Tinton Falls Fire District #1
Borough of Tinton Falls, NJ

Exposure Control Plan

July 24, 2007

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EXPOSURE CONTROL PLAN

Purpose

The purpose of this plan is to assure compliance with the O.S.H.A. 29 C.F.R. 1910.1030, to promote a safe work place and to decrease the exposure to H.I.V., H.B.V. and other communicable diseases. We now know that we should never underestimate the risk of exposure to blood borne pathogens. The Board of Fire Commissioners of Tinton Falls District #1, along with the Fire Chiefs of Wayside Fire Company and the Pine Brook Fire Company will be responsible for compliance with this regulation. The Fire Chiefs will institute as many work practices and engineering controls as possible to eliminate or reduce exposure to blood borne pathogens.

This written exposure control plan will be available from the Exposure Control Officer or Fire Chiefs and will be available in the District Fire Stations at all times. This policy will be available for all members to read. The Exposure Control Officer will review and update it as needed. The Board of Fire Commissioners will review this plan once a year and document this training.

Each member will receive a copy of this plan upon joining, will read and follow this plan. Our members have the most important role in our blood borne pathogen compliance program, for the ultimate execution of much of our **Exposure Control Plan** rests in their hands. In this role they must do things such as:

1. Know what tasks they perform that have occupational exposure.
2. Attend the blood borne pathogens training seminars.
3. Plan and conduct all operations according to work practice controls.
4. Develop good personal hygiene habits.

Training

The District will provide all equipment needed to follow the plan. Each member will take the complete Infection Control Training Program when possible during his or her probationary period. A refresher course will be given once a year to retrain and update all members. The Exposure Control Officer will organize and hold this program with the cooperation of the training committee.

The District will try to ensure a safe work place. If there are any questions or concerns they will be directed to the Exposure Control Officer. Activities delegated to the Exposure Control Officer include, but are not limited to:

1. Overall responsibility for starting the Exposure Control plan for the entire District's operation.
2. Working with management and other employees to develop and administer any additional blood borne pathogens related policies and practices needed to support the effective use of this plan.
3. Looking for ways to improve the **Exposure Control Plan**, and revise and update the plan when necessary.
4. Collecting and maintaining a suitable reference library on the Blood borne Pathogens Standard and blood borne pathogens safety and health information.
5. Knowing current legal requirements concerning blood borne pathogens.
6. Acting as the District's liaison during OSHA inspections.
7. Conduct periodic audits to maintain an up-to-date **Exposure Control Plan.**
8. The Exposure Control Officer will evaluate the manner in which any member may have possibly been exposed to a communicable disease. When complete they will notify the respective Fire Chief, the Exposure Control Officer and Occupational Health and Safety at a Meridian Occupational Health Center. All possible exposures should be referred to a Meridian Occupational Health Center for their evaluation.
9. The Exposure Control Officer will assure that the District carries out all parts of this plan concerning an exposure. The Exposure Control Officer will keep all information confidential.
10. The Exposure Control Officer will be responsible for a monthly quality assurance and compliance report to be presented to the District.
11. Maintain an up-to-date list of personnel requiring training.
12. Develop suitable education/training programs.
13. Scheduling periodic training seminars for the District.

The Exposure Control Officer will be appointed annually by the President of the Board of Fire Commissioners of Fire District #1 and will be appropriately trained in their roles and responsibilities.

Review and Update of the Plan

We recognize that it is important to keep our **Exposure Control Plan** up-to-date. To ensure this, the Exposure Control Officer will review and update the plan under the following circumstances:

1. Annually.
2. Whenever new or modified tasks and procedures are implemented which effect occupational exposure to our members.
3. Whenever we revise the members' jobs such that new instances of occupational exposure may occur.

Training records must be kept in the individual member's files. We will hold them for thirty years and they will include the following:

A. Training dates
B. content or summary on the training
C. names and qualifications of the trainer(s)
D. job titles of trainers
E. Attendees

All members will be responsible for their own safety and health. They will wear all equipment and P.P.E. necessary for each emergency and non-emergency response. Members will report any exposures at once to an Officer or the Exposure Control Officer for immediate follow-up.

