS, Smallpox, Viral Hemorrhagic Fever notify Infection Control before discontinuing precautions.

Example of employee communicable diseases:

- Acute diarrheal illness lasting greater than 48 hours. [*possible C-Dificile or salmonella*]
- Open infected skin lesions that are oozing or weeping on your hands or forearms.
- Diagnosed Strep Throat: You must be on antibiotics 24 hours before returning to work.
- Conjunctivitis (pink eye) drainage must stop before returning to work
- MRSA, VRE or other resistant organism do not prevent an employee from working but they must be cleared by Virtua at Work before returning to work

If you have a rash or think you or a family member may have a communicable disease, check with your supervisor before coming to work.

Other Infection Control Issues:

- **DO NOT** recap or bend needles.
- **DO NOT** apply lip balm or cosmetics or handle contact lenses in areas where a potential exposure may occur.
- Treat all linen as contaminated.
- **DO NOT** place dirty linen on the floor, place into a blue plastic bag.

Disposing of Trash

- **RED BAG TRASH:** ANY item that is heavily soiled with blood or purulent matter and ALL blood bags and bloody tubing
- **HAZARDOUS WASTE CONTAINER**: Chest tube collection sets, filled suction containers which are fluid filled and cannot be placed in the microwave.
- **CLEAR BAG TRASH:** Any other items, except batteries or metal, which are collected separately.

INFECTION PREVENTION INITIATIVES

SIP (Surgical Infection Prevention). Applies to the following surgical procedures: Hysterectomy, Large Colon Resection, Total hip and knee replacements and Vascular procedures.

- Appropriate antibiotics are given pre-operatively
- Antibiotics are given within 60 minutes of the surgical incision
- Post op antibiotics will be discontinued within 24 hours of surgery end time

Other infection prevention / Quality improvement related initiatives that you will be hearing more about this year are:

- SCIP (Surgical care improvement project) – SIP with other quality measures for surgical improvement
- 100,000 Lives campaign – to reduce lives through quality initiatives
- NJHA ICU Collaborative – to reduce ventilator related pneumonia and catheter related bloodstream infections in ICU

REMEMBER: INFECTION PREVENTION IS PATIENT SAFETY

Surgical Services/Labor & Delivery

Blood and Body Fluid Exposure
&
Needlestick/Sharp Injury Events

-Notify Nurse Manager/Nursing Supervisor

-Complete incident report, have supervisor sign, take to Occupational Health/Virtua At Work (VAW) see hours below OR Emergency Department (for after hours). (Put phone/pager number on top of form, where you can be reached, in case of further questions).

-Source individual risk assessment form and consent for HIV testing will be obtained and sent to Occupational Health (VAW) OR Emergency Department

-Source individual labs will be ordered (see "Emp Source Pt")

-Complete one of the attached EPINet forms as appropriate:

Blood and Body Fluid Exposure Report /OR
Needlestick & Sharp Object Injury Report/OR

Forward to:

Employee Health & Safety
Camden Division, 2nd Floor
Fax Number: 856-246-3410 (internal fax number 63410)

Phone and Fax Numbers:
Occupational Health/Virtua at Work (VAW)

Voorhees	**Mt. Holly**
Monday-Friday 8:00 am-4:30 pm	**Monday-Friday 8:00 am-5:30 pm**
Phone 856-325-5310 (55310)	**Phone 609-914-8610 (48610)**
Fax 856-325-5312 (55312)	**Fax 856-914-8626 (48626)**

Call Employee Health & Safety if you have questions 856-246-3411/3422

Needlestick & Sharp Object Injury Report/OR

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FOR MICROSOFT® ACCESS
EXPOSURE PREVENTION INFORMATION NETWORK

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Last Name: _____ First Name: _____

Injury ID: *(for office use only)* S____ Facility ID: *(for office use only)* ____ **Completed By:** ____

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

3) Surgical service: _____

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

4) Surgical procedure being performed: _____

4a) Was it an endoscopic/laparascopic procedure?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

5) What is the job category of the injured worker: (check one box only)

- ☐ 1 Surgeon *(attending)* specify specialty _____
- ☐ 2 Surgeon *(resident)* 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 Attendant
- ☐ 14 Housekeeper
- ☐ 99 Other, describe: _____

