










Monroe Community College

Dental Studies Programs

Blood Borne Pathogen Exposure Policy

INCIDENT PROTOCOL

<i>INSTRUCTOR</i>	<i>STUDENT</i>
	
(FORM 1) Make sure student has cleaned the exposed area. Make sure student has contacted Rochester Regional Health Immediate Care/Pulse	Student is exposed IMMEDIATELY WASH EXPOSED AREA FOR FIVE (5) FULL MINUTES
	
(FORM 2) Follow checklist (FORM 3) and Speak to patient (FORM 2) Give FORM 4 to patient	Report exposure to Instructor or clinical supervisor if offsite
	
Contact Public Safety (EXT. 2912) and file incident report ASAP	Call Rochester Regional Health Immediate Care/Pulse at 585-225-5252 or go directly to office if exposure occurs between 9 am-9 pm
Inform Dr. Marsha Bower (mbower@monroecc.edu) ASAP. An incident report must be filed with Public Safety.	
<u>Rochester Regional Health Immediate Care/Pulse Occupational Medicine Sites:</u> <ul style="list-style-type: none">• 2745 Ridge Road West, Rochester, NY 14626 (585) 225 – 5252• 2685 East Henrietta Road, Rochester, NY 14623 (585) 444-0058<ul style="list-style-type: none">• Hours:<ul style="list-style-type: none">• M-F 9am – 9pm;• Sat & Sun 9am – 8pm	Identify yourself as MCC Student – let receptionist know you had a blood exposure – Go to Rochester Regional Health Immediate Care/Pulse
	
	If the incident occurred offsite, follow the agency policy for post-exposure care. Contact Rochester Regional Health Immediate Care/Pulse (585-225-5252). Inform Dr. Marsha Bower (mbower@monroecc.edu) ASAP.
	
	An incident report must be filed with Public Safety.

Blood Borne Pathogen Exposure Policy
Medical Programs

1. If the exposure occurs at MCC, A student who has accidental exposure to a patient's blood or body fluids should IMMEDIATELY clean the wound thoroughly with soap and water for five minutes and report the exposure to the Clinical Instructor. The student should contact ***Rochester Regional Health Immediate Care/Pulse Occupational Medicine, 2745 Ridge Road West, Rochester, NY, 585-225-5252*** as soon as possible after they have been treated at the clinical site as any necessary testing/follow-up care will be coordinated by RRHIC. The office is open 9 am-9 pm M-F and 9am – 8pm on Sat and Sun.
2. If the exposure occurs at a clinical agency where immediate post exposure care is available, the agency policy should be followed. The student should contact ***Rochester Regional Health Immediate Care/Pulse Occupational Medicine, 2745 Ridge Road West, Rochester, NY, 585-225-5252*** as soon as possible after they have been treated at the clinical site as any necessary testing/follow-up care will be coordinated by RRHIC. The office is open 9 am-9 pm M-F and 9am – 8pm on Sat and Sun.

Tell the receptionist that you are an MCC student and have had a blood/body fluid exposure (indicate specifically what happened: that you stuck yourself with a used needle, cut yourself with a used instrument, splashed patient's blood or body fluid in your eye, etc.) and that you have been seen at the clinical agency. RRHIC may request that you bring in documentation of any treatment received at the clinical agency. Staff at *Rochester Regional Health Immediate Care* is expert in occupational medicine and regularly manages exposure follow-up.

3. If the exposure occurs at a clinical agency where post exposure care and/or blood testing is not available, the **student** should immediately call ***Rochester Regional Health Immediate Care/Pulse Occupational Medicine, 2745 Ridge Road West, Rochester, NY, 585-225-5252***. The office is open 9 am-9 pm M-F and 9am –8 pm on Sat. and Sun.

(If exposure occurs when this office is closed, the student should go to the nearest emergency room for post exposure care and contact RRHIC when it opens for follow-up.)

Tell the receptionist that you are an MCC student and have had a blood/body fluid exposure (indicate specifically what happened: that you stuck yourself with a used needle, cut yourself with a used instrument, splashed patient's blood or body fluid in your eye, etc.) and will be coming in for counseling regarding post exposure prophylaxis (PEP) and blood testing. Students should be prepared to show Student ID and insurance information upon arrival.