Exposure

An exposure incident is specific eye, mouth, other mucous membrane, nonintact skin, or parenteral (subcutaneous, intraorbital, intraspinal, intrasternal, intravenous, etc.) contact with blood or other potentially infectious material that results from the performance of a member's duties. An example of an exposure incident would be a puncture from a contaminated sharp or needle.

Confirmed exposure/contacts would be determined as those that the rescuer is involved with, in any of the following situations.

1. Mouth to mouth resuscitation;
2. Parenteral or mucous membrane contact (i.e., splashes to mouth, nose, eye, nonintact skin) of any patient body fluids.
3. Contamination with feces from an incontinent patient with a history of diarrhea;
4. Needle sticks by a contaminated needle. Needles attached to piggyback tubing at the distal port where there is no blood present will be considered non-contaminated exposure;

5. Direct contact with clothing or bedding suspected of having pediculosis;
6. Human bites or scratches by patients.

Job Classifications

1. High Risk Classifications, reasonably expected to be exposed to blood and body fluids:
   a. Probationary Members - when riding during training, maximum exposure due to unpredictable; uncontrollable; dangerous and sometime life-threatening situations.
   b. Active Members - (Firefighters) maximum exposure due to unpredictable; uncontrollable; dangerous and sometime life-threatening situations.
   c. Life Members - (Firefighters) maximum exposure due to unpredictable; uncontrollable; dangerous and sometime life-threatening situations.
2. Low Risk Classifications, not reasonably expected to be exposed to blood and body fluids:
   a. Life Members – (if not riding on fire apparatus) no exposure
   b. Social Members - when not riding, minimal to no exposure.

Hazard Communications

Once a year a training seminar, following DIVISION OF FIRE SAFETY FIREFIGHTER TRAINING standards and standards accepted by the STATE OF NEW JERSEY OFFICE OF EMERGENCY MEDICAL SERVICES, will be provided to instruct all members with a potential for exposure. It will consist of at least:

1. modes of transmission of communicable diseases
2. symptoms
3. epidemiology
4. warning signals relating to possible exposure
5. post exposure care
6. prevention

All Calls Infectious

All calls, emergencies or otherwise, may involve exposure to blood and other potentially infectious materials and are to be treated as such. Work activities involving potential exposure to blood borne pathogens include, but are not limited to:

1. Bleeding control with spurting blood.
2. Bleeding control with minimal bleeding.
3. Treating burn wounds.
4. Emergency childbirth.
5. Oral/Nasal suctioning.
6. Airway maintenance, oral/nasal.
7. Measuring a blood pressure.
8. Direct patient contact.
9. Handling and cleaning infected equipment and/or materials.
10. CPR.
11. Vomiting or inducing vomiting.
12. Caring for patients with incontinence of urine and/or feces.

Prevention

Methods of Prevention are as follows:

1. The hepatitis B vaccination series will be made available to all members who have the possibility of an occupational exposure. We will make this available within ten working days before doing patient care after appropriate H.B.V. training has been completed.
2. We will train and supply members with the following information on the Hepatitis B vaccination upon joining the one of the District fire companies:
   a. safety
   b. benefits
   c. efficacy
   d. availability at no cost to the member.

   The H.B.V. program is available to any member whom we offered and then refused the vaccine in the past.

   If the U.S. Public Health Service recommends a routine booster at a future date, we will make such booster(s) available to all members at no cost to the member.

   The hepatitis B vaccination series is available by contacting Meridian Occupational Health Center. Should a member choose to refuse the hepatitis B vaccine, they must sign a declination form.

3. **B**ODY **S**UBSTANCE **I**SOLATION will be used with patients who may cause you to contact semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, any body fluid visibly contaminated with blood and all body fluids in situations where differentiating between body fluids is

difficult or impossible. This also includes nonintact body organs. Gloves will be used on all patients, gowns, masks, eye protection and shoe booties will be worn when there is a chance of splash or splatter of blood.