6) Where did the injury 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 *(recovery room)*
- ☐ 99 Other, describe: _____

7) Was the source patient's identity known? (check one box only)
☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

8) For what purpose was the sharp item originally used? (check one box only)

- ☐ 1 Unknown/not applicable
- ☐ 2 Injection, intra-muscular/subcutaneous, or other injection through the skin *(syringe)*
- ☐ 3 To start IV or set up heparin lock *(IV catheter or winged set-type needle)*
- ☐ 4 To connect IV line *(intermittent IV/piggyback/IV infusion/other IV line connection)*
- ☐ 5 Injection into (or aspiration from) IV injection site or IV port
- ☐ 6 To place an arterial line/catheter
- ☐ 7 To place a central line/catheter
- ☐ 8 To place other non-vascular line/catheter
- ☐ 9 To draw venous blood sample
- ☐ 10 To draw arterial blood sample **if used to draw blood was it?** ☐ 1 Direct stick? ☐ 2 Draw from a Line?
- ☐ 11 To obtain a body fluid or tissue sample*(urine/CSF/amniotic fluid/other fluid, biopsy)*
- ☐ 12 Cutting *(surgery)*
- ☐ 13 Suturing muscle/fascia
- ☐ 14 Suturing skin
- ☐ 21 Suturing tissue not listed above, describe: _____
- ☐ 15 Electrocautery
- ☐ 16 Drilling/sawing
- ☐ 17 Retracting tissue/bone
- ☐ 18 Wiring/fixing
- ☐ 19 Using as a tool, not on patient
- ☐ 20 To contain a specimen or pharmaceutical *(glass items)*
- ☐ 99 Other; describe _____

9) Did the injury occur? (check one box only)

- ☐ 1 Before use of item *(item broke/slipped, assembling device, etc.)*
- ☐ 2 During use of item *(item slipped, patient/colleague jarred item, etc)*
- ☐ 3 While manually retracting tissue in operative site
- ☐ 4 While retracting tissue using retractor or other instrument
- ☐ 5 Passing instruments, hand-to-hand
- ☐ 6 Passing instruments, hand-free transfer
- ☐ 7 Between incremental injections
- ☐ 8 In between uses of devices
- ☐ 9 Disassembling device or equipment
- ☐ 10 Sorting, disinfecting, and/or sterilizing instruments
- ☐ 11 While recapping a used needle
- ☐ 12 Withdrawing needle from rubber or resistant material
- ☐ 13 Other after use-before disposal *(in transit to trash, cleaning, left on bed, table, floor, or other inappropriate place, etc.)*
- ☐ 14 From item left on or near disposal container
- ☐ 15 While putting item into disposal container
- ☐ 16 After disposal, stuck by item protruding from opening of disposal container
- ☐ 17 Item pierced side of disposal container
- ☐ 18 After disposal, item protruded from **trash bag** or **inappropriate** waste container
- ☐ 99 Other, describe: _____

10) If the injury was sustained by an anesthesia team member, what anesthesia task was being performed at the time of injury?
Describe: _____

11) At the time of the injury, was the sharp instrument/item? (check one box only)
- ☐ 1 Held by another person
- ☐ 2 Held by injured person
- ☐ 3 Not held by anyone

12) The sharp item was: (check one box only)
- ☐ 1 Contaminated (known exposure to patient or contaminated equipment)
- ☐ 2 Uncontaminated (no known exposure to patient or contaminated equipment)
- ☐ 3 Unknown

was there blood on the device? ☐ 1 Yes ☐ 2 No

13) What type of device caused the injury? (check one box only)
- ☐ Needle-*Hollow Bore*
- ☐ Surgical
- ☐ Glass

Which device caused the injury? (check one box from one of the three sections only)

