

## **ACCIDENTS, INJURIES & ILLNESSES**

The following procedures must be followed if you have been exposed to bloodborne pathogens and you are a student or employee:

**[Procedure for Bloodborne Pathogen Exposure for Students](#)**  
**[Procedure for Bloodborne Pathogen Exposure for Employees](#)**

Each incident, illness, accident or injury must be reported no matter how minor. Submit the completed incident report to campus security as soon as possible.

**[Written Statement of Incident](#)**

Following an exposure to bloodborne pathogens incident, please notify the Infection Control Manager by phone and by sending this form:

**[Report Form for Exposure to Bloodborne Pathogens](#)**

# **CSN Protocol for Students**

## **Exposure to Bloodborne Pathogens**

### **Definition:**

An exposure to Bloodborne pathogens is defined as a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of a student's assigned clinical tasks.

### **Following an Exposure to Bloodborne Pathogens:**

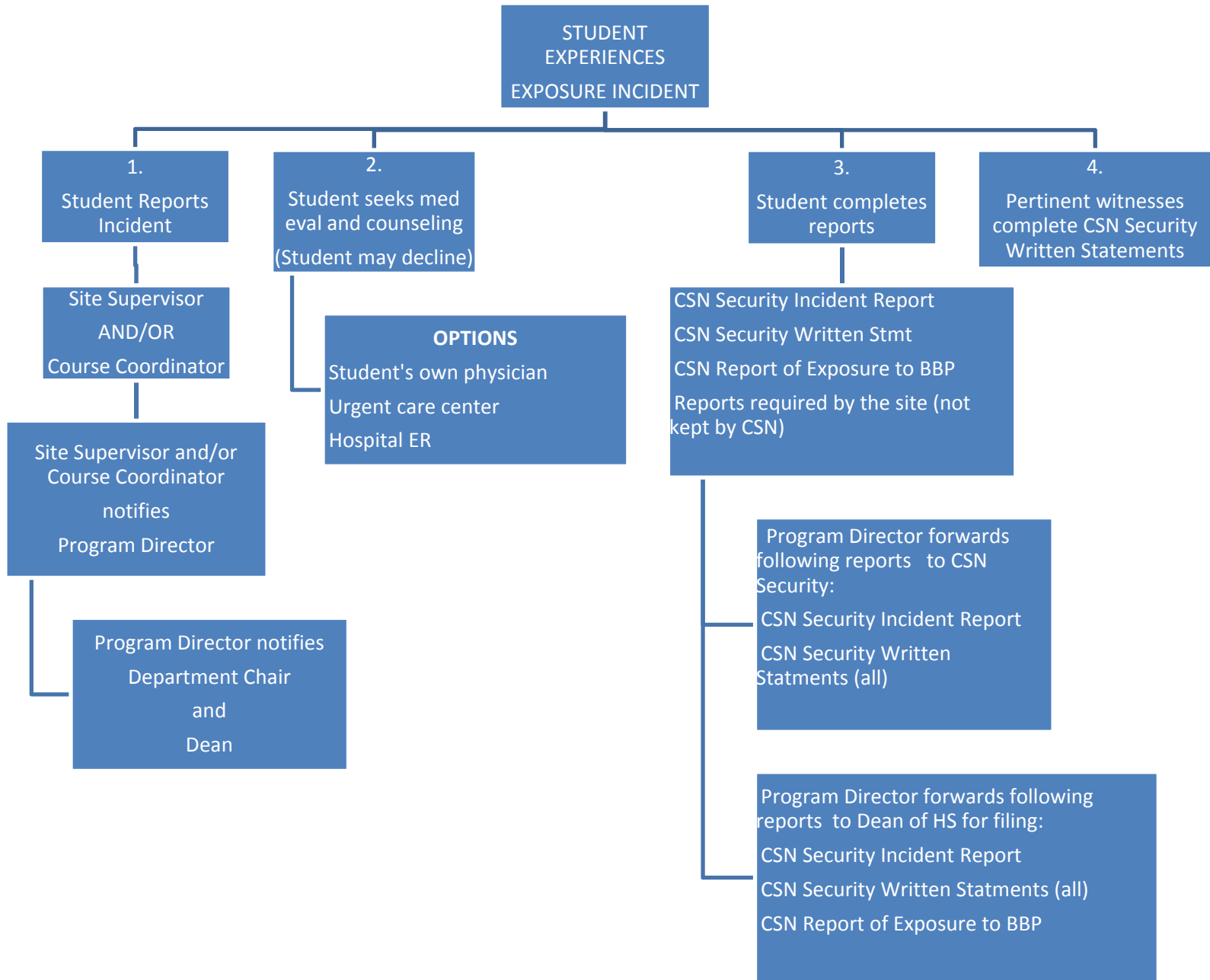
1. STOP the activity.
2. WASH / FLUSH the affected area.
3. IMMEDIATELY REPORT the incident / accident to your SITE SUPERVISOR.
4. GET FIRST AID, as needed.
5. Consider SEEKING MEDICAL EVALUATION and FOLLOW-UP.
6. COMPLETE the necessary REPORTS.

