Charlottesville-Albemarle Rescue Squad

Infection Control Plan

2020 Edition

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Purpose

The purpose of this document is to provide guidelines and procedures for the prevention and mitigation of occupational exposures to infectious diseases for all members of the Charlottesville-Albemarle Rescue Squad. This document shall serve to fulfill the requirements of state and federal agencies regarding infection control. This plan supersedes and replaces any previous infection control plan of the Charlottesville-Albemarle Rescue Squad.

The Designated Infection Control Officer, as appointed by the agency's Chief, shall be charged with enforcing the provisions in this plan and ensuring that the plan is kept updated as needed. This will include, at minimum, an annual review.

This plan has been developed and will remain consistent with:

- Applicable Centers for Disease Control recommendations
- Applicable portions of NFPA 1581 Infection Control Standard for Fire Departments
- OSHA's Bloodborne Pathogen Regulation (CFR 1910.1030)
- Other appropriate industry and regulatory resources

The plan shall be made available to all members in print at the agency's station located at 828 McIntire Road, Charlottesville, VA.

This plan has been developed solely for the use of the Charlottesville-Albemarle Rescue Squad. This plan will not be copied or distributed without approval of the Board of Directors of the Charlottesville-Albemarle Rescue Squad, Inc.

Glossary

Some terminology used in this document must be clarified so that all potential users understand the intended meaning.

Agency: Refers to the Charlottesville-Albemarle Rescue Squad, Inc., a 501(c)(3) non-profit organization which provides emergency medical services and rescue services to Charlottesville, VA and parts of Albemarle County, VA. Aliases include C-ARS, CARS, Charlottesville Rescue.

Designated Infection Control Officer (DICO): An individual designated by the Chief of the agency charged with the execution of the procedures in this plan.

HBV: Hepatitis B virus

HCV: Hepatitis C virus

HIV: Human immunodeficiency virus

Member: Refers to any person officially affiliated with the agency, whether paid or unpaid. Includes both operational staff and administrative or support staff. Such personnel shall be considered members only when acting in an official capacity on behalf of the agency. This also explicitly includes all personnel who may be referred to as “employees” under applicable state and federal legislation or regulation.

Observer: Any person who is not a member of the agency but is invited to accompany members on emergency responses. This includes (but is not limited to) members of the public, members of other emergency response agencies, medical students, medical residents, non-affiliated physicians, nursing students, nurses, and students of approved EMS education programs.

Occupational exposure: Copied from the OSHA Bloodborne Pathogens Regulation (CFR 1910.1030): “reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties”.

Operational member: Any member, as defined above, who performs patient care or other emergency response duties.

Other Potentially Infectious Material (OPIM): From the OSHA Bloodborne Pathogens Regulation (CFR 1910.1030): “(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 bodily 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."

Personal Protective Equipment (PPE): From the OSHA Bloodborne Pathogens Regulation (CFR 1910.1030): "specialized clothing or equipment worn by an employee 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."

Scope

This plan shall apply to all members of the agency while they are acting in an official capacity on behalf of the agency.

The following persons are deemed **at risk** of an occupational exposure and are covered under this plan:

- Basic Life Support Provider
- Advanced Life Support Provider
- Driver/Operator
- Rescue Technician
- Firefighter
- Duty Officer
- Observer
    - With limitations, as explained in “Prevention”

The following persons are deemed **not at risk** of an occupational exposure but are covered under this plan as well:

- Administrative staff
- Communications staff

Designated Infection Control Officer Duties

The Designated Infection Control Officer shall be a single member of the agency, charged with the execution of this plan. The Designated Infection Control Officer may appoint Assistant Infection Control Officers as needed, provided that they meet state and federal requirements for training of Designated Infection Control Officers.

The Designated Infection Control Officer shall be expected to perform the following duties:

- Handle all occupational exposures experienced by members of the agency according to the procedures outlined in this plan.
- Review this plan at least annually.
- Update this plan as required.
- Maintain appropriate certification as a DICO per state and federal requirements.
- Ensure that all operational members are provided with annual retraining as required by state and federal regulations and any other necessary training related to infection control.
- Maintain records related to any and all exposures experienced by agency members until such time as all members involved have been separated from the agency for 30 years.
- Maintain secure personnel records for all operational members for a period not less than 30 years past the member's separation from the agency. These records shall only be used for infection control purposes and shall only be accessible to the Designated Infection Control Officer and Assistant Infection Control Officer(s). These records shall include:
  - Member's name
  - Member's immunization documentation
  - Any documents related to an exposure experienced by the member
- Maintain records of sharps injuries containing the following information:
  - Device used
  - Details of sharps injury
- Perform regular compliance surveillance to ensure that all members follow the procedures in this plan

Prevention

Prevention is the most important aspect of infection control. Both the agency and the members benefit from preventing an occupational exposure from occurring. As such, all members are expected to abide by certain tenets of exposure prevention.

