WHAT TO DO IF YOU ARE INJURED ON THE JOB

- Notify your manager/supervisor immediately.
- If your injury is life threatening, proceed to the Emergency Department.
- All injured employees are to call the TCH 24 hour/7 days a week injury line at **1-866-665-2917** and report your injury. You will be directed by a Registered Nurse for further care, as needed.
- Complete an Employee Accident Report. You are required to complete the Accident Report, have your supervisor sign it and return it to Disability Management/Employee Health within 24 hours of your injury. Failure to do so may result in rejection of your potential claim and benefits.
- All recommended follow-up treatment will require prior authorization from Disability Management/ Employee Health.
- The Christ Hospital has a Modified Duty Program. If a physician determines that you can return to work with temporary restrictions, your supervisor will be contacted to see if your department has work for you within any restrictions. If not, you may be assigned to another department that has work within your temporary restrictions.
- Your injury will be further managed by Disability Management/ Employee Health, if needed.
- The Christ Hospital is **self-insured** for our Workers' Compensation program. **You will not receive a claim number** for your accident unless your diagnosis requires you to be off work. Time off is unpaid if and until the injury is certified as a Workers' Compensation claim.
- If you have any questions , please contact:
  Disability Management/ Employee Health,
  (Phone) 513-585- 4555, (Fax) 513- 585- 4856

The Christ Hospital Employee Accident Report

FAILURE TO COMPLETE AND SUBMIT THIS FORM TO THE DISABILITY MANAGEMENT SERVICES OFFICE WITHING 24 HOURS OF AN ACCIDENT MAY DELAY ANY POSSIBLE CLAIMS.

If you are:

☐ An **EMPLOYEE**, please call The Christ Hospital Employee Injury Line at **1-866-665-2917**; complete this Accident Report and send it to the Disability Management Services office at The Christ Hospital within 24 hours of the accident; and notify your supervisor of the accident.

☐ **AGENCY** staff or a **STUDENT**, please complete this form and send it to the Disability Management Services office.

Occupational injury, exposure, or disease			
Last Name, First Name, Middle Initial		Home Phone #	Social Security Number
Home Address		Job Title	Date of Birth
City	State	Zip Code	Date Hired or Contracted
Department/Dept. phone #	Supervisor's name		Supervisor's phone #
Employee usually works on: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat		Regular work hours: From _____ to _____	☐ Male ☐ Female
Date of injury/exposure/onset of illness, etc.	Time of injury: _____ ☐ am ☐ pm	Describe incident *in detail:* (e.g., specify approximate weight/size of any object involved; name any substance involved...oil/water...etc.; did associate trip or fall, etc., as appropriate) Include names of witness/witnesses. (If you need additional room, please use the back of this form.)	
Specify exact nature of injury and part of body affected (e.g., "fracture of right hand," etc.):			
Where was initial care received? ☐ Emergency Department ☐ Concentra Clinic: (location): _____ ☐ Other (specify): _____			
Did injury or exposure happen on the employer's premises? ☐ Yes ☐ No			
Accident Location (street address)			Employer representative notified:
City	State	Zip Code	Date notified:

Medical Release

I understand that I am allowing any provider that attends to, treats, or examines me to release all medical, psychological, and/or psychiatric information that is related to my injury to my employer, and my employer's representative and Third Party Administrator. Signing this report ***does not*** constitute certification of a Workers' Compensation claim.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

☐ Send or fax a copy to TCH Disability Management Services office on 3 North.
☐ Send a copy to your manager.
☐ Make a copy for yourself.

The Christ Hospital

The Christ Hospital Disability Management Services
Room #3145, 3 North
2139 Auburn Ave.; Cincinnati, OH 45219
Phone: 513-585-4555; Fax: 585-4856 2063

Appendix J

Blood-borne Pathogen Report

Name: _____ Date of birth: _____

Employee #: _____ Department: _____

Department where exposure occurred, if different: _____

The Christ Hospital employee ☐ Yes ☐ No

If No, employed by _____

Workplace location:
☐ The Christ Hospital
☐ Other (specify) _____

Job title: _____ Shift: _____

Work phone: _____ Work fax: _____ Home phone: _____

Home address Street _____

City: _____ State: _____ Zip: _____

Date of injury:_____ Time of injury: _____(☐ am ☐ pm)

Did you notify your supervisor? ☐ Yes ☐ No If No, ask to contact supervisor.

Did you complete an accident report? ☐ Yes ☐ No If No, ask to contact supervisor.

