Grant County Fire Protection District 3

APPENDIX B

The following is a list of communicable diseases listed in W.A.C. 248-100-001 for which routine carrier protection may be inadequate. E.M.S. personnel should be contacted by the receiving hospital when an E.M.S. transported patient has been diagnosed as having one of these diseases:

DISEASE	METHODS OF TRANSMISSION
Diphtheria	Airborne/Body fluids
Hemophilus Influenza	Airborne/Body fluids
Hepatitis B	Blood/Sex
Measles	Airborne/Body fluids
Meningococcal Disease	Airborne/Body fluids
Pertussis	Airborne/Body fluids
Pulmonary Tuberculosis (TB)	Airborne/Body fluids
Rabies	Saliva
Rubella	Airborne/Body fluids
Varicella (Chicken Pox & Disseminated Herpes Zoster)	
Aids	Blood/Sex

APPENDIX C

EMPLOYEE EXPOSURE WORKSHEET

Name of employee:_____Age:_____
EMS Agency:_____Home phone_____
Date of Incident_____Time_____
Agency Incident Number_____
Officer in Charge_____

Yes	No	Action	
		EMPLOYEE	
___	___	HIV consent signed:	Date_____
___	___	Hepatitis screen ordered:	Date:_____
___	___	HIV ordered:	Date_____
		SOURCE PATIENT	
___	___	HIV consent signed:	Date_____
___	___	Hepatitis screen ordered:	Date_____
___	___	HIV ordered: Date_____	
		RESULTS	
___	___	Employee notified of their HIV and Hepatitis test results:	Date_____
___	___	Employee notified of source patient's Hepatitis and HIV test results:	Date_____
___	___	Employee offered Hepatitis B Vaccine:	Date_____
___	___	Source patient's MD notified of lab results:	Date_____
___	___	Copies of lab work (employee and source patient) put in file:	Date_____
___	___	Accident report filed:	Date_____
___	___	Officers investigation report in file:	Date_____
___	___	All paperwork completed:	Date_____
___	___	Employee counseled:	Date_____

Comments:

District Fire Chief's Signature:_____Date:_____

APPENDIX D

DIAGRAM
OF
E.M.S. PATIENT CARE CONTACTS
AND
COMMUNICABLE DISEASE EXPOSURE EVENT SEQUENCES

E.M.S. INCIDENT OCCURS

FIRST RESPONDERS ARRIVE
(Police, Fire Personnel, Ambulance, Citizens)

E.M.S. PERSONAL PROTECTIVE MEASURES UTILIZED

CLIENT/PATIENT CONTACTED

E.M.S. PROTECTIVE BARRIER BREACHED
(BY E.M.S. Employee)

INCIDENT REPORTED TO E.M.S. EMPLOYEE SUPERVISOR
(Initiate Reporting Form for Potential Exposure to Communicable Disease, and Document Appropriately on E.M.I.R. Form)

EMERGENCY RECEIVING CENTER
OCCUPATIONAL HEALTH PROGRAM
(Identifies Source Patient's HBV/HIV Risk Status and Initiates Screening per Institutional Protocol)

NEGATIVE RISK	POSITIVE RISK
NO FURTHER ACTION	EMPLOYEE MANAGEMENT (Per E.M.S. employer's guideline, with advise from Health Department and Emergency Receiving Center.)

APPENDIX E

POLICY FOR COMMUNICABLE DISEASE EXPOSURE REPORTING AND FORM ROUTING

EVENT OCCURS
(contact with body substance)

Step 1 — ORIGINATOR
(form initiated)

Step 2 — OFFICER/SUPERVISOR
(immediate medical care for injuries)

Step 3 — CHIEF OFFICER
(patient follow-up for illness/disease)

Step 4 — EMERGENCY CENTER---OCCUPATIONAL HEALTH OFFICER
OCCUPATIONAL HEALTH PROGRAM
(To confirm disease identification and in consultation
Health Department, advise of appropriate follow-up)

Step 5 — CHIEF OFFICER
(advise employee of follow up)

Step 6 — NON-COMMUNICABLE-----COMMUNICABLE-----COMMUNICABLE

(No Treatment)	(Treatment)	(No Treatment)
COUNSEL EMPLOYEE (document in file)	COUNSEL EMPLOYEE, OPTIONS (document in file)	

