Wake County Fire Departments

ADDRESSING

OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS, AIRBORNE & DROPLET TRANSMITTED DISEASES

April, 2017

IMPORTANT NOTICE

This Plan has been developed solely for the Wake County Fire Departments. The format of this Plan is proprietary and to be used only for the Wake County Fire Department this plan can not be copied without written permission of Katherine West, RN, BSN, MSEd.

SCOPE

The Wake County Fire Departments recognize that many of its personnel are involved in job responsibilities that may place them at risk for direct contact with blood and other potentially infectious materials. It is the goal of the departments to strive to reduce exposure in the department member population and thus reduce the incidence of occupational health risk. It is also the goal of the departments to insure that the patients served are offered protection from infection. Wake County Fire Department's Exposure Control Plan addresses bloodborne pathogens, airborne and droplet transmitted diseases.

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Wake County Fire Department

SCHEDULE FOR IMPLEMENTATION

EXPOSURE CONTROL PLAN - 2017

Bloodborne/Tuberculosis

EDUCATION & TRAINING - 1987
Bloodborne
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RECORDKEEPING - 1992

TUBERCULIN SKIN TESTING - 1992

RESPIRATORY PROTECTION - 1992
PROGRAM

COMPLIANCE MONITORING - June, 2017

SHARPS RISK ASSESSMENT 2016

GENERAL STATEMENT - EXPOSURE CONTROL PLAN

This Exposure Control Plan shall be:

1. Accessible to members within 15 working days of their request

2. Reviewed and updated at least on an annual basis by the Designated Officer(s).

3. Reflective of all current Centers for Disease Control recommended practices for protection of patients and staff.

4. Reflective of applicable, science supported, portions of the NFPA 1581 Infection Control Standard for Fire departments

POLICY STATEMENT:

It shall be the policy of all supervisors and managers of the Wake County Fire Departmenst organization to:

A. Support and enforce compliance with the Exposure Control Program

B. Correct any unsafe acts and refer any individuals for remedial training if required

C. Mandate safe operating practices on scene and in-station

D. Refer any individual for medical evaluation who may possibly be unfit for work for infection control or other reasons

E. Ensure initial medical evaluations (respirators), immunizations and infection control training have been completed prior to allowing any individual to begin EMS response.

F. Participate in education and training programs prior to active duty and attend on-going education and training programs.

G. Insure that staff requests copies of their vaccine/immunization Records

H. Comply with policy of no artificial fingernails or extension to be worn by patient care personnel

I. Assist with enforcement of work restriction guidelines

This plan represents the minimum level of practice. Failure to comply with the requirements of this plan will result in progressive disciplinary action.

EXPOSURE CONTROL PLAN DEVELOPMENT

This Exposure Control Plan was developed by Katherine H. West,BSN,MSEd,CIC, an Infection Control Consultant with Infection Control/Emerging Concepts, Inc., in conjunction with the Wake County Infection Control Committee . Any questions regarding the development of this plan should be addressed to both Katherine West and/or Doug Campbell.

Implementation of this plan is the responsibility of the Wake County Fire Departments.

Katherine H. West

Katherine West,BSN,MSEd,CIC

Infection Control Consultant

November, 2017

DOCUMENTS USED IN THE PREPARATION OF THIS PROJECT:

1. APIC Core Curriculum - Infection Control
2. 29 CFR Part 1910.1030- Bloodborne Pathogens
3. 29 CFR Part 1910.20 - Medical Records
4. Centers for Disease Control and Prevention - 1994
   Guidelines for Prevention and Control of Tuberculosis
5. Centers for Disease Control- 1989 Guidelines for Public
   Safety Workers
6. 42 CFR Part 84 Subpart K, Volume 60, Federal Register
   June 8, 1995:30338
7. West KH: Infectious Disease Handbook for Emergency Care Personnel, ACGIH, 1994
8. NIOSH Alert, Latex Glove Sensitivity, June, 1997
9. CDC Guidelines for Health Care Worker Infection Control, Draft, Federal Register, September, 1998
10. The Source, IC/EC, Inc., 1998, Springfield, Virginia
11. Guidelines for Infection Control in Health-Care Personnel, 1998, AJIC, June, 1998
12. Medical Waste Regulations – State of North Carolina
13. OSHA Instruction CPL 2-2.44D, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, Nov. 5, 1999
14. NIOSH Alert, Preventing Needlestick Injuries in Health Care Settings, November, 1999
15. Needlestick Prevention Act, US Congress, March, 2000

16. Updated Us Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, MMWR, June 29, 2001

17. CPL 2-2.69 Compliance Directive, OSHA Bloodborne Pathogens, November 27, 2001

18. Hand Hygiene Guidelines, Centers for Disease Control and Prevention, October 25, 2002

19. Controlling Tuberculosis in the United States; Recommendations from the American Thoracic Society, CDC and the Infectious Disease Society of America, MMWR, September 25, 2005

20. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, MMWR, December 30, 2005

21. Influenza Vaccination of Health-Care Personnel, MMWR, February 24, 2006, Centers for Disease Control & Prevention, Atlanta, GA

22. A Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP) Part II: Immunization of Adults, December 8, 2006, Centers for Disease Control & Prevention, Atlanta, GA.

23. Recommendations of the Advisory Committee of Immunization Practices (ACIP) 2012-2013 Influenza Prevention and Control, 2012

24. Guidelines for Sterilization and Disinfection, CDC, 2008

25. Immunizations for Healthcare Personnel, November 25, 2011

26. Federal Register Volume 76, Number 212 (Wednesday, November 2, 2011);[Notices] [Pages 67736-67743]

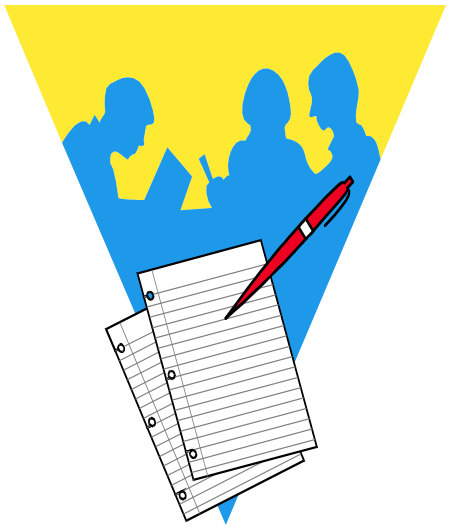
27. Testing for HCV Infection: An Update of Guidance for Clinicians & Laboratorians, May 7, 2013, MMWR, CDC

28. CDC Guidelines: Post Exposure Prophylaxis for HIV, September, 2013

29. CDC Guidelines for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, December 20, 2013

30. OSHAct of 1970, Section 5, Duties, 5 (b).

EXPOSURE DETERMINATION



EXPOSURE DETERMINATION

1. This Plan identifies members who are deemed to be at risk. This determination is assigned without the consideration of the use of personal protective equipment. The exposure determination assignments for personnel was made based on if it could be "reasonably anticipated" that a member would come into contact with blood or other potentially infectious materials. Thus, the core of this Plan will deal with exposure to blood and other potentially infectious materials (OPIM).

2. As all members may have the opportunity to be exposed to an airborne/droplet transmissible disease, this plan will address education and training with regard to, risk assessment, notification of exposure, testing and medical follow up.

EXPOSURE DETERMINATION

The following member groups were reviewed for the purpose of exposure determination assessment;

DEEMED NOT TO BE AT RISK: But covered in this plan

Administrative staff – non patient care

Office Assistant

It should be noted, however, that if these individuals should sustain an exposure, they will be followed under the department's policy for post-exposure management.

AT Risk for Exposure:

Paramedic
EMT's
First Responders
Firefighters
BLS Providers
ALS Providers
Rescue Personnel

RISK TASKS AND PROCEDURES LISTING

AND

RECOMMENDED PERSONAL PROTECTIVE

EQUIPMENT

Guide For The Use of Personal Protective Equipment – Fire/EMS

Task	Gloves	Eyewear/ Mask	Gown
Airway	x	x	available
CPR	x	x	none
Drawing Blood	x	none	none
Decon Equipment	utility	x	If splatter Or splash anticipated
Extrication	x	x	If splatter Or splash anticipated
Injection	none	none	none
Intubation	x	x	available
Delivery	x	x	x
IV Start	x	x	available
Monitor	none	none	none
Oxygen	none	none	none
Suction	x	x	available
Trauma	x	x	x
Vital Signs	none	none	none

Needlestick Injury Risk Assessment

A complete review of needlestick injuries for 2015-16 has been conducted. **No contaminated sharps** injuries have been documented for the past two years.

This department implemented sharps safety devices in 1999.

The following needlesafe products are as follows:

Safety Glide Syringes
Surgilance lancets

The Designated Officer will continue to monitor this issue on an on-going and annual basis.

RISK ASSESSMENT FOR EXPOSURE TO TUBERCULOSIS – **2015/16**

Wake County Fire Departments

Risk assessment was conducted by contacting the state Public Health department office of TB control to obtain numbers of cases reported in our general department area for 2015- 16. The Public Health Department releases the total number of cases for each area of the state. The number of active cases in 2016 was 120 a decrease from 123 reported statewide this shows a continued decline. The number of cases transported by the Wake County Fire Department in 2016, was 0_. This information was verified by contacting the area Public Health Department. For 2016, there were 9,287, reported nationally. This represents more than an 8.4% decrease since 2015. During 2016, the primary case numbers were in foreign-born persons of Asian descent.

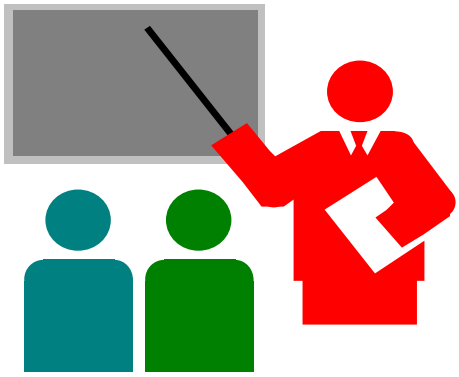
Based on the 2015-2016 case load, the areas serviced by Wake County Fire Departments and the fact that department members do NOT transport patients, this department falls in the " low risk" category using the Centers for Disease Control 2005 TB Guidelines which OSHA is currently enforcing. Under the " low risk" heading, the implementation of a respiratory protection program is **NOT** recommended or required. Wake County Fire Departments have not been notified by area hospitals of any potential exposures. Such notification is required under the Ryan White Emergency Notification Law, Part G.

Based on this determination, there is no formal requirement for a Respiratory Protection Program based on the CDC, 2005 Guidelines for Tuberculosis which OSHA is enforcing.

Members will be instructed to screen patient for TB and suspect patients will be masked, a non-rebreather may be used, and windows opened for risk reduction. This was developed, reviewed and agreed to by Katherine West,BSN,MSEd,CIC, Infection Control Consultant who assisted in this process. Data will be monitored closely to determine the need to alter this risk determination. Data will be tracked by the Designated Officer .

Should the numbers of positive tests results change or a shift in the PPD/TST testing results be noted, this risk assessment will be revisited.

EDUCATION AND TRAINING



GENERAL GUIDELINES FOR EDUCATION AND TRAINING

The Designated Officer, in preparation for this new role, will participate in a formal training program to prepare for this role. Certificate is on file. On or before the end of July, 2016, the department will allow for our DO and instructor to attend a train the trainer session to prepare a key individual to serve as trainer for this department. All members will be provided training at no cost to members and will be offered during normal working hours.

Training will be provided at the time of orientation process and on an annual basis. The trainer will reserve the right to require additional training if he/she feels previous training was not in keeping with standards. Annual training for all current members will be completed within one year of their previous training. Annual training will update personnel on the diseases and department changes in policy/procedure and department exposure rates.

All training content will be reviewed on a continual basis and when changes in procedures or equipment are noted, additional training will be scheduled.

Wake County Fire Departmenst will insure that training is offered in the appropriate language and word level for all members.

Training will include;

1. Each member will have access to a copy of the OSHA standard and the department Exposure Control Plan.
2. A general explanation of the epidemiology of bloodborne disease and their symptoms will be

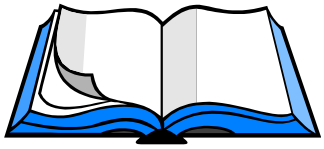
offered.

3. Education on the epidemiology and symptoms of tuberculosis will also be offered.
4. The Bloodborne pathogens to be reviewed will include; HIV, Hepatitis B, Hepatitis C and Syphilis. Tuberculosis will also be covered.
5. The department's exposure control plan will be presented along with information on how an member can obtain a copy of the plan.
6. A review of tasks that each member performs and how they might be at risk for exposure.
7. A review of the use of PPE and the limitations of PPE in certain circumstances.
8. The type of PPE that is available and why that type was selected.
9. In depth information on the hepatitis B vaccine program and TB skin testing program.
10. Information on how to report and document an exposure.
11. Information on what action will be taken and by whom in an exposure situation and how to seek medical attention and follow up.
12. Information on what medical follow up will include following an exposure.
13. Explanation of the signs and labels to be used in the handling and storage of medical waste.
14. Access to medical records upon request

15. Latex Glove Allergy/Sensitivity Issues
16. Work Restriction Guidelines
17. Needle Safe System Use
18. West Nile Virus
19. Flu Vaccine Program
20. Pandemic Flu Plan
21. MRSA & C-diff
22. Vaccine/immunization Program
23. New Influenza Vaccines
24. Donning and doffing of PPE
25. Zika Virus

** All programs will allow for interactive questions and answers with a knowledgeable instructor. The instructor will be knowledgeable in communicable diseases and infection control and be able to relate this information to each specific work area. The EMS Coordinator has received a certificate of specialized training. Certificates are on file.

Definition of Terms



Definition of Terms
OSHA — Occupational Safety & Health Administration
U.S. Department of Labor

Bloodborne pathogens. - 1910.1030
Regulations (Standards - 29 CFR) - Table of Contents

- Part Number: 1910
- Part Title: Occupational Safety and Health Standards
- Subpart: Z
- Subpart Title: Toxic and Hazardous Substances
- Standard Number: 1910.1030
- Title: Bloodborne pathogens.
- Appendix: A

1910.1030(a) ***Scope and Application.*** This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

1910.1030(b) ***Definitions.*** For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an member/volunteer's duties.

Handwashing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Needleless systems means a device that does not use needles for: (1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) The administration of medication or fluids; or (3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an member/volunteer's duties.