Needles *(for suture needles see "**surgical instruments**")*
- ☐ 1 Disposable Syringe *(includes standard, insulin, tuberculin, etc)*
- ☐ 2 Pre-filled cartridge syringe *(includes Tubex™ *, Carpuject ™*-type syringes)*
- ☐ 3 Blood gas syringe *(ABG)*
- ☐ 4 Syringe, other type
- ☐ 5 Needle on IV line *(includes piggybacks & IV line connectors)*
- ☐ 6 Winged steel needle *(includes winged-set type devices)*
- ☐ 7 IV catheter stylet
- ☐ 8 Vacuum tube blood collection holder/needle *(includes Vacutainer™ *–type device)*
- ☐ 9 Spinal or epidural needle
- ☐ 10 Unattached hypodermic needle
- ☐ 11 Arterial catheter introducer needle
- ☐ 12 Central line catheter introducer needle
- ☐ 13 Drum catheter needle
- ☐ 14 Other vascular catheter needle *(cardiac etc.)*
- ☐ 15 Other non-vascular catheter needle *(ophthalmology, etc.)*
- ☐ 16 Huber-type needle
- ☐ 28 Needle, not sure what kind
- ☐ 29 Other needle, please describe: _____

Surgical instrument or other sharp items *(for glass items see "**glass**")*
- ☐ 30 Lancet (finger or heel sticks)
- ☐ 31 Suture needle
- ☐ 32 Scalpel blade, reusable handle
- ☐ 45 Scalpel blade, disposable scalpel
- ☐ 33 Razor
- ☐ 34 Pipette *(plastic)*
- ☐ 35 Scissors
- ☐ 360 Electro-cautery device, needle tip
- ☐ 361 Electro-cautery device, blade tip
- ☐ 362 Electro-cautery device, loop tip
- ☐ 37 Bone cutter
- ☐ 38 Bone chip
- ☐ 39 Perforating towel clip
- ☐ 40 Microtome blade
- ☐ 41 Trocar
- ☐ 42 Vacuum tube *(plastic)*
- ☐ 43 Specimen/Test tube *(plastic)*
- ☐ 44 Fingernails/Teeth
- ☐ 46 Retractors, skin/bone hooks
- ☐ 47 Staples/Steel sutures
- ☐ 48 Wire *(suture/fixation/guide wire)*
- ☐ 49 Pin *(fixation, guide pin)*
- ☐ 50 Drill bit/bur
- ☐ 51 Pickups/Forceps/Hemostats/Clamps
- ☐ 58 Sharp item, not sure what kind
- ☐ 59 Other sharp item: Describe: _____

Glass
- ☐ 60 Medication ampule
- ☐ 61 Medication vial *(small volume with rubber stopper)*
- ☐ 62 Medication/IV bottle *(large volume)*
- ☐ 63 Pipette *(glass)*
- ☐ 64 Vacuum tube *(glass)*
- ☐ 65 Specimen/Test tube *(glass)*
- ☐ 66 Capillary tube
- ☐ 67 Glass slide
- ☐ 78 Glass item, not sure what kind
- ☐ 79 Other glass item: Describe: _____

13a) Brand/Manufacturer of product: (e.g. ABC Medical Company) _____

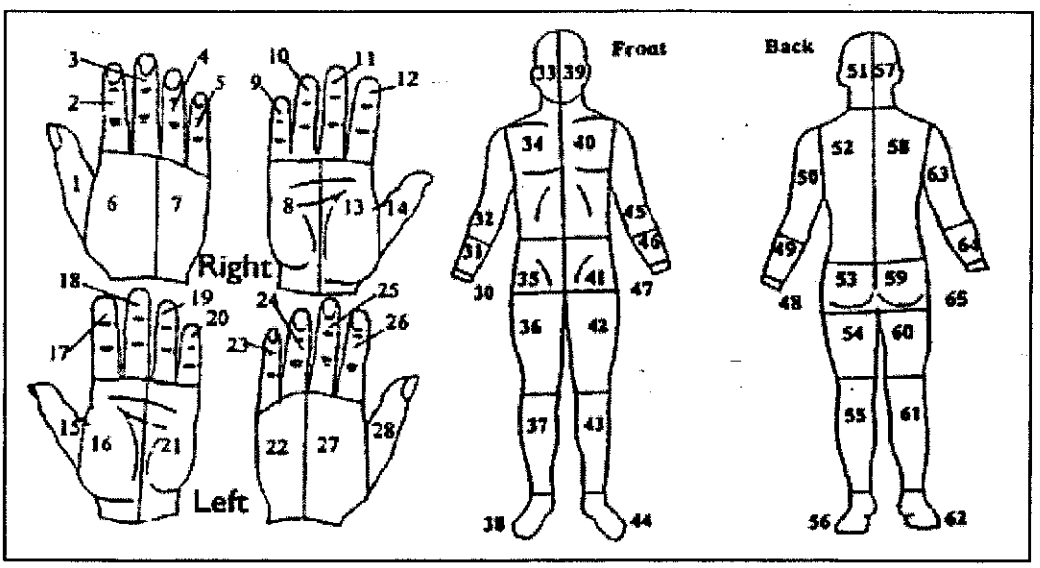
13b) Model:
☐ 98 Known: Please specify: _____ ☐ 99 Unknown

