

	DEPARTMENT OF PUBLIC SAFETY	EFFECTIVE DATE: JUN 24 2008	POLICY NO.: ADM.07.01
	DEPARTMENT ADMINISTRATION POLICY AND PROCEDURES	SUPERSEDES (Policy No. & Date): NEW	
	SUBJECT: MANAGEMENT OF ACCIDENTAL EXPOSURES TO BLOOD OR BODY FLUIDS		Page 1 of 5

1.0 PURPOSE

To provide immediate intervention and care of employees who are occupationally exposed to blood or body fluids.

2.0 REFERENCES AND DEFINITIONS

.1 References

- a. Title 12 (DLIR) Subtitle 8 (DOSH) Administrative Rules, Chapter 205 "Biological Agents/Bloodborne Pathogens"
- b. Hawaii Revised Statutes (HRS), §325-16, Informed Consent for Testing or Disclosure

.2 Definitions

- a. Bloodborne pathogen: An infectious agent (disease-causing germ or virus) that is transmitted by blood or other body fluid.
- b. Exposure: Contact with a bloodborne pathogen in such a way that it could cause disease. Exposures are ranked according to their risk of transmitting the pathogen:
 1. Massive exposure
 - (a) Transfusion of blood
 - (b) Injection of 1 cc or more of blood or hazardous body fluid
 2. Definite exposure
 - (a) Injection of less than 1 cc of blood or hazardous body fluid.
 - (b) Deep (more than 3 mm or into the muscle) injury produced by a blood or body fluid, contaminated needle or instrument.
 - (c) Wound produced by blood or body fluid, contaminated instrument which causes visible bleeding.

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- (d) Open fresh wound which is inoculated with blood or hazardous body fluid.

3. Possible exposure

- (a) Superficial injury produced by blood or body fluid, contaminated needle, or instrument.
- (b) Injury produced by blood or body fluid, contaminated instrument which does not cause spontaneous bleeding.
- (c) Old wound visibly contaminated with blood or hazardous body fluid.
- (d) Eyes or mouth lining contamination with blood or hazardous body fluids.

4. Doubtful exposure

- (a) Superficial injury with needle or instrument that is not contaminated with blood or hazardous body fluid.
- (b) Old wound contaminated with nonhazardous body fluids.
- (c) Eyes or mouth lining contamination with nonhazardous body fluids.

5. Nonexposure

Intact skin visibly contaminated with any body fluid.

- c. Hazardous body fluids: Blood, bloody fluids, and other body fluids which are known or assumed to be associated with transmission of bloodborne pathogens. For HIV, these include blood, any bloody fluid, semen (cum) and vaginal fluids. For HBV, these additionally include saliva and maybe tears, urine and feces.
- d. HBV: The virus that causes Hepatitis B.
- e. HIV: The virus that causes AIDS.

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3.0 POLICY

- .1 All employees must be familiar with practices to prevent or minimize risk of occupational exposure to blood and other hazardous fluids.
- .2 Any occupational exposure shall be managed with first aid, accurate recordkeeping and appropriate referrals.

4.0 PROCEDURES

- .1 When an employee has an exposure during the line of duty, immediate care shall be cleansing of the wound with soap and water or flushing the eyes or mouth with water or saline.

Serious injuries requiring sutures or other aggressive intervention shall be referred promptly to the emergency room by the respective health care staff or staff in charge.
- .2 Employees shall report exposure to their supervisors who will complete a State of Hawaii "Accident Report" form DPS T& S 414 (Attachment A). The report shall be forwarded to the Department of Public Safety (PSD) Personnel Office marked "Employee Injury Report. Confidential."
- .3 Exposed corrections employees shall be referred by the supervisor to the facility Health Care Unit. If the Health Care Unit is closed, the on call physician shall be consulted by telephone (Attachment B). Exposed law enforcement employees shall be referred to the PSD Health Care Office. If the office is closed, the on call physician shall be contacted by phone. The on call physicians' roster shall be distributed to all divisions on a monthly basis.
- .4 Responding health care staff shall insure that first aid has been adequate. The exposure shall be evaluated for degree of exposure (massive, definite, probable, doubtful or none). A "Staff/Visitor Injury/Illness Medical Report" form DOC 0421 (Attachment C) shall be completed, including the measure of severity of the exposure. All copies of the report shall be forwarded to PSD Personnel marked "Employee Injury Report. Confidential."
- .5 The responding health care staff shall provide counseling for the injured employee regarding the significance of the injury and risk of infection based on degree of severity. The employee shall be referred to his or her private doctor with information about recommended treatment options:

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- a. Tetanus vaccination if last vaccine was more than 10 years ago or time unknown and the wound is dirty;
 - b. Hepatitis B immune globulin within 24 hours if the source is known to have hepatitis B or hepatitis of unknown cause and the employee is unvaccinated for HBV.
 - c. Have blood tests for HBV immunity and HIV exposure. The HIV tests should be repeated at six (6) weeks, three (3) months and six (6) months.