Requirements for observers

All observers, as defined in the glossary, shall be informed of the risk of exposure to bloodborne, airborne, and droplet-borne diseases. If they suffer an exposure as defined in this plan, they shall be instructed to seek medical attention for the exposure per this plan. The agency will **not** be financially responsible for the care of these individuals' post-exposure. They shall be permitted to view this plan prior to or during their observation but shall not be permitted to keep a copy of the plan.

All approved observers shall complete a form providing their informed and expressed consent to these provisions prior to accompanying members on any emergency response.

Requirements for new operational members

Prior to commencing emergency responses or patient care as an operational member of the agency, all new members shall:

- Provide all immunization records (including dates) for the following illnesses:
  - Hepatitis B
    - Including documentation of post-vaccination Anti-Hbs titer results if available.
  - Tetanus (Lockjaw)
  - Diphtheria
  - Measles
  - Mumps
  - Rubella (German Measles)
  - Varicella (Chickenpox)
  - Seasonal influenza
- Be offered immunization for the following diseases if no proof of immunization is available
  - Hepatitis B
    - HBV vaccination shall be provided by Albemarle County Fire Rescue (ACFR) per ACFR SAP-DEG-008.
    - Personnel shall provide documentation of received or declined HBV vaccination to the DICO.
  - Seasonal influenza
    - When indicated by CDC guidelines, new personnel shall be offered a seasonal influenza vaccine per Albemarle County Fire Rescue SAP-DEG-012.

        - Documentation of such vaccination shall be provided to the DICO.
- Members are also recommended to obtain immunizations against the following diseases, as applicable:
    - Tetanus (Lockjaw)
    - Measles
    - Mumps
    - Rubella (German Measles)
    - Varicella (Chickenpox)

Requirements for all operational members

These requirements shall apply to all operational members, as defined in the glossary.

- All members shall be offered an annual seasonal influenza vaccination per Albemarle County Fire Rescue SAP-DEG-012.
- All members will report any occupational exposure to a communicable disease to the Designated Infection Control Officer or his/her designee promptly following such exposure. Members will comply with the exposure management procedures contained in this plan.
- Members will report any off-duty or on-duty exposure to diseases listed in the work restriction guidelines. Members may be suspended from operational capacity by the Designated Infection Control Officer or any other Officer of the agency based on these guidelines.
- Members will report any non-exposure sharps injury to the Designated Infection Control Officer within 24 hours of such injury.
- Utilize all PPE as required in order to limit the possibility of occupational exposure.

Personal protective equipment guidelines (all personnel)

- These guidelines are meant to convey a *minimum* level of personal protective equipment required. Providers may and are encouraged to utilize additional PPE as they feel is appropriate.
- All members and observers shall, without exception, wear nitrile examination gloves during any patient encounter or when blood or OPIM is present.
- Any patient performing airway procedures or any procedure in which there is a likelihood of splatter, aerosolization, or splashing of blood or OPIM shall wear a full facemask to include eye and nose/mouth protection.
- Members are encouraged to wear gowns whenever there are large amounts of blood or OPIM present.
- Personnel are not fitted by the agency with respiratory protection against tuberculosis. According to the local department of health, cases of tuberculosis locally do not constitute a high enough threat to justify requiring such fit-testing. This requirement is reviewed annually. Providers are encouraged to employ the additional mechanical ventilation available in the patient compartment of all agency transport vehicles.

Cleaning and Decontamination

All equipment used in patient care is subject to contamination with blood or OPIM, and as such can serve as a vector for various infectious diseases. The following procedures shall be executed to ensure that the risk of infection to both providers and patients is minimized. In addition to infectious diseases covered under this plan, this cleaning should also mitigate the risk of various other diseases including *Clostridium difficile*, VRE, and MRSA.