14) If the item causing the injury was a needle or sharp medical device, was it a" safety design" with a shielded, recessed, retractable, or blunted needle or blade?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown

14a) Was the protective mechanism activated?
☐ 1 Yes, fully ☐ 2 Yes, partially ☐ 3 No ☐ 4 Unknown

14b) Did incident happen?
- ☐ 1 Before activation
- ☐ 2 During activation
- ☐ 3 After activation
- ☐ 4 Unknown

Mark the location of the injury:



15) Was the injury?

- ☐ 1 Superficial *(little or no bleeding)*
- ☐ 2 Moderate *(skin punctured, some bleeding)*
- ☐ 3 Severe *(deep stick/cut, or profuse bleeding)*

16) If injury was to the hand, did the sharp item penetrate?

- ☐ 1 Single pair of gloves
- ☐ 2 Double pair of gloves
- ☐ 3 No gloves

17) Dominant hand of the injured worker:

- ☐ 1 Right-handed
- ☐ 2 Left-handed

18) Describe the circumstances leading to this injury *(please note if a device malfunction was involved)*:

_____
_____
_____
_____
_____
_____

Cost:

	Lab charges (Hb, HCV, HIV, other)
_____	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 OSHA reportable?

☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If yes, days away from work? _____

Days of restricted work activity? _____

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.)

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

* Tubex™ is a trademark of Wyeth Ayers; Carpuject™ is a trademark of Sanofi Winthrop; VACUTAINER™ is a trademark of Becton Dickinson. Identification of these products does not imply endorsement of these specific brands.

Blood and Body Fluid Exposure Report/OR

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EXPOSURE PREVENTION INFORMATION NETWORK

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V1.2/US OR, L&D 1/2002

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) Surgical service: _____

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

4) Surgical procedure being performed: _____

4a) Was it an endoscopic/laparascopic procedure?
☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

5) What is the job category of the injured worker: (check one box only)

- ☐ 1 Surgeon *(attending)* specify specialty _____
- ☐ 2 Surgeon *(resident)* 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 Attendant
- ☐ 14 Housekeeper
- ☐ 99 Other, describe: _____

6) If the injury was sustained by an anesthesia team member, what anesthesia task was being performed at the time of injury?
Describe: _____

7) 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 *(recovery room)*
- ☐ 99 Other, describe: _____

8) Was the source patient's identity known? (check one box only)
☐ 1 Yes ☐ 2 No ☐ 3 Unknown ☐ 4 Not Applicable

9) Which 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 fuid
- ☐ Urine
- ☐ Other, describe: _____

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

10) Was the exposed part: (check all that apply)

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

11) 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/undergarments

12) Which barrier garments were worn at the time of exposure: (check 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 mask with attached eyeshield
- ☐ Surgical gown, disposable
- ☐ Surgical gown, reusable
- ☐ Other, describe: _____

12a) If surgical gown, was it?