Other Potentially Infectious Materials means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an member/volunteer for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

Sharps with engineered sharps injury protections means a nonneedle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the member/volunteer. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls **means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by two-handed technique).**

VACCINATION/ IMMUNIZATION PROGRAM

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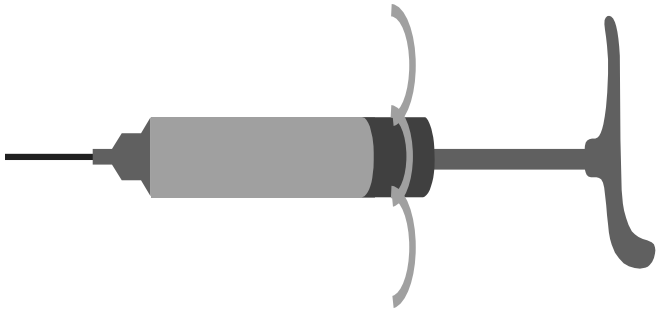


TB TESTING PROGRAM

HEALTH MAINTENANCE

POLICY STATEMENT

NO MEMBER OF THE WAKE COUNTY FIRE DEPARTMENTS SHALL BE

ASSIGNED TO EMERGENCY RESPONSE DUTIES UNTIL CERTIFIED

AS FIT FOR DUTY BY THE DEPARTMENT:

1. Applicants must provide written proof of any previous TB skin test results within 2 weeks of joining, if available

2. Applicants will be offered TB skin tests, HBV immunization, infection control education and training, after the completion of the application process

3. Applicants will show written proof of immunity for Measles, Mumps and Rubella, if available

4. Applicants will show proof of immunity for Chickenpox, if available

5. Personnel exposed to a communicable disease off duty should contact the Designated Officer

6. All illnesses listed under the work restriction guidelines program are to be reported to the Designated Officer

7 New hires and current staff need to request copies of their vaccine/immunization records

Communicable Disease Health History

This information is confidential

Disease	**Date of Illness**
Measles (Rubeola)	_____
Measles (Rubella)	_____
Mumps	_____
Chickenpox	_____
Hepatitis	_____ Type_____
Tuberculosis	_____ Type_____
Meningitis	_____ Type_____
Malaria	_____Type_____
HIV infection	_____

Allergies:

Medications _____

Latex_____

Signature:_____ Date:_____

Immunization Record

Confidential

Immunization/Vaccine	**Date of Administration**
Hepatitis B Vaccine	_____
Antibody Titer	____ Result_____
Measles, Mumps, Rubella	_____
TB Skin Test	_____Result_____
Tetanus/Diphtheria	_____
Chickenpox Vaccine	_____
Flu Vaccine	_____
Tdap Booster `x1`	_____

Release of Information

Health History & Immunization History

Declination Form

I have attended education and training on bloodborne pathogens & TB and I have reviewed the forms requesting health and immunization/vaccination history.

I understand that this information is to be confidential and would only be used to assist in evaluation of whether I should be offered a vaccine or immunization as a prevention measure prior to any exposure event or for post exposure evaluation and treatment.

I decline submitting this information to the Designated Officer. I understand that if I change my mind, I will be able to complete the forms and receive any recommended immunizations or vaccinations.

Chickenpox Prevention and Control

On hire, each member will be asked to complete a health history form. This form will address chickenpox immunity. New members, who do not have immunity to chickenpox by reported history of the disease as a child, will be advised to obtain the new chickenpox vaccine – Varivax.

It should be noted that the Department is responsible for payment of this prevention method. Members will be advised to contact the local health department for immunization clinic hours and fees.

Members who receive chickenpox vaccine (Varivax) should submit proof of vaccination for inclusion in their medical record.

Varicella Vaccine Consent Form

Member Information:

Name: _____

	Yes	No
1. Have you ever had an allergic reaction to a vaccine or medication?		
2. Are you allergic to neomycin or gelatin ?		
3. Are you pregnant or breast- feeding?		
4. Are you under a physicians care?		
5. .Are you currently ill, fever or cold?		
6. In the past 5 months, have you received a blood transfusion		
7. Have you received Immune globulin or varicella immune globulin (VZIG) ?		

Consent:

I have read the information packet on VARIVAX (chickenpox vaccine). I have been given the opportunity to ask questions, and I understand the benefits and risks associated with this vaccine. I understand that I should avoid becoming pregnant for 4 weeks following receipt of this vaccine, and that I should avoid the use of aspirin for 6 weeks after vaccination. If I develop a rash, I must remain off duty until the rash subsides and receive clearance from Infection Control/Safety Officer to return to work.

Signed _____ **Date** _____

Measles, Mumps, Rubella Vaccine Consent Form

Member/ Volunteer Information

Name:_____

	Yes	No
1. Have you ever had an allergic reaction to a vaccine or medication?	_____	_____
2. Are you pregnant?	_____	_____
3. Are you under a physician's care ?	_____	_____
4. Do you currently have a fever or viral illness?	_____	_____
5. Are you allergic to eggs?	_____	_____
6. Are you immunocompromised ?	_____	_____
7. Have you recently received any blood products/transfusions ?	_____	_____

Consent

I have reviewed the information on MMR vaccine (measles, mumps, rubella). I have been given the opportunity to ask questions and to have my questions answered. I understand the benefits and risks associated with this vaccine.

I understand that I should avoid becoming pregnant for 4 weeks following receipt of this vaccine. If I develop any side effects, I will report them to the designated medical care provider.

Signed:_____ **Date:**_____

Vaccine/Immunization Declination Form

After review of my medical records/history, I have been advised that I may not be protected from childhood diseases that are currently on the rise in this country. I am aware that the Centers for Disease Control & Prevention (CDC) recommends that all unprotected healthcare providers be offered protective vaccines/immunizations by their employers. My employer has offered me additional protective vaccines for the following;

Tdap Booster _____

MMR Vaccine_____

Chickenpox Vaccine_____

However, I choose not to participate in the receipt of additional vaccinations/immunizations. I am aware that I am risk for possible exposure to these diseases.

Signature:_____ **Date:** _____

Influenza Vaccination Program

Wake County Fire Departments will make free flu vaccine available to all employees. Flu vaccine will be administered at the Employee Health Center. Flu vaccine is offered beginning in mid- September and ending when advised by the CDC. A consent form will need to be signed by the employee and will be retained on file in the employee medical record.

Influenza Vaccine

Consent Form

Employee Name: _____

I have read the information about the influenza and the vaccine that is being offered. I have read the information on possible side effects and allergies. I have had the opportunity to ask questions and to have the questions answered. Based on this, I elect to participate in this vaccine program.

_____ Date: _____

Signature

Flu Vaccine

Declination Form

This form is to document that I have been offered annual flu vaccine by my employer free of charge.

I have received education and training regarding the benefits of participating in the annual flu vaccine program in conjunction with the Centers for Disease Control and Prevention Guidelines. I have been given the opportunity to ask questions and to have those questions answered. However, I have chosen to decline this offer.

Date:_____ _____

Name/Signature

HEPATITIS B VACCINE ADMINISTRATION PROGRAM

On or before December, 1987, Hepatitis B Vaccine and later (Engerix -B**)** in the form of an on-going vaccine program will be made available to **all** members who have been deemed to be at risk for occupational exposure. Vaccine will be administered at no cost to the member. Vaccine will be administered within 10 days of initial assignment to a position that would place the member at risk. The vaccine program will be administered under the direction of a physician designated by the Fire Departments. Injections will be administered by the Wake County Employee Health located at 310 W. Martin St. in Raleigh. Phone – 919 – 996 – 6000.

If additional times are needed, please contact the Designated Officer. Administration will be in accordance with the published standard set forth by the U.S. Public Health department - Centers for Disease Control. A laboratory that is accredited will conduct any laboratory testing. Testing will be offered at no cost to the member.

For all members at risk, vaccine will be administered - following the education and training. The designated medical care provider at the department will keep records of the injections. The Designated Officer will also keep copies for back up recordkeeping.

HEPATITIS B VACCINE PROGRAM

Each member deemed to be at risk will be instructed regarding the disease, efficiency and safety of the vaccine, route of administration, administration schedule and benefits. There will be ample opportunity for each member to ask questions and have questions answered. This will allow for each member to make an informed decision to participate **or** decline to participate. Members will be asked to sign an **informed** consent sheet which will be kept on file. Members who decline to participate will be asked to sign a declination form in accordance with the provision of 1910.1030, this will also be kept on file in the individual's medical record. Each member participating in the vaccine program will receive a personal record documenting the vaccine series.

Members who elect to sign a declination form will be advised that if they should change their mind, the vaccine will be made readily available to them.

Members who can show proof of previous vaccination against hepatitis B or who can document that they are antibody positive will not be candidates for the vaccine because they have immunity.

Members with a documented allergy to yeast will be **offered** HEPTAVAX HB (Plasma derived) vaccine. Should they decline to receive this vaccine, they will be asked to sign a declination form with added information on their allergy status.

Members who have a documented allergy to MERCURY will be candidates for vaccination with the mercury free vaccine. This will be

should be noted in the members medical file. A **declination** form should be signed and reason for non-participation noted.

Pre-screening will be made available to members who request it - at no cost to the member. Pre-screening for exposure to Hepatitis B will NOT be required for participation in the vaccine program. Post vaccine testing will be offered at no cost to the member. This will be done to insure that there was adequate response to the initial vaccine series. Post vaccine titer testing will be conducted 1-2 months after completion of the vaccine series. Non-responders will be offered an additional series in accordance with the CDC's update guidelines. If the titer is not performed in 1-2 months, it is too late to perform. (personal communication, CDC, 2004)

**** Titers are NOT required on new hire personnel who have been previously vaccinated. Due to universal vaccination, new hires coming out of high school or college will already be vaccinated,**

BOOSTER DOSES

Currently, there is no formal recommendation from the Centers for Disease Control for booster doses of the vaccine at any interval. At present, it is stated that the need for a booster is ***NOT*** indicated due to the "immunogloic memory" offered by this vaccine. Should a formal recommendation for a booster be published, Wake County Fire Departments will make booster doses available to " at risk " members free of charge.

Wake County Fire Departments

HEPATITIS B VACCINE PROGRAM

CONSENT FORM

I have received education and training regarding the hepatitis B vaccine. I have had the opportunity to ask questions and to have those questions answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and consent to receive this vaccine.

_____ _____

Name Date

_____

Signature

Wake County Fire Departments

HEPATITIS B VACCINE PROGRAM
DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Name Date

_____

Signature

Reason: (optional)

Wake County Fire Departments

HEPATITIS B VACCINE IMMUNIZATION RECORD

Vaccine is to be administered in three doses. It should be given in the deltoid muscle of the arm **only**. The schedule for doses is as follows;

Initial dose

Four weeks after the first dose, give second dose

Six months after the first dose, give the last dose

MEMBER NAME:

First Dose _____

Second Dose_____

Third Dose_____

Post Vaccine Testing

Date:_____ Result_____

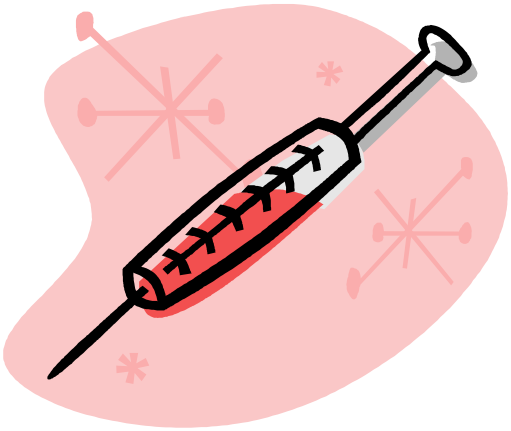
RECORDKEEPING FOR HEPATITIS B VACCINE PROGRAM

EACH MEMBER WILL RECEIVE AN IMMUNIZATION CARD THAT WILL NOTE THE DATES OF ADMINISTRATION OF EACH DOSE OF VACCINE FOR THEIR PERSONAL RECORD. The Employee Health Center staff and the Designated Officer will maintain complete records on vaccine administration. Records will be maintained for the duration of the member's association with Wake County Fire Departments plus an additional thirty (30) years. However, if the individual is on the department for less than one (1) year, the records will be released to the individual at termination. This is in keeping with the requirements of OSHA 1910.1030 and the OSHA medical record standard 1910.1020.

Any member who declines to participate in the program will sign a declination form. The Designated Officer, for the duration of the member's department plus an additional thirty (30) years will keep this form on file.

Members who decline the vaccination and decline to sign the declination form will be referred for counseling and possible administrative action under the disciplinary action policy.

TESTING



MEMBERS DEEMED AT RISK FOR TUBERCULOSIS

AT RISK PERSONNEL : EMS/Rescue personnel with direct patient contact/transport

Members listed in the "at risk" group for possible exposure to tuberculosis will be offered baseline TST/PPD skin testing and post exposure skin testing. TST/PPD administration for baseline and post exposure testing will be administered at the health department.

QFT-TB Gold TB or Tspot TB blood testing may be considered as an option by the department.

TESTING FOR EXPOSURE TO TUBERCULOSIS

All personnel deemed to be at risk for exposure to tuberculosis (TB) will be skin tested upon joining to establish a baseline and then tested on a post exposure basis. This is decreased from last year due to the decrease in cases in the area. If the rate of TB conversion appears to increase in member population in Wake County Fire Departments, testing may be recommended on a more frequent basis.

Testing for TB will be done using the MANTOUX test - administration of TST/PPD given by the intradermal method. QFT-TB Gold is also a possible testing method. This test will be read by a trained health care professional. Each member should sign consent or denial forms. Members who have not previously tested **positive or have not been tested in the last 12 months** will be tested using the two step-method. This is done to address the "booster phenomenon" and is in keeping with the current recommendations of the Center for Disease Control and Prevention (CDC). Consent or denial forms will be requested and kept on file in the member medical records file.

Wake County Fire Departments

Tuberculosis Screening Test

Consent Form

I have attended an educational session on Tuberculosis (TB). This session included information regarding the Mantoux skin test, which is used to determine if the bacteria which causes tuberculosis is residing in my body.

I understand that I may be occupationally exposed to Tuberculosis and that I may be at risk for acquiring Tuberculosis. I understand that the Centers for Disease Control and Prevention (CDC) and the Occupational Safety & Health Administration (OSHA) recommend that I be tested for exposure to TB.