4. **S**TANDARD **P**RECAUTIONS should be consistently used for **ALL** people. Since medical history and examination cannot reliably identify persons infected with H.I.V. or other blood-borne diseases, blood and body fluid precautions should be used. This approach, previously recommended by the Communicable Disease Center, and called "Universal Blood and Body Fluid Precautions" or "Standard Precautions," should be used in the care of **ALL** people. These precautions should be mandatory in emergency care settings where the risk of blood exposure is increased and the infection status of the person is usually unknown. The infection control procedures outlined below must be used as routine professional skills when blood and/or body fluids of any patient are present.
   a. Bandage all cuts and abrasions on your own body (especially your hands) before caring for any patient.
   b. Gloves will be used on all patients when there is a reasonable risk of exposure to blood or bodily fluids. Gowns, masks, eye protection and shoe booties will be worn when there is a chance of splash or splatter of blood. Face masks and goggles, or a plastic face shield must be worn when the possibility of splashing or splattering of blood is likely.
   c. After patient contact, avoid touching your mouth, eyes or other mucous membranes until you have thoroughly washed your hands. We should wash hands immediately after removal of potentially contaminated gloves or other personal protective equipment. Make it a practice to wash your hands after every call. "Dry" soap products, foil wrapped hand-washing preparations or antiseptic solutions can be used if soap and running water are not available. Hand washing is still the best overall protective measure for all! Following any contact of body areas with blood or any infectious materials, members will wash their hands and any other exposed skin with soap and water when possible. They should also flush exposed mucous membranes with water.
   d. Use pocket masks, bag-valve masks or other resuscitative equipment when giving resuscitation to **ANY** patient. Pocket masks should have a one-way valve.
   e. Needle stick injuries and/or any injury breaking the skin must be reported and counted as an injury.
   f. If it becomes necessary to move or handle a dead body, the response should be the same as for situations requiring CPR. Wear gloves and

cover all cuts and abrasions to create a barrier and carefully wash all exposed areas after any patient contact. Such procedures should be followed after contact with the blood of anyone, regardless or whether they are known or suspected to be infected with H.I.V. or H.B.V.. These precautions should also be used when handling amputated limbs, hands, or other body parts.

j. When **unanticipated** contact with body fluids occurs, remove body substances by thoroughly washing hands and face, cleansing cuts and laundering clothing as needed. Following any contamination of an member's gear or clothing, the member will place the soiled items in a red biohazard bag, seal the bag, and then mark the item for laundering at a dry cleaner at the District's expense.

Methods of control

1. Members will not handle needles, sharps and IV catheters.
2. Disposable airway equipment, pocket masks or bag-valve-masks will be used when possible during resuscitative measures.
3. We will supply members with and expect that they wear disposable gloves, heavy extrication gloves, face shields, masks, eye protection, gowns, aprons, and shoe booties. When needed, heavy-duty extrication gloves will be used with disposable latex gloves worn inside. We will instruct members how to choose the appropriate size. Selection criteria should include dexterity, durability, fit and the tasks that we will undertake while the gloves and other protective items are worn.
   a. Latex rubber gloves - minimum acceptable protection to be used in the care of injured or ill patients. A non-latex substitute is available as an option, and also in cases where a patient may have a latex allergy.
   b. Heavy duty gloves - preferred protection to be worn at all possible times by immediate care personnel.
   c. Surgical masks - to be used/worn by either the care providers or preferably the patient when possible if there is a significant risk or respiratory problems such as Tuberculosis, Flu, etc.
   d. Pocket masks - mandated for use in cases when advanced airway equipment is not immediately available.
   e. Goggles/Face shields - to be worn when giving respiratory care such as oral airway insertion, suctioning, etc.

f. Gowns - to be worn when clothing may become soiled with blood, body fluids, secretions or excretions.

g. Shoe booties - to be worn when there is a chance of splash or splatter of body fluids.