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

13) 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: _____

If equipment failure, please specify: Equipment type: _____

Manufacturer: _____

14) 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

15) How much blood/body fluid came in contact with your skin or mucous membranes?(check 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)

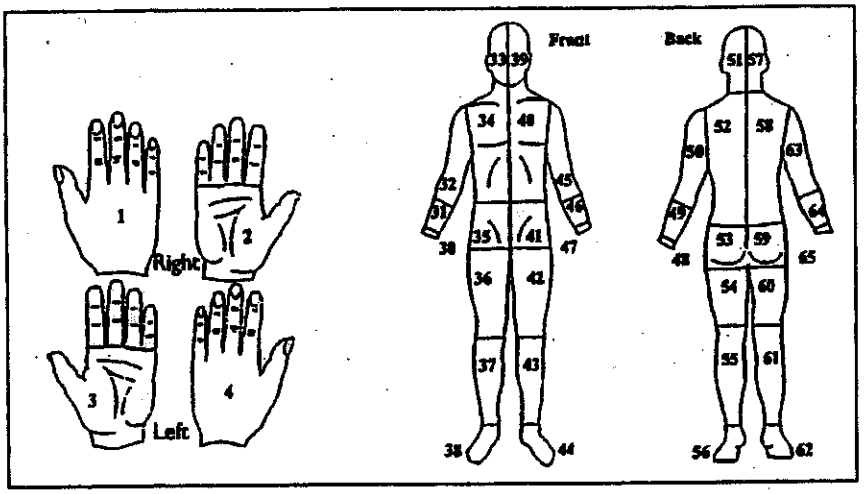
16) Location of the exposure:

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: _____



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

_____

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 OSHA reportable? ☐ 1 Yes ☐ 2 No ☐ 3 Unknown

If yes, days away from work? _____

Days of restricted work activity? _____

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.)

☐ 1 Yes (If yes, follow FDA reporting protocol) ☐ 2 No

HEALTHCENTER INCIDENT REPORT

Confidential Memo to Attorney *(Not part of the Medical Record)*

Nature of the Incident: *(check only ONE code in ONE category)*

▶ PATIENT FALLS ONLY

Was Fall Observed? ☐ Yes ☐ No If yes, by whom? _____

Was Fall Assisted? ☐ Yes ☐ No If yes, by whom? _____

Was a risk assessment performed? ☐ Yes ☐ No Was Patient on Fall Protocol? ☐ Yes ☐ No

Patient at risk per the assessment ? ☐ Yes ☐ No Was Patient Restrained? ☐ Yes ☐ No

Was there a fracture? ☐ Yes ☐ No ☐ Unknown at this time

Fall Score at time of incident _____

Fall Type

☐ Dropped ☐ Fainted ☐ Off commode ☐ OOB
☐ While ambulat. ☐ Found on floor ☐ OOChair ☐ Other _____

Activity Level

☐ Ambulation w/ assist. ☐ Bedrest ☐ Unknown
☐ Ambulation w/o assistance ☐ No restrictions ☐ Other _____

Level of Injury

☐ None ☐ Death ☐ Not known at this time
☐ Minor: No long term injury. Needed minor intervention: monitoring, ointment to abrasion, etc
☐ Moderate: No long term injury. Moderate intervention: sutures, medication, increased LOS, etc
☐ Major: Significant intervention required – repair of fracture repair, hemorrhage, rehabilitation, etc

▶ MEDICATION EVENTS

Select One: ☐ Medication Error or ☐ Possible Adverse Drug Reaction.
If adverse drug reaction, contact Pharmacy immediately & give details in Narrative Description sectio

Medication Name (if drug not listed below write name in "Other / Not Listed")

☐ Heparin ☐ Dilaudid ☐ Lovenox ☐ Cardizem
☐ Insulin ☐ Ancef ☐ Dopamine ☐ Magnesium Sulfate
☐ Potassium ☐ Gentamicin ☐ Epinephrine ☐ Chemotherapy Drug
☐ Tequin ☐ Vancomycin ☐ TPN ☐ Contrast media
☐ Morphine ☐ Other / Not listed _____

Dosage _____ **Frequency** _____

Route: ☐ IM ☐ IV Push ☐ IV infusion ☐ OPTH ☐ PO ☐ PR ☐ TOP
☐ SL ☐ SQ ☐ Epid / Intrathecal ☐ N/A ☐ Other _____

Medication Error - Error Type (Select the one that best applies)

☐ Omission ☐ Wrong rate ☐ Wrong patient
☐ Unauthorized/Wrong drug ☐ Wrong route ☐ Duplication
☐ Wrong dose ☐ Wrong preparation ☐ Other / No patient involved
☐ Wrong time ☐ Wrong dosage form

