

Doña Ana County
FIRE & EMERGENCY SERVICES

SOG- POST EXPOSURE REPORTING FORM

Purpose

Address Occupational Exposure to Blood Borne Pathogens (BBP). Define exposures and identify the reporting & testing process. This policy is to be used in conjunction with Dona Ana County Bloodborne Pathogen Exposure Control Plan No. 2009-02

Policy

This policy applies to all Dona Ana County Fire & Emergency Services employees/ volunteers. Each Dona Ana County Fire District shall have a Designated Officer (DO) this will default to the district chief or his/ her designee. Career fire staff will follow the direction of fire administration staff with exposure reporting.

Definition of Exposure Report

Have you experienced an exposure involving blood or body fluids that are not your own, did these fluids splash/ splatter to your eyes, mouth, nose, open wound, cut or puncture wound on your skin?

If you had “a needle stick” or sustained any other penetrating wound or cut to the skin with a used needle or contaminated item.

If you were in an enclosed space/ area with a patient for more than an hour and this patient has been diagnosed with an active reported communicable infection like Tuberculosis or Meningitis.

If you suspect you were exposed to a communicable/ infections disease and sustained an injury while on the job.

Important! If an individual feels he or she has been exposed during duties of operation they should stop operations as soon as it is safe; move to sanitize, disinfect and wash the exposed areas.

Paper Trail Checklist Packet

- DAC Fire SOG/ Exposure Form
- Authorization to communicate directly with HCP Form (make a copy of the signed form)
- Notice of Exposure & Source Patient Testing (blue form, make a copy of the signed form)
- Provident First notice form for volunteer staff only.
- Career Staff use online: elsol/workerscomp; Notice of Accident (NoA) 575.647.7234 for paid employee's only.
- Company Nurse Injury Hotline page
- DAC Fire PPE unit Check List

- County Manager's Administrative Directive No. 2009-02 Blood Borne Exposure Plan

Procedure / Step by Step

1. Provider has identified a possible Blood Borne Pathogen (BBP) exposure.
2. Individual reports possible exposure of a Blood Borne Pathogen (BBP) to the individual's DO.
- 3 DO investigate to determine if a true BBP exposure occurred. Yes or No, the definition is outlined first page.
4. Not an exposure; none occurred; DO will follow up with counseling with personnel document; personnel will provide feedback.

Resource: Company Nurse Injury Line 1-575-647-7234

5. If an exposure is confirmed; YES.
6. Is source patient testing wanted? 7. Yes, complete the blue NESPT request form (included in packet).
8. The NESPT form will be taken to the receiving hospital by the DO.

Note: Source patient test results reported by the hospital within 48 hours, hospital will contact Department of Health (DOH) for Communicable Disease when results are positive.

If the personnel received injury requiring immediate medical care, report to an urgent care or emergency medical facility. This is suggestive; emergency rooms are limited in actions they can provide to mitigate post exposures. If the individual feels there is a medical need this will not be denied.

9. As per Drug and Alcohol Testing policy personnel is to be tested after treatment (seen at an urgent care or emergency room) is complete; see attached form. As per HR P&P 6-31, B. Post Accident Alcohol & Controlled Substance Testing within 2 hours of persons seeking medical treatment.

NOTE: The intent of this document is to be an exposure process and NOT to be a drug test or accident policy.

(All must complete step 10)

10. *Notice of Accident*; **paid staff** is to complete a NoA on the El Sol website, login is required to complete the NoA.

NOTE: all workman comp issues are dealt with at DAC Legal Department.

Volunteer staff must complete the Provident First Notice Form this is for volunteer staff only. The forms are included in this packet (4 pages.)

11. DO and/or exposed personnel should take the entire completed packet to fire administration the following working day. Fire administration will act as a POC for personnel and DOH representative. Regardless of source patient outcome; personnel exposed should see the DAC medical designated provider within in 72 hours for post exposure follow-up; see step 12.

This is the best method to ensure effective management plan for the individual exposed. Emergency rooms often are not able to meet the needs of an exposures plan. If they issue prescriptions it will be for the personnel to purchase.