4. We will replace gloves when possible if torn, punctured, or when their ability to function as a barrier is compromised. We will not wash or decontaminate them for reuse.
5. For multiple trauma victim calls, we will change gloves between patient contacts if the emergency situation allows. For situations where large amounts of blood are likely to be encountered, it is important that gloves fit tightly at the wrists to prevent contamination of hands around the cuff.
6. The location of the above items is clearly visible on fire apparatus and will be pointed out to every new member and again at yearly training seminars.
   a. Gloves are available of front line fire apparatus.
   b. Complete personal protective kits are available from EMS units.
7. We will instruct members how to use equipment so that they will avoid direct contact with bodily fluids.
8. We will instruct members as to the decontamination of reusable equipment.
9. Used, disposable care items will be deposited in a waste receptacle in an red biohazard; these materials will be disposed of properly at a medical waste receptacle.
10. On scene waste will be deposited in a waste receptacle in an ambulance on scene containing a red biohazard bag; if possible. This bag will be left at the hospital for disposal.
11. We will remove gloves prior to performing any other functions.
12. We will wash hands at the earliest possible time after handling any patient at an emergency scene. If you are on scene and running water and soap is not available, antiseptic hand cleaner will be provided. We will wash hands with running water and soap when possible after.
13. We will wash hands after using the bathroom.
14. We will wash hands before eating.
15. We will wash hands before and after preparing food.
16. Following any contact of any body area with blood or body fluids, members will wash their hands and any other exposed skin with soap and water when possible. Use a towel to turn the faucet handles so you don't re-contaminate yourself and others. Flush exposed mucous membranes with water. Water for flushing is available on the apparatus should running water not be available.
17. Fresh, clean gloves will be worn when decontaminating equipment.

18. Under no circumstances will the bathroom or kitchen areas be used for decontamination of any equipment.
19. Emergency response vehicles must be kept clean and sanitized. They will be cleaned after every exposure incident.
20. We must decontaminate contaminated surfaces with a disinfectant upon completion of procedures or contaminate when by splashes, spills, or contact with blood or other potentially infectious materials.
21. We will inspect all equipment on a scheduled weekly basis to ensure that there are no body fluids present. If found, we will then decontaminate this equipment.
22. We must decontaminate all reusable receptacles on a scheduled weekly basis. The officers of the District fire companies will be responsible for seeing that this is scheduled and done.
23. All body fluid stained personal clothing will be cleaned immediately or when possible after the call with Hydrogen peroxide or 70% isopropyl alcohol at the hospital. The clothing should then be dry cleaned for decontamination.
24. There will be no eating, drinking, smoking, applying of cosmetics or lip balm, or handling contact lenses in the fire apparatus.
25. The line officers of the District fire companies will be required to maintain a working inventory of all of the above-mentioned items for personal protection and decontamination.
26. A biohazard label and the biohazard sign will be used to identify all items, containers or work areas that contain blood or body fluids and for which special precaution must be taken. Labels must be fluorescent orange or orange red and be firmly attached to the container.
27. A member may **temporarily** choose not to wear protective equipment under rare circumstances when in the member's professional judgment, it prevents the delivery of emergency care in a life threatening situations or poses a greater hazard to other members.
    a. An injured person walks up to you when you don't expect, or you are not prepared, and they present to you with a life threatening injury that requires your immediate attention. An example would be an arterial bleed.
    b. A member who must begin mouth to mouth resuscitation on a patient while on a scene before EMS arrival.
    c. When the member chooses to do so, the Exposure Control Officer will investigate and document this event to decide whether we can make changes to prevent such occurrences in the future.

Medical Record Keeping

A. A physical exam is required with each application to the District. This physical should include a test for Hepatitis B immunization. If this test is positive, there is no need for the H.B.V.. If this test is negative, the member is to begin the series immediately upon acceptance into the squad or sign the appropriate declination. We recommend that all members be up to date with DPT, Measles, Mumps and Rubella, and yearly influenza vaccines and yearly P.P.D. This medical record will remain with the District.

B. Should an exposure occur, medical evaluation will be done by an approved physician or in the nearest Emergency Department. An exposure should immediately be reported to the Exposure Control Officer of the District or an Fire Chief in his or her absence. This report will be treated with the strictest confidence. Following this exposure, a written report of the incident will be prepared and recommendations will be made to prevent further such exposure incidents.

C. Exposures should be reported at a meeting of the District. Retaining confidentiality, circumstances related to the exposure should be discussed as a means to educate the District to prevent future exposures.

