



TOWN OF ERVING

HSP-001

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Plan

Blood Borne Pathogen Exposure Control Plan Policy

Approved: _____

Jacob A. Smith
Select Board Chair, Jacob A. Smith

Date: November 14, 2022

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.01 Issue Date / Effective Date

This policy is issued and effective on November 14, 2022.

.02 Purpose

Employees can be exposed to blood and body fluids during their job duties. This Exposure Control Plan is designed to protect employees from unprotected exposure.

.03 Program Coordinators

The following personnel are assigned to implement components of the program:

Task	Person Assigned
Coordinate the Bloodborne Pathogen Program	Department Head
Coordinate follow-up medical for employee exposed to blood splash or needlestick; liaison with source patients to obtain permission for testing	Department Head and Town Administrator
Coordinate sharps disposal	Department Head
Purchase gloves, disinfectant, sharps containers	Department Head
Coordinate Hepatitis-B vaccine	Department Head and Town Administrator
Coordinate new hire and annual training	Department Head and Town Administrator

.04 Definitions

The following definitions are used to implement this program.

- **Blood includes:** Human blood. Animal blood is not included.
- **Bloodborne Body Fluids include:** amniotic fluid, semen, vaginal fluids, and fluids that surround body organs. Human Bites: Saliva can be infectious for Hepatitis-B/C.
- **Bloodborne Body Fluids do NOT include:** urine, feces, vomit, tears, and sweat.
(NOTE: urine, vomit and feces can be infectious for bacteria and viruses that can cause diarrhea, flu, and other disease. However, they are not considered by OSHA to be bloodborne carriers (HIV, Hepatitis-B, Hepatitis-C.)

.05 Exposure Determination

The following safety sensitive employees may have potential exposure to blood, or other potentially infectious materials.

Department	Tasks with potential exposure to blood
Police Department	<ul style="list-style-type: none">- Accident first responder- Crime scene with blood- Injured person- Handling syringes used by the public- Handling evidence which is contaminated with blood- Baby delivery – amniotic fluid; blood- Cleaning detention cells: vomit/feces/fluids- First aid
Fire Department	<ul style="list-style-type: none">- Accident first responder- Injured person- Handling syringes used by the public- Baby delivery – amniotic fluid; blood- Cleaning interior of rescue truck- First aid
Emergency Medical Services	<ul style="list-style-type: none">- Accident first responder- Crime scene with blood- Injured person- Handling syringes used by the public- Handling syringes used by EMS- Baby delivery – amniotic fluid; blood- Cleaning interior of ambulance- First aid

Public Works	<ul style="list-style-type: none"> - Handling syringes used by the public - First aid - Accident first responder - Bodily fluid cleanup in Town Buildings
School	<ul style="list-style-type: none"> - First aid - Injured person - Handling syringes

The above list contains items reasonably anticipated for exposure, but it should be understood that other tasks and incidents with exposure potential may exist. The application of the follow precautions and methodologies should be applied to these incidents as is logically relevant.

.06 Universal Precautions

To protect employees, all blood and body fluid is considered to be infectious, regardless of the perceived or known health status of the student(s) or staff that is being assisted. The following Universal Precautions are used:

- **Universal precautions:** All blood is considered infectious for bloodborne pathogens, regardless of the source student or staff. NOTE: a department may elect to use Standard Precautions, which is stricter than Universal Precautions to include blood, body fluids, vomit, and feces.
- **Vomit, Urine, Feces, Spit:** these materials are not considered bloodborne pathogens under the OSHA standard, unless blood is visible in these materials. However, gloves and disinfectants will be used to prevent the spread of bacteria and viruses that could be present (i.e. Flu).

.07 Work Practices

The following work practices will be followed to prevent unprotected exposure to blood or body fluids:

General Work Practices to be Followed for all Events:

- Don healthcare gloves (neoprene, nitrile), puncture proof gloves to be used with all sharps.
- Handwashing is required after removal of gloves, even if the glove is not contaminated. Antiseptic gel can be used if water and soap is not available. Alcohol gel is not required if handwashing with soap and water is conducted.
- Remove and replace clothing that has become soiled with blood.
- Protect eyes with splash proof goggles if a blood or bodily fluid splash is expected.