I have been given the opportunity to be tested using the Mantoux skin test, at no charge to myself. I have had the opportunity to ask questions regarding TB and the skin- testing program. Based on this information, I elect to participate in this program.

NAME: _____

Signature:_____

Date:_____

Administered By:_____

Read On:_____

Result: _____

Wake County Fire Departments

Tuberculosis Screening Test

Informed Denial

I have attended an educational session on Tuberculosis (TB). This session included information regarding the Mantoux skin test, which is used to determine whether the bacteria causing TB is residing in my body.

I understand that I may be occupationally exposed to TB and that I may be at risk for acquiring TB. I understand that the Centers for Disease Control and Prevention (CDC) and the Occupational Safety & health Administration (OSHA) recommend that I be tested to determine whether I have contracted TB infection.

I have been given the opportunity to be tested using the Mantoux skin test, at no cost to myself. However, I decline TB screening at this time. I understand that, by declining this screening, I am at risk of having TB without my knowledge. I understand that I will be able to obtain testing for TB in the future if I choose to change my mind.

Name:_____

Signature:_____

Date:_____

MEMBER PROTECTION - SCREENING FOR TB EXPOSURE

RATIONALE FOR EXCLUSION

The member jobs removed from the “at risk” determination were based upon review of job duties outlined in the job description and the requirements for the application for the position.

The majority of administrative positions do not demonstrate that there may be "reasonable" risk. Consideration was also given to the aspect of "reasonably anticipated" risk. The ultimate decision regarding risk was made by interview with department personnel. However, in the event that an individual in the not at risk group would be exposed, they would be covered under the post exposure management protocol.

Since ALL personnel are not involved in the transport of patients or the provision of high-risk procedures, they are also exempt from a high-risk listing. (Reference formal risk assessment)

Tuberculosis (TB) Surveillance

Annual TB Screen for Positive Reactions

Name:_____

Job Classification:_____

Since records indicate that you have previously tested positive on PPD skin testing, the following questions must be answered each year as part of our annual TB surveillance program.

Please complete this form and return to:_____

During the past year, have you experienced or are you now experiencing and of the following signs/symptoms?

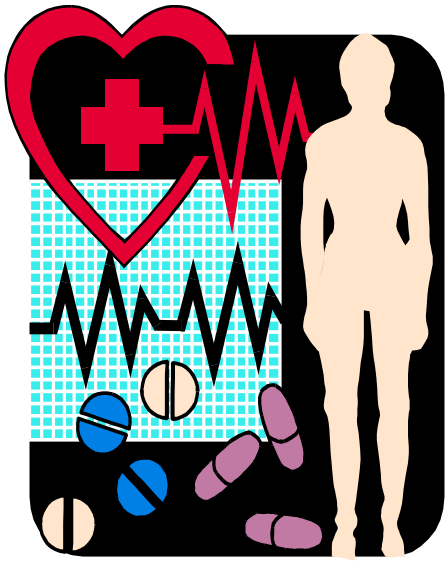
	Yes	**No**
Weight Loss (unrelated to dieting)	_____	_____
Persistent cough (2-3 weeks duration)	_____	_____
Fever/Night sweats		
Weakness or fatigue	_____	_____
Coughing up blood	_____	_____

Signed:_____ Date:_____

HUMAN IMMUNODEFCIENCY VIRUS (HIV) TESTING

PURPOSE**:** To make available, upon request, HIV testing and counseling for reasons other than an on the job exposure.

PROCEDURE**:** Any member requesting HIV testing may contact the Designated Officer or may directly contact the Public Health Department office of HIV testing to obtain free and anonymous testing. It is not the employers responsibility to test in a non-work exposure situation.



Work Restriction Guidelines

Work Restriction Guidelines

CDC Personnel Health Guideline

Summary of suggested work restrictions for health care personnel exposed to or infected with infectious diseases of importance in health care settings, in the absence of state and local regulations (modified from ACIP recommendations[9])

Combination 1997 & 2011 updated version

Disease/problem	Work restriction	Duration
Conjunctivitis	**Restrict from patient contact and contact with the patient's environment**	**Until discharge ceases**
Cytomegalovirus infections	**No restriction**	
Diarrheal diseases		
Acute stage (diarrhea with other symptoms)	**Restrict from patient contact, contact with the patient's environment, or food handling**	**Until symptoms resolve**
Convalescent stage, *Salmonella* spp.	**Restrict from care of high-risk patients**	**Until symptoms resolve; consult with local patents and state health authorities regarding need for negative stool cultures**
Diphtheria	**Exclude from duty**	**Until antimicrobial therapy completed and 2 cultures obtained ≥24 hours apart are negative**
Enteroviral infections	**Restrict from care of infants, neonates, and immunocompromised patients and their environments**	**Until symptoms resolve**
Hepatitis A	**Restrict from patient contact, contact with patient's environment, and food handling**	**Until 7 days after onset of jaundice**
Hepatitis B		
Personnel with acute or chronic hepatitis B surface antigenemia who do not perform exposure-prone procedures	**No restrictions★; refer to state regulations; standard precautions should always be observed**	
Personnel with acute or chronic hepatitis B a antigenemia who perform exposure-prone procedures	**Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as still and technique of worker; refer to state regulations**	**Until hepatitis B e antigen is negative**
Hepatitis C	**No recommendation**	
Herpes simplex		

Genital	**No restriction**	
Hands (herpetic window)	**Restrict from patient contact and contact with the patient's environment**	**Until lesions heal**
Orofacial	**Evaluate for need to restrict from care of high-risk patients**	
Human immunodeficiency virus	**Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought, panel should review and recommend procedures the worker can perform; taking into account specific procedure as well as skill and technique of worker; standard precautions should always be observed; refer to stale regulations**	
Measles		
Active	**Exclude from duty**	**Until 4 days after the rash appears**
Postexposure (susceptible personnel)	**Exclude from duty**	**From 5th day after 1st exposure through 21st day after last exposure and/or 4 days after rash appears**
Meningococcal infections	**Exclude from duty**	**Until 24 hours after start of effective therapy**
Mumps		
Active	**Exclude from duty**	**Until 5 days after onset of parotitis**
Postexposure (susceptible personnel)	**Exclude from duty**	**12 days after first exposure through 25 days after last exposure or 5 days after onset of parotitis**
Pediculosis	**Restrict from patient contact**	**Until treated and observed to be free of adult and immature lice**
Pertussis		
Active	**Exclude from duty**	**Beginning of catarrhal stage through third week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy**
Postexposure (asymptomatic personnel)		
Postexposure (symptomatic personnel)	**Exclude from duty**	**5 days after start of effective antimicrobial therapy**
	Symptomatic personnel	**Exclude from duty**
Asymptomatic personnel -- HCP likely to expose a	**No restriction from duty; on**	

patient at risk for severe pertussis§	**antimicrobial prophylactic therapy**	
Asymptomatic personnel -- other HCP	**No restriction from duty; can receive postexposure prophylaxis *or* be monitored for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis**	
Rubella		
Active	**Exclude from duty**	
Post Exposure (personnel without evidence of rubella immunity)	**Exclude from duty unless receipt of the second dose within 3-5 days after exposure**	**7 days after first exposure through 23 days after last exposure and/or 7 days after rash appears**
Scabies		**Until medically cleared**
***Staphylococcus aureus* infection**		
Active, draining skin lesions	**Restrict from contact with patents and patient's environment of food handling**	**Until lesions have resolved**
Carrier state	**No restriction, unless personnel are epidemiologically linked to transmission of the organism**	
Streptococcal infection, group A	**Restrict from patient care, contact with patient's environment, or food handling**	**Until 24 hours after adequate treatment started**
Tuberculosis		
Active disease	**Exclude from duty**	**Until proved noninfectious**
PPD converter	**No restriction**	
Varicella		
Active	**Exclude from duty**	**Until all lesions dry and crust. If only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period**
Postexposure (susceptible personnel)	**Exclude from duty unless receipt of the second dose within 3-5 days after exposure**	**8th day after 1st exposure through 21st day (28th day if varicella-zoster immune globulin administered) after the last exposure; if varicella occurs, until all lesions dry and crust or, if only lesions that do not crust (i.e., macules and papules), until no new lesions appear within a 24-hour period**
Herpes Zoster		

Localized, in healthy person	**Cover lesions; restrict from care of high-risk patients†**	**Until all lesions dry and crust**
Generalized or localized in immunosuppressed person	**Exclude from duty**	**Until all lesions dry and crust**
Until dissemination id ruled out		
Postexposure (susceptible personnel)	**Restrict from patients contact**	**From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure or, if varicella occurs, until all lesions dry and crust**
Viral respiratory infections, acute febrile	**Exclude from duty**	**Until afebrile ≥24 hours (without the use of fever-reducing medicines such as acetaminophen). Those with ongoing respiratory symptoms should be considered for evaluation by occupational health to determine appropriateness of contact with patients. If returning to care for patients in a protective environment (e.g., hematopoietic stem cell transplant patients), consider for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer.**
HCP in contact with persons at high risk for complications of influenza†		**Those who develop acute respiratory symptoms without fever should be considered for evaluation by occupational health to determine appropriateness of contact with patients and can be allowed to work unless caring for patients in a protective environment; these personnel should be considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of all noncough symptoms, whichever is longer. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact) should be reinforced.**

Abbreviation: HBsAg = hepatitis B surface antigen.

Sources: Adapted from CDC. Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. MMWR 1991;40(No. RR-8); CDC. Guideline for isolation precautions in hospitals: recommendations of the Hospital Infection Control Practices Advisory Committee (HICPAC) and the National Center for Infectious Diseases. Infect Control Hosp Epidemiol 1996;17:53--80; Williams WW. CDC guideline for infection control in hospital personnel. Infect Control 1983;4(Suppl):326--49; CDC. Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). MMWR 1997;46(No. RR-18).

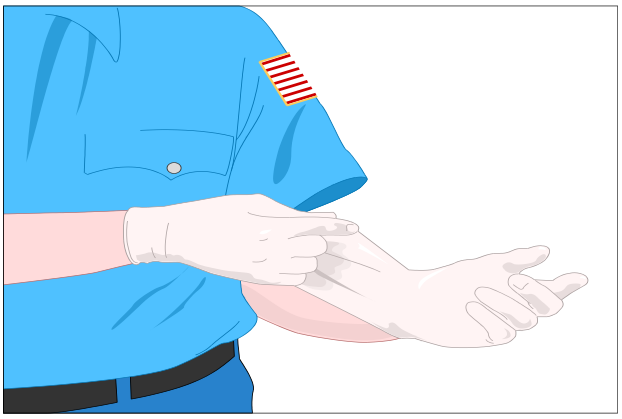
*** Persons who provide health care to patients or work in institutions that provide patient care (e. g., physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, hospital volunteers, and administrative and support staff in health-care institutions). Source: U.S. Department of Health and Human Services. Definition of health-care personnel (HCP). Available at http://www.hhs.gov/ask/initiatives/vacctoolkit/definition.html.**

† Includes children aged <5 years, adults aged ≥65 years, pregnant women, American Indians/Alaska Natives, persons aged <19 years who are receiving long-term aspirin therapy, and persons with certain high-risk medical conditions (i.e., asthma, neurologic and neurodevelopmental conditions, chronic lung disease, heart disease, blood disorders, endocrine disorders, kidney disorders, liver disorders, metabolic disorders, weakened immune system due to disease or medication, and morbid obesity).

§ Includes hospitalized neonates and pregnant women.

¶ Includes patients who are susceptible to varicella and at increased risk for complications of varicella (i.e., neonates, pregnant women, and immunocompromised persons of any age).

ENGINEERING CONTROLS AND WORK PRACTICES



Engineering Controls

Engineering controls address redesign of equipment to insure member risk reduction, procedures which serve to reduce exposure such as cleaning equipment or areas which have been contaminated, and the use of barrier techniques to reduce direct contact with blood and **OPIM**.

Members of the Wake County Fire, will follow the enclosed protocols in the course of their daily work to assist with risk reduction. These protocols are in accordance with the published by the CDC, the National Fire Protection Association (NFPA) 1581, Infection Control recommendations and OSHA.

ENGINEERING CONTROLS/WORK PRACTICES

All members will adopt the practice of Standard Precautions to reduce the risk for exposure to blood and OPIM.

The term Body Substance Isolation/Standard Precautions is a concept that considers blood and ALL body fluids to be potentially infectious. Use of this concept does NOT require that there be good visibility and a controlled work environment. This can, therefore be followed in all work areas of members.

Body Fluids Which 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**

Handwashing

PROCEDURE	**RATIONALE/ACTION**
Hands must be washed before and after patient contact.	Handwashing is the single most important means of preventing the spread of infection
Scrub hands for at least 15 seconds Use friction rub action after the Soap is applied	Friction will assist in the removal of dirt as well as bacteria and other organisms
When running water is not available. Use a waterless handwash solution	Waterless agent such as: Alcare, Hibistat and Cal-Stat may be used The routine use of antibacterial soap Is **NOT** recommended
Rinse hands well under running Water	
Dry with a paper towel	
Use paper towel to turn off water Faucets	Faucets were handled by soiled hands

PERSONAL PROTECTIVE EQUIPMENT

On or before, December 1992, appropriate personal protective equipment will be provided at no cost to the members with occupational exposure. Personal Protective Equipment will be issued based on the needs of each particular work group and the anticipated exposure.

Personal Protective Equipment (PPE) for personnel will include, but not be limited o: disposable gloves, protective eyewear & mask (surgical), Cover gowns, waterless hand wash solution, and a Biohazard bag. PPE is available in each vehicle. Extra supplies are located in the station.

1. A member may decline the use of personal protective equipment in an emergency situation. An investigation will be conducted by the Infection Control Officer to determine if the non- use of personal protective was warranted to meet the needs of the patient. This is in keeping with the OSHA Bloodborne Pathogens Regulation.

2. If clothing becomes contaminated with blood or OPIM then it shall be removed as soon as possible;

3. All PPE shall be removed prior to leaving the workplace; between calls, or if contaminated;

4. When PPE is removed, it shall be placed in an

appropriate area and in a designated container for disposal, uniforms are to be placed in plastic bags for laundering by station personnel. All cost is paid for by the Wake County Fire Departmenst.

5. PPE will be issued in appropriate sizes, and will be readily accessible at the worksite or will be issued directly to the member. This will be a latex free workplace.

