TUBERCULOSIS (TB)

It is the intent of the Hospital to comply with all aspects of its Tuberculosis (TB) standard under the guidelines of OSHA regulations.

I, _____ understand that Tuberculosis (TB) is a disease that is spread from person to person through the air. TB continues to be a public health problem with 20,000 cases reported annually in the United States. Although TB occurs in all segments of the population, high risk groups include:

- Persons with HIV infection
- Close contacts with infectious TB cases
- Persons with medical conditions with increased TB risks
- Foreign-born persons from high prevalence countries
- Low income populations, high risk minorities
- Alcoholics and IV drug users
- Residents of long term care facilities (including prisons)

Transmissions: occurs when there is exposure to the TB bacilli (germs) by airborne droplets into the air when persons with active TB of the lung or larynx cough, sneeze, or laugh. TB can also affect other parts of the body such as the brain, kidneys or spine.

TB Disease: People with TB disease are sick from germs that are active in their body and have one or more symptoms of TB. Infection can be transmitted to others. Permanent body damage and death can result from the disease. Medications such as Isoniazid(INH), Rifampin, Ethambutol, and Pyrazinamide (PZA) which can cure TB are prescribed.

TB infection: People with TB infection (without disease) have the germ that causes TB, but the germ lies inactive in the body. Infection cannot be spread to others. Disease may develop in the future, especially if they are in one of the high risk groups. Medication (INH) may be recommended for 6-12months to prevent TB disease from developing.

Infectious Agent: Mycobacterium Tuberculosis

Incubation: Approximately 4-12weeks

Symptoms: May include chronic cough, malaise (tired all the time), weight loss, weakness, loss of appetite, coughing up blood, fever and/or night sweats. Other symptoms depend on the particular of the body affected.

Isolation: Respiratory of AFB precautions are required, a private room utilizing negative air pressure, and doors and windows MUST remain closed.

Respiratory Protective Equipment: A "HEPA" respirator mask MUST be used when entering an isolation room which occupied or has been occupied in the past hour by a suspect or confirmed infectious TB case.

TB Skin Test: is provided to all employees on hire (if previous skin test negative) and annually thereafter. Employees in high risk areas may be skin-tested every six months. A reaction of 5mm or more of induration is considered positive is employee (1) has close recent contact with an infectious case of TB. (2) Chest X-Ray is consistent with TB, (3) is immunocompromised, or (4) is a member of a group at high risk for HIV infection. A REACTION OF 10MM OR MORE OF INDURATION SHOULD BE CONSIDERED POSITIVE IN ALL OTHER PERSONS.

Multi-Drug Resistant TB (MDR-TB): An infectious TB which is resistant to treatment with INH or Rifampin, MDR-TB is on the increase, especially in HIV positive, homeless, IV Drug users, and individuals with inadequate/incomplete treatment or exposures to people with MDR-TB.

TB Exposure Control Plan: is required by Cal OSHA to protect all individuals from exposure to TB in health care setting.

FOR FURTHER INFORMATION, SEE INFECTION CONTROL MANUAL, "TB EXPOSURE CONTROL PLAN": I certify I have been given the opportunity to ask any questions I have regarding TB and they have been answered fully to my satisfaction.

_____ _____

EMPLOYEE SIGNATURE DATE

BLOODBORNE PATHOGEN POLCY STATEMENT

The hospital is committed to providing the safest possible working conditions for all its employees. To accomplish this, the hospital will comply with all current occupational health, safety and environmental laws. It is the intent of the hospital to comply with all aspects of its Bloodborne Pathogen standard under the guidelines of OSHA regulations.

EMPLOYEE STATEMENT

I, _____ have read the information provided to me on Bloodborne Pathogens. I have an understanding of and will comply with the following:

1. I have a potential for exposure to Bloodborne Pathogens during the performance of my job duties.
2. I understand the epidemiology, symptoms and transmission of HIV, Hepatitis B, and other blood pathogens.
3. I will always practice the appropriate infection control and universal precautions in order to reduce potential risk of infection.
4. I understand that the Hepatitis B vaccine is available to me free of charge.
5. I understand that I should contact the Infection Control/ Employee Health Nurse to set up the time for my vaccinations.
6. I understand that if I decline the Hepatitis B vaccination. I must sign the declination form provided here.
7. I know the proper procedures to follow should I experience an exposure to blood or body fluids.