The following work practices are specific to work events that employees may encounter:

CPR activities:

- A resuscitation mask with one-way valve or Bag Valve Mask Device (BVMD) should be used.

Evidence

- Syringes, needles and other sharps that are required for evidence should be stored in a hard-shell plastic container such that subsequent persons handling the evidence cannot receive a puncture or needlestick.
- Blood contaminated items can be allowed to dry and processed as evidence. The exterior of the bag should be labeled with a biohazard warning.

EMS activities:

- Retractable and self-locking sharps will be purchased for medication administration, including blood sugar lancets, syringes, and IV stylets.
- All medical sharps will be disposed immediately into a medical Sharps Disposal Container.
- No one-handed recapping of used needles is permitted.
- No removal of needle from a syringe is permitted. Dispose entire syringe immediately.
- Used Epi-pens will be retracted into their housing so that the needle is not exposed.
- Disinfect surfaces with a disinfectant labeled for effectiveness against HIV, Hepatitis-B and TB.

First Aid Event:

- Guide injured person to a safe area.
- Encourage self-administration of first aid: Whenever possible, public safety employee should guide the injured person to apply the ice pack, bandaids, and gauze themselves.
- Use a compress as a barrier to prevent employee contact with blood.

Blood Spill or disinfection of dried blood on surfaces:

- .
- Disposable towels may be used to remove initial visible debris.
- Dispose in plastic trash bag or rinse down a sewage drain.
- Spray disinfectant on visible debris.
- Disinfect surfaces with a disinfectant labeled for effectiveness against
 - HIV, Hepatitis-B and TB. Prepare this disinfectant according to label and manufacturer instructions.
- Use paper towels again to remove residue.
- Spray surface again with disinfectant.
- Wait the minutes specified on product label, and wipe with disposable towels.
- Dispose paper towels or rags into a sealed plastic bag and dispose in dumpster as soon as possible.

Large Blood Spill:

- Rinse as much blood and fluids down a drain, if possible.
- Disinfect surfaces with a disinfectant labeled for effectiveness against
 - HIV, Hepatitis-B and TB. Prepare this disinfectant according to label and manufacturer instructions.
- If a bleach solution will be used, do not use full-strength. Use 1 part bleach to 10 parts water. Area should be well ventilated.
- Disposable towels or a wet-vac may be used to remove initial visible debris.
- Dispose paper towels in a plastic trash bag; empty wet-vac into a custodial floor drain that is connected to sewage system.
- Spray disinfectant on visible debris.
- Use paper towels again to remove residue.
- Spray surface again with disinfectant.
- Wait the minutes specified on product label to allow disinfectant to work and wipe dry with disposable towels.
- Dispose paper towels or rags into a sealed plastic bag and dispose in dumpster as soon as possible.
- Rinse mops handles and wet-vac with disinfectant.

Cleaning Feces/Vomit

Note: Feces and Vomit are not considered Bloodborne pathogens unless blood is visible. Feces and Vomit are not known to be contagious for Hepatitis B, or HIV. However, Feces and Vomit can be contagious for the flu, Hepatitis-A, and norovirus. Therefore, these work practices are provided:

- Rinse as much blood and fluids down a drain, if possible.
- Disinfect surfaces with a disinfectant labeled for effectiveness against HIV, Hepatitis-B and TB. Prepare this disinfectant according to label and manufacturer instructions.
- If a bleach solution will be used, do not use full-strength. Use 1 part bleach to 10 parts water. Use in a well-ventilated area.
- Disposable towels or a wet-vac may be used to remove initial visible debris.
- Dispose paper towels in a plastic trash bag; empty wet-vac into a custodial floor drain that is connected to sewage system.
- Spray disinfectant on visible debris.
- Use paper towels again to remove residue.
- Spray surface again with disinfectant.
- Wait the minutes specified on product label to allow disinfectant to work and wipe dry with disposable towels.
- Dispose paper towels or rags into a sealed plastic bag and dispose in dumpster as soon as possible.
- Rinse mops handles and wet-vac with disinfectant.

.08 Personal Protective Equipment

Personal Protective Equipment is selected based on the potential for exposure to blood or body fluids during a particular task. For that reason, different gloves may be selected for different tasks. Personal protective equipment must be provided free of charge.