Note: DOH representative may request additional test and recommendations thru the DAC medical designated provider as part of the employee's Exposure Management Plan. This is an "on the job exposure" and will require Workman's Comp Paperwork (for career staff not volunteers) and follow-up through our Risk Management Program. Treatment, disease management and prophylaxis form DOH for Infectious Disease Exposure should be coordinated through the DAC medical provider. This is to effectively manage the cost of blood tests and medications. Medical provider is able to discuss risks and treatment options for BBP exposure.

A fire staff member may refuse treatment options for BBP exposure, only after reporting the incident as per DAC policy. They may refuse to seek primary follow-up with DAC designated contract provider upon completing this form.

I (place name of individual exposed) _____ acknowledge all the information in this packet was present to me. I fully understand and recognize my options for BBP exposures and a medical primary follow-up to an exposure. I have completed my paperwork as per policy. At this particular time I do not wish to have a primary follow-up to this particular BBP exposure with Dona Ana County's contract medical provider.

Signature: _____ **Date:** _____

(Optional)

12. Personnel may follow-up the following working day with:

Primary; WorkMed at 2525 S Telshor 521.1919 8-5 M-F

Secondary: Occupational Medicine 360 2525 S Telshor 556.0360 8-4 M-F

Note: Step 12 is intent to provide follow up and not for emergency care.

IMPORTANT: Failure to complete this form & submit the outline process will result lack of proper completion and the contract provider for DAC will not cover the financial cost.

_____ **Initials**

13. Fire administration reports the incident to Risk Management Office and/ or legal.

Post-Exposure Evaluation & Follow-Up:

The Legal Department will coordinate with the exposed employee or volunteer and designated health care professional to complete a confidential medical evaluation, follow-up and referral for counseling if necessary. Health care professional must provide a limited written opinion to the County about the exposure incident and the employee must receive a copy of that opinion.

Source Patient Testing

(Blue request form needs to be delivered to medical facility as soon as possible after notification.)

MMC ER: 575.521.2286

Liaison:

Dir. Infection Control Twyla Anderson: 575.521.2240

MVRMC ER: 575.556.6800

Liaison:

Infection Preventionist Rodney Valdez: 575.556.6894

Source Patient Information:

Name: _____ DOB _____ Age _____

Gender _____

Patient was transported to _____ at approximately (time): _____

Patient # _____ (If used for anonymity/billing purposes)

DO Contracted receiving medical facility to request testing / delivered written request/ information: Yes No Date _____ Time _____

To whom was the request made? _____

Source patient blood drawn? Yes No

Medical facility liaison notified DO regarding test results: Yes No

Name of person who notified DO: _____

Receiving medical facility will carry out exposure notification/ management as soon as possible but within 48 hours as required in the Ryan White Law Public Law, SB 1793, and PartG

Test Results:

(Attach any received documentation)

Date _____ Time: _____

Final Exposure Disposition

(Info needed on whom to contact as per County Legal/ Risk Management Departments)

Exposure Information:

(Body Fluids That Fall Under "Other Potentially Infectious Materials" (OPIM): cerebrospinal fluid, synovial fluid, amniotic fluid, pericardial fluid, vaginal secretions (sexual contact), semen (sexual contact), ANY BODY FLUID CONTAINING GROSS VISIBLE BLOOD.)

- Blood Borne Airborne/Droplet
- Exposed to: Blood Bloody Fluid Other _____
- Contaminated needle stick injury
- Blood/ OPIM direct contact with surface of the eye, nose or mouth
- Blood/ OPIM direct contact with open area of the skin
- Cuts with sharp object covered with blood/ OPIM
- Human bite/blood drawn

Area Exposed:

Hands Face Eyes Nose Mouth Other _____

Task being performed:

PPE used: Yes No Type: _____

Needle safe device used: Yes No Not Available

First Aid Performed: Yes No Not Available Description of FAP or Decontamination

Employee's immunization status checked: Yes No

Immunization info: _____

Was medical Treatment provided: Yes No

DO Investigation Date: _____ Time: _____

DO Name: _____ Contact info: _____

Sharps Injuries will be maintained at DAC legal Department.

