

Doña Ana County
FIRE & EMERGENCY SERVICES

SOG- POST EXPOSURE REPORTING FORM (Rev.2.2019)

Purpose

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

Outlined process is for Dona Ana County Fire & Emergency Services Employees. Stations should have a Designated Officer (DO). The process is the same for career and volunteer with the only difference is the insurer.

Definition of Exposure Report

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

If you had “a needle stick” or sustained any other penetrating, wound or cut to the skin with a used needle or contaminated item. Needle sticks require additional information to be reported please see this section.

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

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

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

Checklist Packet

- DAC Fire SOG/ Exposure Form
- NM Workers' Authorization Form <http://elsol/safety-and-risk-management>
- Notice of Exposure & Source Patient Testing- **NESPT** (3 pages)
- VIFIS notice form for volunteer staff only.
Online: <https://donaanacounty.org/node/145700>
- Online: El Sol/ Workers Comp; Notice of Accident (NoA)
- DAC Fire PPE unit Check List
- County Manager's Administrative Directive No. 2009-02 Blood Borne Exposure Plan (El Sol)

Procedure / Step by Step

1. Individual has identified a possible Blood Borne Pathogen (BBP) exposure.
2. Individual reports possible exposure of a Blood Borne Pathogen (BBP) to DO.
3. DO investigate to determine if a true BBP exposure occurred. Yes or No, the definition is outlined first page.
4. Not an exposure; none occurred; follow-up with counseling and feedback.
5. Exposure confirmed, YES.
6. *As per El Sol instructions for injured person.*
 - a. *If you have an emergency, call 911 or go to the nearest emergency or urgent care medical facility.*
 - b. *For all other injuries, notify your supervisor.*
 - c. *(omit)*
 - d. *After each doctor's visit, go directly to The Legal Department with your paperwork. Do not return to your department until you first go to The Legal department. There may be additional forms to complete and submit.*
7. Complete Patient Source Testing Form.
8. Yes, complete the NESPT request form (included in packet).
9. The NESPT form taken to the receiving hospital.

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

If the personnel received injury requiring immediate medical care, report to an urgent care or emergency medical facility. Understand; emergency rooms are limited in actions they can provide to mitigate post exposures.

10. Notice of Accident; complete a NoA on the El Sol website, login is required access NoA.
 - a. Claims report to DAC Legal Department.

Note: DOH representative may request additional test and recommendations thru the DAC medical designated provider as part of the employee's Exposure Management Plan. This is an "on the job exposure" and will require Workers' Comp Paperwork and follow-up through our Risk Management Program. Treatment, disease management and prophylaxis form DOH for Infectious Disease Exposure should be coordinated through the DAC medical provider.

11. Follow-up with DAC Contract Provider: WorkMed at 2525 S Telshor 575-521-1919 8-5 M-F

Post-Exposure Evaluation & Follow-Up:

The Legal Department will coordinate with the exposed employee and designated health care provider to complete a confidential medical evaluation, follow-up and referral for counseling if necessary.

Source Patient Testing

Delivered to medical facility as soon as possible after notification.

MMC ER: 575.521.2286

Liaison:

Dir. Infection Control Twyla Anderson: 575.521.2240

MVRMC ER: 575.556.6800

Liaison:

Infection Preventions Valerie Heald: 575.556.6894

Source Patient Information:

Name: _____ DOB _____ Age _____

Gender _____

Patient transported to _____ at approximately (time): _____

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

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

To whom was the request made? _____

Source patient blood drawn? Yes No

Medical facility liaison notified DO regarding test results: Yes No

Name of person who notified DO: _____

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

(Attach any received documentation)

Date _____ Time: _____

Final Exposure Disposition

Info needed for County Legal/ Risk Management Departments

Exposure Information:

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

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

Open cut

Area Exposed:

- Hands Face Eyes Nose Mouth Other _____

Task Description:

Protective Personal Equipment used: Yes No

Type: _____

Needle safe device used: Yes No Not Available

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

Employee's immunization status checked: Yes No

Immunization info: _____

Was medical Treatment provided: Yes No

If yes where and by whom: _____

Date: _____ Time: _____

Contact info: _____

Sharps Injuries maintained at DAC legal Department.