Blood borne or Airborne Exposure Follow up Procedures

The following is a guideline for proper evaluation and treatment of Tinton Falls Fire District #1 members who inadvertently have been exposed, through either percutaneous or mucosal contamination, to blood products or secretions from patients at risk for carrying Hepatitis B and H.I.V.. The term "member" refers to the person who has sustained inadvertent exposure, and "source" refers to the person from whom the blood came.

Throughout this procedure, if the physician recommends Hepatitis B vaccine and the exposed squad member refuses, we should document this on the member's health chart (to be kept in the strictest of confidentiality) and the remainder of the recommended therapy should be given. The District will maintain these records. Tetanus prophylaxis should be offered if the patient is not up to date.

Parenteral exposure is defined as puncture (needle stick) or cut (a scalpel blade, a sharp instrument) with a contaminated device.

Mucous membrane exposure is defined as a splash to the eye or mouth with blood or other body fluids.

Cutaneous exposure is defined as exposure involving large amounts of blood or prolonged contact with blood especially when the exposed skin is chapped, abraded, or afflicted with dermatitis.

A. If a member sustains any of the above exposures, and we know the source patient, then . . .

1. The source patient should be informed by hospital personnel of the incident and tested for serologic evidence of H.I.V. infection and Hepatitis B surface antigen positivity after consent is obtained.
2. Refer to source patients' admitting hospital regarding obtaining consent for testing an incompetent patient.
3. An Emergency Response Employee (“ERE”) Report is to be completed in accordance with the Ryan White Act.

B. If the source patient has AIDS, is H.I.V. positive, or refuses the test;

1. The member should be evaluated clinically and serologically for evidence of H.I.V. infection when possible after the exposure.
2. The member should be advised to seek medical attention for any febrile illness that occurs within twelve weeks after the exposure.
3. Seronegative members should be retested six weeks, twelve weeks, six months, and one year post-exposure. This will be done at the District's expense.
4. If the source patient is H.I.V. Negative but is considered in a high-risk group, the member should be retested six weeks, twelve weeks, six months, and one year post-exposure. This will be done at the District's expense. High-risk groups include:
    a. IV drug abusers
    b. Sexual partners of IV drug abusers
    c. Newborns of H.I.V. positive mothers
    d. Homosexual and bisexual men
    e. Haitians
    f. Hemophiliacs
    g. Patients receiving multiple blood transfusions

C. the member's health record will contain the following:

1. the member's name and social security number
2. a copy of the member's hepatitis B vaccine status.
    a. dates of any vaccinations
    b. medical records relative to the member's ability to receive vaccinations
3. dates of tetanus vaccinations

D. the Emergency Responder Exposure report form will contain the following:
   1. the date, time and location of the exposure
   2. what potentially infectious materials were involved in the incident
   3. document the route of exposure and how exposure occurred
   4. identify and document the source individual
   5. what job was being done when the exposure occurred?
   6. what caused the exposure to occur?
   7. what personal protective equipment was being used at the time of the exposure?
   8. what actions were taken as a result of the exposure?
      a. member's decontamination
      b. notifications made.
   9. copies of the results of the examination, medical testing and follow up procedures that took place because of the exposure.
   10. a copy of information will be provided to the consulting physician as a result of any exposure to blood borne pathogens.
   11. all information will be kept confidential and will not be released without the written permission of the member.
   12. These records will be held and maintained by the District.

E. Obtain consent and test the member's blood when possible to determine infectivity and document (if consent for testing is given) the source individual's blood test results. If we know that the source was infectious for H.B.V. or H.I.V., testing need not be repeated to determine the known infectivity of the source.
   1. provide the exposed squad member with the test results
   2. provide the exposed squad member with information about applicable disclosure laws and regulations concerning the source identity and infectious status.

F. Obtain consent, collect, and test the member's blood when possible after the exposure incident.

G. If the exposed member consents to baseline blood collection but does not consent to H.I.V. serologic testing, the member's blood samples must be preserved for at least ninety days. If, within ninety days of the exposure incident, the member agrees to have the baseline sample tested, such testing will be conducted when feasible.