Nature of injury: ☐ contact ☐ needlestick ☐ splash ☐ puncture/laceration

If the injury is a needlestick or puncture/laceration, complete ***Part I*** and ***II***.

If the injury is contact or splash, complete ***Part I*** and ***III***.

Part I: Source:

Is source patient: ☐ known ☐ unknown

If known, is source: ☐ outpatient ☐ inpatient Medical Record Number:_____

Source Name: _____ Date of birth: _____

Facility/Room Number: _____ Attending physician: _____

Diagnosis: _____

Is source known to be HIV positive? ☐ Yes ☐ No

Is source known to be Hepatitis B positive? ☐ Yes ☐ No

Is source known to be Hepatitis C positive? ☐ Yes ☐ No

Does source abuse IV drugs or have other risk factors? ☐ Yes ☐ No

If yes, specify: _____

Has employee completed the Hepatitis B vaccine series (3 doses)? ☐ Yes ☐ No ☐ Uncertain

If yes, is employee a known "non-responder"? ☐ Yes ☐ No

Has employee had a tetanus immunization within the last 10 years? ☐ Yes ☐ No ☐ Uncertain

Part II: Needlestick/Laceration/Puncture:

If a device was involved in the injury, specify device (see master list):

Brand name of device: _____

If device is a needle, specify gauge: _____ Hollow bore? ☐ Yes ☐ No

If suture needle, curved or straight: _____

If a needle/sharp medical device, was it engineered with a protective mechanism? ☐ Yes ☐ No

If Yes, was that protective mechanism activated? ☐ Yes ☐ No
If not activated, did the injury occur: ☐ before the mechanism was activated?
☐ during the activation of the mechanism?
If No, could the injury have been prevented by a protective mechanism? ☐ Yes ☐ No

What procedure was being performed when exposure happened?

☐ suturing
☐ IV start
☐ blood draw
☐ injection (specify): _____
☐ other (specify): _____

Body part injured: _____

Was the injury
☐ superficial (little or no bleeding)
☐ moderate (skin punctured, some bleeding)
☐ severe (deep stick/cut, or profuse bleeding)

Did the injury happen:

☐ before use of item (e.g., item broke during assembly, etc.)
☐ during use of item
☐ between steps of a multistep procedure
☐ during disposal
☐ while recapping needle

If blood was visible, what was the amount? ☐ small ☐ medium ☐ large

Part III: Contact/Splash:

Did the blood/body fluid (check all that apply):

☐ touch unprotected skin
☐ touch skin through gap between protective garments
☐ soak through protective garment/clothes

Was the exposed part:

☐ intact skin
☐ eyes
☐ nose
☐ non-intact skin
☐ mouth
☐ other, describe: _____

Which body fluids were involved in the exposure (check all that apply):

☐ blood or blood product
☐ vomit
☐ other, describe: _____
☐ CSF
☐ peritoneal fluid
☐ amniotic fluid
☐ urine

Personal Protective equipment worn at time of injury:

☐ single pair of gloves
☐ gown
☐ other: (specify)_____
☐ double pair of gloves
☐ goggles
☐ no gloves
☐ face shield

Describe the circumstances that caused the injury, detailing the procedure being performed at the time: _____

_____

Describe other safety devices or methodologies employee would recommend be used to help prevent another similar injury: _____

_____

Signature of person completing form: _____

Date: _____

The Christ Hospital

Blood Borne Pathogen Exposure from Known Patient

Employee contacts TCH Injury Line @ 1-866-665-2917 to report exposure

For the Employee:

1. Go to the main hospital lab (C-level) and pick up an exposure packet. It will contain: the lab order form; an HIV testing consent form; a sheet of recommended precautions; and an Employee Accident Report.

2. Sign the HIV consent; read and sign the recommended precautions sheet; fill out the Employee Accident Report and give to your Supervisor. Your supervisor will need to sign and date the Employee Accident Report when you return to your department.

3. Take the completed exposure packet to Registration. They will attach your registration information and that of your source patient, if applicable, to the lab order form.

4. Return to the lab and give the order form to the lab technician. The lab will draw your blood for Needle stick II and HIV.

5. TCH Injury Line will provide the source/patient initial HIV results to you. You will be contacted by TCH Disability Management/ Employee Health for additional follow up.

6. All forms in this packet need to be forwarded to TCH Disability Management/ Employee Health, (FAX 585-4856) within 24 hours of the accident.