### **REPORTS to be completed:**

- CSN Security Incident Report [available by calling Campus Security 651-5613 (CH campus)]
- [CSN Security Written Statement](#) from pertinent individuals involved or who witnessed the incident.
- [CSN Report of Exposure to Bloodborne Pathogens](#)

### **NOTES:**

- Student may decline medical evaluation and/or follow-up. If a student voluntarily makes this known to the course director, this may be documented in the case file.
- Medical evaluation, treatment and follow-up care after an accident or exposure incident is the FINANCIAL RESPONSIBILITY OF THE STUDENT. Medical insurance is mandatory for every student enrolled in a healthcare program at CSN and must be purchased through a private carrier.
- Students are NOT covered by CSN Workers' Compensation Program.
- Confidentiality shall be maintained as much as possible. Details of the incident shall be shared only with those who have a need to know.





Department of Environmental Health & Safety

## Post-Exposure to Bloodborne Pathogens PROCEDURES

(Exposure to another person's blood or body fluids by cut or stick to skin OR splash to eyes, nose, mouth)

### *EMPLOYEES*

#### INFECTION CONTROL MANAGER

**Jean M. Wolff, RDH, MSEd**  
6375 W. Charleston Blvd  
Las Vegas, NV 89146  
'K' Building, Room 314, W3K  
651-5595 – office  
651-7490 – fax  
806-1001 – cell  
jean.wolff@csn.edu

#### MEDICAL ATTENTION

The initial medical evaluation following an exposure to bloodborne pathogens can take place at any physician's office, quick care or other medical facility.

This link will provide you with healthcare provider options.  
<http://rms.unlv.edu/workerscompensation/wcclinics.php>

**PLEASE NOTE:** Medical evaluation, treatment, and follow-up care after a work related accident or exposure is covered by workers' compensation insurance. *A C-1 form must be completed and filed with the workers' compensation office within 7 days.*

#### Following an exposure to bloodborne pathogens:

1. **STOP** the activity.
2. **WASH / FLUSH** the affected area.
3. **GET FIRST AID**, as needed.
4. **IMMEDIATELY REPORT** the incident/accident to your SUPERVISOR and to the INFECTION CONTROL MANAGER.
5. **COMPLETE** necessary **REPORTS**
  - CSN Written Statement – Incident Report available from program assistants, campus security office and on the School of Health Sciences website
    - *Return to campus security*
  - Report for Exposure to Bloodborne Pathogens available from program assistants, the Infection Control Manager and on the School of Health Sciences website.
    - *Return to Infection Control Manager.*
  - Notice of Injury or Occupational Disease Incident Report (C-1 form) available from program assistants, CSN website and Human Resources. *Return to Workers' Compensation Coordinator **within 7 days.***
6. **SEEK MEDICAL ATTENTION.** The initial appointment may be with any physician or care facility you wish. For the second or additional follow-up appointments, you must choose a physician contracted by your Managed Care Organization. For more information call the Worker's Compensation Office at 702-895-5404 or view this website.  
<http://rms.unlv.edu/workerscompensation/workerscompensation.php>
7. The CSN Infection Control Manager is available for guidance in obtaining medical evaluation, treatment and follow-up care.