H. Following the post-exposure evaluation, the treating physician will provide a written opinion to the Exposure Control Officer. This opinion is limited to a statement that the member has been informed of the results of the evaluation and told of the need, if any, for further evaluation or treatment. All other findings

are confidential. The Exposure Control Officer must provide a copy of the written opinion to the member within fifteen days of the evaluation.

I. A copy of the Blood borne pathogens standard, a description of the member's job duties as they relate to the incident, a report of the specific exposure (an accident report), including the route of exposure, and relevant members' medical records, including Hepatitis B vaccination status will be supplied to the treating physician.

J. All records pertaining to the exposure incident must be held on file for at least the duration of employment plus thirty years.

K. Should a member sustain a human bite, routine medical and surgical therapy (including an assessment of tetanus vaccination status) should be implemented as soon as possible. Victims of bites should be evaluated as described above for exposure to blood or any other infectious body fluids.

Equipment/Apparatus Decontamination

DISINFECTION PROCEDURES (For items contaminated by blood, semen, vaginal secretions, urine, feces and saliva and/or other body fluids).

Any equipment or devices known or suspected to be contaminated with blood or body fluids should be used once and disposed of, or be thoroughly cleaned and disinfected after use while at the hospital. We will wipe all visible contaminated spills with a paper towel before disinfecting. This paper towel will be disposed of as biohazardous waste and red-bagged to be deposited in the hospital.

1. “TB-Cide Quat” is recommended. Should this not be available, a mixture of ten parts water to one part chlorine bleach (10:1 solution, prepared immediately before use) can be used to disinfect equipment that is not adversely effected. Does not use bleach on metal (it may discolor or eat the metal). Persons should wear disposable heavy-duty kitchen gloves when cleaning surfaces. All sections of the vehicle should be cleaned regularly as part of routine maintenance.
2. Because there can be a risk of transmission of H.I.V. through blood in saliva, disposable airway equipment and resuscitation bag-masks should be available. Reusable equipment should be cleaned with hot, soapy water and air-dried, then disinfected with bleach or other disinfectant as above.
3. Unless the stethoscope and blood pressure cuff are contaminated with blood or body fluids, no special precautions are indicated. If the blood pressure cuff is contaminated, we should remove the bladder and the outside should be washed in hot water or dry-cleaned. The bladder can be cleaned with “TB-Cide Quat.” If this is not available, use full strength Lysol. If the stethoscope is contaminated, it

should be also be cleaned with “TB-Cide Quat.” We should wipe the ear tips and bell of the stethoscope after each patient use with a suitable disinfectant agent.

4. All persons involved in the clean up must wash thoroughly with an antibacterial soap.

THESE DECONTAMINATION PROCEDURES ARE ONLY NEEDED IF THE PERSON HAS SPIT, VOMITED, BLED, URINATED OR DEFECATED on EQUIPMENT

Cleaning Procedures for Turnout Gear
(per N.F.P.A. 1581)

1. Before washing, heavily soiled garments should be pretreated.
   a. Apply liquid detergent to the soiled area.
   b. Rub gently to create a lather.
   c. Wash as the turnout manufacturer recommends.
   d. Never use chlorine bleach!
2. Washing procedures. (Use Gear Washer Machine in Station 36-2)
   a. Turn washing machine power on.
   b. Follow posted directions on machine.
   c. Add garments to be washed.
   d. Set machine for a washing cycle
   e. Machine should be programmed for a double rinse. This ensures detergent removal.
   f. Remove garments from the machine and dry by hanging in a shaded area that receives good cross ventilation or hang on a line and use a fan to circulate the air.

Tinton Falls Fire District #1

Exposure Report Form - Employee Vaccine Immunization History

Member's Name: _____ Date of Joining: _____

1. **H.B.V.** vaccination series completion date: _____

Comments: _____

_____

_____

Results of subsequent antibody testing: _____

2. **Tuberculosis** skin test: Pos. ____ Neg. _____ Date: _____

Comments: _____

_____

_____

3. **Measles:**

Did you have measles as a child? Yes _____ No _____

If yes, date: _____

If no, were you vaccinated before 1957? Yes _____ No _____

If yes, date: _____

Have you had a second vaccination any time after 1956?