These procedures do not pertain to the cleaning of the exterior of agency vehicles as required for public relations and vehicle maintenance reasons. That cleaning must also be performed, but is not within the scope of this document.

These procedures are subject to change at any time as needed to address novel pathogens.

Beginning of shift decontamination (all vehicles)

- Clean the assigned vehicle of any visible dirt/debris. Disinfection of surfaces and equipment will be inadequate as long as visible contamination or dirt remains. Feel free to use disinfectant substances to assist in removal of visible contamination or dirt, but then reapply to assure disinfection.
- Due to the patient population that the agency serves, there is a reasonable likelihood of *C. difficile* colonization on surfaces of patient care equipment. According to the CDC and the Environmental Protection Agency, there are limited agents that are effective against *C. difficile*. These agents are also effective against the other common pathogens we encounter. As such, the agency shall utilize agents effective against *C. difficile* in decontamination at the beginning of each shift.
    - Utilize any agent specified in EPA List K, which lists EPA-registered disinfectants that are effective against *C. difficile*. Such disinfectant will be provided at the agency's quarters based on market availability. When using an agent with which you are unfamiliar, be sure to utilize the agent according to the manufacturer's instructions.
    - Since many of the approved disinfectants include bleach or other potent oxidizers, be careful to avoid contact with any dyed fabrics.
    - Clean all interior surfaces of the vehicle, as well as exterior handles. Be careful around electronic equipment to avoid damage. Clean all reusable patient care equipment (stretcher, stethoscope, blood pressure cuff, jump bag etc.). Mop the floor of the patient compartment with an approved disinfectant.
- Replace any sharps containers if they are found to be at or above ¾ full. Dispose of them according to the procedures in this plan.

Post-patient encounter decontamination (all vehicles)

- If the patient is suspected of being positive for a *C. difficile* infection, clean all equipment that was utilized in the care of the patient, as well as any surfaces which may have been contaminated during patient care with one of the agents specified in EPA List K.
  - Suspect *C. difficile* infection in patients:
    - With a documented diagnosis (at any time) of *C. difficile*
    - Being transported from a skilled nursing facility
    - Presenting with diarrhea or a report of diarrhea
- If the patient is not suspected of *C. difficile* infection, you may still clean used equipment and surfaces with List K disinfectants. However, it would also be appropriate to use any disinfectant labeled as an EPA-registered hospital-grade disinfectant. These disinfectants are often provided for EMS use at receiving facilities.
- Always replace all linen used during any patient encounter at the conclusion of the transport. All of our receiving facilities participate in a linen exchange program. Place the soiled linens in their collection bins for cleaning and obtain an equal number and type of clean linens for redressing the stretcher following disinfection of the stretcher.
  - Dispose of linen that is saturated with blood or OPIM in biohazard disposal containers.
- Dispose of any and all single-use equipment at the conclusion of a transport, as detailed below.
- Reusable invasive procedural equipment shall be cleaned according to guidelines set by the agency's supply officer. These guidelines shall be available to all providers in writing at the agency's station.

Post-patient encounter decontamination (providers)

Following any patient encounter, dispose of all used PPE in the manner appropriate for that PPE. Clean any gross contamination from your skin with soap and water according to the directions outlined under hand hygiene. Then, perform hand hygiene:

- Soap and water: required when hands are visibly dirty, after known or suspected exposure to *C. difficile*, after known or suspected exposure to *norovirus*, after known or suspected exposure to *B. anthracis*, before eating, or after using the restroom.
  - When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. Avoid using hot water, to prevent drying of skin.

- In other situations, it is appropriate to use an alcohol-based hand sanitizer according to the manufacturer's recommendations.

Disposal of equipment

Much of our equipment is single-use-only. It should be disposed of properly to prevent contamination and exposure risks. Unless listed below, treat such equipment as unregulated waste and dispose of in regular trash receptacles.

- Regulated Medical Waste includes:
  - Any equipment contaminated with gross amounts of blood or OPIM as defined by the OSHA Bloodborne Pathogens regulation.
  - Any sharp which has been used in contact with blood or OPIM.
  - Any container containing sharps that have been used in contact with blood or OPIM.
  - Any other material listed in the Virginia Administrative Code 9VAC20-120-150, or such as meets the characteristics described in 9VAC20-120-140.

