NEIDL Agent Incident Reporting Summary October 2020 - December 2020, Q4								
Date of Incident	**Incident Type / Agent Involved**	**BSL**	**Transmissable Person to Person**	**Description**	**Reportable Incident**	**Reportable of Clinical Illness**	**Agency Reported To**	**Comments / Corrective Actions**
10/8/20	ABSL2 mouse bite to right index finger	ABSL-2		A researcher notified ROHP that she was bitteby a non-infectious ABSL2 mouse today.	Yes		BPHC	EHS discussed the incident with the employee. The employee was scruffing an ABSL-1 mouse to perform an IP injection of antibodies when the mouse bit the employee's right index finger. The mouse was not infected or administered any hazardous material at the time of the incident and was sourced from a commercial laboratory. The root cause was attributed to inadequate procedure and upon consultation with EHS and ASC the employee will be anesthetizing all mice prior to handling.
10/27/20	Abrasion to right eye	N/A		The ROHP on call physician received a call 10/27/20 at 5:30 pm that a mechanic working in the NEIDL simulation lab sustained an injury to his right eye.	No		N/A	EHS conducted a follow up investigation with the mechanic who reported they were removing a brass pin from a door hinge and when the pin was pulled free It accidently hit the eye and scratched it. The mechanic irrigated the eye using an eyewash station then sought additional medical follow up for an eye evaluation. The root cause was attributed to lack of PPE. Going forward the mechanic will wear safety glasses when performing this task
11/18/20	Sterile needle stick to right finger	ABSL-2		A NEIDL research assistant called ROHP at 2:25 pm to report she accidentally stuck her right index finger with a sterile needle in the ABSL2.	No		N/A	EHS conducted a follow up investigation with the employee who reported the accidental needlestick occurred while removing the sterile needle from its package to implant a temperature chip into a mouse. The employee confirmed that the needle had not touched the mouse yet and reports no biological or hazardous agents were involved with this incident. The root cause was attributed to lack of awareness/understanding the procedure. The employee will undergo additional training to review proper hand placement and potential utilization of forceps for ths procedure.