USE OF PERSONAL PROTECTIVE EQUIPMENT

GENERAL STATEMENTS

GLOVES -

Gloves shall be worn when it can be reasonably anticipated that a member may have hand contact with blood or OPIM, mucous membranes, and non-intact skin, when performing patient care procedures, or handling or touching contaminated items or surfaces. When encountered within an environment that has the potential for gloves to tear or there are gross amounts of OPIM, the employee shall double glove.

In an effort to comply with the **NIOSH Alert, Wake County Fire Departments will** move toward more use of vinyl gloves and away from latex gloves.

Disposable gloves shall be replaced as soon as practical when they become contaminated, torn or ripped.

Disposable gloves shall not be washed for reuse
Following glove removal, hands should be washed

Heavy-duty utility gloves should be used when cleaning contaminated equipment, surfaces or when disposable gloves are insufficient.

Heavy duty utility gloves can be washed and reused as long as they are not torn or cracked.

Leather Gloves are to be worn for extrication
and search activities.

MASKS -

Masks combination shall be worn when there is suspect that an individual may have an airborne transmissible disease. The style mask issued shall be the molded fitted type.

If the patient is SUSPECT for or DIAGNOSED with TB,
a mask is required, place a surgical mask on the patient or a N95 on the department member.

Masks in conjunction with protective eyewear will be used when it is anticipated that there is the opportunity for gross splatter of blood or OPIM into the eye, nose or mouth.

PROTECTIVE CLOTHING -

Appropriate protective clothing such as cover gowns or aprons or similar outerwear shall be worn in exposure situations. The type to be used will be based on the exposure anticipated. ***Turnout gear is appropriate for firefighters.***

POCKET MASKS -

All personnel trained in the administration of CPR will be trained in the use of either a bag/mask device or a pocket mask. All personnel will

be trained in the proper use of the pocket mask, and the method for proper disposal or cleaning.

PERSONAL PROTECTIVE EQUIPMENT CLOTHING

Uniforms ***will not*** be considered personal protective equipment for department personnel. Uniforms are considered to be contaminated when covered with blood/ OPIM and the area is too large to spot clean.

All clothing contaminated with blood or other body fluids, to include personal clothing, will be laundered and paid for by the department.

Cleaning will be at NO cost to department personnel. Gloves will be worn when handling contaminated clothing prior to bagging. All **contaminated** clothing will be removed as soon as possible and washed in detergent and hot water at the station. For clothing that is heavily covered with blood, the use of water soluble bags will be considered Reference policy/procedure in section on workplace practices. This will also be addressed in training.

ADDITIONAL PPE -

Disposable examination gloves in various sizes-

Gloves- Nitrile gloves – Supremo SE by microflex

Utility Gloves -

Protective Eyewear – Gateway

Waterless Handwash Solution- Alcohol based – Dawn Mist - Deval

Bag/Mask Device

Cover gown – Disposable

Turn out Gear

PPE Kits: cover gown, gloves, mask, Bio bag, antimicrobial wipes by Protect Aide.

Additional PPE is available in the back on the unit

**** Note that shoe covers and head covers are not necessary for PPE in FIRE/EMS activities.**

Respirators are NOT needed for EMS – CDC down-graded to surgical masks for all diseases including Ebola

CLEANING SCHEDULE

CONTAMINATED AREAS OF THE VEHICLE WILL BE CLEANED AFTER EACH RUN. THIS PROCEDURE SHOULD BE COMPLETED AS SOON AS POSSIBLE.

Cleaning solution is:

Bleach/water solution - which will be used for ALL BLOOD cleaning activities

Decontamination of the vehicle will be done by following the posted weekly cleaning schedule. Cleaning will be conducted in the designated cleaning area. This will allow for adequate ventilation and rinsing of equipment. Documentation of the cleaning will be noted on the Cleaning Record Form. Variance from the standard will be set by the supervisor and based upon patient call volume.

Any equipment used and taken to the medical facility and left with the patient will be cleaned by the medical facility prior to return to the department. This is in accordance with OSHA 1910.1030.

All primary cleaning will be done at the hospital

CLEANING SCHEDULE

ALL CLEANING NOT PERFORMED AT THE HOSPITAL WILL BE DONE IN THE DECONTAMINATION AREA – at the station in the Bay Area.

ROUTINE CLEANING the stock cleaning solution will be Bleach/Water solution or approved disinfectant. All vehicles will be cleaned following contamination with blood/body fluids and this will be documented on the cleaning form. (See cleaning form).

GUIDE TO THE CARE OF SPECIFIC CONTAMINATED EQUIPMENT

key: 1 = DISPOSE

2 = CLEANING (Soap & water)

3 = DISINFECTION (Bleach/water @ 1:100)

4 = HIGH-LEVEL DISINFECTION (Cavicide/ Cidex OPA)

5 = LAUNDER

ITEM	PROCEDURE
AIRWAY	1
BACKBOARDS	2
BITE STICKS	1
B/P/CUFFS	2,3,5
BULB SYRINGE	1
CERVICAL COLLARS	1 OR 2(gross contamination)
DRESSINGS/PAPER PRODUCTS	1
DRUG BOXES	2,3
ELECTRONIC EQUIPMENT	CHECK MANUFACTURERS RECOMMENDATIONS
FIREFIGHTER , PPE	5
KED	3
LARYNGOSCOPE BLADES	4 OR 1
LINENS	1 or 5
NEEDLES/SYRINGES	1
O2 CANNULAS/MASKS	1
HUMIDIFIERS	1 OR 2
PENLIGHTS	2
POCKETS MASKS	1 OR 3
RESTRAINTS	2
BAG/MASK DEVICE	1 OR 4
SCISSORS	2 OR 3
SPLINTS	2
STETHOSCOPE	2
STRETCHER	2 OR 3
STYLETS	1 OR 4
SUCTION CATHETERS	1
SUCTION JARS	1 OR 4
UNIFORMS	5

POST TRANSPORT CLEANING

Following patient transport to the hospital, cleaning will be conducted at the hospital using solution supplied by the medical facility and cleaning will be conducted by the ED staff. Any medical equipment that must be left with the patient at the hospital should be cleaned by the hospital staff before pick up by the Wake County Fire Departments personnel. If not cleaned, it should be properly bagged in accordance with OSHA 1910.1030 for transport to the station for cleaning.

CARE AND CLEANING

EQUIPMENT CATEGORIES

There are three distinct levels of patient care equipment; each of which requires a different level of cleaning/decontamination.

Non-Critical Equipment - such as Stethoscopes and Blood Pressure Cuffs. This level of equipment requires **Cleaning.**

Semi-Critical Equipment - such as Stretchers, Vehicle Walls and Floors, Communication Headsets, Defibrillator. This level of equipment requires **Disinfection.**

Critical Equipment - such as Resuscitation Equipment or Intubation Equipment. This level of equipment requires **Sterilization or High-Level Disinfection.**

Definitions:

CLEANING

Cleaning is the physical removal of dirt and debris. Members should use soap and water, combined with scrubbing action. The scrubbing action is the **KEY** to rendering all items safe for patient use. All equipment requires a minimum of cleaning. Cleaning must take place prior to any required Disinfection, High-Level Disinfection or Sterilization.

DISINFECTION

Disinfection is reducing the number of disease-producing organisms by physical or chemical means. Members should clean the item with soap and water then apply a Disinfection solution. Solutions such as bleach and water at a 1:100 dilution ratio are acceptable Disinfectants. A fresh Disinfectant Solution must be made every day. **DO**

NOT use bleach solution in the cleaning of electronic equipment unless recommended by the manufacturer . Refer to the SDS for

each Disinfectant Solution to decide what personal protective equipment may be needed. Remember, Disinfectants can be toxic or caustic. Disinfection Solution should have an EPA Registry Number. Routine disposal of the germicidal cleaning water in the drainage system is acceptable.

HIGH-LEVEL DISINFECTION

High-Level Disinfection is the use of chemical liquids for sterilization. Members should clean items then place the them in special solutions for a prescribed time. Items need to be

removed using sterile process. Items must then be rinsed with sterile water.

Then items must be stored in sterile wrapping until the next use.

Refer to the Safety Data Sheets for each Disinfectant Solution to learn what

personal protective equipment may be needed. Routine disposal of the germicidal

cleaning water into the sanitary sewer system is acceptable.

Infection Control Cleaning Log

Week of:_____

Area	Mon.	Tues.	Wed.	Thurs.	Fri.
Stock dates checked					
Bench and Doors cleaned					
Driver Area Cleaned					
PPE stocked					
Sharps Container checked Full at ¾ mark					

LINENS

The fire and rescue department uses an exchange linen system for transport services. The hospitals will exchange linens with EMS. Cleaning of linens is performed by hospital staff.

HANDLING OF CONTAMINATED LAUNDRY

All bags containing contaminated laundry will be placed in appropriate bags and taken to the designated area for cleaning. Contact the Infection Control Officer for any questions. Wake County Fire Departments. Fire personnel will verify that the individual charged with laundering the contaminated clothing will put on gloves (heavy duty-dishwashing style). Carefully open the bag and empty the contents into the washing machine. If there is the chance for blood splatter, then a cover gown should be worn. No special solution needs to be added to the wash. No special washing cycle is required. No special washing machine is required. Use a normal washing method.

Procedure for Cleaning Glucose Monitoring Devices

Procedure	Action/Rationale
Fingerstick pens – reusable	**Have been linked to Hepatitis B outbreaks**
Never to be used for more than one person	
Use single use lancets	**Failure to change, lancets, disposable platforms or endcaps between each patient**
Auto-disabling fingerstick devices	**Should be used – disposable**
Dispose in sharps container	**Sharps are medical waste**
Blood Glucose Meters	
Assign to each person **Wear gloves** **Change gloves between each patient**	**Potential exposure to blood-** **Gloves are general trash**
If shared, clean and disinfect after every use **Follow the manufacturer's instructions**	**Basic infection control practice**

Adapted from-www.cdc.gov/injectionsafety/blood-glucose-monitoring

CPR Manikin Cleaning and Training Issues

Basic Considerations:

1. Students should be told in advance that the training sessions will involve "close physical contact" with fellow students.

2. Students should not actively participate in training sessions if they have dermatological lesions on hands or oral areas; if they are known to currently be infected with a communicable disease, or if they have been exposed to an infectious process.

3. If more than one cardiopulmonary resuscitation (CPR) manikin is used, students should be assigned in pairs, with each pair having contact with only one manikin.

4. All persons responsible for CPR training should be thoroughly familiar with good handwashing procedures and the proper cleaning of manikins.

5. Manikins should be inspected routinely for cracks or tears in the plastic surfaces; these could make cleaning more difficult.

6. The clothes and hair of the manikin should be washed monthly or whenever visibly soiled.

Cleaning After Each Participant:

1. After each participant, the manikin's mouth and lips should be wiped with a 2X2-gauze pad wetted with a solution of 1:100 bleach and water solution or 70% isopropyl alcohol. The surface of the manikin should remain wet for at least 30 seconds before it is wiped dry.

2. If a protective face shield is used, it should be changed for each student.

For Two-Rescuer CPR:

1. During the two-rescuer CPR, each student should have his/her own CPR mask, as there is not time to disinfect between students. The second student to practice ventilation should "simulate ventilation. This recommendation is consistent with the current training recommendations of the American Heart Association.

2. Training in the "obstructed airway procedure" involves the student using his/her finger to sweep foreign matter out of the manikin's mouth. This action could contaminate the student's finger, if there is an open area, with saliva from the previous student. The finger sweep should be either simulated, performed on a manikin which has been decontaminated or use a finger cot.

Cleaning of Manikins:

1. Rinse all surfaces with fresh water

2. Wet all surfaces with a mixture of bleach and water at a ***1:100 dilution*** (1/4-cup bleach per gallon of water). This solution must be mixed fresh for each class.

3. Rinse with fresh water and dry all surfaces. Rinsing with alcohol will aid drying time of internal surfaces and will prevent the survival and growth of bacteria and/or fungus.

POST - EXPOSURE NOTIFICATION/MANAGEMENT AND RECORDKEEPING

CLARIFYING EXPOSURE TO BLOODBORNE PATHOGENS

THE FOLLOWING OCCURRENCE SHOULD BE REPORTED DIRECTLY TO THE DESIGNATED OFFICER ;

1. **A CONTAMINATED NEEDLESTICK INJURY**

2. **BLOOD/OPIM IN DIRECT CONTACT WITH THE SURFACE OF THE EYE, NOSE, OR MOUTH**

3. **BLOOD/OPIM IN DIRECT CONTACT WITH AN OPEN AREA OF THE SKIN**

4. **CUTS WITH A SHARP OBJECT COVERED WITH BLOOD/OPIM**

5. **HUMAN BITES – BLOOD DRAWN**

IMMEDIATE NEEDS POST EXPOSURE:

1. **IF THE EXPOSURE IS A SHARPS INJURY;**

    A. **LET THE AREA BLEED FREELY**

    B. **WASH THE AREA WITH SOAP AND WATER OR THE WATERLESS HANDWASH SOLUTION**

    C. **NOTIFY THE DESIGNATED OFFICER**

2. **IF THE EXPOSURE WAS A SPLASH TO THE EYE, NOSE OR MOUTH;**

    A. **FLUSH THE AREA FOR 10 MINS. WITH WATER**

    B. **NOTIFY THE DESIGNATED OFFICER**

DESIGNATED OFFICERS FOR DISEASE/EXPOSURE REPORTING AND MEDICAL FOLLOW UP

Members who feel that they may have had an exposure should contact the Designated Officer:

Designated Officer -

Doug Campbell - 919 – 625 – 0729 – 24/7

Alternate- **Eric Hisey - 919 – 219 - 5779 24/7**

POST EXPOSURE MANAGEMENT

In accordance with OSHA 1910.1030, and the Ryan White Law, members will be instructed to contact the Designated Officer if they feel that they have been involved in a possible exposure situation. Exposure reporting will be done with regard to bloodborne and airborne/droplet transmissible diseases.

The Designated Officer will conduct the initial investigation of the incident and contact the appropriate hospital contact, if needed.

Should exposure management/treatment be deemed indicated, member will be advised by the Designated Officer, where to seek additional medical treatment and what that treatment should include.

Post-exposure evaluation and medical treatment for fire/rescue will be made available at no cost to the member. It will be set up at a reasonable time at the office of Wake County Employee Health as has been presented to member in the training sessions.

Treatment will be conducted by or under the direct supervision of a licensed physician or other health care professional who is familiar with the OSHA standard, the Centers for Disease Control and Prevention medical follow up guidelines and the criteria for pre and post exposure counseling.