If the HBV tests are negative, the employee should start the HBV vaccine series.
 - d. The documenting health care staff shall document the counseling and results. The report of counseling of the injured staff and any test results shall be forwarded to PSD Personnel marked "Employee Injury Document. Confidential" for recordkeeping purposes.
- .6 If the employee has a massive or definite exposure, the employee should be instructed to go to the nearest emergency room for treatment.
 - .7 The Department shall assume the cost of all post exposure care that is recommended in this procedure when the Department is provided with confirmation of the care provided. Unauthorized post exposure health care costs will not be covered by the Department.
 - .8 The responding health care staff shall determine if the source is in custody in one of the State's correctional facilities. If the HIV and HBV status is unknown, the inmate shall be approached by a facility health care professional and requested to provide blood for analysis for HBV serology and HIV antibodies. If the inmate consents to provide blood, an "Informed Consent for HIV Blood Test" form DOC 0402 (Attachment D) shall be signed. Pre- and post-test antibody counseling shall be provided as required by law.

The inmate shall be asked to sign a "Consent to Release Medical Information" form DOC 0404 (Attachment E) specifying release of his/her HIV and HBV status to a physician designated by exposed employee. When a consent is signed, the facility's attending physician or the HCD shall release the information to a physician designated by the employee. A copy of form DOC

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0404 shall be forwarded to PSD Personnel, with the name of the exposed employee, marked "Employee Injury Information. Confidential."

5.0 SCOPE

This procedure applies to all employees within the Department.

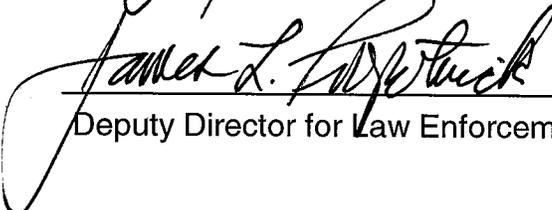
APPROVAL RECOMMENDED:


Deputy Director for Administration

6/6/08
Date

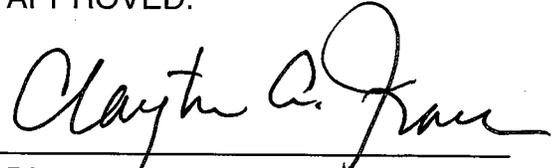

Deputy Director for Corrections

6/18/08
Date


Deputy Director for Law Enforcement

6-19-08
Date

APPROVED:


Director

6/24/08
Date



STATE OF HAWAII ACCIDENT REPORT

SUPERVISOR COMPLETES ITEMS

1. Date MO DAY YR

2. Injured's Name (Last, First, M.I.) 3. Social Security Number 4. Date of Birth 5. Sex 6. Marital Status 7. Address 8. City 9. State 10. Zip Code

11. Department-Unit Name 12. Position Title 13. Years in Position

14. Time of Accident 15. Date of Injury/Illness 16. Date Reported 17. Date Disability Began 18. Work Return Date

19. Location of Accident 20. On State Property? 21. Nature of Injury/Illness (sprain, cut, etc.)

22. Part of Body (Right knee, left thumb etc.) 23. Treating Physician's Name and Address

24. What was the injured doing at the time of the accident?

25. What equipment or machine was being used?

26. How did the accident occur? Describe in detail the events that led to the accident.

27. Describe any hazardous conditions, items or practices which contributed to the accident.

29. Names and phone numbers of witnesses A. B. C.

30. This accident was: A. Preventable B. Non-Preventable

31. How could the accident have been prevented?

Table with 3 columns: Item, Issued, Used. Rows include A. Hard Hat, B. Safety Glasses, C. Goggles, D. Face Shield, E. Ear Muff/Plugs, F. Respirator (Type), G. Clothing (Type), H. Gloves, I. Foot Protection (Type), J. Other (Describe).

