

# INFECTIOUS CONTROL EXPOSURE PACKET

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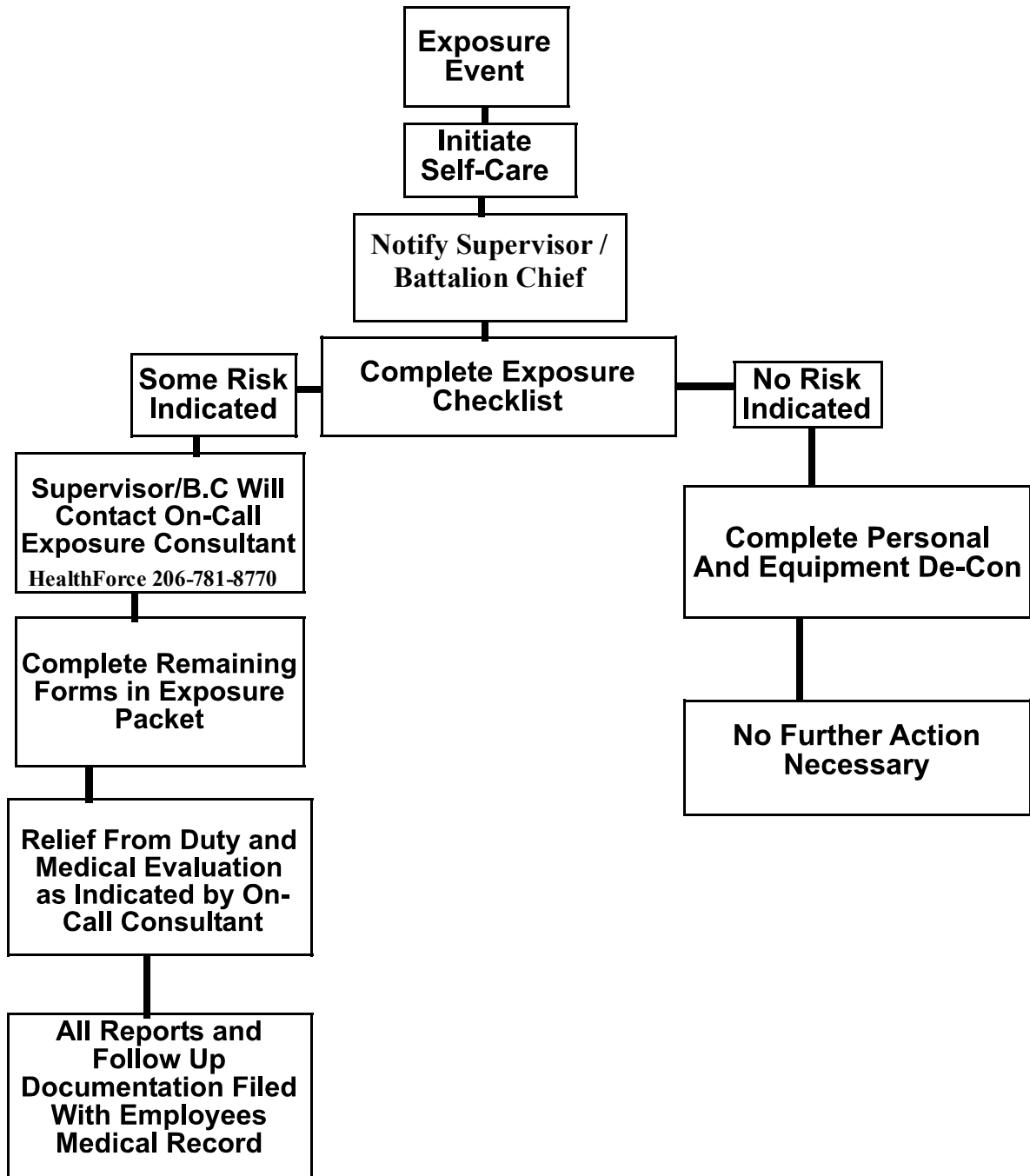
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### Body Fluid Exposure Flow Chart