Step 7 — REVIEW SITUATION FOR FUTURE PREVENTION
MODIFY CURRENT POLICY/PROCEDURE?
OBTAIN APPROPRIATE INPUT/APPROVALS FOR PROGRAM MODIFICATION
FORMALIZE MODIFICATIONS
EDUCATE ALL EMPLOYEES OF ANY MODIFICATION
IMPLEMENT MODIFICATIONS

GRANT COUNTY FIRE DISTRICT #3

1201 CENTRAL AVENUE S • P.O. BOX 565 • QUINCY, WA 98848
P: (509)787-2713 | WWW.GCFD3.NET

DATE: February 17, 2000

TO: All Employees

FROM: District Fire Chief

RE: Infectious Disease Education Program

Grant County Fire District #3 is required, by law, to have an Infectious Disease Education Program and to offer you the opportunity to participate in the program at no cost to you.

We are further required to make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident. To comply with this requirement we will offer the vaccination series to all personnel that are eligible to respond to emergency incidents where blood or other contaminated products may be present. We must have either the attached Hepatitis B Vaccine Declination form or the Vaccination Consent form, signed by all employees or individuals of this department. A copy of the form will be retained in your file Please read the attached information sheet regarding Hepatitis B, complete one of the forms and return to the District Fire Chief as soon as possible.

INFORMATION ABOUT HEPATITIS B VACCINE (RECOMBIVAX HB)

THE DISEASE

Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active Hepatitis and Cirrhosis. HBV also appears to be a causative factor in the development of liver Cancer. Thus, immunization against Hepatitis B can prevent acute Hepatitis and also reduce sickness and death from chronic active Hepatitis, Cirrhosis and Liver Cancer.

THE VACCINE

RECOMBIVAX HB (Hepatitis B Vaccine (Recombinant), MSD) is a noninfectious subunit viral vaccine derived from Hepatitis B surface antigen (HBsAg) produced in yeast cells. This vaccine is prepared from recombinant yeast cultures and is free of association with human blood or blood products. Clinical studies have established that RECOMBIVAX HB, when injected into the Deltoid Muscle, induced protective levels of antibody in greater that 90% of 564 healthy adults. The duration of protective effect of RECOMBIVAX HB is unknown at present, and the need for booster doses is not yet define. This vaccine is indicated for immunization against infection caused by all known subtypes of Hepatitis B virus. It will not prevent Hepatitis caused by other agents, such as Hepatitis A Virus, Non-A, Non-B Hepatitis viruses or other viruses known to infect the liver. Full immunization requires three (3) doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop Clinical Hepatitis in spite of immunization.

ADVERSE REACTIONS

RECOMBIVAX HB is generally well-tolerated. No serious adverse reactions attributed to the vaccine have been reported during the course of clinical trials. As with any vaccine, there is the possibility that broad use of the vaccine could reveal adverse reactions not observed in clinical trials. There could be a local reaction at the injection sight consisting principally of soreness and could include pain and tenderness. The most frequent systemic complaints of the body as a whole include fatigue/weakness and headaches.

IF YOU HAVE ANY QUESTIONS ABOUT HEPATITIS B OR THE HEPATITIS B VACCINE, PLEASE ASK.

VACCINATION CONSENT FORM

GRANT COUNTY FIRE PROTECTION DISTRICT #3

DATE:_____

EMPLOYEE NAME:_____

SOCIAL SECURITY NUMBER:_____

I have read the attached INFORMATION ABOUT HEPATITIS B VACCINE **and** have attended an informational session conducted by the District, regarding hepatitis B and hepatitis B vaccine.

I understand that due to my occupational exposure to blood and other potential material, 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.

I have had the opportunity to ask any questions and consult my personal physician. I understand that there is no guarantee that I will become immune to Hepatitis B or that I will not experience any side effects from the vaccine. I also understand that I must have three (3) doses of the vaccine and to keep my scheduled appointments to receive all three (3) doses.

_____ _____
Employee's Signature Date

_____ _____
Employer's Signature Date

****

Date Received

1st Dose_____ Location ___Left ___Right Deltoid

2nd Dose_____ Location ___Left ___Right Deltoid

3rd Dose_____ Location ___Left ___Right Deltoid

VACCINATION DECLINATION FORM

GRANT COUNTY FIRE PROTECTION DISTRICT #3

DATE:_____

EMPLOYEE NAME:_____

SOCIAL SECURITY NUMBER:_____

I understand that, due to my occupational exposure to blood or other potentially infectious material, 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 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 to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date