Medication Error – Initial Breakdown Point (Select the one that best applies)

☐ Not transcribed ☐ Physician order problem ☐ Medication admin problem
☐ Transcribed wrong ☐ Wrong medication dispensed ☐ PYXIS
☐ Charting error ☐ Medication unavailable ☐ IV Pump/Device related error
☐ Communications problem ☐ Labeling problem ☐ Narcotic count discrepancy
☐ Other _____

▶ TREATMENT / PROCEDURE RELATED

☐ Blood transfusion issue ☐ Mislabeled specimen ☐ Reporting of test results
☐ Cancellation ☐ Missing specimen ☐ Respiratory / Cardiac code
☐ Consent problem ☐ Not documented ☐ Technique
☐ Delay _____ ☐ Omitted ☐ Transcription error
☐ Deviation from procedure ☐ Pt./ Site Identification ☐ Transfer / moving of patient
☐ Documentation ☐ Positioning ☐ Unplanned transfer
☐ IV / Injection site ☐ Prep ☐ Other
☐ IV administration issue ☐ Repeat procedure

▶ ANESTHESIA RELATED

☐ Incorrect anesthetic agent* ☐ Chipped teeth ☐ Technique
*Identify agent _____ ☐ Extubation ☐ Other _____
☐ Aspiration ☐ Intubation

▶ OBSTETRICS RELATED

☐ Apgar Score < 5 @ 5 min. ☐ Maternal injury ☐ Prolonged labor
☐ Contamination ☐ Neonatal injury ☐ Unattended delivery
☐ Fetal / Maternal death ☐ Precipitous delivery ☐ Other _____

▶ PATIENT INDUCED

☐ AMA ☐ Elopement ☐ Patient refused treatment ☐ Self induced injury
☐ Attempted suicide ☐ Fight among patients ☐ Other _____

▶ EQUIPMENT / PRODUCT ISSUES

Product/Equipment Name _____ Lot Number _____
Manufacturer Name _____ Serial Number _____
Catalog Number _____ Other Identifying Info _____
Device removed from service? ☐ Yes ☐ No

▶ SECURITY RELATED

☐ Bomb threat ☐ Property missing/damaged:
☐ Disaster internal/external ☐ Infant abduction ☐ Dentures ☐ Jewelry
☐ Fire or fire alarm ☐ Physical violence ☐ Eye glasses ☐ Cash
☐ Other _____ ☐ Hearing aid ☐ Other _____

▶ SURGERY RELATED

☐ Article Left in Patient _____ ☐ Death ☐ Sponge / needle / instr count
☐ Delay in starting ☐ Unplanned return / Repeat surgery
☐ Cancelled ☐ Pt./ Site Identification ☐ Unplanned removal of organ or part of organ
☐ Consent problem ☐ Prep
☐ Contamination ☐ Resp. / Cardiac code ☐ Other _____

▶ EVENT / CATEGORY NOT LISTED

☐ Blood borne exposure (Non-employee) ☐ Food poisoning ☐ Utility failure _____
☐ Burn (type) _____ ☐ Other _____

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Patient Name _____

Patient Account No. _____ Medical Record No. _____ Room # _____

TYPE OF PERSON INVOLVED

☐ Inpatient ☐ ASC ☐ Other outpatient ☐ Visitor
☐ ED patient ☐ SDS ☐ No patient involved ☐ Other _____

EVENT DATE & TIME

Date of Incident: _____ Time of Incident (24 hour): _____

DEPARTMENT(S) INVOLVED IN EVENT *(Check all depts. that apply. i.e. nurse = nursing services)*

☐ Admitting & Registration ☐ Food Services ☐ PT/OT
☐ Ambulatory Surgery ☐ IV Therapy ☐ Pharmacy
☐ Blood Bank ☐ Laboratory ☐ Plant Operations
☐ Cardiac Rehabilitation ☐ Maintenance ☐ Radiation Oncology
☐ Central Supply ☐ Materials Management ☐ Radiology
☐ Dialysis ☐ Medical Staff ☐ Respiratory Therapy
☐ Dietary ☐ Nursing services ☐ Security
☐ Electrodiagnostics (EKG) ☐ Operating Room Nurses/Staff ☐ Social Services
☐ Emergency Department ☐ Pastoral Care ☐ N/A (no dept involved)
☐ EVS ☐ Patient Transport ☐ Other _____