No Sharps Exposure.

Report must include: date of the injury, type and brand of device involved, department and work area, typed explanation of how the incident occurred.

OSHA 29 CFR 1904 Recordkeeping to be done by the Legal Department

Sharps Injury Log to be reported to

Completed by (DO) _____ **Date** _____ **Time** _____

Doña Ana County
FIRE & EMERGENCY SERVICES

This is to supplement County Manager's Administrative Directive No. 2010-01, Dona Ana County Personal Protective Equipment Policy.

PPE Responder & PPE Check List; equipment shall be provided to the responder on all "response units" as per NM Dept. of Health and EMS Systems Bureau.

- Face Shield & surgical face mask with helmets
- Impermeable gown or full apron
- Disposable EMS gloves; nitrile examination gloves with extended cuffs.
- Disposable N95 respirator
- Eye protection
- Safety vest / jacket (ANSI 2008 Complaint)
- Disposable splash protection
- Tyvex coveralls (optional)

Decontamination

- Secured double bagged medical waste container.
- Sani-Cloth & Metricide Disinfectant
- Hand sanitizer per unit

Prevention with the proper sharps equipment

- All catheters are Auto-guard
- Safety Lancets

Workers' Name:

DOB:

SSN:

Claim Number:

AUTHORIZATION TO COMMUNICATE DIRECTLY WITH HCP

I authorize communication between my Health Care Provider (HCP) and the adjuster, employer, medical case manager, attorney, or other representatives of my employer and its insurance carrier to discuss issues without me being present that pertain to my accident/injury, causation, return to work status or additional medical care that may be requested.

MY DECISION TO SIGN OR NOT SIGN THIS FORM DOES NOT AFFECT ANY BENEFITS THAT MAY BE DUE.

Worker's signature: _____

Date: _____

Witness to signature: _____

Date: _____

Trabajadores Nombre:

DOB:

SSN:

Demanda Número:

AUTORIZACIÓN A COMUNIQUÉSE DIRECTAMENTE CON HCP

Autorizo la comunicación en medio mi abastecedor del cuidado médico (HCP) y el ajustador, patrón, encargado médico del caso, abogado, u otros representantes de mi patrón y de su portador de seguro a discuta las ediciones sin mí que es presente que pertenecen a mi accident/injury, causalidad, vuelta al estado del trabajo o asistencia médica adicional que pueden ser solicitado.

MI DECISIÓN A LA MUESTRA O NO FIRME ESTA FORMA NO AFECTE CUALQUIER VENTAJA ESA PUEDE SER DEBIDO.

FirmadeWorker's: _____

Fecha: _____

Firma del testigo: _____

Fecha: _____

NOTICE OF EXPOSURE AND SOURCE PATIENT TESTING REQUEST

TO BE COMPLETED BY FIRST RESPONSE AGENCY

RECEIVING HOSPITAL: (CIRCLE) MMC MVRMC OTHER _____
556-7272

FIRST RESPONDER NAME: _____ DATE EXPOSED: _____

AGENCY: _____ TIME: _____

PHONE: _____

SOURCE PATIENT NAME: _____ DATE TRANSPORTED: _____

TRANSPORTED TO: _____ TIME TRANSPORTED: _____

TYPE OF EXPOSURE:

_____ MOUTH TO MOUTH RESUSCITATION

_____ INTUBATION

_____ THROAT EXAM

_____ SUCTIONING

_____ BLOOD/BODY FLUID CONTACT WITH:

_____ EYES

_____ NOSE

_____ MOUTH

_____ PUNCTURE/CUT W/ SHARP

_____ OPEN WOUND/LESION

_____ NON-INTACT SKIN

ADDITIONAL DESCRIPTION

AGENCY'S DESIGNATED INFECTION CONTROL OFFICER: _____

DICO CONTACT: CELL PHONE: _____ OFFICE: _____

NAME/TITLE OF PERSON COMPLETING THIS SECTION: _____

SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE RECEIVING HOSPITAL

IDENTIFIED DISEASE: _____

DATE SPECIMEN COLLECTED: _____

REPORTED TO AGENCY'S DESIGNATED INFECTION CONTROL OFFICER:

DICO NAME: _____ DATE: _____

AGENCY: _____ TIME REPORTED: _____

NAME/TITLE OF PERSON COMPLETING THIS SECTION: _____

SIGNATURE: _____ DATE: _____



Important Notice Regarding Fraud

- ❖ ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.
- ❖ ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- ❖ ***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- ❖ ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- ❖ ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ❖ ***For residents of Maine, Tennessee, Virginia and Washington:***
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- ❖ ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of Maryland :*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- ❖ ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- ❖ ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- ❖ ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- ❖ ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- ❖ ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- ❖ ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Volunteer Only



FIRST NOTICE OF CLAIM

PROVIDENT AGENCY, INC.
 272 ALPHA DRIVE - P.O. BOX 11588
 PITTSBURGH, PA 15238
 TOLL-FREE: 800-447-0360
 PHONE: 412-963-1200
 CLAIMS DEPT FAX: 412-963-0148
 www.providentbenefits.com

BOTH SECTIONS MUST BE COMPLETED

| | | | |
|--|-------------------------|--|--|
| Name | | Date of Birth / / | Social Security Number |
| Address | | City | State Zip Code |
| Email Address | | Home Phone Number () | |
| What is your regular, full time occupation? | | Employed By (Name of Company) | |
| Employer's Address | | City | State Zip Code |
| Please enclose pre-injury pay stub or the prior years W2 or Schedule C (if self-employed). | | Wages/Earnings Hourly: Weekly: | Date of Hire (Full Time Occupation) / / |
| Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM | Date of Accident / / | Place of Accident | Date Last Worked / / |
| What is your injury or illness? | | How did it happen? | |
| Name and Address of Treating Physician | | Name and Address of Hospital | |
| Did you lose any Time from Work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time | | Did you file with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| I was totally disabled from / / to / / | | | |
| I was partially disabled from / / to / / | | | |
| Date you have or are expected to return to work / / | | | |

I CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I hereby authorize any physician, hospital, insurer, governmental agency, other organization or person having any records, data or other information concerning me to furnish such records, data or information as may be requested by Provident Life and Accident Insurance Company or its duly authorized representative. I understand that in executing this authorization I waive the right for such information to be privileged. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Claimant Signature _____

THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM MUST BE SIGNED AND RETURNED TO PROVIDENT AGENCY.

THIS SECTION TO BE COMPLETED BY AUTHORIZED MEMBER OF FIRE DEPARTMENT, RESCUE OR AMBULANCE SQUAD

To be complete by an official of the Named Insured (must be someone other than the claimant or claimant's family member).

| | |
|---|-------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was a member of your organization at the time of injury or illness | Policy Number |
| <input type="checkbox"/> Yes <input type="checkbox"/> No – Claimant was engaged in an authorized activity at the time of injury or illness | |
| Name of Fire/Rescue/Ambulance Company/District or Relief Association | Your Municipality |
| Print Name and Title | Signed |
| Address | Date / / |
| City | State Zip Code |
| Telephone Number () | |
| Is the claimant a <input type="checkbox"/> Volunteer <input type="checkbox"/> Career <input type="checkbox"/> PT employee <input type="checkbox"/> Auxiliary <input type="checkbox"/> Other | |

See Fraud Warning Important Notice sheet attached.

Volunteer Only



Provident Agency, Inc. - Main Office: PO Box 11588 - 272 Alpha Drive
Pittsburgh, PA 15238-0588
Toll-Free: 800-447-0360 Fax: 412-963-0148

NOTE: This authorization allows the _____ to release all information pertaining to an injury that occurred on or about _____ to Provident Agency, Inc. You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; and employer that has information about my health, financial or credit history, earnings, employment history, or other insurance claims and benefits including Social Security benefits, to disclose any and all of this information to persons who administer claims for Provident. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Provident obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Provident has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above. I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

(Claimant Signature)

(Date Signed)

(Print Name)

(Social Security Number)

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.