Task	Personal Protective Equipment
Possibility of direct hand contact with blood or contact with a bleeding person	Healthcare gloves
CPR	Healthcare gloves CPR mask
Picking up discarded syringes	Puncture-resistant gloves
Crime scene with extensive amounts of blood	Healthcare gloves Goggles Poly-coated tyvek coverall or similar Poly-coated tyvek booties or similar
Possibility of splash to face	Disposable face mask; Goggles or full-face shield
Possibility of spattering to worker's clothing	Healthcare coverall
Crime scene with extensive amounts of blood	Healthcare gloves Goggles Poly-coated tyvek coverall Poly-coated tyvek booties
Disinfecting interior of ambulance	Healthcare gloves
Disinfecting detention cell; Cleaning blood spills Cleaning feces/vomit	Waterproof utility gloves Goggles

Disposable gloves should be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised. Typically, used gloves may be placed in regular trash. In circumstances where gloves are soaked and dripping with blood, the gloves should be placed in a leak-proof plastic bag with a biohazard label.

Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Clean with soap and water before storage. Store in a dry place at room temperature.

.09 Compliance Methods: Disinfection

Decontamination of surfaces and equipment will be done as soon as possible after contact with blood or body fluids.

The product selected should have a product label which shows that the product has been tested against HIV, Hepatitis B and TB. Prepare this disinfectant according to label and manufacturer instructions.

Bleach is not the best choice for disinfecting ambulances, electronic equipment, and other surfaces that can be corroded by bleach. Choose a commercial product labeled for HIV, Hepatitis B and TB.

If bleach is selected due to cost, the following recipe is recommended by the CDC. Do NOT use bleach full strength out of the bottle – it can cause respiratory and eye irritation. Prepare a solution of 600 parts per million of bleach. Prepare the bleach solution on the same day that you use it.

Recipe for 600 ppm Bleach	
Bleach (household, 6%)	Water
2 teaspoon	1 Quart
3 tablespoon	1 gallon
$\frac{3}{4}$ cup	5-gallon spray container

.10 Regulated Waste

Regulated waste will be disposed of in accordance with the MA Department of Public Health Regulation 105 CMR 480.000 (Storage and Disposal of Infectious or Physically Dangerous Medical or Biological Waste) in addition to the OSHA standard on bloodborne pathogens.

The following materials must be disposed in a Sharps Disposal Container:

- Syringes
- Lancets
- IV stylets
- Epi pens
- Suture needles
- Used razors

The following materials can be disposed in regular trash:

- Paper towels, rags that are contaminated with blood, but blood cannot be squeezed out of the fabric.
- Used band-aids and gauze when blood cannot be squeezed out of fabric
- Feminine hygiene products

The following materials should be disposed in a plastic “red bag” that is labeled as medical waste:

- Paper towels, rags that are contaminated with copious amounts of blood in which blood is dripping out of the fabric.

- Used gloves when blood is dripping out of fabric.

.11 Laundry

Clothing that is contaminated with blood may be laundered. If laundry is sent off site to a third party, inform them that the clothing is contaminated with blood.

- Place contaminated laundry into a plastic bag, label as contaminated.
- Put laundry into washing machine, directly out of the plastic bag without sorting. Don healthcare gloves (neoprene, nitrile) to put clothing into the machine.
- Use hot water wash,
- Add ¼ cup bleach using machine instructions.

.12 Hepatitis B Vaccine

The Hepatitis-B vaccine is very effective in preventing transmission of the Hepatitis-B virus. Department personnel should be vaccinated as follows, depending upon their potential exposure to blood and body fluids:

The Hepatitis-B Vaccine should be offered to personnel who have potential exposure to blood or infectious body fluids:

Staff	Hepatitis B Vaccine
Police/ Fire /EMS/ Public Works/ School who perform tasks with potential exposure to blood or body fluids	Offer Hepatitis-B within 10 days of assignment

The vaccine is administered in accordance with health care provide guidance.

Employees who decline the vaccine will sign a waiver which uses the wording in Appendix A of the OSHA Standard (see attached Appendix A). Persons who have previously received the vaccine should decline the vaccine – a new vaccine series is not required if an employee changes location of employment.

Employees who initially decline the vaccine but who later wish to have it may then have the vaccine provided at no cost.

.13 Post-exposure Evaluation and Follow-up

Needlestick or Blood-Exposure Follow-up should be provided within 24 hours.