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COLLEGE OF SOUTHERN NEVADA POLICE DEPARTMENT  
**VOLUNTARY STATEMENT**

Event # \_\_\_\_\_

THIS PORTION TO BE COMPLETED BY OFFICER		
Specific Crime	Date Occurred	Time Occurred
Location of Occurrence	Sector/Beat	<input type="checkbox"/> City <input type="checkbox"/> County

Your Name (Last/First/Middle)					Date of Birth		Social Security#	
Race	Sex	Height	Weight	Hair	Eyes	Work Schedl. (Hours)	(Days Off)	Business / School
Residence Address (Number & Street)		Bldg/Apt.#	City		State	Zip Code		Res Phone:
Residence Address (Number & Street)		Bldg/Apt.#	City		State	Zip Code		Bus. Phone:
Residence Address (Number & Street)		Bldg/Apt.#	City		State	Zip Code		Occupation
Residence Address (Number & Street)		Bldg/Apt.#	City		State	Zip Code		Depart Date (if visitor)
Best place to contact you during the day					Best time to contact you during the day			Can you identify the Suspect? <input type="checkbox"/> Yes <input type="checkbox"/> No

**DETAILS**

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I HAVE READ THIS STATEMENT AND AFFIRM TO THE TRUTH AND ACCURACY OF THE FACTS CONTAINED HEREIN. THIS STATEMENT WAS COMPLETED AT (LOCATION) \_\_\_\_\_ ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_ AT \_\_\_\_\_ (AM/PM), \_\_\_\_\_

WITNESS/OFFICER: \_\_\_\_\_ (SIGNATURE)

WITNESS/OFFICER \_\_\_\_\_ P# \_\_\_\_\_ (PRINTED)

SIGNATURE OF PERSON GIVING STATMENT \_\_\_\_\_

# COLLEGE OF SOUTHERN NEVADA

## REPORT of Exposure to Bloodborne Pathogens

Following an exposure to bloodborne pathogens incident, please notify the Infection Control Manager by phone and by sending this completed form to:

**Jean Wolff, Infection Control Manager**  
College of Southern Nevada W3K  
6375 W. Charleston Blvd  
Las Vegas, NV 89146  
Office 702-651-5595 Cell 702-806-1001 Fax 702-651-7490

Do not write in this space
CSN Security Incident Report Number: _____
Exposure to BBP Case Number: _____
Number of Written Statements Taken for the Incident: _____

### EXPOSED INDIVIDUAL

Name: PRINT \_\_\_\_\_ Sex: M / F  
Date of Birth \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Phone: home \_\_\_\_\_ Phone: cell \_\_\_\_\_ Phone: work \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check one:

- Employee; indicate department \_\_\_\_\_
- Student; indicate program where enrolled \_\_\_\_\_
- Campus Visitor

### SOURCE INDIVIDUAL

Identify the source individual (the person to whom the exposed individual was exposed), if one exists:

Name: \_\_\_\_\_ Phone: HOME \_\_\_\_\_ OTHER \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### INCIDENT DETAILS

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ Time Incident was reported: \_\_\_\_\_

Name and title of person *initially* notified: \_\_\_\_\_

Location where incident took place: \_\_\_\_\_

Did the accident/exposure result in any of the following? (check all that apply)

- percutaneous exposure (break in skin that caused bleeding)
- mucous membrane contact (eyes, nose, mouth)
- abraded skin, chapped skin, dermatitis
- other, please explain \_\_\_\_\_

Did the incident involve exposure to potentially infectious materials (blood, saliva, body fluids, contaminated solutions)?

- YES  NO describe: \_\_\_\_\_

\*\*\*\* OVER PLEASE \*\*\*\*

**EXPOSED INDIVIDUAL'S STATEMENT**

Describe precisely how the incident occurred. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Describe what was done immediately after the incident. \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe how this incident could have been prevented.  
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\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of person making report

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Supervisor/Witness

Date \_\_\_\_\_

END OF REPORT