DISABILITY CLAIM

(PLEASE HAVE ALL SECTIONS COMPLETED AND RETURNED TO)
Provident Agency, Inc.; 272 Alpha Drive; P.O. Box 11588
Pittsburgh, PA 15238
Phone: 800.447.0360 Fax: 412.963-0148

Authorization for Release of Protected Health Information

You are not required to sign the authorization, but if you do not, we may not be able to evaluate or administer your claim(s). I understand if I do not sign this authorization or if I alter its content in any way, Provident may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). Please sign and return this authorization to Provident Agency, Inc. noted above.

I authorize _____ to release information from the record of:

Name of Facility/Person: _____
Birth Date: ____/____/____
SS # / MR #: _____
Name of Facility/Person: Provident Agency, Inc. Phone: (412) 963-1200 Fax: (412) 963-0148
Name of Facility/Person: _____ Phone: _____ Fax: _____
272 Alpha Drive, PO Box 11588, Pittsburgh, PA 15238
Facility/Person Address

for the purpose of (PROVIDE A DETAILED DESCRIPTION): Insurance Benefits

Parts 1 and 2 must be completed to properly identify the records to be released:

1. Type of records to be released and approximate date(s) of service (check all that apply):

- Inpatient Emergency Department Dates: _____ to _____
- Outpatient Physician Office/Clinic

I authorize the release of: (check all that apply) Mental Health Information Drug and Alcohol Information, contained in the records indicated above.

2. Specific information to be released (check all that apply):

- Consults Medical History & Physical Exam Physician Orders
- Discharge Summary/Instructions Medication Records Progress Notes
- Laboratory Reports/Tests Operative Report Psychiatric/Psychological Eval
- Mammography Reports Pathology Report Radiology Report
- Emergency Dept. Reports EKG Report (s)
- Other: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release

I understand that this Authorization is valid for a period of two (2) years from the date of the signature, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information.

Date of Signature _____ Signature of Patient (14 years of age or older may authorize release of inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor may authorize release of Drug & Alcohol treatment information.) _____
Date of Signature _____ Signature of Authorized Representative N/A
 Parent or Legal Guardian Power of Attorney
 Next of Kin of Deceased Executor of Estate
Please provide supporting documentation

ORAL AUTHORIZATION (for persons physically unable to sign)

NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses are required)

Date _____ Witness # 1 _____ Date _____ Witness # 2 _____

IN CASE OF WORKPLACE INJURY:
ACCION a seguir en caso de un accidente en el trabajo



1-575-647-7234

AVAILABLE 24 HOURS A DAY

- 1** Injured worker notifies supervisor.
Empleado lesionado notifica a su supervisor.
- 2** Supervisor / Injured worker immediately calls injury hotline.
Supervisor / Empleado lesionado llama inmediatamente a la línea de enfermeras/las.
- 3** Company Nurse gathers information over the phone and helps injured worker access appropriate medical treatment.
Profesional Médico obtiene información por teléfono y asiste al empleado lesionado en localizar el tratamiento médico adecuado.

EMPLOYER NAME
(NOMBRE DE COMPAÑIA)

SEARCH CODE
(CÓDIGO DEL BÚSQUEDA)

Dona Ana County, NM

NMDAC

Notice to Employer/Supervisor:

Please post copies of this poster in multiple locations within your worksite. If the injury is non-life threatening, please call Company Nurse prior to seeking treatment. Minor injuries should be reported prior to leaving the job site when possible.