I understand that failure to use the Personal Protective Equipment provided to me or to comply with guidelines of the hospital's Bloodborne Pathogen Policy will result in disciplinary action which may include termination. I have been the opportunity to ask questions regarding Blood-borne Pathogen and have received answers to my questions.

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

INFECTION CONTROL/EMPLOYEE HEALTH NURSE DATE

BLOODBORNE PATHOGEN (BBP) QUIZ

EMPLOYEE NAME: _____ DATE: _____

1. Placentia-Linda Hospital has a Bloodborne Pathogen Exposure Control Plan in Employee Health. Circle the correct answer:
    a. TRUE
    b. FALSE
2. Which vaccine exists to prevent you from bloodborne pathogens infection?
    a. Hepatitis B Vaccine
    b. Hepatitis C Vaccine
    c. HIV
3. Name two "infectious materials" that can contain bloodborne pathogens.
    _____
    _____
    _____
4. List two procedures that can prevent bloodborne pathogens exposure.
    _____
    _____
    _____
5. List two possible initial actions to follow immediately after exposure.
    _____
    _____
    _____
6. Who should you report to immediately after an exposure? Circle the correct answer(s).
    a. Emergency Department
    b. Employee Health
    c. House Supervisor
7. There is no need to cover cuts, scrapes, rashes, etc., if you are wearing gloves. Circle the correct answer.
    a. TRUE
    b. FALSE
8. Name three types of personal protective equipment that can help guard against infection from bloodborne pathogens.
    _____
    _____
    _____

THIS IS A CONFIDENTIAL MEDICAL RECORD

CALIFORNIA

TO BE COMPLETED BY PRE-PLACEMENT *EMPLOYEE*:

Do you have knowledge of any limitation you have that would affect your ability to perform the job you have been offered? NO ☐

If "YES", please describe this limitation below.

_____

_____

Do you need reasonable accommodations to perform the job you have been offered? NO ☐

If "YES", please describe this limitation below.

_____

_____

To the best of my knowledge, I am free and clear of active infection and able to perform the essential functions of my assigned duties as required. I hereby certify that the information I have provided on this form is complete and accurate. I understand and agree that should any of the information I have provided be untrue, incomplete, or misrepresented, I may be subject to disciplinary action, up to and including termination.

Employee Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE HEALTH *NURSE*

Based on the information provided by the pre-placement employee and named above, this individual is:

1. Free and clear of signs or symptoms of infectious diseases. YES ☐ NO ☐
2. Able to perform the essential functions of the assigned duties. YES ☐ NO ☐

Employee Signature: _____ Date: _____

THIS IS A CONFIDENTIAL MEDICAL RECORD

PRE-PLACEMENT HEALTH QUESTIONNAIRE

Employee Name: _____ Date:_____

Address: _____Telephone:_____

Department: _____ Job Title/ Classification: _____

YOU HAVE BEEN MADE AN OFFER OF EMPLOYEMENT AT THIS HOSPITAL. AS PART OF THE PRE-PLACEMENT PROCESS, ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURETLY.

COMPLETE THE FOLLOWING SECTION ONLY IF YOU HAVE BEEN INFORMED THAT YOU WILL HAVE POTENTIAL RISK OF EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS.

1. Have you received the Hepatitis vaccine? YES ☐ NO ☐
2. Do you want the Hepatitis B Vaccination? YES ☐ NO ☐

PLEASE COMPLETE ATTACHED HEPATITIS B CONCENT/DECLINATION FORM

YES ☐	NO ☐	1. Have you been screened for Rubella (German Measles)?
YES ☐	NO ☐	2. Do you have immunity to Rubella?
YES ☐	NO ☐	3. Have you been screened for Varicella (Chicken Pox)?
YES ☐	NO ☐	4. Do you have immunity to Varicella?
YES ☐	NO ☐	5. Have you been screened for Rubella (Measles)?
YES ☐	NO ☐	6. Do you have immunity to Rubella?
YES ☐	NO ☐	7. Have you been screened for Mumps?
YES ☐	NO ☐	8. Do you have immunity to Mumps?
YES ☐	NO ☐	9. Have you been vaccinated for Smallpox?
		a. If "YES" when? _____

_____ _____

Signature Date

THIS IS A CONFIDENTIAL MEDICAL RECORD

CALIFORNIA

HEPATITIS B CONSENT/DECLINATION FORM

I have been informed of the symptoms and mode of transmission of bloodborne pathogens including Hepatitis B (HBV). I have been informed about the benefits and risks of Hepatitis B Vaccine.