___ **No Sharps Exposure.**

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

OSHA 29 CFR 1904

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

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS**

Worker/Patient FULL NAME: _____ DOB: _____ SSN: XXX-XX-_____

FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with Section 52-10-1 NMSA 1978, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed \$1.00 per page for the first ten (10) pages or up to twenty-cents (\$0.20) for each page thereafter. A copy of this authorization may be used as an original.
Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (Worker's Name) _____, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:	WorkMed	
Address:	2525 S. Telshor Blvd.	
	Las Cruces, NM 88011	
Telephone No.:	(575) 521-1919	

I authorize the following records released (check box, as appropriate): **ALL RECORDS** **SPECIFIC DATES**
provide a date range for records authorized to be released _____

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (check any that may apply).

Treatment for alcohol and/or substance abuse Sexually transmitted diseases HIV or AIDS
 Behavioral or Mental Health, including Psychiatric or Psychological Records of the Department of Health Medical Cannabis Program

Signature of Worker/Patient/Personal Representative

Date

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be Picked Up Mailed Emailed Faxed Other (specify): _____

Authorized Recipient/s:	BITCO Insurance Co.	CorVel Corporation	Doña Ana County
Address:	P.O. Box 718	P.O. Box 35850	845 N. Motel Blvd.
	Shawnee, KS 66201-0718	Albuquerque, NM 87176	Las Cruces, NM 88007
Telephone No.:	(913) 262-4664	(505) 938-7218	(575) 647-7225
Fax/Email:	(913) 262-0997	(866) 401-2837	(575) 525-5925

**EXPIRATION and
CONDITIONS**

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

Signature of Worker/Patient

Date

Signature of Personal Representative (if any)

Date

Printed Name of Personal Representative

Relationship to Worker/Patient

Example 6.4

Occupational Exposure Worksheet		
Caller name: _____	Date: _____	Time: _____
Employee name: _____	Exposure date: _____	
Employer: _____	Exposure time: _____	
Phone: (w) _____	(h) _____	(c) _____
Any other agencies responding to same incident? _____		
Type of Exposure: <input type="checkbox"/> ID <input type="checkbox"/> HAZMAT		Source of Exposure:
<input type="checkbox"/> Mucous membrane _____		<input type="checkbox"/> Blood _____
<input type="checkbox"/> Needle/sharp _____		<input type="checkbox"/> Vomit _____
<input type="checkbox"/> Open skin _____		<input type="checkbox"/> Urine _____
<input type="checkbox"/> Intact skin _____		<input type="checkbox"/> Saliva _____
<input type="checkbox"/> Respiratory _____		<input type="checkbox"/> Feces _____
<input type="checkbox"/> Clothes/equip _____		<input type="checkbox"/> Respiratory _____
<input type="checkbox"/> Airborne _____		<input type="checkbox"/> Smoke _____
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____
<u>Narrative of exposure incident:</u>		

<u>Precautions:</u>		
<input type="checkbox"/> Eyewear	<input type="checkbox"/> Mask	<input type="checkbox"/> SCBA <input type="checkbox"/> Turnouts <input type="checkbox"/> Gloves <input type="checkbox"/> Other
<u>Immunizations:</u>		<u>Counseling Issues</u>
<input type="checkbox"/> HepB Vacc Date: _____	<input type="checkbox"/> HIV stats	<input type="checkbox"/> PEP
<input type="checkbox"/> Titer Date: _____	<input type="checkbox"/> Hep B	<input type="checkbox"/> Hep C
<input type="checkbox"/> Tetanus Date: _____	<input type="checkbox"/> Standard Prec	<input type="checkbox"/> Risks
<input type="checkbox"/> Tb Date: _____	<input type="checkbox"/> Blood donation	<input type="checkbox"/> Sex
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Tb/Airborne	<input type="checkbox"/> Meningitis

Example 6.5

Blood and Body Fluid Exposure

Field Operations Guide (FOG)

Any of the following events will be considered a bloodborne exposure and require the DICO (Designated Infection Control Officer) to follow all steps outlined here.