All treatment for exposure management will follow the published recommendations set forth by the U.S. Public Health department -(the Centers for Disease Control and/or the Advisory Committee on Immunization Practices).

The established program for medical evaluation and follow up will be conducted by an accredited laboratory at no cost to the member. All laboratory tests will be conducted through Employee Health .

Medical records of exposure medical management will be

confidential

Confidential elements will include the following;

1. Documentation of the route of exposure, and the circumstances under which the exposure occurred
2. The identification of the source individual, unless it is not feasible, that this information be obtained
3. In the state of North Carolina - THERE IS "DEEMED CONSENT" FOR TESTING, if there is an occupational exposure. In the State of North Carolina, the source individual need not consent to testing IF there is clear documentation of a health care worker exposure
4. Results of the testing of the source individuals blood test shall be made available to the exposed member. The exposed member **should hold this information confidential.**
5. **Medical facilities must give out the source patient test results. This is NOT a HIPAA violation**

POST EXPOSURE REFERRAL

General Guidelines

Bloodborne Exposures

Wake County Fire Department will have the Designated Officer advise the exposed member as to whether or not an exposure occurred. The Designated Officer will work with the medical facility to perform source patient testing. If the source patient tests positive, the Designated Officer will initiate the referral for post-exposure management following a question and counseling session for the exposed employee.

The exposure member, if deemed necessary, will be offered Hepatitis B (HBV), Human IMMUNODEFICIENCY virus (HIV), Hepatitis C and VDRL testing. If the member consents to baseline blood testing, but does not wish to have testing done at that time for HIV, then the medical care provider will preserve the blood for at least 90 days. If within the 90 days following the incident, the member elects to have the testing performed, then it will be done as soon as possible. (OSHA). However, it should be noted that most medical facilities to do hold blood for more than 5 – 7 days.

Exposures which require medical treatment (prophylaxis) will be offered treatment that is in accordance with the published protocols set forth by the CDC. Protocols for HBV, HCV, HIV, Syphilis, Tuberculosis and childhood diseases are to be available**.**

ALL exposed members will receive counseling, this will be conducted by a health care professional who has been trained in pre- and post test counseling.

Airborne/Droplet Exposures –

Under the Ryan White Law, Part G, 2009 version, the medical facility is responsible to notify the Designated Officer if a crew transported a patient suspect for or diagnosed with an airborne/droplet transmitted disease. The Designated Officer will then interview the crew to determine whether an exposure occurred.

Hospital Responsibilities

The Hospital will be furnished a listing of the exposed member's job duties as they relate to the exposure incident. This provider will make final exposure determination. The hospital is responsible for obtaining source patient blood sample for testing. This will include; rapid HIV, rapid HCV, Hepatitis B surface antigen and syphilis as appropriate.

Documentation of the route of exposure and the circumstances of the exposure will be furnished by the Designated Officer to assist with this determination, if the designated officer disagrees with this, the public health officer will be contacted.

Members who feel that they have been exposed and it is ruled not to be an exposure, may obtain their own medical follow up at their own expense.

**The Hospital will carry out exposure notification/management within 48 hours as outlined in the Ryan White Law.

The receiving hospital is responsible for source patient blood testing. Rapid HIV and rapid Hepatitis C are the tests to be performed on the source patient. This is done to comply with the 1998/2005/2013 CDC Guidelines and to expedite testing on the behalf of the exposed member. Rapid testing

takes 10 – 100 minutes depending on the test ordered for the laboratory to perform. Source patient test results will be called to the Designated Officer. The Designated Officer will then review the results with the exposed member.

Employee Health's Responsibility –

Counseling and baseline testing of the member will be done by the departmental medical facility. Baseline tests drawn on the member will depend on the availability of source patient test results and a positive HBV titer test on file.

If the member insists on treatment when a non-exposure has been ruled, the office will contact the designated officer.

If the approved departmental medical facility is not open, then employees will be referred to the Emergency Department for follow up.

Letters of written opinion are an OSHA requirement and are to be completed within 15 days of the exposure event and sent to the DICO.

If the exposure involves HIV and falls under the CDC Guidelines for offering post exposure prophylaxis (PEP) the physician will access the CDC consultation line "expert" recommendations. The CDC consultation line can be reached by calling – 1-888-448-4911.

Wake County Fire Department's Responsibilities

The Department will furnish any and all relevant medical information to the office of the designated medical care provider.

If the exposure was a needle stick injury or an exposure to TB resulting in a positive skin test, the Designated Officer will complete an OSHA 300-report form and the Sharps Injury Log.

The Designated Officer **WILL** receive a summary of the written opinion within the 15 day time frame set forth in the regulation. An additional letter of written **opinion** will be forwarded directly to the member, by the Physician at City Employee Health the medical care provider for the department.

The Designated Officer will document that the member has been informed of the evaluation results. This should be in accordance with the 48 hour time frame set forth in **the Ryan White Law.**

All records will be maintained for duration of the member's department plus an additional thirty (30) years as set forth in the OSHA regulation.

Record Keeping Requirements for Sharps Injuries

The OSHA 300 Log

Group sharps injuries in with all other work-related injuries. Is a different document with different requirements than the Needlestick Injury Log.

A work related sharps injury is recordable on the OSHA 300 log if:

- ❑ It causes a death
- ❑ It causes an illness
- ❑ It involves an injury which requires medical treatment beyond first aid (even if treatment is offered and refused).
- ❑ Sharps injury = exposure

First Aid	Medical Treatment (recordable)
❑ Antiseptics during first visit	❑ Treatment of infection
❑ Application of bandage	❑ Application of antiseptics at 2nd and 3rd visits
❑ Use of non-prescription medications	❑ Administration of >1 dose of prescription medication
❑ Single dose of prescription medication	❑ Administration of hepatitis vaccination
❑ Administration of tetanus shot or booster	❑ Lab test or x-ray that shows injury or infection
❑ Lab test or x-ray that shows no injury or infection from that injury	

The Sharps Injury Log (States may have additional requirements)

All contaminated sharps injuries must be recorded. Non-sharp related exposures are not recorded here.

- ❑ The report has names
- ❑ Department where exposure incident occurred
- ❑ How the incident occurred
- ❑ Type and brand of sharp involved in the exposure incident
- ❑ This information may be recorded on a separate document or may be included in the data you collect following an exposure investigation. It is acceptable to maintain the information in computer files if you are able to sort the report for sharps injuries only and access it in a timely manner for OSHA if requested

Sharps Injury Log

Month:_____

Member Name	Device Used	Task Performed	Location of the Incident	Description of How Incident Occurred

State Testing Law

10A NCAC 41A .0202 CONTROL MEASURES – HIV

The following are the control measures for the Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection:

(1) Infected persons shall:

(a) refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure;

(b) not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;

(c) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;

(d) have a skin test for tuberculosis;

(e) notify future sexual intercourse partners of the infection;

(f) if the time of initial infection is known, notify persons who have been sexual intercourse and needle partners since the date of infection; and,

(g) if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

(2) The attending physician shall:

(a) give the control measures in Item (1) of this Rule to infected patients, in accordance with 10A NCAC 41A .0210;

(b) If the attending physician knows the identity of the spouse of an HIV-infected patient and has not, with the consent of the infected patient, notified and counseled the spouse, the physician shall list the spouse on a form provided by the Division of Public Health and shall mail the form to the Division. The Division shall undertake to counsel the spouse. The attending physician's responsibility to notify exposed and potentially exposed persons is satisfied by fulfilling the requirements of Sub-Items (2)(a) and (b) of this Rule;

(c) advise infected persons concerning clean-up of blood and other body fluids;

(d) advise infected persons concerning the risk of perinatal transmission and transmission by breastfeeding.

(3) The attending physician of a child who is infected with HIV and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the following circumstances:

(a) If the child is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child's parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee.

(i) If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee.

(ii) If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.

(b) If the child is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:

(i) notify the parents;

(ii) notify the committee;

(iii) assist the committee in determining whether an adjustment can be made to the student's school program to eliminate significant risks of transmission;

(iv) determine if an alternative educational setting is necessary to protect the public health;

(v) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by school personnel; and

(vi) consult with the superintendent or private school director to determine which school personnel directly involved with the child need to be notified of the HIV infection in order to prevent transmission and ensure that these persons are instructed regarding the necessity for protecting confidentiality.

(c) If the child is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.

(4) When health care workers or other persons have a needlestick or nonsexual non-intact skin or mucous membrane exposure to blood or body fluids that, if the source were infected with HIV, would pose a significant risk of HIV transmission, the following shall apply:

(a) When the source person is known:

(i) The attending physician or occupational health care provider responsible for the exposed person, if other than the attending physician of the person whose blood or body fluids is the source of the exposure, shall notify the attending physician of the source that an exposure has occurred. The attending physician of the source person shall discuss the exposure with the source and, unless the source is already known to be infected, shall test the source for HIV infection without consent unless it reasonably appears that the test cannot be performed without endangering the safety of the source person or the person administering the test. If the source person cannot be tested, an existing specimen, if one exists, shall be tested. The attending physician of the exposed person shall be notified of the infection status of the source.

(ii) The attending physician of the exposed person shall inform the exposed person about the infection status of the source, offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred, and, if the source person was HIV infected, give the exposed person the control measures listed in Sub-Items (1)(a) through (c) of this Rule. The attending physician of the exposed person shall instruct the exposed person regarding the necessity for protecting confidentiality.

(b) When the source person is unknown, the attending physician of the exposed persons shall inform the exposed person of the risk of transmission and offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred.

(c) A health care facility may release the name of the attending physician of a source person upon request of the attending physician of an exposed person.

(5) The attending physician shall notify the local health director when the physician, in good faith, has reasonable cause to suspect a patient infected with HIV is not following or cannot follow control measures and is thereby causing a significant risk of transmission. Any other person may notify the local health director when the person, in good faith, has reasonable cause to suspect a person infected with HIV is not following control measures and is thereby causing a significant risk of transmission.

(6) When the local health director is notified pursuant to Item (5) of this Rule, of a person who is mentally ill or mentally retarded, the local health director shall confer with the attending mental health physician or mental health authority and the physician, if any, who notified the local health director to develop a plan to prevent transmission.

(7) The Division of Public Health shall notify the Director of Health Services of the North Carolina Department of Correction and the prison facility administrator when any person

confined in a state prison is determined to be infected with HIV. If the prison facility administrator, in consultation with the Director of Health Services, determines that a confined HIV infected person is not following or cannot follow prescribed control measures, thereby presenting a significant risk of HIV transmission, the administrator and the Director shall develop and implement jointly a plan to prevent transmission, including making recommendations to the unit housing classification committee.

(8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.

(9) Local health departments shall provide counseling and testing for HIV infection at no charge to the patient. Third party payors may be billed for HIV counseling and testing when such services are provided and the patient provides written consent.

(10) HIV pre-test counseling is not required. Post-test counseling for persons infected with HIV is required, must be individualized, and shall include referrals for medical and psychosocial services and control measures.

(11) A local health department or the Department may release information regarding an infected person pursuant to G.S. 130A-143(3) only when the local health department or the Department has provided direct medical care to the infected person and refers the person to or consults with the health care provider to whom the information is released.

(12) Notwithstanding Rule .0201(d) of this Section, a local or state health director may require, as a part of an isolation order issued in accordance with G.S. 130A-145, compliance with a plan to assist the individual to comply with control measures. The plan shall be designed to meet the specific needs of the individual and may include one or more of the following available and appropriate services:

(a) substance abuse counseling and treatment;

(b) mental health counseling and treatment; and

(c) education and counseling sessions about HIV, HIV transmission, and behavior change required to prevent transmission.

(13) The Division of Public Health shall conduct a partner notification program to assist in the notification and counseling of partners of HIV infected persons.

(14) Every pregnant woman shall be offered HIV testing by her attending physician at her first prenatal visit and in the third trimester. The attending physician shall test the pregnant woman for HIV infection, unless the pregnant woman refuses to provide informed consent pursuant to G.S. 130A-148(h). If there is no record at labor and delivery of an HIV test result during the current pregnancy for the pregnant woman, the attending physician shall inform the pregnant woman that an HIV test will be performed, explain the reasons for testing, and the woman shall be tested for HIV without consent using a rapid HIV test unless it reasonably appears that the test cannot be performed without endangering the safety of the pregnant woman or the person administering the test. If the pregnant woman cannot be tested, an existing specimen, if one exists that was collected within the last 24 hours, shall be tested using a rapid HIV test. The attending physician must provide the woman with the test results as soon as possible. However, labor and delivery providers who do not currently have the capacity to perform rapid HIV testing are not required to use a rapid HIV test until January 1, 2009.

(15) If an infant is delivered by a woman with no record of the result of an HIV test conducted during the pregnancy and if the woman was not tested for HIV during labor and delivery, the fact that the mother has not been tested creates a reasonable suspicion pursuant to G.S. 130A-148(h) that the newborn has HIV infection and the infant shall be tested for HIV. An infant born in the previous 12 hours shall be tested using a rapid HIV test. However, providers who do not currently have the capacity to perform rapid HIV testing shall not be required to use a rapid HIV test until January 1, 2009.

(16) Testing for HIV may be offered as part of routine laboratory testing panels using a general consent which is obtained from the patient for treatment and routine laboratory testing, so long as the patient is notified that they are being tested for HIV and given the opportunity to refuse.

History Note: Authority G.S. 130A-135; 130A-144; 130A-145; 130A-148(h);

Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. February 1, 1990; November 1, 1989; June 1, 1989;
Temporary Amendment Eff. January 7, 1991 for a period of 180 days to expire on July 6, 1991;
Amended Eff. May 1, 1991;
Recodified from 15A NCAC 19A .0201 (d) and (e) Eff. June 11, 1991;
Amended Eff. August 1, 1995; October 1, 1994; January 4, 1994; October 1, 1992;
Temporary Amendment Eff. February 18, 2002; June 1, 2001;
Amended Eff. November 1, 2007; April 1, 2005; April 1, 2003.