The Rochester Regional Health Immediate Care staff will provide any added treatment that may be needed for the injury, perform a risk assessment and will provide appropriate testing and prophylactic treatment medications. Follow-up appointments will be made as necessary.

4. The Clinical Instructor will utilize the *Blood Borne Pathogen Checklist (Form 3)* to:
 - Confirm that the exposed **Student** has thoroughly washed the area for a full 5 minutes and has contacted RRHIC.
 - Follow MCC's or the agency policy/procedure for testing the **Source Patient** for HIV and Hepatitis. Results should be sent to Rochester Regional Health Immediate Care/Pulse Occupational Medicine.
 - If the exposure occurs at an agency where testing is not available, the **Source Patient** should be directed to have the blood drawn as soon as possible at *Rochester Regional Health Immediate Care/Pulse Occupational Medicine* at 2745 Ridge Road West (225-5252).
 - Inform the **Source Patient** of the exposure utilizing Form2. If they agree to testing they will be contacted by *Rochester Regional Health Immediate Care/Pulse Occupational Medicine* regarding the results of their blood testing.
 - Advise the **Source Patient** that any charges not covered by the patient's personal insurance will be covered by MCC. Bills should be submitted to the respective Director of Chairperson of the Medical Program for follow up, who will forward to Administrative Services for payment.
 - Ensure that the student goes to Public Safety to complete an Incident Report form.

The Exposed Student will be informed of the **Source Patient's** HIV and Hepatitis status as soon as possible by *Rochester Regional Health Immediate Care/Pulse* and treated as indicated.

**INFORMATION FOR PATIENTS WHEN A STUDENT HAS BEEN EXPOSED TO
YOUR BLOOD/BODY FLUIDS**

1. A student has been accidentally exposed to your blood or body fluid.

There is no risk to you because of this exposure.

2. Certain infections could be transmitted to the student from exposure to your blood.

- a. We ask for your cooperation in obtaining information about blood diseases that you may have. If you know that you have HIV, Hepatitis B or Hepatitis C, please inform the student so that the appropriate treatment of the student can begin as soon as possible.

3. You will be asked to go to Rochester Regional Health Immediate Care /PULSE Occupational Medicine, the consulting clinic for MCC and to sign a consent form agreeing to have your blood tested and the results released to RIC for the treatment of the student for:

- a. Human Immunodeficiency Virus (HIV)
- b. Hepatitis B
- c. Hepatitis C

Any bills related to this testing that are not covered by your health insurance should be submitted to:

**Monroe Community College
Dental Hygiene Department
1000 East Henrietta Road
Rochester, NY 14623**

4. If you choose to have the blood testing done by your Primary Care Physician, the consent form should be signed in the clinic and given to your Primary Care Physician. You will be asked to consent to release the results regarding these blood tests to Rochester Regional Health Immediate Care/PULSE Occupational Medicine, the consulting clinic for MCC. The blood results will be used to determine if the student requires any treatment. The results will be shared with the student. Neither PULSE nor the student may disclose your results to anyone else without your written permission.
5. Rochester Regional Health Immediate Care (RIC)/PULSE Occupational Medicine will contact you regarding your blood test results. These results can also be sent to your primary care physician if you wish.

BLOOD BORNE PATHOGEN EXPOSURE CHECKLIST

BLOOD BORNE PATHOGEN POLICY DENTAL STUDIES

STUDENT UNPROTECTED EXPOSURE TO BLOOD/BODY FLUIDS PROCEDURES

Rochester Regional Health Immediate Care/Pulse Occupational Medicine Sites:

- 2745 Ridge Road West, Rochester, NY 14626 (585) 225 – 5252
- 2685 East Henrietta Road, Rochester, NY 14623 (585) 444-0058
- Hours M-F 9am – 9pm; Sat & Sun 9am – 8pm