Visit us online: www.CompanyNurse.com

Doña Ana County
FIRE & EMERGENCY SERVICES

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- Safety vest / jacket (ANSI 2008 Complaint)
- Disposable splash protection
- Tyvex coveralls (optional)

Decontamination

- Secured double bagged medical waste container.
- Sani-Cloth & Metricide Disinfectant
- Hand sanitizer per unit

Prevention with the proper sharps equipment

- All catheters are Auto-guard
- Safety Lancets

County Manager's Administrative Directive No. 2009-02

Supersedes Directive No. 2006-2

**TITLE: Bloodborne Pathogen Exposure Control Plan
 For Doña Ana County**

I. PURPOSE

The purpose of this document is to serve as the Exposure Control Plan (ECP) for **Doña Ana County in compliance with the OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030.**

- A. This plan ensures that all designated employees (as defined herein) are:
 - 1. Aware of potential hazards from exposure to bloodborne pathogens.
 - 2. Advised of the appropriate procedures to minimize the risk of exposure.
 - 3. Provided with necessary personal protective equipment and vaccinations.
 - 4. Establishes post exposure procedures and recordkeeping.

- B. This plan will not supercede an Exposure Control Plan developed by a County department, but will supplement other County plans if not complete.

- C. It is the policy of Doña Ana County to provide a safe and healthful work environment for all of its employees by minimizing exposure to bloodborne pathogens.

II. BACKGROUND

Certain pathogenic microorganisms can be found in the blood of infected individuals. These "bloodborne pathogens" (BBP) may be transmitted from the infected individual to other individuals by blood or certain body fluids. Employees in certain job classifications and certain authorized volunteers (Covered Employees) have a potential for exposure to blood or other potentially infectious material (OPIM) of others. Those employees have a risk of becoming infected with these bloodborne pathogens, developing disease, and in some cases, dying. Infected individuals are also capable of transmitting the pathogens to others. The two most significant bloodborne pathogens are Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV). On December 6, 1991, OSHA issued a standard for occupational exposure to these bloodborne pathogens. The standard became effective March 6, 1992. Additionally the standard was revised effective April 18, 2001 to include the "Needlestick and Prevention Act."

III. RESPONSIBILITY

The County Manager is responsible for the administration and delegates the following authority to implement this plan. The Risk Manager shall conduct annual reviews to assess proper implementation of procedures, assure that training records are maintained, and medical records are kept properly. The Risk Manager shall update this plan as necessary with concurrence from the Safety and Loss Control Committee. The Risk Manager shall also report any noncompliance to the County Manager and the Safety and Loss Control Committee. The Risk Manager shall assist the department directors with training as requested.

Each County department is responsible for complying with all elements of this plan except where noted. Questions about the policy are to be referred to the County Risk Manager. The department director shall ensure that Covered Employees receive training as required and that the plan is followed.

IV. ELEMENTS OF THE PLAN

- A. Exposure Determination.
- B. Methods of Compliance
 - 1. Universal Precautions
 - 2. Engineering and Work Practice Controls
 - 3. Personal Protective Equipment (PPE)
 - 4. Housekeeping
- C. Hepatitis B Vaccination
- D. Post-exposure Evaluation and Follow-up
- E. Communication of Hazards to Employees
 - 1. Labels & Signs
 - 2. Information and Training
- F. Record Keeping

V. EXPOSURE DETERMINATION (Covered Employees)

This plan applies to any employee or authorized volunteer (**Covered Employee**) who may have occupational exposure to other individuals' blood or certain bodily fluids. The current job classifications for which exposure may occur are listed below.

- | | | |
|----|--|------------------------|
| A. | Deputies, Detectives and Investigators | (Sheriff's Department) |
| B. | Animal Control Officers | (Sheriff's Department) |
| C. | Crime Scene Techs. Evidence Custodians | (Sheriff's Department) |
| D. | Correctional Officers | (Detention Center) |
| E. | Medical Staff | (Detention Center) |
| F. | Solid Waste Transfer Station Attendants | (Utilities Department) |
| G. | Environmental Codes Enforcement Officers | (Sheriff's Department) |
| H. | Grounds Workers | (Facilities and Parks) |
| I. | Custodial Workers | (Facilities and Parks) |
| J. | Maintenance Workers | (Facilities and Parks) |
| K. | Firefighters | (including volunteers) |
| L. | Emergency Medical Technicians | (including volunteers) |
| M. | Wastewater Operators | (Utilities Department) |

VI. METHODS OF COMPLIANCE

A. Universal Precautions refers to a concept of bloodborne disease control that requires that all human blood and certain OPIM be treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

The Universal Precautions are to be followed wherever the potential exists for contact with human blood or OPIM.