Report needlestick or blood exposure immediately to your immediate supervisor.

Employees who experience an “Exposure Incident” should be sent to the following healthcare provider within the first 24 hours.

The Town encourages employees to use the nearest and best health care facility that is preferred by the employee. Because of proximity, the Town suggests emergency medical care can be sought at:

Bay State Franklin Medical Center
164 High Street
Greenfield, MA 01301

Police & Fire personnel will complete injury on duty (IOD) forms (Appendix B). Public Works and employees will complete supervisors report of incident form (Appendix C). All employees will complete Massachusetts Department of Public Health Unprotected Exposure Form (Appendix D).

Immediate medical attention is required after an “Exposure Incident.” An exposure incident includes:

- Needlestick with a used syringe;
- Laceration or puncture with a medical instrument that has been used on a patient (i.e., suture needle, dental instruments);
- Splash to your eyes, nose or mouth;
- Splash to non-intact skin;
- Human bite that has broken your skin.

If you experience an Exposure Incident, get medical treatment within the first 24 hours. Studies have shown that receiving medical treatment for a needlestick within the first 24 hours is able to prevent transmission of HIV and Hepatitis.

Employees may not decline going to a healthcare provider for evaluation. (The employee may decline the advice or treatment offered by a healthcare provider, but they must obtain the evaluation.) The medical exam is confidential – the employer should not receive medical test results or other medical information regarding the employee.

Instructions after a Needlestick:

- Discard the syringe into the Sharps Disposal Container.
- Do not bring the syringe to the doctor – the blood in the syringe is not tested for HIV or Hepatitis.
- Wash the puncture area with soap and water.
- Do not disinfect your skin with bleach or disinfectant – this can damage the skin and make transmission of Hepatitis or HIV easier.
- Be prepared to tell the healthcare provider about:
 - Location of puncture on your skin
 - How deep the puncture/laceration
 - Whether or not there was visible blood inside the syringe tube
 - Whether or not there was visible blood on the needle

Source Testing:

When the identity of the source person is known, he or she may be contacted to inform them that a public safety employee was exposed to the person’s blood, and request consent for the person to obtain testing for HIV, Hepatitis B and Hepatitis C. The results are not released to the public safety department – the results should be maintained privately between the source person’s healthcare provider, the source person, and the exposed employee. If consent is not obtained from the source of the exposure, it shall be documented that consent cannot be obtained.

.14 Training

Training for all employees who are reasonably anticipated to have occupational exposure to blood and OPIM will be conducted prior to the initial assignment and annually. Training records will be maintained for three years from the date on which the training occurred.

Training will include:

- The OSHA Bloodborne Pathogens Standard
- Symptoms and transmission of bloodborne diseases
- The employer's exposure control plan, i.e., points of the plan, lines of responsibility, how the plan will be implemented, etc.
- Control measures
- Personal protective equipment available in this department and an explanation of the basis for its selection and use
- Post-exposure follow/up and evaluation
- Hepatitis B vaccine program
- Appendix A to Section 1910.1030:

Appendix A Hepatitis B Vaccine Declination Form

Employee Hepatitis B Vaccine Declination

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: _____

Signature: _____ Date: _____

Appendix B Injury on Duty Forms

Chubb Police and Fire Fighter Accident Program NOTICE OF CLAIM FORM

A claim is being filed for: ☐ Medical Benefits ☐ Disability Benefits ☐ Medical and Disability Benefits

Forward Questions/Claims to:

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

Claim Instructions: The Policyholder should: Complete and sign Sections I, III and V.
The Claimant should: Complete and sign Sections II, III and IV.

Section I – Policyholder Information – To be completed by Commanding Officer

Policyholder Name		Policyholder Number	
Policyholder Address		Commanding Officer Phone Number	
Claimant (Injured Party) Name		Claimant Date of Birth	Claimant Social Security Number
Claimant Insured Person Status <input type="checkbox"/> On-Call Volunteer <input type="checkbox"/> Junior Officers <input type="checkbox"/> Auxiliary <input type="checkbox"/> Career Police <input type="checkbox"/> Career Fire Fighter			
Claimant Address (Street, City, State and Zip Code)		Claimant Phone Number	
Date of Accident (mm/dd/yyyy)	Time of Accident hh:mm	<input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident
Complete description of Accident			
Indicate injured body part(s)			
Nature of sickness (if applicable)		Date sickness first commenced	
Note – Please also include a copy of the Incident Report, if available.			
Policyholder Certification Signature Required: I hereby certify the claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.			
_____ Title of Commanding Officer		_____ Signature of Commanding Officer	
		_____ Date	

Section II – Claimant Information – To be completed by Claimant

If filing a claim for Medical Benefits: Submit itemized medical bills to address referenced above and sign the Claimant Certification statement listed below.