For the Patient/Source:

7. The source patient's blood cannot be tested without consent. It is your responsibility to ensure that a nurse or supervisor gets HIV consent from the patient. The completed patient/source consent form is faxed to 585-4856, Disability Management, with the original placed in the patient/source chart. If the patient refuses or is unable to sign the form, call the Nursing Supervisor @ 585-1047 and notify the lab that consent was not obtained.

8. While at the lab, ask if any blood is available from the patient.

9. If no blood is available from the patient, the lab will get samples of the patient's blood and order Needle stick I and HIV testing on the samples.

The Christ Hospital

Blood Borne Pathogen Exposure from Unknown Patient

Employee contacts TCH Injury Line immediately @ 1-866-665-2917

For the Employee:

1. Go to the main hospital lab (on C-level) and pick up an exposure packet. It will contain: the lab order form; an HIV testing consent form; a sheet of recommended precautions; and an Employee Accident Report

2. Sign the HIV consent; read and sign the recommended precautions sheet; fill out the Employee Accident Report and give it to your Supervisor. Your supervisor will need to sign and date that Employee Accident Report when you return to your department.

3. Take the completed exposure packet to Registration. They will attach your registration information and that of your source patient, if applicable, to the lab order form.

4. Return to the lab and give the order form to the lab technician. The lab will draw your blood for Needle stick II and HIV tests.

5. TCH Injury Line nurse will contact you to discuss the source/patient initial HIV results with you. and the prophylaxis treatment protocol. You will be contacted by Disability Management/Employee Health for additional follow-up.

6. All forms in this packet need to be forwarded to TCH Disability Management/ Employee Health, (FAX 585-4856) within 24 hours of the accident.

The Christ Hospital Disability Management/ Employee Health Department will follow up with you when the lab results are complete.

The Christ Hospital

Recommended Precautions Following an Exposure

For individuals who have been exposed to a blood-borne pathogen the following are the Centers for Disease Control and Prevention (CDC) recommendations:

- Refrain from blood, semen, or organ donation for 6 months.
- Prevent or limit the exchange of body fluids in your sexual activities for 6 months.
- Avoid pregnancy and breast-feeding for 6 months. **If an exposed woman is breastfeeding, she does not need to discontinue after exposure to Hepatitis B or Hepatitis C infected blood.**
- Report to The Christ Hospital Disability Management Department, 513-585-4555; symptoms such as constant fatigue, loss of appetite, recurrent fever, light colored stool, aching muscles and joints, nausea, vomiting, yellow color to skin or whites of eyes, dark urine, itching skin, swollen lymph glands, rapid weight loss.

I acknowledge that I have received information appropriate to my exposure and have had the opportunity to discuss information.

Employee signature: _____
Date: _____

Sign and send to Disability Management/ Employee Health, fax: 585-4856

The Christ Hospital

Source/Pt

INFORMED CONSENT TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS

1. ***What is the HIV Antibody Test?***
   Detecting HIV involves testing blood for antibodies to the human immunodeficiency virus-the virus that causes AIDS. If testing finds these antibodies, a series of various tests will then be done on the same blood sample to make sure the results of the first test were accurate. In some cases, further testing even beyond that may be required to confirm the diagnosis.

   What does this mean to you? A positive test result means that you have been infected with the AIDS virus, but it does not mean you have AIDS. If you test positive, it's very important that you learn what treatment is available and how to avoid infecting others.

2. ***Voluntary Testing***
   Taking the HIV antibody test is voluntary, not required, If you want to withdraw your consent, you must do so within an hour after your blood is drawn for testing.

   Anonymous testing sites are available where you can get counseling and testing without giving your name and address.

3. ***Confidentiality of Test Results***
   HIV test results are confidential and can only be released with your consent, or otherwise as permitted by state law.

Name (please print): _____

Informed Consent to Test for HIV

I have been advised of the medical reasons for performing this test, and the behavior that are known to pose a risk for transmission of HIV. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I authorize The Christ Hospital to perform an HIV antibody test on me, or the above patient for whom I am legal guardian.

Signature of person to be tested (or guardian, if appropriate) Date

_____ Unable to _____Refused to sign consent. (Refer to RN supervisor)

Fax to Disability Management/ Employee Health 585-4856

The Christ Hospital

Employee

INFORMED CONSENT TO TEST FOR HUMAN IMMUNODEFICIENCY VIRUS

1. ***What is the HIV Antibody Test?***
   Detecting HIV involves testing blood for antibodies to the human immunodeficiency virus-the virus that causes AIDS. If testing finds these antibodies, a series of various tests will then be done on the same blood sample to make sure the results of the first test were accurate. In some cases, further testing even beyond that may be required to confirm the diagnosis.