I understand that the Hepatitis B vaccine is available at no cost to employees whose jobs involve the risk of direct contact with blood or other potentially infectious material. I understand that vaccinations shall be given according to the recommendations for standard medical practice in the community.

PLEASE CHECK YOUR OPTION(S) AS APPLICABLE:

- ☐ I wish to receive the vaccine.
- ☐ I am in the process of receiving the Hepatitis B Vaccine.
- ☐ I have already received the Hepatitis B Vaccine.

  Number of injections _____ Date of last injection _____
- ☐ I have had a titer drawn on _____

  Results show: ☐ Positive/ Immunity ☐ Negative/ No Immunity ☐ Unknown

I understand that due to my occupation, exposure to blood or other potentially infectious materials, I may be at risk for accruing 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 have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B Vaccine, I can received the vaccination series at no charge to be. (Appendix A to section 1910.1030-Hepatitis B Declination).

_____

Print Employee Name:

_____ _____

Employee Signature: Date:

Employee Name: _____ Date: _____

Department: _____

TUBERCULOSIS (TB) QUIZ

Please circle the correct answers:

TRUE FALSE 1. Symptoms of TB include chronic cough, weight loss, weakness, loss of appetite, fever and/or night sweats.

TRUE FALSE 2. People with positive TB skin tests who do not have active disease are not considered to be contagious to others.

TRUE FALSE 3. People with TB disease that have one or more symptoms of TB can be contagious to others and require medical treatment and medications.

TRUE FALSE 4. TB may be transmitted by inhaling airborne germs when people with active TB cough, sneeze, or laugh.

TRUE FALSE 5. Room assignment for person with TB disease must be in the private room with negative air pressure and doors must remain closed.

TRUE FALSE 6. All patients should be encouraged or taught to cover their mouth and nose when they sneeze or cough.

TRUE FALSE 7. A particulate respirator (TB Mask) must be used when entering a room of a patient with suspected or confirmed infectious TB.

TRUE FALSE 8. TB screening is required at least annually of all employees.

TRUE FALSE 9. People at high risk for TB may include persons with HIV infection, residents of Long Term Care facilities, and close contact with infectious TB cases.

TRUE FALSE 10. TB is becoming more resistant to medications because of inadequate or incomplete treatment.

EMPLOYEE NURSE **ONLY**:

PASS _____ FAIL _____

IMMUNIZATIONS ATTESTATION FORM FOR HEALTHCARE PERSONNEL

The following six immunizations and screening tests are recommended by the Centers of Disease Control and Prevention (CDC) for all healthcare workers. ***These immunizations are available through the Occupational/ Employee health Office (ext.4239***). Please complete this attestation and sign, date, and return to **Placentia-Linda Employee Health Office**. Failure to agree to receiving required immunization(s) with exception of a bona fide reason due to medical condition (letter from D required) or religious reasons (attestation to be signed) may be a condition of hire.

Name: _____ Date: _____

1. Influenza
   Annual vaccination is needed because of antigenic shifts. The vaccine is contraindicated in those severely allergic to eggs or egg protein. It is offered annually free of charge and has been shown to help reduce the spread of influenza to patients and one's family members.
   - ☐ a. I understand I need to be vaccinated annually for influenza
   - ☐ b. I have been vaccinated for influenza this flu season. [Documentation Required]
   - ☐ c. I have a contraindication to receiving the influenza vaccine. [Documentation Required]

2. TDAP
   Tetanus, diphtheria, and acellular pertussis vaccine and recommended in 2006 for healthcare personnel in response to an epidemic of adult pertussis. Pertussis presently accounts for up to 25% of chronic cough in some adult populations and can be lethal if spread of infants. At the present time, it is suggested that the vaccine be taken once, but will most likely become the vaccine of choice every ten years, replacing the old TD (tetanus/adult diphtheria) injection. Vaccination with TDAP should be delayed if you have received a tetanus immunization within the last 2 years (since Arthus reasons occur in those receiving tetanus too frequently.
   - ☐ a. I have received the TDAP vaccine. [Documentation Required]
   - ☐ b. I am declining TDAP vaccine due to bona fide medical or religious reasons. [Documentation Required]
   - ☐ c. If declined, I will not provide care for infants less than twelve (12) months old.