1. Blood or amniotic fluid splash to the eyes, nose, or mouth.
2. Blood or amniotic fluid comes in contact with nonintact skin.
3. Contaminated needlestick.
4. Blood or amniotic fluid soaked clothing over nonintact skin.

The DICO will complete the following steps immediately and initial each box as completed.

- Upon dispatch contact unit and verify progress of source patient blood testing.
- Verify decontamination has been completed by the exposed employee.
- Place the unit out of service upon completion of the call.
- Contact supervisor to advise of the exposure and confirm the dispatch of the DICO.

The DICO will complete the following steps as soon as possible after the exposure and initial each box as completed.

- Contact hospital for source patient testing.
- Have source blood sample drawn by authorized medical personnel.
- Verify exposed employee gets follow-up counseling and treatment, if required.

During the course of the FOG either the DICO or EMS Field Supervisor will contact the unit OIC (officer in charge) to determine destination and provide further instructions. This completed form will be presented to the DICO upon arrival.



Source: <https://www.donaanacounty.org/node/145700>

www.donaanacounty.org > Departments > Administration > Legal

*(This is a generic posting not specific to BBP Exposure)

There are two things you need to do:

1. Get medical treatment as needed. See directions below.
2. Report the injury or illness. See directions below.

A. Getting Medical Treatment – Emergency v. Non-Emergency

1. If the injury requires emergency care immediately call 911 or go to the nearest ER.
2. Notify your supervisor. Your supervisor or his/her designee shall transport you to your first visit to the medical provider. (see options below), or to the nearest urgent care facility.
 - a. **Work Med**
Open: 8 a.m. – 5 p.m. Monday – Friday
Located at: 2525 S. Telshor Blvd. Las Cruces, NM
(575) 521-1919
 - b. **Any Urgent Care Facility**
3. Make sure that a drug and alcohol screening is conducted at the medical facility you are receiving treatment at. In the event the medical facility refuses the screening, it is your responsibility to make arrangements with WorkMed to have it done.
 - a. Note: WorkMed is available on-call to complete the screening.

B. Reporting the Injury

- a. Your supervisor has been instructed to fill out a Notice of Accident on El Sol, which will inform Legal of your injury.
- b. You are responsible for filling out the Claim Form.
- c. If you are a Sheriff's Department volunteer click on the "Sheriff" link above.
If you are a Fire Department volunteer click on the "Fire" link above
- d. You will need to fill out the claim form in its entirety and provide it to the Legal Department for processing. You can fax it to (575) 525-5965, or hand-deliver it to a Legal representative.
- e. It is your responsibility to get the claim form to Legal to be processed. If you do not fill out the Claim Form we cannot process your claim with the insurance.
- f. If you have any questions or concerns contact the Legal Department at (575) 647-7225.



ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Glatfelter Claims Management, Inc.
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957. Fax: (717)747-7051

**PLEASE COMPLETE THIS FORM
IN FULL FOR PROMPT SERVICE**

NOTE: Important State Information Included

DATE OF THIS REPORT _____

SECTION 1 – CLAIMANT INFORMATION

To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Name _____ Soc. Sec. No. _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Weight _____ Height _____

Gender _____ Marital Status _____ Name of Spouse (if applicable) _____

Date of Incident or Organization's Activity _____ Year _____ Time _____ AM PM

Full-Time/Regular Occupation _____ Annual Income _____

Name/Address of Full-time Employer _____

Length of Employment in this Work _____ Employer's Phone Number _____

SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?

