

## Massachusetts Department of Public Health Bloodborne Pathogen Exposure Incident Recording Form

<b>EMPLOYER:*</b>		<b>UNIQUE EXPOSURE INCIDENT NUMBER:*</b>	
<b>EXPOSED WORKER'S NAME:</b> (or unique ID number)		<b>OSHA RECORDABLE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
<b>STATUS OF EXPOSED WORKER:</b> <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER <input type="checkbox"/> NON EMPLOYEE PRACTITIONER <input type="checkbox"/> TEMP / CONTRACT <input type="checkbox"/> STUDENT		<b>TIME WORK SHIFT BEGAN:*</b> _____ : _____ am/pm	
<b>DATE OF INCIDENT:*</b> ____ / ____ / ____	<b>TIME OF INCIDENT:*</b> _____ : _____ am/pm	<b>DATE REPORTED:</b> ____ / ____ / ____	<b>TIME REPORTED:</b> _____ : _____ am/pm
<b>TYPE OF EXPOSURE:*</b> <input type="checkbox"/> Percutaneous <input type="checkbox"/> Mucous membrane <input type="checkbox"/> Skin Was skin intact?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> Bite		<b>TYPE OF FLUID:</b> <input type="checkbox"/> Blood / blood products <input type="checkbox"/> Visibly bloody body fluid <input type="checkbox"/> Non-visibly bloody body fluid <input type="checkbox"/> Visibly bloody solution (iv fluid, etc.) <input type="checkbox"/> Non-visibly bloody solution <input type="checkbox"/> Other _____ (specify) <input type="checkbox"/> Unknown	
<b>FOR PERCUTANEOUS INJURIES:</b> <b>DEPTH OF INJURY:</b> <input type="checkbox"/> Superficial <input type="checkbox"/> Moderate <input type="checkbox"/> Deep <input type="checkbox"/> Unknown		<b>BLOOD VISIBLE ON DEVICE BEFORE EXPOSURE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>BODY PART INJURED:</b> <input type="checkbox"/> Arm <input type="checkbox"/> Mouth / nose <input type="checkbox"/> Hand <input type="checkbox"/> Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other _____ (specify)		<b>PERSONAL PROTECTIVE EQUIPMENT WORN BY WORKER AT TIME OF EXPOSURE:</b> <input type="checkbox"/> Gloves (single pair) <input type="checkbox"/> Eye protection <input type="checkbox"/> Other _____ <input type="checkbox"/> Gloves (double pair) <input type="checkbox"/> Face shield (specify) <input type="checkbox"/> Gloves (triple pair) <input type="checkbox"/> Gown/Garment <input type="checkbox"/> None of the above <input type="checkbox"/> Mask	
<b>OCCUPATION:*</b>			
<input type="checkbox"/> Anesthesiologist	<input type="checkbox"/> Fireperson / First responder	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Registered Nurse
<input type="checkbox"/> Attendant / orderly	<input type="checkbox"/> Food service	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Researcher
<input type="checkbox"/> Attending physician	<input type="checkbox"/> Hemodialysis technician	<input type="checkbox"/> Nursing Assistant	Resident
<input type="checkbox"/> Central supply	<input type="checkbox"/> Home health aide	<input type="checkbox"/> Nursing student	<input type="checkbox"/> PGY-1
<input type="checkbox"/> Clerical / administrative	<input type="checkbox"/> Housekeeper	<input type="checkbox"/> OR / surgical technician	<input type="checkbox"/> PGY-2
<input type="checkbox"/> Clinical lab technician	<input type="checkbox"/> Intern	<input type="checkbox"/> Patient care technician	<input type="checkbox"/> PGY-3