FOLLOWING EXPOSURE TO A DECEASED PATIENT

The Medical Examiner will perform necessary blood testing on the deceased patient if there is a documented health care worker exposure. The Medical Examiner will expedite the testing process to assist in meeting the prescribed time frames for post-exposure medical follow up. Notification of the Medical Examiner will be done by the Designated Officer. (Page 10 of the Ryan White Law)

** NOTE: It may be helpful to tag the body bag to note that an exposure has occurred.

POST-EXPOSURE REPORTING FORM

&

Post Exposure Protocols

Physician Counseling Documentation Form

This form is to serve as documentation that _____ _____ a Member of _____. Has been advised of the results of laboratory testing that was performed on_____2016/17. This laboratory work was performed for the purpose of:

_____Post exposure medical follow up

_____ Annual physical exam

_____ Post hiring physical examination

Appropriate counseling was provided to this Member and all test results will remain confidential. A copy of the results will be held in the Member's confidential medical record.

_____ _____

Physician Signature Member Signature

Declination Form

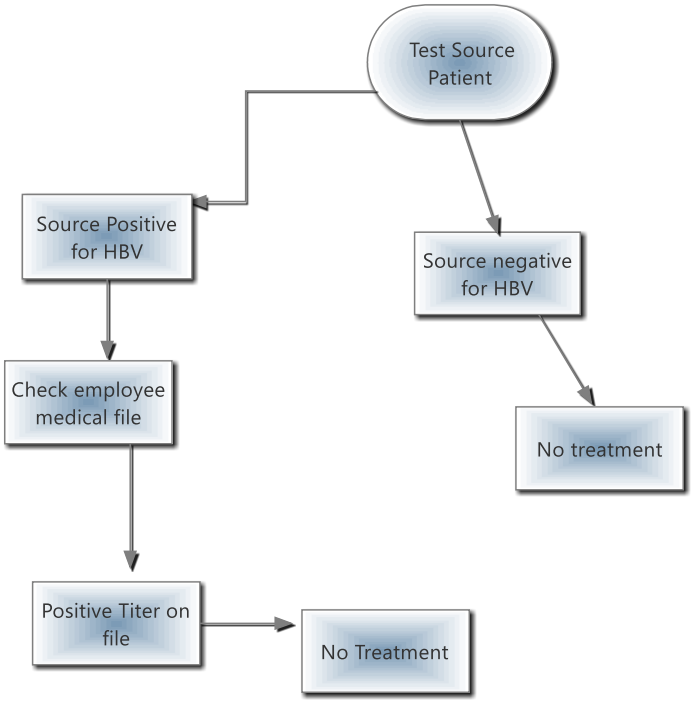
Post – Exposure Medical Treatment

I understand that due to my occupational exposure I may be at risk for acquiring _____ disease. I have been given the opportunity to be treated prophylatically for this exposure, at no charge to myself. However, I decline follow up medical treatment at this time. I understand that by declining this treatment, I continue to be at risk for acquiring the disease to which I have been exposed. I understand that if I acquire this disease I will be placed under the departments work restriction guidelines.

Name_____
Date:_____

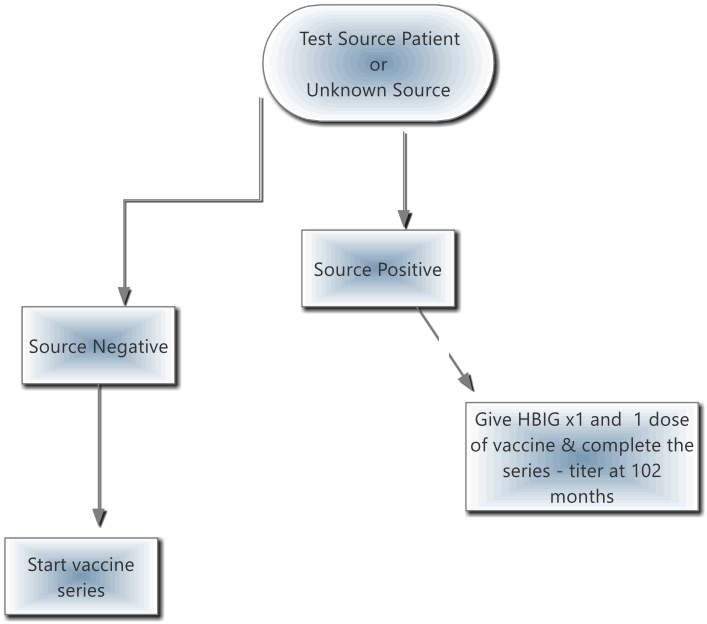
Signature_____

Post - exposure HBV Known Responder



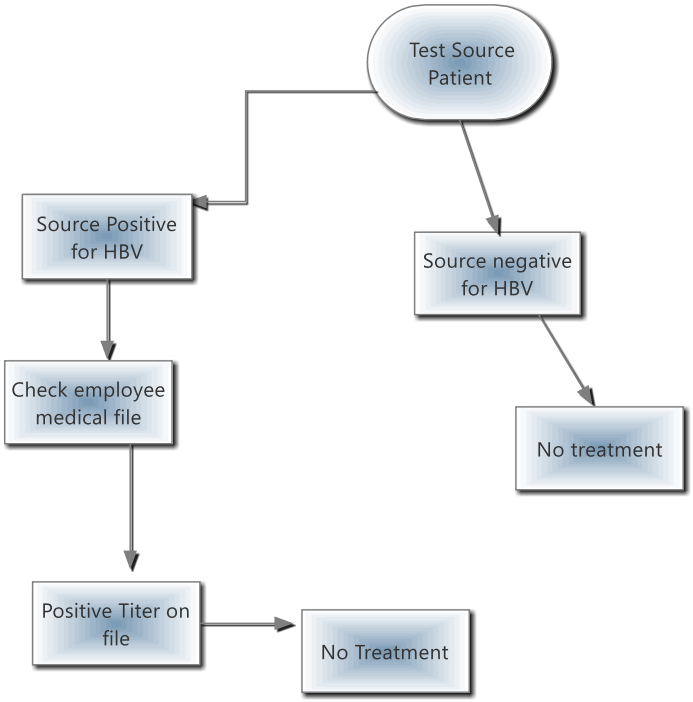
CDC, MMWR, June 29, 2001, Dec. 8, 2006, Nov., 2011, 2013

Post - exposure HBV - Non Vaccinated or Incompletely Vaccinated Employee



CDC, MMWR, June 29, 2001, Dec. 8, 2006, Nov. 2011, 2013

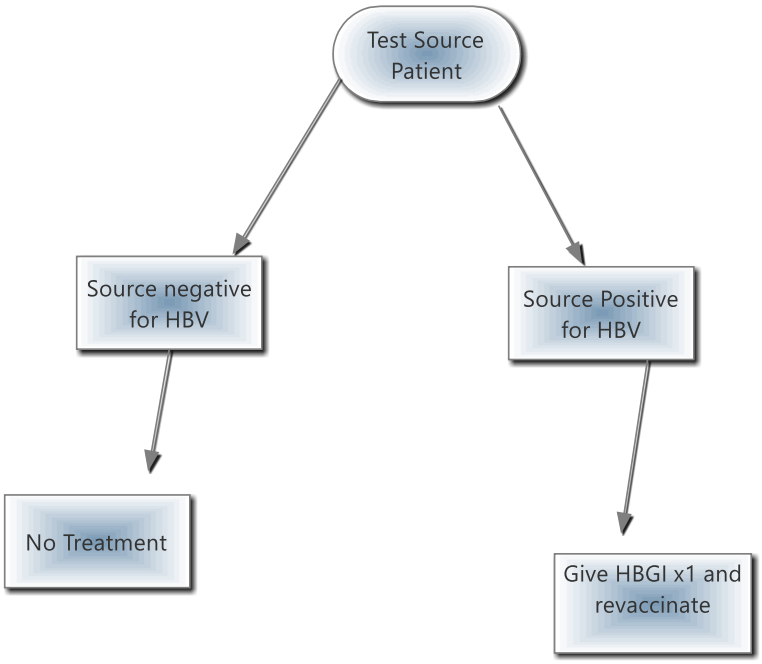
Post - exposure HBV Known Responder



CDC, MMWR, June 29, 2001, Dec. 8, 2006, Nov., 2011, 2013

Post - exposure Known Vaccine

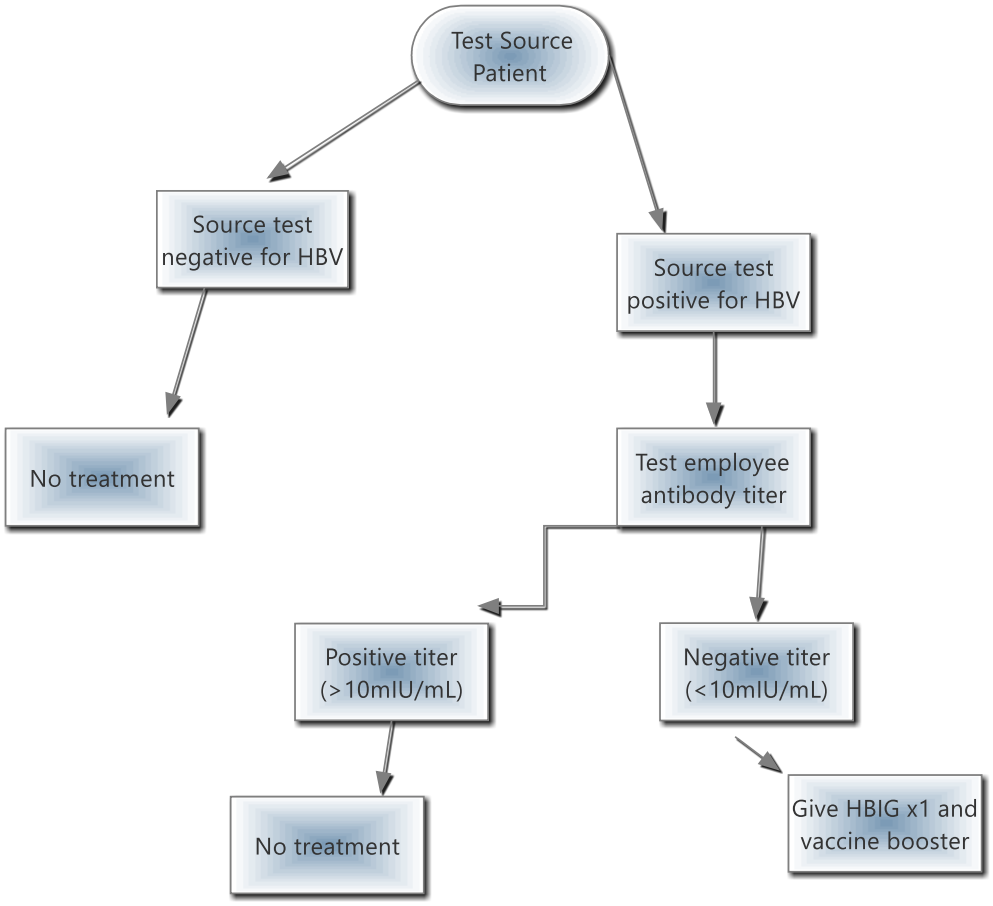
Non - Responder - 3 Dose Series



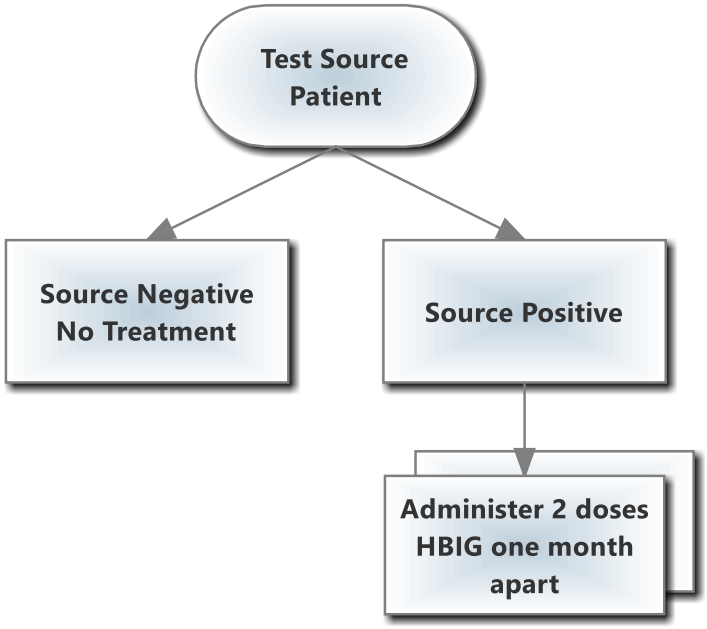
CDC, MMWR, June 29, 2001, Dec. 8, 2006, Nov. 2011, 2013

Post - exposure HBV Vaccine

Response Unknown

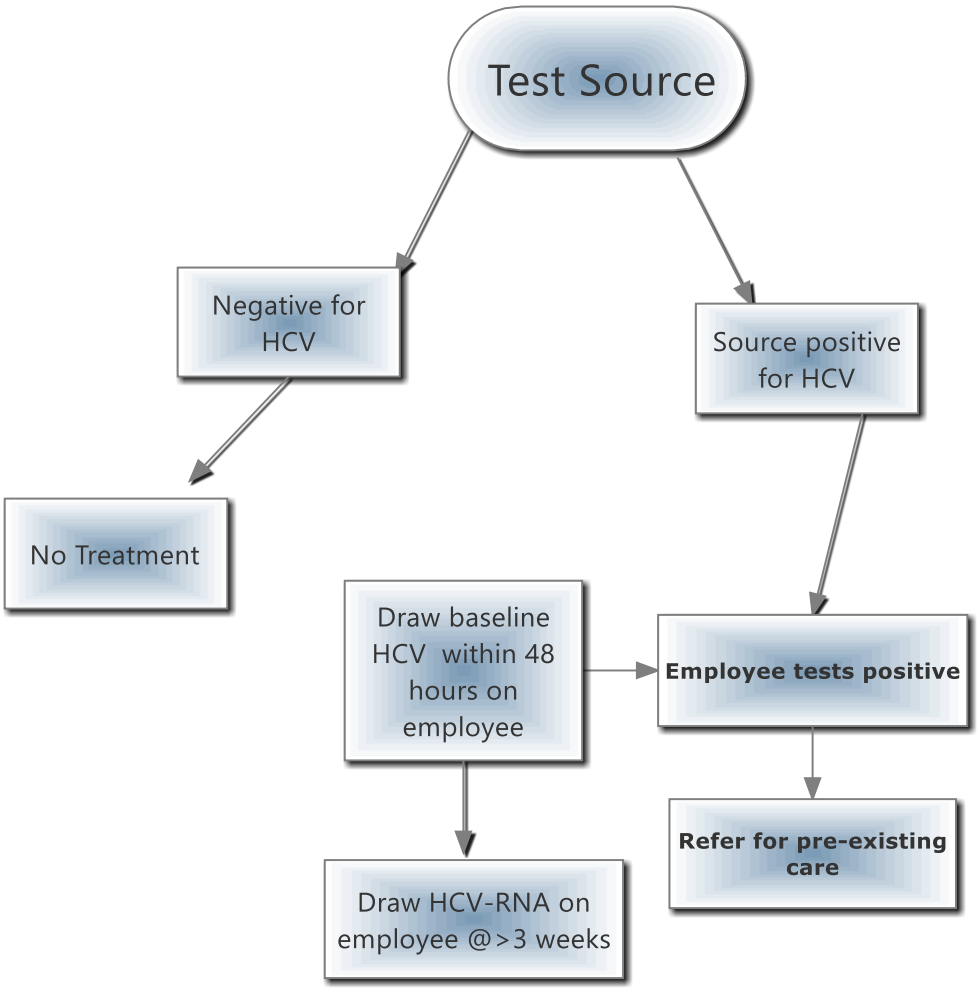


Post Exposure Follow Up Hepatitis B Vaccine Non - Responder - 2 Series of Vaccine