## **INFECTIOUS CONTROL EXPOSURE CHECKLIST-EMPLOYEE**

**FOR USE WHEN A PERCUTANEOUS OR MUCOCUTANEOUS EXPOSURE HAS OCCURRED**

### **Immediate (on-site) Response**

**1. INITIATE SELF CARE.** If BBP entry site is puncture or wound, bleed the wound site and wash with soap/water or other disinfectant ASAP. For exposure to mucous membranes, blow the nose and expectorate from the mouth immediately then flush mucous membranes with water or saline.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**2. CONTACT THE ON-DUTY BATTALION CHIEF/ MSO/ or Supervisor ASAP.**

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**3. Complete BODY FLUID EXPOSURE WORKSHEET PAGE 4 to decide exposure extent.**

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

If Body Fluid Exposure Worksheet indicates "No Risk" **STOP HERE**

### **Medical Management of Exposure defined as "Some Risk"**

**4.** If you have a type of exposure defined as "Some Risk" by the Exposure Worksheet, you should put yourself out of service as soon as possible. Transportation will not be a problem; arrange this with the Battalion Chief.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**5.** If you need to seek medical care for any exposure, you will be sent to an appropriate medical facility as determined by the on-call Exposure Consultant.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**6.** Take with you the HEALTH CARE PROFESSIONAL (HCP) REPORTS, Pages 7, 8, and 9. These are to be filled out by the HCP. The employee report to be sent back to you only. The Employer Report must be sent back to the agency by the HCP within ten (10) days. A release back to work must be signed by the HCP and be given to employee's supervisor before being allowed to return to work.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**7.** In this packet is a copy of the BLOODBORNE PATHOGENS RULE. Ask the Health Care Professional if they have a copy of the rule. If not, give them this copy.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**8.** Contact AIDS Prevention Project if source serostatus not known and the on-call Exposure Consultant is unable to obtain it.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

## INFECTIOUS CONTROL EXPOSURE CHECKLIST-EMPLOYEE

### Post-Exposure Documentation

**9.** When you are done and have completed your plan of treatment, you must fill out the following paperwork available from your Department (as applicable):  
a. Worker's Compensation Form, Volunteer/Pension Reporting Form, Agency Accident/Injury Report, Sharps Injury Log.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

### Post-Exposure Follow-up

**10.** Contact the on-duty Battalion Chief. Advise that you are done and when you will be returning to work. (You will need a return to work note from the Health Care Professional (HCP Employer Report).

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

**11.** Battalion Chief provides a copy of the completed HCP evaluation to employee and to employee's record.

DATE: \_\_\_\_\_

Employee Initial: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Infection Control Officer: \_\_\_\_\_ Date: \_\_\_\_\_

## **INFECTIOUS CONTROL EXPOSURE**

## BODY FLUID EXPOSURE WORKSHEET

Employee

Name: \_\_\_\_\_

Date of Exposure: \_\_\_\_\_ Time of Exposure: \_\_\_\_\_

Incident #: \_\_\_\_\_ Current Date: \_\_\_\_\_ Time: \_\_\_\_\_

Unit Assignment: \_\_\_\_\_ Name of Officer in Charge: \_\_\_\_\_

### SOURCE OF EXPOSURE

\_\_\_\_\_ Blood \_\_\_\_\_ Semen/Vaginal Secretions

Other Bodily Fluids if Contaminated with Blood (OBF)