<input type="checkbox"/> Counselor / Social worker	<input type="checkbox"/> Laundry staff	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Respiratory Therapist / tech
<input type="checkbox"/> Dentist	<input type="checkbox"/> Law enforcement officer	<input type="checkbox"/> Phlebotomist	<input type="checkbox"/> Safety / security
<input type="checkbox"/> Dental assistant / tech	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Physician assistant	<input type="checkbox"/> Surgeon
<input type="checkbox"/> Dental hygienist	<input type="checkbox"/> Maintenance	<input type="checkbox"/> Physical therapist	<input type="checkbox"/> Transport / messenger
<input type="checkbox"/> Dental student	<input type="checkbox"/> Medical assistant	<input type="checkbox"/> Psychiatric technician	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Dietician	<input type="checkbox"/> Medical student	<input type="checkbox"/> Public health worker	<input type="checkbox"/> Other _____ (specify)
<input type="checkbox"/> EMT / paramedic	<input type="checkbox"/> Morgue technician	<input type="checkbox"/> Radiologic technician	
<input type="checkbox"/> Fellow	<input type="checkbox"/> Nurse Anesthetist	<input type="checkbox"/> Radiologist	
<b>DEPARTMENT OR WORK AREA WHERE EXPOSURE INCIDENT OCCURRED:*</b> <i>Select all that apply</i>			
Identify specific location (room number, floor etc): _____			
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> Labor and delivery	<input type="checkbox"/> Phlebotomy room
<input type="checkbox"/> Ambulatory care clinic	<input type="checkbox"/> Employee health / Infection control	<input type="checkbox"/> Laundry room	<input type="checkbox"/> Post anesthesia care unit
<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Endoscopy / bronchoscopy /cytoscopy	<input type="checkbox"/> Long term care	<input type="checkbox"/> Psychiatry ward
<input type="checkbox"/> Blood bank	<input type="checkbox"/> Exam room	<input type="checkbox"/> Medical / surgical ward	<input type="checkbox"/> Radiology department room
<input type="checkbox"/> Cardiac cath laboratory	<input type="checkbox"/> Hematology / Oncology	<input type="checkbox"/> Microbiology	<input type="checkbox"/> Rehabilitation unit
<input type="checkbox"/> Central sterile supply	<input type="checkbox"/> Histology / pathology	<input type="checkbox"/> Morgue / autopsy room	<input type="checkbox"/> Procedure room _____ (specify)
<input type="checkbox"/> Central trash area	<input type="checkbox"/> Home health visit (home)	<input type="checkbox"/> Nursery	_____
<input type="checkbox"/> Clinical chemistry	<input type="checkbox"/> Hospital grounds	<input type="checkbox"/> Obstetrics / gynecology ward	_____
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Intensive care unit	<input type="checkbox"/> Operating room	<input type="checkbox"/> Other location _____ (specify)
<input type="checkbox"/> Dental Clinic	<input type="checkbox"/> Jail unit	<input type="checkbox"/> Pain clinic	
<input type="checkbox"/> Dermatology		<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Detox unit		<input type="checkbox"/> Pharmacy	