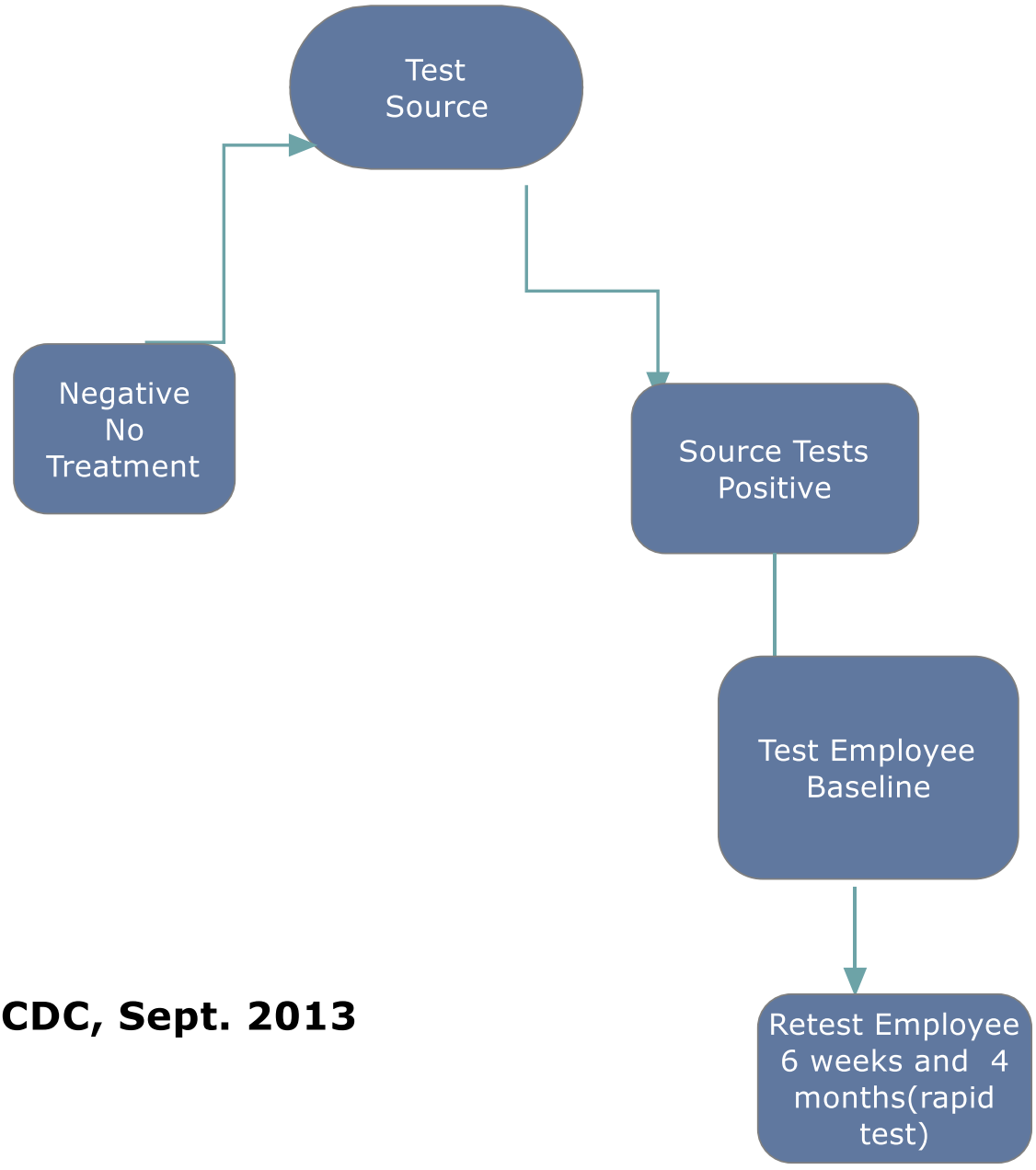
CDC Guidelines - November, 2011

Post - exposure HCV



2017

Post Exposure Protocol - HIV



CDC, Sept. 2013

Post Exposure Medical Treatment for Exposure to HIV

Post Exposure Prophylaxis (PEP)

I understand that the exposure that I sustained meets the criteria for offering antiretroviral drug treatment in accordance with the Centers for Disease Control and Prevention's recommendations dated May 15, 1998, June 29, 200 , 2005 and September, 2013.

I understand that these drugs are offered because "theoretically initiation of antiretroviral PEP soon after exposure may prevent or inhibit systemic infection by limiting the proliferation of virus in the initial target cells or lymph nodes".

I understand that post-exposure prophylaxis (PEP) is a four- (4) week course of treatment. I understand that this drug treatment is associated withan increased risk for side effects. I have been advised that side effects may include; nausea, vomiting, malaise/fatigue, headache, or insomnia.

I have been offered counseling by a licensed health care provider and have had an opportunity to ask questions regarding the following:

_____ Source patient test results (include viral load test)
_____ What is known and unknown about PEP
_____ Side effects
_____ Use of drugs in pregnancy (need for pregnancy testing)
_____ Baseline and every 2 week blood work
_____ Current medication & drug interaction
_____ Drug allergies
_____ Efficacy/toxicity of these drugs
_____Refraining from- sexual activity, donating blood, tissues or organs
_____ Importance of using condoms if sexually active

Based on this counseling session, I elect to receive PEP treatment in accordance with the current recommendations.

Member Signature:_____ Date:_____

Physician Signature:_____
Physician's Name (print)_____

Developed by Katherine West, IC/EC, Inc.

EXPOSURE TO SYPHILIS

PROCEDURE	ACTION/NOTES
Wash area well with soap & water Report exposure and complete any necessary reporting forms	Reduces the number load of organisms Assists with exposure recordkeeping and documentation for work comp.
Await source patient test results **Rapid testing is now available**	Exposure healthcare personnel are Entitled to this information
Report for medical evaluation and/or testing	If results are positive on the source then post exposure treatment is appropriate
Treatment – IM injection of long-acting Penicillin 2.4 million units	If penicillin allergic, oral Doxycycline or tetracycline may be given

Exposure to Tuberculosis

PROCEDURE	ACTION/NOTES
If an unprotected exposure occurs, And, the Member has no documented negative test in the past three months, and was not previously positive, a MANTOUX skin should be given as soon As possible	Persons who have tested positive in the past should not be tested A PPD skin test is good for 3 months
If this skin test is negative, the Member Should be retested in 8-12 weeks	Person with a positive test on file, DO NOT require a skin test. The incubation period is 4-12 weeks
If the exposed Member tests positive, (>5mm reaction) or shows signs or symptoms of TB, a chest x-ray should be preformed	
Members testing positive following an exposure should be evaluated for preventive therapy in accordance with the current CDC guidelines	Evaluation is important for each person because some may develop drug induced hepatitis. Pregnant members also need close evaluation
If INH or RIF therapy is prescribed, then liver function studies should be monitored on a monthly basis	Alcoholic beverages should be avoided
Healthy Member who are receiving prevention treatment for TB exposure should be allowed to continue to work	

New a 12 weeks course of treatment is available (CDC, 2012)

Post – Exposure Medical Management

Chickenpox (Varicella)

In the event that a non-immunized member is exposed to the chickenpox, the member should complete an incident report and communicate with the Designated Officer.

The Designated officer will refer the exposed member for post-exposure medical management. Healthy staff members will be offered vaccine post exposure. Members who are pregnant or immuno-compromised will be offer VariZIG . Post-exposure treatment may involve antibody testing and consideration of the administration of Varicella-zoster immune globulin (VariZIG).

The exposed member should be removed from duty form the 10th day following the exposure until the 21st day. If the member has not developed the chickenpox, they may then return to duty. If the member does develop the chickenpox, then he/she may not return to work until all lesions are crusted and dried.

Members who have an on the job exposure will be covered under the departments insurance policy.

Post Exposure Medical Follow Up Measles, Mumps, Rubella

Procedure	**Action/Rationale**
Check employee medical record For immunity documentation	This will establish the need for treatment
No documentation is available	
Offer MMR vaccine as a prevention Measure for measles, Rubella	There is no need to titer before offering vaccine
If exposure to mumps, place on Work restriction	Mumps vaccine is NOT effective given post exposure

Post Exposure Medical Follow Up – Bacterial Meningitis

Procedure	**Action/Rationale**
Document exposure: Mouth-to-mouth, spraying of secretions, direct contact with patients oral or nasal secretions, contact with vomitus in eye, nose, mouth	CDC Guidelines define
If exposure confirmed to bacteria Meningitis ,post exposure treatment May included;	
Rifiphen PO x 2days	Turns all body fluids orange
Should not be administered to Women on birth control pills	Will interfere with pregnancy protection
Cipro 1 x oral	Not to be given to anyone who is pregnant May cause joint and tendon damage
o Rocephin	For a pregnant member following an exposure

Post Exposure Protocol – Pertussis

Procedure	Action/Rationale
Document an actual exposure-	Considered highly communicable
An obvious exposure that involves direct contact with respiratory, oral, or nasal secretions from a case-patient during the contagious period (e.g., a cough or sneeze in the face, sharing eating utensils, sharing water bottles, kissing, mouth-to-mouth resuscitation, or performing intubation or nasotracheal suctioning without a mask).	
&	
Check vaccination record	Vaccination does not always confirm immunity
No Tdap booster documented- May not eliminate risk for disease	Z- Pack or Erythromycin PO x 14 days
Infected Healthcare worker contact- Contacts may remain in the workplace if they comply with prophylaxis and lack respiratory symptoms; they should be under surveillance for 21 days after their last known exposure	

CDC Immunization Guidelines, Nov, 2011

Sharps Injury Log **Confidential**

Month:_____

Member Name	Device Used	Task Performed	Location of the Incident	Description of How Incident Occurred

State Medical Waste Regulations

North Carolina Regulated Medical Waste

- Which waste stream should this waste material go into?
  - **How does North Carolina classify waste from healthcare facilities?**
  - **What is "regulated medical waste" (RMW)?**
  - **What goes where in North Carolina?**
- How do I manage Regulated Medical Waste?
  - **Do I need a permit to handle RMW?**
  - **How do I store RWM?**
  - **Are there any training requirements?**
  - **What records do I have to keep, and what reports do I have to file?**
- What will happen with the Regulated Medical Waste stream?
  - **Off-Site Transport/Disposal**
  - **On-site Treatment Requirements**
- Where can I get more information?
  - **Contacts**
  - **Statutes, regulations and guidelines**
  - **Additional resources**

Which waste stream?

In this section, you will find information that will help you determine how various types of healthcare facility waste ar classified in North Carolina.

Waste Categories

North Carolina classifies wastes generated by health care facilities into four main categories:

- Hazardous wastes**. This refers to a class of wastes specifically defined in a federal law (the Resource Conservation and Recovery Act, or RCRA). These wastes contain certain toxic chemicals or have certain characteristics that cause them to be a significant risk to the environment and/or human health. Certain some chemotherapy waste is hazardous waste. In North Carolina, hazardous waste regulations are enforced by the North Carolina Department of Environment and Natural Resources (NC DENR).**
- Medical waste. **Medical waste means any solid waste which is generated in the diagnosis, treatment or immunization of human beings or animals, in research, or in the production or testing of biologicals. It does not include any hazardous waste, radioactive waste, or household waste.**
- Regulated medical waste (RMW)**. These are a special subcategory of medical wastes that present**

significant health risks such as the potential for infectious disease transmission, and special rules apply to them. In North Carolina, RMW is defined in general as "blood and body fluids in individual containers in volumes greater than 20 ml, microbiological waste, and pathological waste that have not been treated pursuant to specific standards. However, if a waste has been designated as a "hazardous waste" by the NC DENR, the hazardous waste rules apply. (Refer to the regulation for details).

- Municipal solid waste**. These wastes present fewer environmental or health risks than medical wastes. Municipal solid waste can be disposed of into dumpsters.**

It is important that you categorize your facility's waste accurately.

- **Hazardous waste disposed of as regulated medical waste or municipal solid waste, or regulated medical waste disposed of as municipal solid waste are violations of the law and can result in substantial penalties.**
- **Conversely, most medical waste may be handled as general solid waste and does not require special handling or treatment.**
- **Correctly identifying and segregating your RMW can reduce the cost of disposal. Regulated medica waste makes up only a small portion of the total medical waste stream. In North Carolina, roughly 9 to 15 percent of the waste stream at hospitals is regulated medical waste. Some facilities, such as long-term care facilities, generate medical waste, but little or no regulated medical waste. Use the guidance and references below to accurately categorize your wastes. For additional help, see Contacts below.**
- **Regulated medical waste that is treated to specific standards can be disposed of as municipal solid waste, provided that no local rules prohibit it.**

Definition of Regulated Medical Waste

"Regulated Medical Waste" means blood and body fluids in individual containers in volumes greater than 20 ml, microbiological waste, and pathological waste that have not been treated pursuant to specific rules (treatment requirements are covered under 1207 of the medical waste management rules).

Managing Regulated Medical Wastes

Requirements, for healthcare facilities that generate regulated medical waste and send it off-site to a treatment/disposal facility

Registration, Permits

Generators of regulated medical waste are not required to register with the state of North Carolina and no RMW generator permits are required by the state of North Carolina. Also, permits are not required for hospitals and similar facilities that treat only waste generated within the facility. Permits are required for facilities that treat medical waste from off-site.