EVENT LOCATION *(Where did the event occur? - Check ONE code)*

Berlin	Marlton	Memorial		Voorhees	
☐ BCHE	☐ M2S	☐ A2N	☐ AASC	☐ V2B	☐ V6B
☐ BEVE	☐ M3N	☐ A3NE	☐ ACCU	☐ V3B	☐ V6O
☐ BHIC	☐ M3S	☐ A4NE	☐ AL&D	☐ V3G	☐ VICU
☐ BICU	☐ M4N	☐ A4NW	☐ AMAP	☐ V4B	☐ VLD
☐ BMSU	☐ M4S	☐ A5ST	☐ AMBU	☐ V4G	☐ VNEO
☐ BPCU	☐ MICU	☐ A6ST	☐ APED	☐ V4O	☐ VNUR
Camden	☐ MPCU	☐ A7ST	☐ ASCN	☐ V5B	☐ VPED
☐ VEC			☐ ASDS	☐ V5O	☐ VPCU

Locations common to all hospitals:

☐ Admitting & Registration ☐ Dialysis unit ☐ Pharmacy
☐ Ambulance ☐ Electrodiagnostics (EKG) lab ☐ PT/OT
☐ Blood Bank ☐ Emergency Room ☐ Pulmonary Function Lab
☐ Cafeteria ☐ Endo ☐ Radiology-Nuc Med / US
☐ Cardiac Cath Lab ☐ Hospital grounds ☐ Recovery Room/PACU
☐ Center for Women ☐ Laboratory ☐ SPU
☐ Central supply ☐ Lobby / Waiting Room ☐ Unknown
☐ Clinics ☐ Operating room ☐ Other _____
☐ Coffee / gift shop ☐ Parking lot /garage

SEVERITY of INJURY (for all NON-FALL events)

For Medication Event - select 0 - 7 ONLY, for all other non-fall events, select appropriate severity.

☐ 0 – Event did not reach or harm the patient (near miss)
☐ 1 – Event reached the patient, but did not cause any harm
☐ 2 – Event reached the patient, did not cause any harm but required additional monitoring
☐ 3 – None or temporary patient harm. Treatment or intervention required
☐ 4 – Same as #3, +initial/prolonged hosp stay
☐ 5 – Possible permanent patient harm
☐ 6 – Near death event (e.g. anaphylaxis)
☐ 7 – Patient death
☐ Not applicable

TREATMENT

Did patient receive treatment for this event? ☐ Yes ☐ No ☐ N/A ☐ Unknown at this time

**NARRATIVE DESCRIPTION - Please continue on back of page if needed.

Include nature and site of injury, plus any treatment(s) received

_____ Date of Report _____
(Reporter's Signature)

_____ Date _____
(Supervisor's Signature)

Virtua HEALTH

EMPLOYEE INCIDENT REPORT

Facility where incident occurred: (Please circle one)

ASC BERLIN MARLTON MEMORIAL SUMMIT VOORHEES

All employees who sustain a work related injury, illness or exposure are required to immediately report the incident to their supervisor and fill out this form completely. Treatment for this incident is authorized through Occupational Health (M-F (no holidays) 8:00 AM – 5:00PM) and injuries that occurred after normal business hours and holidays should seek treatment in the ED. Employees must present this form to Occupational Health or the ED.

TO BE COMPLETED BY EMPLOYEE

Employee Name: Today's Date:

Department: Job Title: Employee ID#

Time employee began work on date of injury: AM/PM

Date of Incident: Time of incident: AM/PM

Facility **and** department where injury occurred:

Name(s) of witnesses:

Give detailed description of how injury occurred:

Did incident occur during your lunch? □ Yes □ No Break? □ Yes □ No

If applicable, please indicate the name of the object, machine, tool or substance being used when injury happened:

- -

(If equipment (ie:carpet, door, chair, etc.) is involved, isolate the equipment until Risk Management inspects)

Acknowledgement

Please indicate where the employee was sent for evaluation and/or Medical Treatment:

□Emergency Department □Occupational Health □Refused Treatment

Employee Signature: Manager's Signature:

To Be Completed by the Treating Physician

Nature of Injury: Date:________________

Time:_______________

Employee was evaluated. He/she is able to return to work immediately (same shift) Yes/No

Any physical limitations (If yes, please note):

If employee is uaable to return to work immediately or if further treatment is needed, employee must be referred to Occupational Health the <u>next business</u> day for any further care.