All sharps (whether or not they have been contaminated with blood or OPIM) shall be disposed of only in containers designed for this purpose. These containers will be sealed as indicated by the manufacturer and then placed in the same containers as other regulated medical waste.

Regulated medical waste shall be disposed of **only** in red biohazard trash bags, and disposed of in appropriate containers such as the biohazard trash cans available at many receiving facilities. Such waste may also be disposed of in marked containers provided at the agency's quarters. The final disposal of this waste shall be contracted out by the agency.

The agency contact for waste disposal will be the supply officer. Contact the supply officer if a pickup is necessary.

Exposure Management

- Call any of the primary DICOs first while **<u>you are still at the hospital</u>.** We are available 24/7/365 unless otherwise communicated to the organization and the other DICOs. If we do not answer immediately, call 1-2 more times shortly afterward. If we still do not answer, continue down the list. They will handle the initial steps and then hand the case over to me when I become available.
- Utilize phone communications for exposure reporting. Non-urgent infection control matters can be handled via email or phone.
    - When you call, make sure you have the following information ready:
        - What happened/explanation of the exposure.
        - Patient's name and DOB.
        - Patient's MRN from facility to which the patient was transported.
    - At this point, the DICO will take the following actions:
        - Determine if there was an actual exposure
        - If determined an actual exposure. The DICO will contact the charge nurse from the receiving ED to request the following blood tests:
            - HBV surface antigen
            - Rapid HCV antibody
            - Rapid HIV
            - Syphilis if HIV or HCV tests are positive
        - Provide instructions on any further care/testing/follow-up. We have a standing agreement with Dr. Dan Sawyer, an infectious disease physician, for follow-up.
        - Document the exposure in accordance with applicable laws and regulations.

DO NOT:

- Panic! Although healthcare providers are at a higher risk for exposure than the general public, we still have a very low risk of exposure.
- Take medical direction from ED staff. They are not trained in infection control and have vastly different policies for handling exposures than we do.
- Register as a patient at the ED or go to an urgent care facility unless you require care for an injury. Exposures do not require baseline blood tests or immediate treatment.
- Discuss the exposure with anyone except infection control personnel, unless you wish to do so. The details of the exposure are considered protected health information. You may discuss it if you wish but you cannot be compelled to do so. Other personnel involved in the incident are also not to discuss the exposure with anyone but the DICO.

Appendix A: Infection Control Officers

Designated Infection Control Officers

Kevin Livingstone
Cell phone: 571-455-6096
Email: infectioncontrol@cvillerescue.org

Assistant Infection Control Officer

Michael Berg
Cell phone: 434-466-7551
Email: carsmedic@gmail.com

Appendix B: Work Restriction Guidelines

As defined by the Centers for Disease Control.

WORK RESTRICTIONS FOR HOSPITAL WORKERS EXPOSED TO OR INFECTED WITH SELECTED INFECTIOUS DISEASES

DISEASE OR SYMPTOM	RELIEVE FROM DIRECT PATIENT CONTACT	PARTIAL WORK RESTRICTION	DURATION
Casts	Possibly	**Required to meet all infection control and safety in the workplace guidelines**	Until cast is removed
Conjunctivitis, infectious (pink eye)	Yes	No	Must be on antibiotic a full 24 hours before RTW
Cytomegalovirus infections	No		
Diarrhea Acute stage (with other SX) Convalescent stage, Salmonella spp.	Yes Possibly	Restrict from patient contact, contact with pt's environment, or food handling Restricted from care of high-risk patients.	Until SX resolve Until SX resolve; consult with DSHS regarding negative stool cultures
Diphtheria Active Asymptomatic carriers Post-exposure (HCWs with no Td booster dose in the previous 5 years)	 Exclude from Duty Exclude from Duty Exclude from Duty		Until antimicrobial therapy is completed AND 2 nasopharyngeal cultures obtained ≥ 24 hours apart. Same as active diphtheria Same as active diphtheria
Entero-viral (intestinal) infections	Possibly	Personnel should not care for infants, newborns, high-risk patients and their environments	Until symptoms resolve
Fever over 100.5 degrees	Exclude from Duty		Until temperature returns to normal
Hepatitis, viral Hepatitis A	Restrict from patient contact, patient environments and food handling.		Until 7 days after onset of jaundice