32. Type of case: (check one) A. For record only B. Work comp/Liability Claim

33. Nature of case (check all that apply) A. Injury or illness B. Lost time C. Equipment damage

34. I have seen and agree with the above information.

Employee's signature

Date

Inter-Office
MEMORANDUM

S A M P L E

DEPARTMENT OF PUBLIC SAFETY

ATTACHMENT B

No. _____

Suspense: _____

February 17, 1993

TO: All HCUs
FROM: Dr. Kim Thorburn, HCD *Direct*
SUBJECT: PHYSICIAN STANDBY COVERAGE, MARCH 01-28, 1993

Physician standby coverage for the subject period is as follows:

<u>Physician</u>	<u>Phone</u>	<u>Dates</u>
Dr. Hubacker	531-8204 (R) 486-2600 (HCF)	March 01-07, 1993
Dr. Kimbrell	263-4221 (R) 848-2535 (OCCC)	March 08-14, 1993
Dr. Thorburn	841-3533 (R) 587-1250 (HCO)	March 15-21, 1993
Dr. Hubacker	531-8204 (R) 486-2600 (HCF)	March 22-28, 1993

Please notify Dr. Thorburn of any unusual medical or administrative emergencies.

HCO:KMT:tm

c: Dr. Kimbrell
Dr. Hubacker
Jessie Doi-Cunha, Community Beds Manager

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

FACILITY _____

STAFF/VISITOR INJURY/ILLNESS MEDICAL REPORT

Name: _____

Date of Injury: _____

SSN#: _____

Time of Injury: _____

Date of Birth: _____

Date of Report: _____

Time of Report: _____

Place Injury Occurred: _____

Staff's description of symptoms or staff's/witnesses description of event of Injury:

Nurse's assessment of injury/illness:

Physician's examination (If seen by a physician):

First Aid given/by whom:

Disposition:

Signature of Person Completing Report

Original: HCO RRA
Yellow: Personnel Record
Pink: Facility Safety Officer
Golden Rod: BA

Signature of Examining Physician

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

INFORMED CONSENT FOR HIV ANTIBODY BLOOD TEST

I have agreed that my blood will be tested in order to detect whether or not I have antibodies in my blood to the HIV which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood.

I understand that the test results may, in some cases, indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect that a person has antibodies to the virus when the person has the virus (false negative). I also have been informed that currently there are no other blood tests that may be used to identify the virus, which is the causative agent of AIDS, and that the blood test is not itself diagnostic of the disease AIDS.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks, and alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment. I further understand that no additional release of the results will be made without my written authorization except as required by the communicable disease reporting requirements of the State Department of Health.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results and have had all of my questions answered. Further, I acknowledge that I have given consent for the performance of a blood test to detect antibodies to the HIV.

Date: _____ 19 _____

Signature

Witness

Printed Name

STATE OF HAWAII
DEPARTMENT OF PUBLIC SAFETY

CONSENT TO RELEASE MEDICAL INFORMATION

To: _____ (Name of Doctor or Facility)	FROM: _____ (Name of Doctor & Facility)
_____	_____
(Address)	(Address)
_____	_____
(City) (State) (Zip Code)	(City) (State) (Zip Code)

I hereby request and give my consent to release the following information _____
contained in my medical record for the purpose of _____

I understand I have the right to revoke this consent upon demand at anytime prior to the actual release of information. I further understand that this consent is valid for ninety (90) days from the "Date of Signature."

_____	_____
(Print Name)	(Date of Birth)
_____	_____
(Signature of Patient/Agent)	(Date of Signature)

I also consent to the release of alcohol/drug abuse treatment records, HIV test results, or psychiatric records, under the same conditions as above. I understand the sensitive nature of the information and that such information cannot be released without my specific consent.

_____	_____
(Signature of Patient/Agent)	(Date of Signature)

REDISCLASURE IS PROHIBITED

The confidentiality of the information contained in a medical record is protected by federal law. Federal regulation (42 CFR Part 2) prohibits any further disclosure of medical information except with the specific written consent of the person to whom it pertains. A general authorization is not sufficient authorization for the further release of information one facility obtained from the medical record of another facility.

Original: To Doctor/Facility in Possession of Medical Information Requested.
Yellow: Medical Record
Pink: Inmate