Physician Name (Print): Physician Signature:

Administration

Routing, as applicable (Initial and Date) ____

1. Fax to Employee Health and Safety at 856-246-3410 2. Original to Human Resources to forward to EH&S

For Employee Health and Safety use only

Is this OHSA Recordable: Yes/No Logged into database: Yes/No Date:___________________

Medical Record received: Yes/No ER Record received Yes/No Date:___________________

Was injury caused by a hazardous environment Yes/No

Is so, was IR faxed to Risk Management: Yes/No Date:____________________

Plant engineering notified: Yes/No Date:___________________ Name of Contact:______________

If injury was caused by Hazardous Environment was it corrected? Yes/No Date:_________________

Copy of work report requested: Yes/No Date:_______________ Date Received: Yes / or Date:_____________

□ See Attached Work Order #14513 (9/05)

VIRTUA HEALTH SYSTEM
SOURCE INDIVIDUAL RISK ASSESSMENT FORM
FOR BLOODBORNE PATHOGEN EXPOSURE

This form is to be completed by the Administrative Nursing Supervisor (or "bed control" nurse). When completed, provide information to the Emergency Department medical provider who is treating the exposed individual. Form is to be included in exposed individual's Occupational Health department record.

Source Pt. Initials: _____ Source Pt. Room #: _____ Source Pt. Age: _____

Source Pt. Medical Record #: _____Source Pt. Diagnosis: _____
(Include all digits – including # after hyphen)

Source Pt. Social Security Number: _____ Date of Exposure: _____

Exposed Individual Name: _____

		Circle Yes or No for each item listed
Yes	No	Have you ever used intravenous drugs?
Yes	No	Have you ever been told that you have Hepatitis C?
Yes	No	Have you ever been told that you have Hepatitis B?
Yes	No	Have you ever been told that you are HIV positive?
Yes	No	If known HIV positive, have you ever taken medications to treat?
Yes	No	If known HIV positive, are you currently taking any medications to treat?
Yes	No	Have you ever been told that you have AIDS?
Yes	No	Have you ever had a test for HIV or AIDS?
Yes	No	Have you ever received a blood transfusion or blood products ?
Yes	No	Are you a hemophiliac or bleeder?
Yes	No	Are you homosexual or bisexual?
Yes	No	Are you the sexual partner of a homosexual/bisexual, IV drug user or hemophiliac?
Yes	No	Have you ever lived outside of the U.S., in a country with a high rate of HIV?
Yes	No	Do you have any other known risk factors for Hepatitis B, Hepatitis C, or HIV? If yes, explain:
Yes	No	Are you a dialysis patient?
Yes	No	Are you a recipient of a tissue or organ transplant?
Yes	No	If the source is an infant, is the mother and/or sexual partner an IV drug user, hemophiliac, bisexual or homosexual?
Yes	No	If the source is an infant, is the mother and/or sexual partner someone known to have Hepatitis B, Hepatitis C, or HIV?

Lab values: (If available)
CD 4 count: _____ Viral Load: _____ Liver function studies: SGOT _____ SGPT _____

Source Patient's lab studies ordered: _____ YES Date: _____ Time: _____

- _____ Order set = Emp Source Pt (Source Individual)

Comments:
_____

Completed by: _____ Date: _____

Results reported to: _____ (ED physician or RN only) Location: _____

THIS FORM MUST BE GIVEN TO THE ED AT THE TIME EMPLOYEE IS BEING EVALUATED FOR EXPOSURE.

Thank You

for completing this orientation to Virtua and reviewing the Bloodborne Pathogen and Needlestick Prevention Policy.

We look forward to working with you during your graduate medical education experience and hope that this guide helped acquaint you with Virtua Health and our facilities.

⇨ Click here to submit your information.