DISEASE OR SYMPTOM	RELIEVE FROM DIRECT PATIENT CONTACT	PARTIAL WORK RESTRICTION	DURATION
Hepatitis B HCW with acute or chronic Antigenemia: -HCWs who do not perform exposure-prone invasive procedures -HCWs who perform exposure- prone invasive procedures	 No Possibly	 Observe Standard Precautions. No restriction unless epidemiologically linked to transmission of infection. Do not perform exposure-prone invasive procedures until cleared by an expert review panel that reviews and recommends the procedures the worker can perform.	 Until HB e AG is negative
Hepatitis C (or other non-A, non-B hepatitis)	No	Observe Standard and Barrier Precautions for procedures that involve trauma to tissues or contact with mucous membranes or non-intact skin.	Period of infectivity has not been determined.
Herpes Simplex Genital Hands (herpetic whitlow) Orofacial	 No Yes Possibly	 Restrict from patient contact and contact with patient's environment Personnel should not care for high-risk patients. Must cover lesions on Duty	 Until lesions heal Until lesions heal
Human Immunodeficiency Virus	Possibly	Do not perform exposure-prone invasive procedures until evaluated by an expert review panel to review and recommend the procedures the worker can perform.	
Measles Active Post-exposure (susceptible HCWs)	Yes Yes		Until 7 days after the rash appears From the 5th day after 1st exposure through the 21st day after last exposure and/or 7 days after the rash appears.
Meningococcal Infections	Exclude from Duty		Until treated and cleared by medical provider

DISEASE OR SYMPTOM	RELIEVE FROM DIRECT PATIENT CONTACT	PARTIAL WORK RESTRICTION	DURATION
Mumps Active Post-exposure (susceptible HCWs)	 Yes Yes		Until 9 days after onset of parotitis From the 12th day after 1st exposure through the 26th day after last exposure or until 9 days after onset of parotitis
Parvovirus (Fifth disease)	Possibly	Restrict from caring for high-risk patients, children and pregnant women.	Until resolution of SX
Pediculosis (Lice)	Exclude from Duty		Until treated and observed to be free of adult and immature lice
Pertussis (Whooping Cough) Active Post-exposure (asymptomatic) Post-exposure (SX HCWs)	 Exclude from Duty No Exclude from Duty	 Antimicrobial prophylactic therapy recommended	21 days from the onset of rhinitis or acute cough ***or*** until 5 days after the start of effective antimicrobial therapy Ex: Z Pack (500 mg/250 mg) X 5 days or Clarithromycin 500 mg po bid x 7 days or Erythromycin 500 mg po qid x 14 days Until 5 days after the start of effective antimicrobial therapy
Poison Ivy/Oak/Sumac	Possibly	Employee must scrub body to remove all residue. Must keep weeping dermatitis covered. Surgical HCWs cannot scrub.	If dermatitis becomes infected, full work restrictions must be enforced. Surgical personnel cannot scrub until healed
Ringworm Scalp Skin	 Exclude from Duty No	 Cover skin lesions while on Duty	 Until treated and cleared by medical provider
Rubella Active Post-exposure (susceptible HCWs)	 Exclude from Duty Exclude from Duty		 Until 5 days after the rash appears From the 7th day after the 1st exposure through the 21st day after the 1st exposure and/or 5 days after the rash appears
Scabies	Exclude from Duty		Until treated and cleared by medical provider

DISEASE OR SYMPTOM	RELIEVE FROM DIRECT PATIENT CONTACT	PARTIAL WORK RESTRICTION	DURATION
Staphylococcus aureus infection Active, draining skin lesions or MRSA Carrier state	Exclude from duty as long as lesions are open and/or draining Possibly.	Restrict from pt care, pt's environment or food handling. Cover lesions while on duty. Strict Contact Precautions practiced when in contact with dressing or drainage. No restriction, unless HCW is linked to transmission of the organism	24 hrs after effective antibiotic treatment and cleared by a medical provider, preferably an I.D. practitioner Refer to an Infectious Disease practitioner
Streptococcal Infection Group A	Exclude from Duty	Airborne Precautions practiced.	24 hrs after effective antibiotic treatment and cleared by a medical provider
Tuberculosis Active disease PPD Converter	 Exclude from Duty No	 No restrictions	 Until receiving adequate therapy, if three consecutive day sputum smears are negative for AFB, and cough is resolved
Upper respiratory infections	Possibly	During particular seasons (winter when influenza and/or RSV are prevalent), consider excluding personnel with acute febrile upper respiratory infections (including influenza) from care of high-risk patients.	Until acute symptoms resolve
Varicella (chickenpox) Active Post-exposure (susceptible HCWs)	Exclude from Duty Exclude from Duty	 Exposed susceptible individuals working in low risk or non-patient care areas may work from the 10th to the 21st day wearing a mask and eating alone (not in cafeteria)	Until all lesions dry and crusty From the 10th day after the 1st exposure through the 21st day after the last exposure (28th day if VZIG administered). If varicella occurs, until all lesions dry and crusty
Zoster (shingles) Active (localized in normal person)	Possibly Exclude from Duty	Cover lesions; restrict from care of high-risk patients. (Patients who are susceptible to varicella and at increased risk for complications of varicella, such	Until all lesions dry and crusty From the 10th through the 21st day after exposure and if