Claimant Certification Signature Required:

I hereby certify the above information to be true and accurate to the best of my knowledge.

Signature of Claimant

Date

(12/11)

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Section II – (Continued) Claimant Information

[If filing a claim for Disability Benefits: Fully complete all items in this section and submit to address referenced on page 1.]

Normal Occupation		Normal Occupation Work Hours		Name of Normal Occupation Employer	
Address of Normal Occupation Employer			Contact Phone Number		Contact Fax Number
Contact Name for Normal Occupation Employer		Exact duties unable to perform – Normal occupation			
Date last worked Normal Occupation Employer		Date returned to work – Normal Occupation Employer _____ <input type="checkbox"/> Full Duty <input type="checkbox"/> Light Duty			
Verification of Earnings (Submit Normal Occupation pay stubs for the last 3 months. If self-employed, send copy of your prior year's tax return)					
Attending Physician's Name		Attending Physician's Address			
Attending Physician's Phone Number			Attending Physician's Fax Number		
Do you have disability (loss of wages) coverage through? (Check all that apply) <input type="checkbox"/> Regular Occupation Policy <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Other _____					
<i>Claimant Certification Signature Required:</i> I hereby certify the above information to be true and accurate to the best of my knowledge.					
_____ Signature of Claimant			_____ Date		

Section III – Fraud Warning Statement – To be signed by Policyholder and Claimant (Based on State of residence)

For residents of Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, D.C., Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia and Wisconsin: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Alabama, Hawaii, Oregon, Vermont, Virginia, and Wyoming: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto is subject to a denial and/or reduction insurance benefits and may be subject to any civil penalties available.

For residents of California, California law requires the following: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I hereby certify the foregoing statements made by me on this form to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

_____ Signature of Policyholder (Commanding Officer)	_____ Date
_____ Signature of Claimant	_____ Date

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(12/11)

Section IV – Medical Records Release

Cabot Risk Strategies LLC
15 Cabot Road
Woburn, MA 01801-1003
Tel. Number 800-222-5963
Fax Number 781-376-9907

MEDICAL RECORDS RELEASE

DATE OF INJURY _____

NATURE OF INJURY _____

I hereby authorize any hospital, physician or other person who has attended me to furnish to Cabot Risk Strategies LLC and Chubb Group of Insurance Companies all information with respect to this illness or injury and the resulting hospital or medical records, consultations, treatments or prescriptions. A copy of this authorization shall be considered as effective and valid as the original.

Name (Print)

Signature

Date

Section V – Wage and Salary Verification

Cabot Risk Strategies LLC
 15 Cabot Road
 Woburn, MA 01801-1003
 Tel. Number 800-222-5963
 Fax Number 781-376-9907

WAGE AND SALARY VERIFICATION

Date	Our Policyholder	Date of Injury	Claim Number
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EMPLOYER'S NAME AND ADDRESS	EMPLOYEE'S NAME AND ADDRESS
	Social Security No.:

Thank you for your cooperation.

1.	OCCUPATION:
2.	DATES OF EMPLOYMENT: From _____ through _____
3.	Gross Earnings during 52-week period <i>PRIOR</i> to Accident: \$ _____
4.	Wage or salary as of date of Accident: a) \$ _____ <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month b) Usual number of days worked per week: _____
5.	Dates Absent Following Accident: a) Date Disability began: _____ b) Date returned to work: _____
6.	Was Employee paid during this absence: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, amount paid: \$ _____
7.	Is Employee entitled to benefits under a wage or salary continuation plan? <input type="checkbox"/> YES <input type="checkbox"/> NO a) If YES, amount paid or available: \$ _____ <input type="checkbox"/> PER WEEK <input type="checkbox"/> PER MONTH b) If Yes, Are cash or traditional retirement credits reduced under your plan by amount of benefits paid?
8.	Is Employee eligible for any individual/group health insurance/HMO/other benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Date: _____ Print Name & Title: _____ Telephone No.: _____ Signature

Appendix C Supervisors Report of Accident – Intake Form

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY: _____ TIME OF INJURY _____ ACKNOWLEDGE/DATE REPORTED _____

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED? WHY?