Student Name: _____ **M#:** _____

Telephone Number: _____ **Instructor:** _____

Agency Where Exposure Occurred: _____

Date of Exposure: _____

_____ **Make sure the exposed area has been washed thoroughly for five (5) full minutes.**

On Campus Exposure

_____ **Advise the Source Person of need for blood work to be done. Have source person and student contact *Rochester Regional Health Immediate Care/Pulse Occupational Medicine* to arrange testing and follow-up assessment/care.**

_____ **Make sure *Rochester Regional Health Immediate Care/Pulse Occupational Medicine* has been contacted and necessary follow-up assessment/care has been arranged.**

_____ **Give the Source Patient the sheet “Information for Patients When a Student has been exposed to your Blood and Body Fluids”. Reassure them that there is no risk to them!**

_____ **Send the Source Patient to have blood work at *Rochester Regional Health Immediate Care/Pulse Occupational Medicine*.**

_____ **If the Source Patient chooses not to have blood work at *Rochester Regional Health Immediate Care/Pulse Occupational Medicine*, give patient “Informed Consent to Perform HIV testing and Authorization for Release of HIV-related Information for Purposes of Providing Post-exposure Care to a Health Care Worker Exposed to a Patient’s Blood or Body Fluids” form and ask that they have blood work completed as soon as possible. The results will need to be sent to *Rochester Regional Health Immediate Care/Pulse Occupational Medicine*.**

_____ **Contact Public Safety (extension 2912) and they will come to clinic to complete an Incident Report.**

_____ **Make sure the student submits an insurance claim through their insurance carrier.**

Faculty/Staff Signature indicates review of steps with student

Off Campus Exposure

_____ Follow agency protocol for immediate post exposure care if available.

_____ Make sure *Rochester Regional Health Immediate Care/Pulse Occupational Medicine* has been contacted as soon as possible and that necessary follow-up assessment/care has been arranged.

(If post exposure care is not available at the agency, RRHIC should be contacted immediately for post exposure care.)

_____ Inform the Source Patient that a student has been exposed to their blood/body fluids and that they will be asked to consent to having blood drawn to test for HIV and Hepatitis. Reassure them that there is no risk to them!
Results of testing should be sent to *Rochester Regional Health Immediate Care/Pulse Occupational Medicine*.

_____ Instruct student to go to Public Safety to complete an Incident Report

This form authorizes release of health information including HIV-related information. You may choose to release only your non-HIV health information, only your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood; or by special court order. Under New York State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to \$5,000 and a jail term of up to one year. However, some re-disclosures of health and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for more information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019. You may also contact the NYS Division of Human Rights at 1-888-392-3644.

By checking the boxes below and signing this form, health information and/or HIV-related information can be given to the people listed on page two (and on additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your health information must provide you with a copy of this form.

- I consent to disclosure of (please check all that apply):
- My HIV-related information
 - My non-HIV health information
 - Both (non-HIV health and HIV-related information)

Name and address of facility/person disclosing HIV-related information:

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

Relationship to person whose information will be released: _____

Describe information to be released: _____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized: From: _____ To: _____

Exceptions to the right to revoke consent, if any:

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment, or eligibility for benefits
(Note: Federal privacy regulations may restrict some consequences):

Please sign below **only** if you wish to authorize all facilities/persons listed on pages 1,2 (and 3 if used) of this form to share information among and between themselves for the purpose of providing health care and services.

Signature _____ Date _____

* This Authorization for Release of Health Information and Confidential HIV-Related Information form is HIPAA compliant. If releasing only non-HIV related health information, you may use this form or another HIPAA-compliant general health release form.

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:		
6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:		
7. Purpose for Release of Information:		
8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____		
<div style="display: flex; justify-content: space-between;"> INSERT START DATE INSERT EXPIRATION DATE OR EVENT </div>		
<input type="checkbox"/> All health information (written and oral), except:		
<p>For the following to be included, indicate the specific information to be disclosed and initial below.</p> <p><input type="checkbox"/> Records from alcohol/drug treatment programs</p> <p><input type="checkbox"/> Clinical records from mental health programs*</p> <p><input type="checkbox"/> HIV/AIDS-related Information</p>	Information to be Disclosed	Initials
9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:	

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW	DATE
<p>Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.</p>	
STAFF PERSON'S NAME AND TITLE	SIGNATURE
	DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.