3. Varicella

   A past history of chicken pox or shingles is acceptable evidence of immunity to varicella. If you are unsure of past infection, a varicella titer can be drawn. Two varicella vaccinations are now recommended for adults who have not had the natural disease. Recent data indicate that at least 10% of single-injection recipients of the vaccine are at risk of developing "break-through" disease. ***The vaccine is a live vaccine hence is not recommended for pregnant women.***

   - ☐ a. I have had natural varicella disease.
   - ☐ b. I have serologic documentation of immunity to varicella. [Documentation Required]
   - ☐ c. I have had two varicella immunizations. [Documentation Required]
   - ☐ d. I am declining the Varicella vaccine due to bona fide medical or religious reasons. [Documentation Required]

4. Hepatitis B

   Three vaccinations are recommended over the six-month period. The vaccination series can be completed at any time and does not need to be restarted if vaccination was delayed. It is contraindicated in those who have a history of anaphylaxis to common baker's yeast. The vaccine is not a live virus vaccine and can be given to pregnant women. The CDC recommends post-vaccination testing for antibody level 4-8weeks after the final dose. If antibodies are present at that time, it is presumed that the individual is protected for life.

   - ☐ a. I have received three (3) Hepatitis B Vaccines. [Documentation Required]
   - ☐ b. I have been tested in the past and had a protective level of hepatitis B Surface Antibody (anti-HBs) of greater than 10mIU.mL [Documentation Required]
   - ☐ c. I have not received all three Hepatitis B Vaccinations.
   - ☐ d. I have never been tested for protective antibody (anti-HBs)
   - ☐ e. I am declining the Hepatitis vaccine due to bona fide medical or religious reasons. [Documentation Required]

5. MMR (Measles, Mumps, Rubella)

   Two MMR vaccinations after one year of age are recommended by the CDC for healthcare personnel. For unvaccinated healthcare personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should consider vaccinating personnel with two (2) doses of MMR vaccine at the appropriate interval (for measles and mumps) and one (1) dose of MMR vaccine for (for rubella), respectively.

   This live vaccine is contraindicated in pregnancy, immunocompromised hosts, recent recipients of immune globulin, and those who have had anaphylaxis to gelatin or neomycin.

   - ☐ a. I was born before 1957 (1956 or earlier).
   - ☐ b. I have serologic evidence of protective antibodies to all three diseases.[Documentation Required]
   - ☐ c. I have not received two MMR vaccinations. [Documentation Required]
   - ☐ d. I am declining the MMR vaccine due to bona fide medical or religious reasons. [Documentation Required]

6. Tuberculosis Screening: *Please check all that apply.*
   - ☐ I have no signs or symptoms consistent with tuberculosis [cough for over three (3) weeks, fatigue, night sweats, fever, and unplanned weight loss].
   - ☐ I am tuberculin skin test (TST) negative and was last tested on: (date) _____ [Documentation Required]
   - ☐ I have had a positive TST in the past (now termed latent infection) and have had a chest x-ray following my positive TST that showed no active disease. [Documentation Required]
   - ☐ I have completed an INH regimen in accordance with CDC guidelines. (date) _____ [Documentation Required]
   - ☐ I have had Tuberculosis disease and do not have active disease. My last chest X-Ray showing no active disease was (date) _____ [Documentation Required]

7. For Microbiologist Only
   - ☐ Meningococcal Vaccine
   - ☐ Typhoid Vaccine
   - ☐ If you have received any of these vaccines in the past. [Documentation Required]
   - ☐ I am declining the meningococcal and/or Typhoid Vaccine due to bona fide medical or religious reasons. [Documentation Required]

_____

Employee Signature

_____

Print Name

_____

Date