CAUSE: _____ INJURY: _____
BODY PART: _____ OCCUPATION: _____

EMPLOYEE NAME _____ SOCIAL SECURITY # _____
SEX(M or F) _____ MARITAL STATUS _____ DATE OF BIRTH _____
DATE OF HIRE _____ DEPARTMENT _____
SUPERVISOR NAME _____ PHONE NUMBER _____

EMPLOYEE ADDRESS _____
TELEPHONE NUMBER: HOME _____ WORK _____
CELL _____ EMAIL _____

LOCATION ACCIDENT OCCURRED _____ INJURED ON PREMISE? YES NO
AVERAGE WEEKLY WAGE _____ DID EMPLOYEE LOSE TIME FROM WORK? YES NO
NUMBER OF DEPENDENTS _____

DID EMPLOYEE RETURN TO WORK YES NO IF YES, DATE RETURN TO WORK: _____
IF NO, LAST DAY WORK _____ 1ST DAY OF DISABILITY _____ 5TH DAY OF DISABILITY _____

WAS MEDICAL TREATMENT SOUGHT? YES NO
MEDICAL FACILITY _____

DATE REPORTED A WORK RELATED: _____ WITNESS _____
TO WHOM WAS INJURY REPORTED TO _____

*******Supervisor's Complete Below*******

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

WAS EMPLOYEE WEARING SAFETY GEAR? YES NO
IF NO, EXPLAIN: _____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS

REMARKS _____

Investigated By _____ Date _____
Reviewed By _____ Date _____

Appendix D Massachusetts Department of Public Health Unprotected Exposure Form



**MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH**
(DO NOT SEND THE ORIGINAL FORM OR A COPY TO THE DEPARTMENT OF PUBLIC HEALTH)

UNPROTECTED EXPOSURE FORM

(Please print or type)

Today's Date / /	Incident Date / /	Receiving Facility
Transporting Ambulance Service		Ambulance Trip Report #
Address		Designated Infection Control Officer (DICO)
Telephone # for DICO		It is recommended the prehospital emergency care agencies type or print in the name and telephone number of the current DICO before blank forms are provided to their personnel.

Patient Information	Rescuer Information
Name	Name
Incident Location	Address
Incident Type <input type="checkbox"/> Medical <input type="checkbox"/> Trauma	City/State/Zip
Transportation <input type="checkbox"/> Emergency <input type="checkbox"/> Routine	Day Phone
Check box(es) which best indicate your exposure. <i>Explain in detail in the spaces provided below.</i>	Evening Phone
	Profession
Exposure Route: <input type="checkbox"/> Needlestick <input type="checkbox"/> Open cut <input type="checkbox"/> Bite <input type="checkbox"/> Puncture <input type="checkbox"/> Mouth <input type="checkbox"/> Eye <input type="checkbox"/> Other:	Department/Employer
Exposure Type: <input type="checkbox"/> Blood <input type="checkbox"/> Sputum <input type="checkbox"/> Saliva <input type="checkbox"/> Other:	
Precautions: <input type="checkbox"/> Mask <input type="checkbox"/> Eye Wear <input type="checkbox"/> Gown <input type="checkbox"/> Exam gloves <input type="checkbox"/> Gloves <input type="checkbox"/> Other: _____ (latex, nitrile, vinyl) (work type)	
Cleaning: <input type="checkbox"/> Hand Washing <input type="checkbox"/> Washing Contaminated Skin <input type="checkbox"/> Other:	

Describe the nature of the unprotected exposure **in detail** (attach additional pages if needed)

Describe the steps taken by the rescuer to minimize the exposure:

You must provide the information on this form to the facility that received the patient from whom you received the exposure. I understand that in the case of certain exposures (e.g. needlestick with a bloody needle) it is crucial for the exposed rescuer to seek immediate medical evaluation for treatment that might reduce the risk of infection. Completion of the Unprotected Exposure Form may be done during or after the medical evaluation.