   What does this mean to you? A positive test result means that you have been infected with the AIDS virus, but it does not mean you have AIDS. If you test positive, it's very important that you learn what treatment is available and how to avoid infecting others.

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Name (please print): _____

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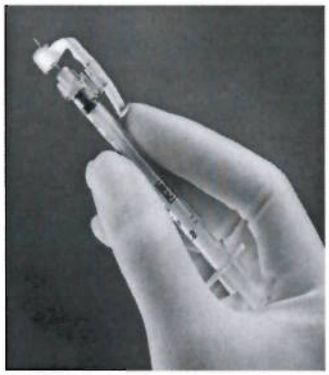
I have been advised of the medical reasons for performing this test, and the behavior that are known to pose a risk for transmission of HIV. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction. I authorize The Christ Hospital to perform an HIV antibody test on me, or the above patient for whom I am legal guardian.

Signature of person to be tested (or guardian, if appropriate) **Date:**

Fax to Disability Management/ Employee Health 585-4856

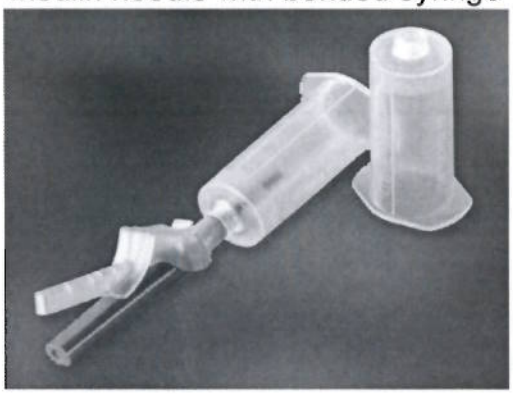
Sharps with safety devices



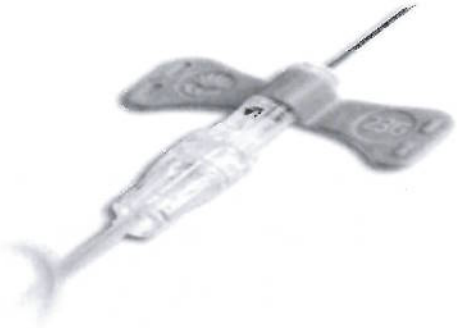
BD Safety Glide tuberculin or
Insulin needle with bonded syringe

BD Eclipse IM needles

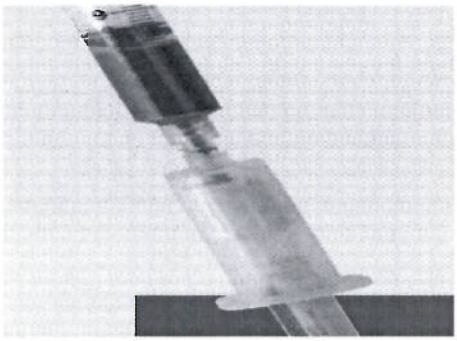
BD Safety Loc, used
In Special Care Nursery



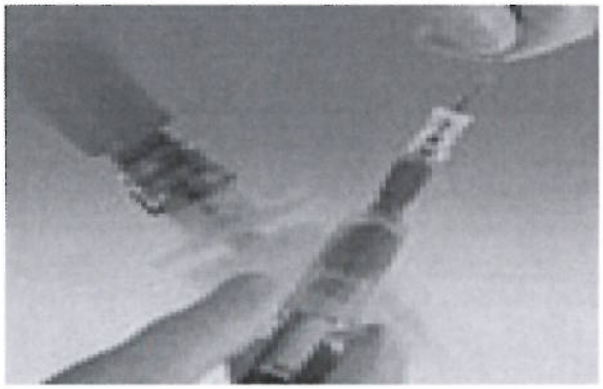
BD Eclipse Needle / Vacutainer system



BD Safety Butterfly / Vacutainer system



BD Blood Transfer Device; blood-filled
Syringe to vacutainer system



BD Vacutainer Luer Lock access device;
Tubing to vacutainer system

BD Urine Collection system

The Christ Hospital

Clinical Laboratory

Handling Of Needle Stick Injury Testing Requirements

All Testing Authorized by :_____

Employee Testing :

Place Employee Registration Label Here	Phlebotomist Initials: _____ Time of Collection: _____

Tests to be ordered:
HIVR
NDSTKII

Source Testing :

Place Source Patient Registration Label Here	Phlebotomist Initials: _____ Time of Collection: _____

Tests to be ordered:
OCCEXP (Occupational Exposure Screen)
NDSTKI