B. Engineering and Work Practice Controls

1. Engineering work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.
2. Department management shall solicit input from non-managerial employees who are potentially exposed to blood borne pathogens and from contaminated sharps and in identification, evaluation, and selection of effective engineering work practice controls.
3. Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness
4. Hand Washing: is the single most effective means preventing the spread of infections. Hands must be washed immediately when:
 - a. contaminated with blood or OPIM.
 - b. after gloves are removed.
5. Keep hands away from eyes, mouth, or any mucous membrane.
6. When hand washing facilities are not immediately available, antiseptic hand cleanser in conjunction with clean cloth/paper towels, or antiseptic towelettes shall be used. Hands shall be washed with soap and running water as soon as possible.
7. Eye wash stations that can provide a 15-minute source of water are to be available to Covered Employees at their normal worksites. Otherwise portable eye wash containers providing at least 16 oz of eyewash are to be available to Covered Employees in vehicles and remote sites.

C. Personal Protective Equipment (PPE)

Personal Protective Equipment will be considered "appropriate" only if it does not permit blood or OPIM to pass through or reach the employee's work clothes, skin, eyes, mouth, or other mucous membranes under normal conditions of use. Supervisors of Covered Employees should review PPE needs with Risk Management. PPE includes:

1. Disposable gloves must be of appropriate quality for the procedure performed and of the appropriate size for each employee.
2. Disposable (single use) gloves shall be replaced as soon as practicable if they are torn, punctured, or when their ability to function as a barrier is compromised.
3. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

4. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, exhibit other signs of deterioration, or when their ability to function as a barrier is compromised.
5. Masks, in combination with eye protection devices (such as goggles or glasses with side shields or chin-length face shields) shall be worn whenever splashes, spray, splatter, or droplets of blood or other body fluids may be generated, and eye, nose, or mouth contamination can be reasonably anticipated.
6. Appropriate protective clothing such as gowns, aprons, lab coats, or similar outer garments shall be worn in occupation exposure situations. The type and characteristics will depend on the task and degree of exposure anticipated.
7. Required personal protective equipment will be provided and maintained at no cost to the employee.

D. Housekeeping

1. General

- a. Department Supervisors shall ensure that the worksite is maintained in a clean and sanitary condition. They shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the type of surface to be cleaned, type of hazard present, and tasks or procedures being performed in the area.
- b. All equipment and environmental and work surfaces shall be decontaminated with an approved disinfectant immediately or as soon as feasible when surfaces become contaminated with blood or OPIM.
- c. Broken glassware that may be contaminated is only picked up using mechanical means, such as a brush and dustpan.

2. Regulated Waste

- a. Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded, and closed prior to removal to prevent spillage or protrusion of contents during handling.
- b. All regulated waste will be stored and disposed of in accordance with federal, state and local regulations.
- c. Contaminated sharps are discarded immediately or as soon as possible in containers that are closable, puncture-resistant, leak proof on sides and bottoms, and appropriately labeled or color-coded. Sharps disposal containers must be easily accessible and as close as feasible to the immediate area where sharps are used.

d. Employees who encounter improperly disposed needles on County property shall dispose of the needles in puncture resistant, leak proof and re-sealable containers that have a biohazard label. Labels and or containers are available from Risk Management. The following should be noted.