Packaging and Storage

- Packaging of Regulated Medical Waste for Off-Site Treatment. **There are certain specific rules that healthcare facilities must follow for packaging regulated medical waste. These include**:
    - **Regulated Medical Waste must be packaged in a plastic bag in a rigid fiberboard box or dru in a manner that prevents leakage of the contents.**
    - **The outer surface of the box or drum must be labeled with a biohazard symbol; the words "INFECTIOUS WASTE" or "MEDICAL WASTE"; the date of shipment; and the name, address and phone number of the generator, transporter, storage facility and treatment facility.**

- **The medical waste management rules do not require a biohazard label on the plastic bag or use of red bags. However, generators should be aware that OSHA rules may require labelin of bags containing some types of medical waste.**

- Storage of Regulated Medical Waste Prior to Shipment Off-Site for Treatment**. There are certain specific rules that health care facilities must follow for packaging regulated medical waste. These include**:
  - **A plan must be maintained at the facility to ensure proper management of regulated medica waste.**
  - **Areas used to store regulated medical waste must be accessible only to authorized personnel.**
  - **All medical waste, including regulated medical waste, must be stored in a manner so as not to create a nuisance either by noxious odors or by encouraging the presence of insects or vermin.**
  - **RMW must not be compacted.**
  - **Regulated medical waste that will be shipped off-site for treatment must be stored in packaging suitable for transportation and in a manner that maintains the integrity of the packaging, including labels and markings.**
  - **All floor drains in the storage area must discharge directly to an approved sanitary sewer (sewer or septic system).**
  - **Ventilation must be provided.**
  - **There are no maximum time limits for storage of RMW destined for off-site treatment.**

- Packaging Requirements for Regulated Medical Waste Which Will Be Treated On-Site. **The packaging requirements only apply to regulated medical waste that is being shipped off site for treatment. There is no packaging requirement for regulated medical waste treated on-site.**

- Storage Requirements for Medical Waste Which Is Not Classified as Regulated Medical Waste**. If none of the medical waste being stored is regulated medical waste, the waste is subject to the storage requirements of general solid waste. As with regulated medical waste, non-regulated medical waste must be stored in a non-putrescent state, and vermin and insects must be controlled.**

Training Requirements

- **All employees involved with the on-site management of RMW must be trained in accordance with the requirements of the OSHA Exposure to Bloodborne Pathogens regulations (29 CFR 1910.1030)**

Plans, Recordkeeping and Reporting

These rules apply to facilities that generate 50 pounds or more regulated medical waste per month.

Generators must prepare a plan to ensure proper management of regulated medical waste. The plan must be maintained at the generating facility. Generators must maintain records for each shipment of RMW. The records must include:

- **Amount of waste by number of packages,**
- **Date shipped off-site,**
- **Name of transporter, and**

- **Name of storage or treatment facility.**

There are no reporting requirements. However, these records must be maintained at the generatorÕs facility for at least three years.

Treatment and Disposal of Regulated Medical Waste

In this section, you will find information on the proper final disposition of the Regulated Medical Waste (RMW) stream including RMW sent off-site and RMW treated on-site.

Regulated medical waste may be treated on-site or at a facility that is an integrated part of the generating facility (e.g., one or more healthcare facilities located in a single county or two contiguous counties, facilities affiliated with a university, or facilities that serve a single service area).

On-site Treatment Requirements

The following are acceptable methods for treating regulated medical wastes:

- **Blood and body fluids in individual containers in volumes greater than 20 ml: Incineration o sanitary sewage systems provided the sewage treatment authority is notified.**
- **Microbiological waste: Incineration, steam sterilization, microwave treatment, or chemical treatment.**
- **Pathological wastes: Incineration.**

Other methods of treatment shall require approval by the NC Division of Waste Management (see **Alternative Medical Waste Treatment Technologies**.

The following general rules apply to healthcare facilities that treat regulated medical waste:

- **Regulated medical waste may be stored prior to treatment for no more than seven calendar days and may be stored no longer than seven calendar days after treatment.**
- **Only authorized personnel may have access to areas used to store RMW.**
- **All areas used to store RMW must be kept clean. Vermin and insects shall be controlled.**
- **Neither carpets nor floor coverings with seams may be used in storage areas.**
- **Prior to treatment, all RMW be confined to the storage area.**
- **All floor drains must discharge directly to an approved sanitary sewage system.**
- **Ventilation must be provided and must discharge so as not to create nuisance odors**
- **A plan shall be prepared, maintained and updated as necessary to ensure continued proper management of Regulated medical waste at the facility.**
- **Records or treatment must be maintained for at least three years, including: each shipment and shall include the following information: name and address of generator, date received; amount of waste received by number of packages (piece count), date treated, and name and address of ultimate disposal facility.**
- **Facilities that treat waste generated off-site shall submit an annual report to the Division of Waste management, by August 1 of each year.**
- **Specific operational requirements for steam sterilization, incineration, chemical and microwave**

treatment requirements can be found in the Medical Waste Management Rules.

OSHA Regulations

In addition to the state medical waste environmental regulations there are some Occupational Safety and Health Administration (OSHA) rules that apply to medical/infectious waste. North Carolina is one of 24 states operating an approved occupational safety and health program. This program is operated by the Occupational Safety and Health Administration. OSHA rules (Occupational Exposure to Bloodborne Pathogens Standards) impact various aspects of medical/infectious waste, including management of sharps, requirements for containers that hold or store medical/infectious waste, labeling of medical/infectious waste bags/containers, and employee training. These requirements can be found in the HERC section entitled OSHA Standards for Regulated Waste.

More Information

In this section, you will find links to points of contacts at the North Carolina agencies responsible for regulating healthcare facility waste, links to the text of the regulations, and additional resources that you might find of interest o this topic.

Contacts

North Carolina Department of Natural Resources, Division of Waste Management.

Statutes, Regulations and Guidelines

Medical Waste Management Rules: Section 1200 -

Medical waste is also subject to all general requirements for solid waste found in the solid waste management regulations.

N.C. Hazardous Waste Section - Administers the RCRA Subtitle C program which regulates some types of waste from medical facilities including some chemotherapy waste.

Additional Resources

A guidance document, Look Here First, discusses North Carolina medical waste issues and regulations.

Alternate (non-incineration) Technologies - Includes a list of approved medical waste treatment systems availab for use in North Carolina, information on obtaining state approval, and links to other governmental agencies.

A Guide to Bloodborne Pathogens in the Workplace. A guide published by the N.C. Department of Labor, Division of Occupational Safety and Health.

COMPLIANCE MONITORING

COMPLIANCE MONITORING

The Wake County Fire Department recognizes its responsibility to provide personal protective equipment, education and training, post exposure reporting/follow-up for its member at risk for exposure. It also notes the responsibility of the members to comply with the established policy/procedures set forth in the Exposure Control Plan. Thus, members identified, as having job responsibilities which place them at risk, will conduct compliance monitoring activities on a regular basis. The time frame between monitoring will be decided by the designated officer.

The purpose of compliance monitoring is to verify that the program for reducing member exposure is "on track". It will also ensure that the department is in compliance with all applicable laws, standards and guidelines. Compliance monitoring will also serve to identify training needs or problem identification. The Department's disciplinary action policy will be followed for members who do not comply with this established plan. (See Rules of Conduct)

OSHAct 1970 Section 5 Duties states –

- "each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct".
-
- **Intervention- Compliance Monitor**

Member Name:

Member Interview:

Date:_____

Observer:_____

COMPLIANCE MONITOR-EMS
Compliance Monitor – EMS

Scene Monitor – Check List _____ Date: _____

Task/Procedure	Compliance Yes	No	Comments
1. Personal protective equipment was available	☐	☐	
2. Handwashing was observed	☐	☐	
3. Needle/Sharps container was used	☐	☐	
4. Gloves were used according to established policy	☐	☐	
5. Eyewear was indicated and used as per SOP	☐	☐	
6. Masks were used according to SOP	☐	☐	
7. Personal protective equipment was appropriate	☐	☐	
8. Patient was advised regarding the use of PPE	☐	☐	
9. If PPE was not used per SOP, explain the circumstances	☐	☐	
10. Patient history information was handled according to department policy	☐	☐	
11. Patient family was advised regarding use of PPE	☐	☐	
12. Exposures were promptly reported	☐	☐	
13. All needles and debris were removed from the scene	☐	☐	
14. PPE was properly disposed of according to Department procedures	☐	☐	
15. Vehicles were cleaned following transport	☐	☐	
16. Cleaning was done using the proper agent	☐	☐	
17. Contaminated areas were cleaned	☐	☐	

Fire/Rescue Station
Compliance/Quality Monitor

Date: _____ Area: _____

Criteria	Compliance		Observation/Notes
	Yes	No	
Station area is clean	☐	☐	
Kitchen is clean/orderly	☐	☐	
Refrigerator is set at _____°	☐	☐	
Trash is in a covered container	☐	☐	
Bathrooms are clean	☐	☐	
Handwashing solutions are available	☐	☐	
Handwashing solution containers are filled	☐	☐	
Waterless hand wash solutions are available	☐	☐	
Personal Protective attire is readily available	☐	☐	
Laundry facilities are provided ☐ **In Station** ☐ **Contracted Service**	☐	☐	
Specified area for cleaning equipment	☐	☐	
Contaminated linen is bagged and labeled as biohazard	☐	☐	
Stocked medical supplies are in a clean area	☐	☐	

Fire/Rescue Station
Compliance/Quality Monitor

Date: _____ Area: _____

Criteria	Compliance		Observation/Notes
	Yes	No	
Exposure incidents and follow up are in the Member health record	☐	☐	
Immunization records are in each Member health file	☐	☐	
Education and training records are in each Member health file	☐	☐	
Member job descriptions contain information on OSHA Category assignment	☐	☐	
Members are participating in the hepatitis B vaccine program	☐	☐	
Members have reviewed the departments infection control program	☐	☐	

Fire/Rescue Station
Compliance/Quality Monitor

Date: _____ Area: _____

Criteria	Compliance		Observation/Notes
	Yes	No	
Solutions for high level disinfection are in date, covered and in an appropriate container	☐	☐	
There is documentation of all routine cleaning of vehicles/equipment	☐	☐	
Needle-disposal containers are located in each decontamination area	☐	☐	
Staff is aware of the policy for reporting exposure situations	☐	☐	
Bio-hazards signs are properly posted	☐	☐	
Infectious waste containers are readily available	☐	☐	
There is a designated area for storage of infectious waste	☐	☐	
Records area maintained for infectious waste removal and disposal	☐	☐	
Blood specimens being sent out are properly labeled, contained	☐	☐	
Exposure incidents have been reviewed and discussed	☐	☐	
Exposure follow up is documented for each incident	☐	☐	

Action/Follow Up **Date of next review:**

DISCIPLINARY ACTION POLICY

The purpose of the exposure control plan is to reduce the risk for occupational exposure. Our plan is effective if followed as written. Periodic and unannounced monitoring will be conducted to ensure that members are complying with this plan.

Compliance with the exposure control plan is a member responsibility. Non-compliance will be noted and records maintained of each incident and member interview. Retraining and education will be offered. The Rules of Conduct book outlines the policy.

RECORDKEEPING

SUMMARY RECORDKEEPING

On or before March 30, 2002, Wake County Fire Departments will insure that accurate recordkeeping will be established and maintained for each member deemed to be at risk for occupational exposure.

These records will be maintained by the Designated officer – in conjunction with the departmental medical office. Some records (immunizations/testing) will also be maintained by the DICO.

Information for the medical records will include:

1. Name and social security number of the member (last 4 digits)
2. A copy of the hepatitis B vaccine record, titer results, and PPD status
3. Consent/Denial forms
4. A copy of results of examinations and follow up procedures
   As required by the OSHA regulation
5. A copy of the healthcare providers written opinion(s) following an exposure
6. A copy of the information provided to the healthcare provider as required to assist with medical follow up

ALL MEMBER MEDICAL RECORDS WILL BE KEPT CONFIDENTIAL. ALL FILES WILL BE LOCKED AND MAINTAINED BY THE DESIGNATED OFFICER.

Member medical records will be maintained for at least the duration of their employment plus 30 years. in accordance with the OSHA standard, 1910.1030.

Should a member submit a written request for a copy of their medical records, this will be done within 15 days of the request. This would be submitted to Wake County Employee Health @ 919-996-6700

TRAINING RECORDS

Training records will include;

1. dates of the training session
2. the content (outline) or summary of the material presented
3. the name and qualifications of the instructor
4. the names and job titles of all persons attending the training session
5. the members signature

ALL training records will be maintained for three (3) years.

Training records are <u>not</u> confidential records and will be provided upon request to the member or the member's representative within 15 days of the request. If the Wake County Fire Department should cease to do business, it shall notify the Director of the North Carolina State OSHA office at least three months prior to the end of business. The Director may require that all records be transferred to him/her before the end of the three-month period.

All medical records will be kept confidential. Contents will *not* be disclosed or reported to any person within or outside the workplace. without the member's express written consent, except as required by law or regulation.

Department members who wish to obtain a copy of their medical record, must fill out the request form and the department will make a copy available within 15 days free of charge. available.

OSHA Regulations (Standards - 29 CFR)

Sample authorization letter for the release of Member medical record information to a designated representative (Non-mandatory) - 1910.1020AppA

- Standard Number: **1910.1020AppA**
- Standard Title: **Sample authorization letter for the release of Member medical record information to a designated representative (Non-mandatory)**
- SubPart Number: **Z**
- SubPart Title: **Toxic and Hazardous Substances**

I, _____, (full name of worker/patient) hereby authorize _____ (individual or organization holding the medical records) to release to _____ (individual or organization authorized to receive the medical information), the following medical information from my personal medical records:

_____

_____

(Describe generally the information desired to be released).

I give my permission for this medical information to be used for the following purpose:

_____

_____

but I do not give permission for any other use or re-disclosure of this information. (Note: Several extra lines are provided below so that you can place additional restrictions on this authorization letter if you want to. You may, however, leave these lines blank. On the other hand, you may want to (1) specify a particular expiration date for this letter (if less than one year); (2) describe medical information to be created in the future that you intend to be covered by this authorization letter; or (3) describe portions of the medical information in your records which you do not intend to be released as a result of this letter.)

_____

_____

Full name of Member or Legal Representative

_____

Signature of Member or Legal Representative

_____

Date of Signature [6R 31427, June 20, 1999