Post-exposure (susceptible to Chickenpox)		as neonates, and immunocompromised persons of any age Exposed susceptible individuals working in low risk or non-patient care areas may work from the 10th to the 21st day wearing a mask and eating alone (not in cafeteria)	varicella occurs, until all lesions dry and crusty

Appendix C: Forms

- Observer Consent Form
- Immunization Record Form
- Exposure Report Form
- Sharps Injury Report Form

C-ARS Observer Consent Form

The purpose of this document is to inform all observers accompanying Charlottesville-Albemarle Rescue Squad members on emergency responses of the risks of injury and occupational exposure associated with observing.

Emergency scenes are inherently unsafe and may subject providers, patients, and observers to occupational exposure to known or novel pathogens (potentially resulting in infection), bodily injury, and/or death.

In order to observe at the Charlottesville-Albemarle Rescue Squad as a non-member, observers must acknowledge these risks and also that:

- The Charlottesville-Albemarle Rescue Squad does not insure observers.
- The Charlottesville-Albemarle Rescue Squad's Infection Control Plan does not cover observers in the event that they sustain an occupational exposure.
- The Charlottesville-Albemarle Rescue Squad is free of any financial or civil liability with regards to the health or wellness of observers who are not members of the agency.

This consent form is only valid for a period of 24 (twenty-four) hours from the time that it is signed and witnessed. After that time, if the observer chooses to observe again, a new form is required. All forms will be submitted to the Designated Infection Control Officer and will remain on file for no less than 1 (one) year.

Observer Name:

_____

Observer Signature:

_____

Agency Representative Name(Preferably Duty Officer or Captain, but any full member may witness)**:**

_____

Agency Representative Signature:

_____

Time and Date Form Signed: _____

C-ARS Exposure Report Form

The purpose of this form is to provide documentation of an occupational exposure of a C-ARS member to blood or OPIM. See the C-ARS Infection Control Plan for further information.

Member Information

Name: _____

Preferred phone number (including area code): _____

Social security number: _____

Preferred email address: _____

Source Patient Information

Name: _____

Sex (circle one): M F

Age: ____

Medical Record Number (MRN) at receiving facility: _____

Patient destination (unit and room): _____

Incident Information

Incident date and time: _____

Incident number: _____

Incident location: _____

Exposure information

Exposure type (circle one): Bloodborne Airborne

Exposed to (circle as many as apply): Blood Fluid visibly contaminated with blood

OPIM (specify): _____

Area exposed (circle as many as apply): Mouth Eyes Nose New, open wound

Other (specify): _____

Task being performed: _____

If a sharp was used, name and size of device used: _____

Exposure reported to: _____

Injury (circle one): Y N

First aid performed (circle one): Y N

PPE Used (Circle appropriate): Gloves Mask Eye Protection Gown

Infection Control Officer Use

Deemed to be an occupational exposure (circle one): Y N

Date and time notified: _____

Date and time facility staff contacted regarding source patient testing: _____

Facility staff member contacted: _____

Date and time source results received by ICO: _____

Date and time source results communicated to member: _____

Physician to whom member was referred for follow up: _____

Member must also provide a written explanation of how exposure event occurred to DICO within 24 hours of exposure.

C-ARS Non-exposure Sharps Injury Report Form

The purpose of this form is to provide a method by which members of C-ARS may report sharps injuries that do not result in occupational exposure.

Member name: _____

Incident date and time: _____

Incident number: _____

Task being performed: _____

Name and size of device used: _____