1. Needles should never be recapped.
2. Use a mechanical device or tool (forceps, pliers, broom, dustpan, etc.) to pick up a needle.
3. Breaking or shearing of needles is dangerous – do not do it.
4. A drop box for contaminated needles is available at:

Public Health Building
1170 N. Solano
Las Cruces, NM 88001

3. Laundry

Do not launder contaminated clothing at home. There is a risk of contaminating other laundry and family members.

a. Laundry contaminated with blood or OPIM shall be handled as little as possible. Appropriate PPE shall be worn when handling. Place in a labeled or color-coded bag or container (or self-dissolving plastic bag, if available), and take it to a commercial laundry and identify the bag as containing potentially contaminated clothing.

b. Risk Management recommends each department with this type of exposure create a purchase order with American Linen and request several self-dissolving plastic bags from them. The bag containing the contaminated clothing will need to be taken to:

American Linen
550 N. Church St.
Las Cruces, NM. 88001
505-526-6641

VII: HEPATITIS B VACCINE

- A. The Hepatitis B vaccine shall be offered to all employees who are identified in the **EXPOSURE DETERMINATION (Covered Employees) section** or are later determined to have an occupational exposure.
- B. It shall be made available, at no cost, to all Covered Employees after their initial training and within 10 working days of initial assignment to duties that expose them to blood or OPIM unless: (1) the employee has previously received the complete Hepatitis B vaccination series and has records of the vaccinations, (2)

the vaccine is contraindicated for medical reasons, or (3) the Covered Employee signs a declination form.

- C. Risk Management will coordinate all Covered Employee Hepatitis B vaccinations, will maintain a vaccination status log of each Covered Employee (except for volunteers).
- E. If the employee initially declines the Hepatitis B vaccination but at a later date decides to accept the vaccination, the vaccination shall then be made available.
- F. All employees who decline the offered Hepatitis B vaccination shall sign the OSHA-required waiver indicating their refusal (form below).
- G. Note: the Center for Disease Control does not currently recommend a post vaccination testing for most occupational classes except health care workers. Booster vaccinations are also not routinely recommended. For special circumstances, consulting a Medical Professional is recommended.

VIII. POST-EXPOSURE EVALUATION AND FOLLOW-UP

- A. When the employee incurs an exposure incident, it shall be reported immediately to their supervisor and the Risk Management Department. All exposure incidents shall be reported, investigated, and documented.
- B. An immediate attempt should be made to obtain a sample of the blood or OPIM that created the exposure.
- C. Following a report of an exposure incident, Risk Management will coordinate with the exposed employee and designated health care professional to complete a confidential medical evaluation, follow-up, and referral for counseling if necessary.
- D. The health care professional must provide a limited written opinion to the County about the exposure incident, and the employee must receive a copy of that opinion.

IX. Communication of Hazards to Employees

1. Labels & Signs

- a. Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers container blood or OPIM; and other containers used to store, transport blood or OPIM.
- b. Labels required by this section must comply with OSAH 1910.1030 (g) (1) (i) [B] and shall be fluorescent orange or orange-red with letters and symbols of contrasting color.
- c. Labels shall be affixed by string, wire, adhesive, or other method that prevents their loss or other unintentional removal.
- d. Red bags or containers may be substituted for labels.

2. Information and Training

All Covered Employees and all newly hired employees shall participate in a training program. Training will occur before assignment to a task where occupational exposure may take place and at least annually thereafter for Covered Employees. Additional training will be provided when changes such as modification of tasks or procedures affect the employee's occupational exposure.

The training program will include the following topics and can be coordinated through Risk Management:

- A. Review the County's Exposure Control Plan and how the employee can obtain a copy of the written plan.
- B. Minimum training elements outlined in OSHA 1910.1030 (g) (2) (vii)

X. RECORDKEEPING

A. Training Records

Training records are completed for each employee upon completion of training. These documents will be kept for at least three years.

The training records include:

- the dates of the training sessions
- the contents or a summary of the training sessions
- the names and qualifications of persons conducting the training
- the names and job titles of all persons attending the training sessions

Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to department director or Risk Management.

B. Medical Records

Medical records are maintained for each employee with occupational exposure in accordance with 29 *CFR* 1910.1020, "Access to Employee Exposure and Medical Records."

Risk Management is responsible for maintenance of the required medical records. These confidential records are kept in the Risk Management Department for at least the duration of employment plus 30 years.

Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to the Risk Management Department.