**IS THIS THE DEPARTMENT TO WHICH THE WORKER IS REGULARLY ASSIGNED?**  YES  NO  N/A

**IF NO, TO WHICH DEPARTMENT IS THE WORKER REGULARLY ASSIGNED?** \_\_\_\_\_

**WHAT DEVICE OR ITEM WAS INVOLVED IN THE INJURY?\***

<p><b>Hollow bore needle</b></p> <input type="checkbox"/> Biopsy needle <input type="checkbox"/> IV stylet <input type="checkbox"/> Hollow-bore needle, type unknown <input type="checkbox"/> Huber needle <input type="checkbox"/> Hypodermic needle attached to a disposable syringe <input type="checkbox"/> Hypodermic needle attached to IV tubing <input type="checkbox"/> Phlebotomy needle (other than butterfly) <input type="checkbox"/> Prefilled cartridge syringe <input type="checkbox"/> Spinal or epidural needle <input type="checkbox"/> Unattached hypodermic needle <input type="checkbox"/> Winged steel needle <input type="checkbox"/> Winged steel needle attached to a vacuum tube collection holder <input type="checkbox"/> Winged steel needle attached to IV tubing <input type="checkbox"/> Vacuum tube collection holder / needle <input type="checkbox"/> Other type of hollow bore needle _____ (specify)	<p><b>Suture needle</b></p> <input type="checkbox"/> Curved suture needle <input type="checkbox"/> Straight suture needle <p><b>Glass</b></p> <input type="checkbox"/> Capillary tube <input type="checkbox"/> Medication ampule / vial / IV bottle <input type="checkbox"/> Pipette <input type="checkbox"/> Slide <input type="checkbox"/> Specimen / test / vacuum tube <input type="checkbox"/> Other glass item _____ (specify) <p><b>Additional dental / surgical devices</b></p> <input type="checkbox"/> Dental bur <input type="checkbox"/> Dental pick <input type="checkbox"/> Drill bit <input type="checkbox"/> Hypodermic needle attached to non-disposable syringe <input type="checkbox"/> Elevator <input type="checkbox"/> Extraction forceps <input type="checkbox"/> Root canal file <input type="checkbox"/> Rod (orthopaedic) <input type="checkbox"/> Other dental / surgical device or item _____ (specify)	<p><b>Other sharp object</b></p> <input type="checkbox"/> Bone chip / chipped tooth <input type="checkbox"/> Bone cutter <input type="checkbox"/> Bovie electrocautery device <input type="checkbox"/> Bur <input type="checkbox"/> Explorer <input type="checkbox"/> Histology cutting blade <input type="checkbox"/> Lancet <input type="checkbox"/> Laser <input type="checkbox"/> Pin <input type="checkbox"/> Razor <input type="checkbox"/> Retractor <input type="checkbox"/> Scaler / curette <input type="checkbox"/> Scalpel blade <input type="checkbox"/> Scissors <input type="checkbox"/> Tenaculum <input type="checkbox"/> Trocar <input type="checkbox"/> Wire <input type="checkbox"/> Other type of sharp object _____ (specify) <input type="checkbox"/> Sharp object, type unknown
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**WAS THE DEVICE PART OF A PRE-PACKAGED KIT?**  Yes  No  Unknown

**MANUFACTURER OF DEVICE:\*** \_\_\_\_\_

**BRAND OF DEVICE:** \_\_\_\_\_

**MODEL OF DEVICE:** \_\_\_\_\_

**DID THE DEVICE HAVE ENGINEERED SHARPS INJURY PREVENTION FEATURES?**  Yes  No  Unknown

**IF YES, WHEN DID THE INJURY OCCUR?**

<input type="checkbox"/> Before activation of safety feature	<input type="checkbox"/> Safety feature failed; after activation	<input type="checkbox"/> Other _____ _____ (specify)
<input type="checkbox"/> During activation of safety feature	<input type="checkbox"/> Safety feature not activated	
<input type="checkbox"/> Safety feature improperly activated	<input type="checkbox"/> Passive safety feature, activation not required	<input type="checkbox"/> Unknown

**IF YES, WAS THE WORKER TRAINED IN THE PROPER USE OF THE SHARPS INJURY PREVENTION FEATURE?**

Yes → Describe training: \_\_\_\_\_

No

**IF YES, INDICATE THE MECHANISM OF THE SHARPS INJURY PREVENTION FEATURE:**

<input type="checkbox"/> Blunting	<input type="checkbox"/> Sliding sheath	<input type="checkbox"/> Other _____
<input type="checkbox"/> Retractable	<input type="checkbox"/> Hinged cap	<input type="checkbox"/> Unknown

**PURPOSE OR PROCEDURE FOR WHICH SHARP WAS USED OR INTENDED:\***

**Line procedures:**

- To insert a peripheral IV line or set up a heparin lock
- To insert a central IV line
- To insert an arterial line
- To connect IV line (intermittent IV / piggy back / IV infusion / other IV line connection)
- To flush heparin / saline
- Other injection into IV injection site or IV port \_\_\_\_\_ (specify)
- Other line procedure \_\_\_\_\_ (specify)

**Blood procedures:**

- Dialysis / AV fistula site
- Draw blood from arterial line
- Draw blood from central or peripheral IV line or port
- Draw blood from umbilical vessel
- Fingerstick / heel stick
- Percutaneous arterial puncture
- Percutaneous venous puncture (e.g. phlebotomy)
- Other blood sampling \_\_\_\_\_ (specify)