Yes _____ No ___

If yes, date: _____

4. **Mumps**: Vaccination date: _____ Contraction date: _____
5. **Rubella:** Vaccination date: _____ Contraction date: _____
6. **Polio:** Vaccination date: _____ Contraction date: _____
7. **Chicken Pox:** Vaccination date: _____ Contraction date: _____
8. **Tetanus/Diphtheria:** Last known vaccination: _____

Tinton Falls Fire District #1

Exposure Report Form - Blood or Body Fluids

To be completed by emergency responder at the time of incident

Date: _____ Time: _____

Exposed Member Information:

Name: _____ Rank: _____

Soc. Sec. #: _____ Phone (H): _____

Address: _____

City: _____ State: _____ Zip: _____

Incident information:

Call Address: _____ Time out: _____

Type of Call (e.g., MVA, medical, cardiac, trauma, etc.): _____

Exposure Description: _____

Date of Exposure: _____ Time of exposure: _____

1. What body fluids were you in contact with?

Blood: _____ Feces: _____ Saliva: _____ Sputum: _____

Sweat: _____ Tears: _____ Urine: _____ Vomitus: _____

Other (describe): _____

2. What was the method of contact?

_____Needle stick with contaminated needle

_____Blood/body fluid into natural body opening (e.g., nose, mouth, eye)

_____Blood/body fluid into cut, wound, sores, or rashes less than 24 hours old

Please specify: _____

_____ Blood/body fluid on intact skin

_____ Other (describe specifically): _____

3. How did the exposure occur? Be specific._____

_____

_____

4. What action was taken in response to the exposure to remove the contamination (e.g., hand washing)? _____

_____

5. What personal protective equipment was being used at the time of exposure?

_____

_____

6. Please describe any other information related to the incident (use a separate piece of paper if needed): _____

_____

_____

_____

_____

Source of exposure: _____

Name of Patient (source of exposure):_____ Sex: _____

Receiving hospital: _____

Transported in (vehicle number): _____

Medical information:

1. Did you seek medical attention? _____ Date: _____

If yes, where? _____

2. Did you contact the Hospital Infection Control Officer? _____

If yes, give date and time: _____

Name of Hospital Infection Control Officer: _____

_____ _____

Member's Signature Date

_____ _____

District Exposure Control Officer's Signature Date

To be completed by Squad Exposure Control Officer:

Communicable disease follow-up needed: Yes* _____ No _____

** If yes, Exposure Control Officer must complete the Communicable Disease Exposure Follow-up Form. This procedure applies either if this is a known disease exposure or if such information is determined at a future date.*

Communicable Disease Exposure Follow-up Form

To be completed by the Exposure Control Officer

Member Name: _____ Date of Exposure: _____

Call Address:_____ Time of Exposure: _____

Exposure source (patient's name): _____

Patient's Communicable Disease Diagnosis: _____

_____

How was the diagnosis made known to you? Give source name and phone number: _____

Date diagnosis was made known to you: _____

Has member ever received appropriate vaccination?

Yes _____ No _____ N/A _____

If yes, which vaccination and when? _____

* *

Please document all interactions (telephone, verbal, correspondence, or other) with employee or source (patient) treatment facility concerning the exposure, including dates: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Communicable Disease Exposure Follow-up Form (Continued)

Tinton Falls Fire District #1
Post - Exposure Evaluation and Follow-up Checklist

The following steps must be taken, and information transmitted, in the case of any member's exposure to Blood borne pathogens:

ACTIVITY	COMPLETION DATE
Member furnished with documentation regarding exposure incident.	_____
Source individual identified (_____) *source individual must remain confidential)*	_____
Source individuals' blood tested and results given to exposed member (if consent has been granted) ____ consent has not been able to be obtained.	_____
Exposed member's blood collected and tested.	_____
Appointment arranged for member with health care professional (_____) *Professional's name*	_____
Documentation forwarded to health care professional • Blood borne pathogens standard • Description of member's duties • Description of exposure, including routes of exposure • Result of source individual's blood testing • Member's medical records	_____

_____ _____

Exposure Control Officer Date