2. How did the injury or illness occur?

3. Please describe the injury or illness.

4. Date of first day of full-time occupation missed due to above injury or illness (if applicable) _____ N/A

5. Date able to return to work (if applicable) _____ N/A

6. Attending Physician's Name, Address and Telephone Number _____

7. Name and Address of Hospital _____

8. Date Hospitalized From _____ To _____

**SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, EMPLOYER, INSURANCE COMPANY OR
WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION**

I authorize any Health Care Provider, Employer, Insurance Company, Workers' Compensation Carrier, Person or Organization to release information regarding my medical history, treatment, earnings, or benefits payable, including disability or employment related information, to Glatfelter Claims Management Inc., for the purpose of determining benefits that may be payable under the VFIS Accident and Sickness (A&S) policy. If medical benefits are determined to be payable under the VFIS A&S policy, I authorize payment to be made directly to my medical provider(s). A photocopy or digital copy of this authorization is valid in place of the form containing my original signature. This authorization shall be valid for the duration of my claim.

Signature of Injured Member or Next of Kin _____ Relationship _____ Date _____

SECTION 4 – CERTIFICATION

To be completed by official of named insured organization (must be other than injured person)

- Was the injured person a member of your organization at the time of the above described incident? Yes No
- If claimant is a member of organization, please select type of member: Junior Adult Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization? Yes No

• Name and Address of Organization _____ • Policy Number _____

_____ • Organization Telephone Number _____

_____ • Home Telephone Number of Official Signing Below _____

I certify that the above is true.

Signed _____ Title _____ Date _____

Doña Ana County
FIRE & EMERGENCY SERVICES

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

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

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

Decontamination

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

Prevention with the proper sharps equipment

- All catheters are Auto-guard
- Safety Lancets

County Manager's Administrative Directive No. 2009-02
Supersedes Directive No. 2006-2

TITLE: Bloodborne Pathogen Exposure Control Plan
For Doña Ana County

I. PURPOSE

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

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

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

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

II. BACKGROUND

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

III. RESPONSIBILITY

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

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

IV. ELEMENTS OF THE PLAN

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

V. EXPOSURE DETERMINATION (Covered Employees)

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

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

VI. METHODS OF COMPLIANCE

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

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

B. Engineering and Work Practice Controls

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

C. Personal Protective Equipment (PPE)

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

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

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

D. Housekeeping

1. General

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

2. Regulated Waste

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

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

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

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

3. Laundry

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

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

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

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

VII: HEPATITIS B VACCINE

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

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

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

VIII. POST-EXPOSURE EVALUATION AND FOLLOW-UP

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

IX. Communication of Hazards to Employees

1. Labels & Signs

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

2. Information and Training

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

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

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

X. RECORDKEEPING

A. Training Records

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

The training records include:

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

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

B. Medical Records

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

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

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

Print Employee Last Name

Print First Name

Employee #

Department

Doña Ana County Consent Form

Hepatitis-B Vaccine

I consent to be immunized against Hepatitis B. I acknowledge the following:

1. I have been informed that I am at risk of acquiring Hepatitis B because of the nature of my professional responsibilities.
2. I have been informed of the risks, benefits, and presently known side effects of the Hepatitis B vaccine. I have been given the opportunity to ask questions and have had them answered to my satisfaction.
3. I must receive three (3) doses of vaccine over a period of six (6) months to confer optimal immunity.
4. I understand, however, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse reaction to the vaccine.
5. In the event that I experience any adverse side effects or do not become immune from the vaccine, I hereby hold Doña Ana County harmless from any and all liability to the extent permitted under the law.

Signature of Employee

Date

Vaccination Record

Injections:	Emp. Initial	Date:	Nurse	Facility I.D
Initial dose: _____				
1 month: _____				
6 months: _____				

Always return this form to Risk Management after each vaccination.

Doña Ana County Declination Form

Hepatitis B Vaccine

I understand that due to my occupational exposure to blood or other infectious materials that I may be at risk of acquiring the Hepatitis B virus infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to me. However, I decline the 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 the Hepatitis B vaccine, I can receive the vaccine series at no charge to me.

Print Name

Title

Signature

Date