I further understand that I will be informed of an unprotected exposure, only if the patient is diagnosed as having a bloodborne infectious disease dangerous to the public health, as defined in 105 CMR 172.001 and if, in the view of medical personnel, my documented exposure is capable of transmitting that disease.

Rescuer's Signature: _____ Date: _____

Form Received By: _____ Date: _____

DO NOT SEND THE ORIGINAL FORM OR A COPY TO THE DEPARTMENT OF PUBLIC HEALTH Rev. 05/26/2004
(Side 1 of 2) (Instructions and Information on Reverse)

(COPY BOTH SIDES!)

**Massachusetts Department of Public Health
Unprotected Exposure Form**

An Unprotected Exposure Form should be completed for any prehospital emergency care worker (e.g. an EMT, firefighter, police officer, or corrections officer) who believes he/she may have had an unprotected exposure to a patient's blood or *other contaminated* body fluid(s) in the course of attending, assisting or transporting a person to a health care facility as part of his/her professional duties. It is the responsibility of each care provider to complete and file a form with the receiving facility.

If you believe you may have had an unprotected exposure, ***you should seek immediate medical evaluation for possible prophylactic immunization and/or treatment, as indicated.*** **You must provide the information on this form to the facility that received the patient from whom you received the exposure.** Ambulance *personnel* or other emergency care providers having an unprotected exposure must complete a form on arrival and leave it at the health care facility with the patient. Other individuals shall file their own forms with the receiving facility within 24 hours of the unprotected exposure.

The health care facility will review the information, which you provide and will determine if you have sustained an unprotected exposure as defined in DPH regulations. If the patient to whom you were exposed is diagnosed as having a bloodborne infectious disease dangerous to the public health, and if you sustained an unprotected exposure which, in the opinion of the health care facility, is capable of transmitting such a disease, the facility shall provide oral notification within forty-eight (48) hours of the diagnosis and written notification within seventy-two (72) hours of the diagnosis. This notice shall be given to the designated infection control officer for your agency who ***must*** be listed on the unprotected exposure form. Upon notification, the designated infection control officer shall notify you. The notice shall include the appropriate precautions and actions which you should take, the identity of the disease to which you were exposed, necessary precautions to prevent the transmission of the disease to others, and instructions to contact a physician for medical follow-up. **NOTE: The health care facility's determination that you have had an unprotected exposure does NOT necessarily indicate that you have contracted an infectious disease.** The report from the health care facility to the designated infection control officer to you is confidential and is governed by M.G. L. c. 111, §111C and DPH regulations 105 CMR 170.000, 171.000 and 172.000.

N.B. – Due to the time it may take to diagnose a patient with an infectious disease, or the possibility that a patient may never be diagnosed, and the time it may take to notify you of the exposure, the Department recommends that anyone who believes they have suffered an unprotected exposure, such as a needlestick with a bloody needle, should see a physician immediately. Certain prophylactic regimens should be started within hours of an unprotected exposure.

INSTRUCTIONS:

PLEASE PRINT CLEARLY

- Complete all information on the form.
- Check all boxes that apply:
 - ☐ the exposure route to you of a patient's blood or bodily fluid(s).
 - ☐ the type of the patient's bodily fluid(s) to which you were exposed.
 - ☐ ***body substance isolation*** precautions you used (even if they were breached).
 - ☐ post incident cleaning you performed.
 - ☐ if you checked any "Other" box(es), explain in the space(s) ***provided***.
- In the blank narrative sections explain fully the exposure and any treatment you have obtained. Use additional blank sheets, if necessary, and staple ***them*** to the form. The more accurately you explain the circumstances, the easier it will be for the facility personnel to evaluate your exposure.
- EMT's must also leave a copy of the ambulance trip record at the receiving facility.
- Each EMT and other prehospital emergency medical health care ***providers who have*** sustained an unprotected exposure must file his/her own form. The form(s) shall be submitted to the receiving health care facility upon patient arrival or within 24 hours.
- Transportation or treatment of the patient(s) must not be delayed in order to complete the form(s).
- ***Make a copy for your own records and/or for your designated infection control officer, in accordance with your employer's policies and procedures.***

DO NOT SEND THE ORIGINAL FORM OR A COPY TO THE DEPARTMENT OF PUBLIC HEALTH

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