\_\_\_\_\_ Spit/Saliva \_\_\_\_\_ Sero-Sanguinous Fluid \_\_\_\_\_ Feces

\_\_\_\_\_ Urine \_\_\_\_\_ Pus \_\_\_\_\_ Other(List) \_\_\_\_\_

\_\_\_\_\_ Vomitus

### TYPE OF EXPOSURE

A. Some Risk

Broken Skin

\_\_\_\_\_ Needle Stick

\_\_\_\_\_ Laceration, Abrasion

\_\_\_\_\_ Open (weeping) lesions or scratches

\_\_\_\_\_ Puncture, Incision

Mucous Membrane

\_\_\_\_\_ Eye \_\_\_\_\_ Mouth \_\_\_\_\_ Nose

B. No Risk

\_\_\_\_\_ Intact Skin

\_\_\_\_\_ Contaminated Clothing/Personal

\_\_\_\_\_ Protective Equipment

### ACTION

A. \_\_\_\_\_ Some risk - Proceed with evaluation per on-call Exposure Consultant.

B. \_\_\_\_\_ No risk - Change contaminated clothing/personal protective equipment.

DURATION OF EXPOSURE: \_\_\_\_\_ min/hr

### EXTENT OF EXPOSURE

\_\_\_\_\_ Drop(s) of Body Fluid \_\_\_\_\_ Large Amount of Body Fluid

\_\_\_\_\_ Other (Explain) \_\_\_\_\_

### CONCLUSION

Disposition:

\_\_\_\_\_ To Counseling on \_\_\_\_\_ (Date)

\_\_\_\_\_ To Testing on \_\_\_\_\_ (Date)

\_\_\_\_\_ To Change Clothing

\_\_\_\_\_ Report Closed and Filed

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Exposed Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN TO CHECKLIST STEP 4

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Appendix A of Exposure Control Plan

REPORTABLE EXPOSURE FOLLOW UP
CONFIDENTIAL EMPLOYEE REPORT
TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

CAUTION: This is a limited report containing only the information allowed and required by OSHA Regulations to be released to the Employee ONLY.

EMPLOYEE NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF EXPOSURE: \_\_\_\_\_ ESTIMATED TIME: \_\_\_\_\_

Route of Exposure:

\_\_\_\_\_
\_\_\_\_\_

Circumstances of Exposure:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Table with 4 columns: SOURCE INDIVIDUAL, POS, NEG, UNK. Rows include HIV TESTING, HBB TITRE, HBC TESTING, OTHER.

Table with 2 columns: EMPLOYEE BLOOD COLLECTION DONE?, YES, NO. Rows include SENT FOR HIV TESTING, SENT FOR HBC TESTING, SENT FOR TITER HBB, IS HEPATITIS B VACCINATION? INDICATED, GIVEN.

Are there any other medical conditions that may result from exposure to blood or other potentially infectious materials that require further evaluation or treatment?

Health Care Professional Name: \_\_\_\_\_
Address: \_\_\_\_\_
Phone: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Signature: \_\_\_\_\_

**REPORTABLE EXPOSURE FOLLOW UP  
BACK TO WORK RELEASE  
TO BE COMPLETED BY HEALTH CARE PROFESSIONAL**

Employee Name: \_\_\_\_\_ is authorized to return to work.

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Health Care Professional:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Employee must return this completed form to employer to be authorized to return to duty.

**REPORTABLE EXPOSURE FOLLOW UP  
 REPORT TO EMPLOYER  
 TO BE COMPLETED BY HEALTH CARE PROFESSIONAL**

CAUTION: This is a limited report containing only the information allowed and required by OSHA Regulations to be released to the Employer.

Employee Name: \_\_\_\_\_

	YES	NO
Employee has been provided completed Health Care Report with 15 days of exposure.	_____	_____
Is Hepatitis B Vaccination indicated? _____	_____	_____
Was Hepatitis B Vaccination given?	_____	_____
If not, is signed declination form attached?	_____	_____
Was Tetanus shot required?	_____	_____
Was Tetanus shot given?	_____	_____
I HAVE a copy of the Bloodborne Pathogens Rule.	_____	_____
I HAVE BEEN PROVIDED with a copy of the Bloodborne Pathogens Rule. _____	_____	_____
This employee has been informed of the results of the evaluation and told of the need, if any, for further evaluation and treatment.	_____	_____
Health Care Professional		
Name: _____		
Address: _____ Phone: _____		
Signature: _____ Date: _____		

This report must be returned to the employer within 10 days of the completion of the evaluation by the Health Care Professional.

Please return to: \_\_\_\_\_