**Other procedures:**

- Cutting (e.g. surgery / autopsy)
- Drilling
- Epidural / spinal anesthesia
- Intramuscular (IM) injection
- Shaving
- Subcutaneous / intradermal injection / skin test placement
- Suture removal
- Suturing
- To obtain a body fluid or tissue sample (CFS / amniotic / biopsy)
- To obtain laboratory specimens
- Transferring blood / body fluid to another container
- Other procedure (not a line procedure or blood sampling procedure) \_\_\_\_\_ (specify)
- Unknown

**Dental procedure:**

- Dental drilling
- Hygiene (prophy, root plane, curettage)
- Oral surgery**
- Simple extraction
- Surgical extraction
- Fracture reduction
- Other \_\_\_\_\_ (specify)
- Unknown
- Orthodontic procedure
- Periodontal surgery
- Restorative (amalgam, composite, crown)
- Root canal
- Other \_\_\_\_\_ (specify)
- Unknown

**Where did the injury occur?**

- Inside the patient's mouth
- Outside the patient's mouth
- Unknown

**DID THE INJURY OCCUR BEFORE USE OF THE ITEM?\***

- Yes  No  Unknown

If yes, go to the narrative description of the incident.

**DID THE INJURY OCCUR DURING USE OF THE ITEM?**

- Yes  No

↓  
If yes, choose one that describes best how injury occurred and go to the narrative description of the incident:\*

- Collided with co-worker or other person
- Device malfunction
- Incising
- Manipulating suture needle in holder
- Palpating / Exploring
- Passing, receiving or transferring equipment during use of the item
- Patient moved and jarred device
- Sharp object dropped
- Suturing
- Tying sutures
- While inserting needle in line
- While inserting needle in patient
- While manipulating needle in line
- While manipulating needle in patient
- While withdrawing needle from line
- While withdrawing needle from patient
- Other \_\_\_\_\_ (specify)
- Unknown

**DID THE INJURY OCCUR AFTER USE AND BEFORE DISPOSAL OF THE ITEM?**

- Yes  No

↓  
If yes, choose one that describes best how injury occurred and go to the narrative description of the incident:\*

- Activating safety device
- Cap fell off after recapping
- Collided with co-worker or other person
- Disassembling device or equipment
- Decontamination / processing of used equipment
- During clean-up
- Failure to activate safety device
- Handling equipment on a tray or stand
- In transit to disposal
- Opening / breaking glass containers
- Processing specimens
- Passing, receiving or transferring equipment after use of the item
- Recapping (missed or pierced cap)
- Sharp object dropped after procedure
- Struck by detached I.V. line needle
- Transferring blood / bodily fluids into specimen container
- Other \_\_\_\_\_ (specify)
- Unknown

**DID THE INJURY OCCUR DURING OR AFTER DISPOSAL OF THE ITEM?**

- Yes  No

↓  
If yes, choose one that describes best how injury occurred and go to the narrative description of the incident:\*

- Collided with co-worker or other person
- In trash
- In linen / laundry
- In pocket / clothing
- Left on table / tray
- Left in bed / mattress
- On floor
- Over-filled sharps container
- Punctured sharps container
- Protruding from opened container
- Sharp object dropped during / after disposal
- Struck by detached I.V. line needle during / after disposal
- While manipulating container
- While placing sharp in container, injured by sharp being disposed
- While placing sharp in container, injured by sharp already in container
- Other \_\_\_\_\_ (specify)
- Unknown

This form meets the requirements of recording sharps injuries under M.G.L. 105 CMR 130.1001 *et seq.*

Please complete this form with the exposed health care worker.

**\*REQUIRED DATA ELEMENTS FOR RECORDING**

**WHO WAS HOLDING THE DEVICE AT THE TIME OF THE INJURY?**

Exposed Worker    Other person    No one

**NARRATIVE DESCRIPTION OF THE INCIDENT:**

**WHAT SUGGESTIONS DOES THE WORKER HAVE FOR PREVENTING SIMILAR INJURIES IN THE FUTURE?**

Prepared by:

Date:

Title: