TRINITY EMS, INC.

EXPOSURE CONTROL PLAN

CORPORATE HEADQUARTERS:

1221 WESTFORD STREET
LOWELL, MASSACHUSETTS 01853

PREFACE

It should be noted that the Occupational Safety and Health Administration (O.S.H.A.) never reviews or endorses educational material or programs developed in the private sector. It should be pointed out, however, that all information in this program is based directly on federal, primarily O.S.H.A., guidelines and materials as well as Massachusetts and New Hampshire Emergency Medical Services rules and/or regulations. Whenever appropriate, information has been taken from the standard, regulation, or rule itself, so there is a minimum of interpretation.

Specific Regulations / Rules utilized in the development of this program include but are not limited to:

FEDERAL:

29 CFR 1910.1030 – *Bloodborne Pathogens*
29 CFR 1910.1200 – *Hazardous Communication*
29 CFR 1910.132 – *Personal Protection General Requirements*
29 CFR 1910.134 – *Respiratory Protection*

STATE:

Massachusetts –

105 CMR 170.000 – *Emergency Medical Services System*
105 CMR 172.000 – *Regulating the Reporting of Infectious Diseases*

New Hampshire –

Saf-C 5900 – *Emergency Medical Services*

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REVIEW / LIST OF CHANGES

Policy Number	Type of Change (Addition/Deletion/Revision)	Date of Original	Date of Change
Full Program	Initial Program Development	07 / 1998	
Full Program	Review and outsourced to consulting agency		2001
Full Program	Trained / re-trained all Field Staff and included the training into New Hire Orientation Program.		02-04/2011
State Exposure Packets	Completed revisions of NH & MA Exposure Packets & distributed via E-mail to all Assistant Managers & Directors.		12/2011
Full Program	Completed update and revision of entire program, posted program on Company Intranet & notified field and managerial staff of publication		12/2011
Full Program	Annual Review of Program – Changed title of oversight to Director of Clinical Services & Education		3/2012
Full Program	Annual Review of Program – No changes or edits		2/2013
Full Program	Annual Review of Program – No changes or edits		3/2014

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 1 – PURPOSE

O.S.H.A.

The Occupational Safety and Health Administration (OSHA) is the federal agency that has been granted the power to oversee and regulate safe work practices in the workplace. It is an effort to minimize the incidence of worker illness, injury and death in the workplace.

Relative to this, OSHA has enacted the **BLOODBORNE PATHOGEN STANDARD,** codified as 29 CFR 1910.1030 to "Reduce Occupational Exposure to Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens". OSHA has also mandated that all healthcare facilities, services etc. adhere to the "GUIDELINES FOR PREVENTING THE TRANSMISSION OF TUBERCULOSIS IN HEALTH-CARE FACILITIES", published by the Center for Disease Control (CDC).

OBJECTIVES:

This Exposure Control Plan encompasses a number of principles that need to be adhered to when there is the potential to come in contact with or be exposed to pathogens. These principles include but are not limited to the following:

- Minimize, reduce, and avoid any type of exposure to pathogens to the greatest extent possible.
- Risk of exposure to bloodborne and airborne pathogens should never be under estimated, if in doubt - assume that a risk of exposure is involved.
- There must be continuous reassessment, updating and practice of safe work practices and engineering controls to minimize or eliminate the potential exposure to pathogens.

This Exposure Control Plan should be utilized to help both the employer and the employee meet the intent of the OSHA standards and mandates. The Objective of this plan is to:

- Protect all employees from health hazards associated with exposure to any pathogens.
- Provide appropriate treatment and counseling should an employee be exposed to any pathogen.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 2 – DESIGNATED INFECTION CONTROL OFFICER (DICO)

DEFINITION

Federal and state statutes, rules and regulations reference the need to designate an individual as the primary person responsible for the exposure control program. The healthcare industry has generally identified this person as the Infection Control Officer or Specialist.

The statutory references most commonly apply the term DESIGNATED INFECTION CONTROL OFFICER (DICO). For the purposes of this plan, the acronym "DICO" will be used throughout, from this point forward, to indicate the person responsible for administration of the Exposure Control Plan.

Oversight and initial implementation of the DICO role has been assigned to the Director of Clinical Services & Education at the Corporate Headquarters.

DICO RESPONSIBILITIES

The activities and responsibilities of the DICO include, but are not limited to the following:

- Overall responsibility for the implementation and administration of the Exposure Control Plan for the entire company.
- Working with other members of management and the employees to develop and administer any additional pathogen exposure related policies and practices needed to support the effective implementation of this plan.
- Research and implement further methods to enhance the overall Exposure Control Plan, as well as to revise and update the plan as needed.
    - To ensure compliance with the standard however, the plan must be reviewed annually.
- Maintain a suitable reference library or area on all applicable OSHA Infection Control Standards, guidelines and related health and safety information.
- Maintain current knowledge of legal requirements concerning pathogens and exposure control.
- Act as the company's liaison during any OSHA inspection.
- Conduct periodic audits to maintain an up-to-date exposure control plan.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 3 – LEVELS OF RESPONSIBILITY

For an effective implementation of the Exposure Control Plan, the following categories must be represented and involved:

- Management
- DICO
- Employee Representative
- Training/Education Personnel

This plan will define each role and responsibilities of each individual or group. Within this plan, positions have been identified and not individuals as people may change but the positions of accountability do not.

Should there be additions of staff or re-assignment of employees, the DICO must be notified of the change/addition so that all records can be updated to ensure compliance.

SAFETY/EXPOSURE CONTROL COMMITTEE

In response to the Needle Stick Safety and Prevention Act as well as to assist the DICO, the company's SAFETY/EXPOSURE CONTROL COMMITTEE will help ensure timely and proficient implementation and maintenance of the Exposure Control Program. This committee will be composed of the following individuals:

- DICO
- Human Resources
- Supervisory Personnel
- Employee Representative Chair Car Personnel
- Employee Representative EMT-Basic
- Employee Representative EMT-Paramedic

COMPANY MANAGEMENT AND SUPERVISORY PERSONNEL

Management and supervisory personnel are responsible for exposure control in their respective areas. They work directly with the DICO and employees to ensure that proper exposure control procedures are followed.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 4 – AVAILABILITY OF THE PLAN

This Exposure Control Plan is available to any employee at any time via the Company Intranet which is gained through any computer with standard internet access. Employees are advised of this availability during orientation, annual re-training and during education/training sessions.

This Exposure Control Plan is maintained by the Director of Clinical Services & Education and the DICO. It is available to all staff electronically through the Company Intranet via any computer with internet access.

Furthermore a copy of this plan is located**:**

- 1221 Westford Street Lowell, MA – Corporate Headquarters
- 7 Stewart Street Haverhill, MA. – Haverhill Operations
- 10 Jean Street Suite #12 Chelmsford, MA – Education Center

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 5 – AVAILABILITY OF LAWS, REGULATIONS, OTHER REFERENCES

Laws, regulations and other references that pertain to the Exposure control plan are available to any employee.

- Some references and sample forms are available within this manual:
  - Section E - Appendix
- Other references which are extensive or which are subject to constant update and revisions are centrally maintained at the company's headquarters.
- The DICO is also responsible for collecting and maintaining a suitable reference library on exposure control standards and related health and safety information.

Any references not included in Section E - Appendix of this plan can be viewed by contacting the DICO at the company's headquarters.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 6 – REVIEW & UPDATE OF THE PLAN

Review and Update of the Plan

The plan is required to have periodic review and updating. It is imperative that this plan remain current with changing statutes and regulations. The plan review is also mandated by new research, the recall or introduction of new products and by changing epidemiology or disease patterns.

This plan must be reviewed and updated under the following circumstances:

- Annually, on or before February 28th of each year.
- Whenever new or modified procedures or tasks are implemented which affect occupational exposure of our employees.
- Whenever a job or role is changed that will bring about new instances of occupational exposures.
- Whenever new positions have been added to the workforce that may involve pathogen contact / exposure.

Should you have any suggestions that could improve this program please forward them to the DICO at any time.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 7 – LABELS & SIGNAGE

Labels and Signage

Bio-Hazard labels provide a warning of possible exposure to pathogens. The company mandates a comprehensive labeling program throughout the entire operation.

We utilize manufacture recommended or appropriate aftermarket labeling products. When appropriate red “color-coded” containers will be utilized as well. The DICO is responsible for establishing labeling procedures and selecting appropriate aftermarket labeling products. Management/supervisory personnel are responsible for assuring that all procedures are followed.

Minimally, the following items are subject to labeling:

- Contaminated Equipment
- Containers of regulated waste
- Sharps disposal containers
- Any other container used to store, transport, or ship blood and other infectious materials.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 8 – ORIENTATION & TRAINING

The education and training of employees is of the highest priority when attempting to minimize and/or eliminate potential exposure to pathogens. Therefore all employees who have the potential to be exposed to either airborne or bloodborne pathogens are mandated to attend and participate in a comprehensive training program on exposure control to assure their safety.

All employees will be updated annually to show current knowledge and proficiency in the standards and policies. Additionally, all new employees and any current employee who changes his/her position/risk category, must receive additional training that is now mandated at the time of the new job/position assignment.

The DICO is responsible for assuring that all employees who have any potential exposure to pathogens receive this training. The following individual(s) may also have a role in training our personnel as needed and appropriate:

- Medical Director
- Public Health Officials
- Infection Control Nurses From Local Hospitals
- Technical Support Representatives from Vendors providing equipment and/or supplies

TRAINING TOPICS

The topics in the training session will include, but are not limited to the following:

- The Bloodborne and Airborne Pathogen Standards, laws and Regulations
- The epidemiology and symptoms of bloodborne and airborne diseases
- The transmission modes of bloodborne and airborne pathogens
- This Exposure Control Plan, Resources and Reference Material available to the employee.
- Approved methods for recognizing tasks and activities that may potentially expose the employee to infectious materials.
- A review of the use of and the limitations of methods that will prevent or reduce exposure, including:
    - Engineering Controls
    - Workplace Practices
    - Personal Protective Equipment (PPE)
- Proper selection and use of Personal Protective Equipment (PPE), including:
    - Types Available
    - Proper Use of such
    - Location of PPE within the work area
    - Removal
    - Handling
    - Cleaning and Decontamination
    - Disposal
- Visual Warnings of Bio-Hazards within facilities including labels, signs, and “color-coded” containers.

- Information on the Hepatitis B Vaccination Program (HBV) including:
    - Efficacy
    - Safety
    - Methods of Administration
    - Periodic Re-Testing
    - Medical Evaluation of Positive Tests
- Actions to take and who to contact when a potential exposure has taken place involving blood, respiratory secretions or other potentially infectious materials.
- The procedures to follow if an exposure incident occurs, including all paperwork, i.e. incident reports, unprotected exposure forms etc.
- Information on the post-exposure evaluation and follow-up, including medical consultation, that the company will provide.

TRAINING METHODS

The company will present the program in a number of formats including, but not limited to:

- Classroom type atmosphere with personal instruction
- Videotape presentation / scenarios
- Internet (on-line) learning
- Presentation Handouts
- Employee Review Sessions

As per the Federal Standard and because all employees need an opportunity to ask questions and interact with the instructor(s), time will be scheduled for such in all training sessions.

EDUCATION RECORD KEEPING

To ascertain the training needs as well as to document the training process, the following records will be maintained by Education Division as well as the company in regard to the Exposure Control Program:

- Dates of all training sessions
- Contents / summary of the training sessions
- Names and qualifications of the instructor(s)
- Names and job titles of the employees attending the training sessions

Record keeping is facilitated through the use of computer data bases and the utilization of forms, attendance rosters, payroll sheets etc. All data will be maintained by the Education & Human Resources Department and originals/copies will be maintained by the company as required/mandated.

All training records are available for examination and copying by management, employees, and regulatory officials.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 9 – POST-EXPOSURE INCIDENT INVESTIGATION

Should an employee become involved in an incident where exposure to pathogens may have occurred, there are two mandated procedures:

- All circumstances surrounding the exposure incident must be investigated by the DICO or his/her designee with assistance from supervisory personnel.
    - A copy of the "EXPOSURE INCIDENT INVESTIGATION FORM" is located in Section E - Appendix of this program.
- The employee must be referred for medical consultation and any required treatment as expeditiously as possible.
    - Refer to C.08 – Unprotected Exposure / Follow-Up and Medical Consult in this program.

A review and investigation of every exposure incident that occurs within the operation will begin immediately and most certainly within 48 hours post incident. As treatment protocols change within the healthcare environment, treatment must be initiated prior to any investigation to ensure timely medical evaluation and treatment.

A written summary of the incident and its findings will be prepared along with any recommendations for avoiding similar incidents in the future. At a minimum, the following information must be collected by the DICO:

- When the incident occurred:
    - Date
    - Time
- Where the incident occurred
- What potentially infectious materials were involved in the incident:
    - Type of material - (Blood, Body Fluid, Respiratory Secretions etc.)
    - Source of Material
- Risk of Contamination from the unprotected Exposure
    - History of the patient involved if known
    - Potential of the patient being a carrier of infectious disease if known
    - Specific source and location of possible infectious material if known
    - Potential long term aspects if known

- What circumstances the incident occurred:
    - Type of procedure was being performed
    - What caused the incident

- Personal Protective Equipment (PPE) being used at the time of the incident:

- Actions taken as a result of the incident:
    - Employee decontamination
    - Cleanup
    - Notifications made.
    - Medical Care and Follow-Up
    - Documentation
- Institute post-exposure follow-up procedures, bloodborne or airborne as appropriate.

CHAPTER A: GENERAL PROGRAM MANAGEMENT
SECTION 10 – MEDICAL RECORD KEEPING

To assure that all appropriate and necessary medical information is available to healthcare professionals participating in the Exposure Control Program, the company will maintain a complete medical record on each employee. The Human Resource Manager will be responsible for establishing and maintaining these records, which include the following information:

- Name of the Employee
- Social Security Number of the Employee
- Copy of the employee's Hepatitis B Vaccination status
    - Dates of any vaccinations
    - Medical Records relative to the employee's ability to receive vaccination
- Copy of the employee's testing and evaluation relative to TB exposure and protection including:
    - Medical Evaluation for use of the Respirators
    - Results of annual Mantoux testing, periodic re-testing and any resulting medical follow-up.
- Copies of the results of the examinations, medical testing and follow-up procedures and correspondence with medical authorities.
- A copy of the information provided to the consulting health care professional as a result of any exposure to pathogens.

It is recognized that all information contained within the medical record is confidential. The company will not disclose or report this information to anyone without the written consent of the employee except in those cases where reporting to governmental agencies is required by law.

All medical records will be maintained by the company for the employment period plus a minimum of seven years.

CHAPTER B: EXPOSURE DETERMINATION
SECTION 1 – EXPOSURE DETERMINATION / BLOODBORNE PATHOGENS

For a successful implementation and maintenance of this Exposure Control Program it is critical that the company identify tasks, procedures, or situations that employees may encounter which present the potential of exposure.

Once all tasks, procedures, and situations are listed, a job can be typically assigned to a risk category relative to bloodborne pathogens.

- Job classifications in which ***ALL*** employees have occupational exposure to bloodborne pathogens.

- Job classifications in which ***SOME*** employees have occupational exposure to bloodborne pathogens.

- Job classifications in which there is ***NO*** potential exposure to bloodborne pathogens during normal course of duties.

As tasks, procedures, and situations change, job classifications may change.

The DICO will work with management and supervisors to revise and update these lists as required.

CHAPTER B: EXPOSURE DETERMINATION
SECTION 2 – CLASSIFICATION / ***ALL*** HAVING BLOODBORNE EXPOSURE

The jobs listed in this classification are those where it has been determined that ALL employees have/may come in contact with human blood, body fluids or other potentially infectious materials, which may result in possible exposure to bloodborne pathogens.

JOB	ASSIGNED AREA
Chair Car Operators	Operations
Emergency Medical Technicians - Basic	Operations / Clinical Services
Emergency Medical Technicians - Intermediate	Operations / Clinical Services
Emergency Medical Technicians - Paramedic	Operations / Clinical Services
Student / Field Interns	Operations / Clinical Services
Assistant Operations Managers	Operations
Other Uniformed Management Staff	Administration

CHAPTER B: EXPOSURE DETERMINATION
SECTION 3 – CLASSIFICATION / ***SOME*** HAVING BLOODBORNE EXPOSURE

The jobs listed in this classification are those where it has been determined that ***SOME*** employees have/may come in contact with human blood, body fluids or other potentially infectious materials, which may result in possible exposure to bloodborne pathogens.

JOB	ASSIGNED AREA
Senior Management: Non-Uniformed	If Inspecting Field Ops
Dispatchers that are EMTs or Paramedics	Dispatch
Fleet Manager	Fleet
Mechanics	Fleet – when inspecting or detailing patient care vehicles

CHAPTER B: EXPOSURE DETERMINATION
SECTION 4 – CLASSIFICATION / *NO* POTENTIAL BLOODBORNE EXPOSURE

The jobs listed in this classification are those where it has been determined that ***NO*** potential for contact with human blood, body fluids or other potentially infectious materials, which may result in possible exposure to bloodborne pathogens.

JOB
Sales and Marketing Staff
Human Resource Staff
Billing Office Staff
Receptionist(s)

CHAPTER B: EXPOSURE DETERMINATION
SECTION 5 – BLS WORK ACTIVITIES INVOLVING BLOODBORNE EXPOSURE

This listing includes those Basic Life Support tasks and procedures within the company's operations where employees may come in contact with human blood, body fluids, or other potentially infectious materials which may result in exposure to bloodborne pathogens.

A. Patient Assessment

B. Airway Care
1. Opening the airway
2. Clearing the airway
3. Suctioning the airway
4. Insertion of oral or nasal airway
5. Insertion of an LMA or King-tube device

C. Procedures to Assist Patient Breathing
1. Mouth-to-mouth
2. Mouth-to-mask
3. Bag-Valve-Mask device
4. Positive Pressure device

D. Oxygen Therapy / Administration
1. Nasal Cannula
2. Simple Mask
3. Partial Non-Rebreather Mask
4. Non-Rebreather Mask
5. Humidification

E. Cardiopulmonary Resuscitation

F. Bandaging Techniques
1. Closed Wounds
2. Open Wounds
3. Special Wound Care

G. Bleeding Control
1. Direct Pressure
2. Elevation
3. Pressure Points
4. Tourniquets
5. Splints
6. Pressure Bandages

H. Obstetrical Care
1. Delivery of Infant
2. Complications / Abnormal Delivery
3. Care of Newborn
4. Care of Mother - Post Delivery

I. Spinal Immobilization
   1. Cervical Spine Immobilization
   2. Full Spinal Immobilization

J. Fracture Management
   1. Splint / Sling & Swathe Application
   2. Traction Splint Application

K. Automatic External Defibrillation

L. Patient Lifts, Moves, and Carries

M. Ambulance Cleaning, Disinfection, and Maintenance

N. Equipment Cleaning, Disinfection, and Maintenance

O. Administration or assistance in administration of intramuscular, nasal, nebulized, oral or sub lingual medications

P. Finger Stick for Glucose Testing

CHAPTER B: EXPOSURE DETERMINATION
SECTION 6 – ALS WORK ACTIVITIES INVOLVING BLOODBORNE EXPOSURE

This listing includes those Advanced Life Support tasks and procedures within the company's operations where employees may come in contact with human blood, body fluids, or other potentially infectious materials which may result in exposure to bloodborne pathogens.

A. Intravascular Therapy
   1. Initiation of peripheral intravenous needles
   2. Initiation of intra-osseous needles
   3. Monitoring patency of an Intravenous insertion
   4. Initiation of a Heparin Lock
   5. Initiation of a Saline Lock
   6. Blood Draw for Testing
   7. Operation of IV Infusion Pump
   8. Monitoring patency of an Intra-osseous insertion

B. Finger Stick for Glucose Testing

C. Administration of Medications
   1. IV Push
   2. IV Infusion
   3. Intramuscular Injections
   4. Sublingual Administration
   5. Oral Administration
   6. Endotracheal
   7. Nebulizer
   8. Intra-osseous Push
   9. Subcutaneous injections
   10. Intranasal

D. Advanced Airway Management Procedures
   1. Endotracheal Intubation
   2. Nasotracheal Intubation
   3. Cricothyrotomy
   5. Deep Tracheal Suctioning
   6. Removal of Foreign Object via Magill Forceps
   7. Care of Patients with Tracheostomy Tubes
   8. Insertion of LMA, King-tube or Combi-tube

E. Chest Decompression

F. Insertion of Nasogastric Tube

G. Vagal Maneuvers

H. Manual Defibrillation / Cardioversion

I. Application of External Pacemaker

CHAPTER B: EXPOSURE DETERMINATION
SECTION 7 – CLASSIFICATION OF RISK / AIRBORNE PATHOGENS

All company personnel listed below who are engaged in patient care and transportation, are at risk of coming in contact with respiratory droplets and / or oral / nasal secretions or other potentially infectious materials, which may result in possible exposure to airborne pathogens.

JOB	ASSIGNED AREA
Chair Car Operators	Operations
Emergency Medical Technicians – Basic	Operations / Clinical
Emergency Medical Technicians - Intermediate	Operations / Clinical
Emergency Medical Technicians - Paramedic	Operations / Clinical
Student / Field Interns	Operations / Clinical
Assistant Managers	Operations
Other Uniformed Management Staff	Administration

RISK CATEGORY

The risk Category is assigned based upon possible exposure to Microbacterium Tuberculosis. In accordance with the Center for Disease Control's protocol described in the nest following policy (B.08), the above group is classified as MODERATE / INTERMEDIATE RISK. All personnel in this group are subject to TB policies and procedures as outlined in Section D of this manual.

CHAPTER B: EXPOSURE DETERMINATION
SECTION 8 – RISK ASSESSMENT / AIRBORNE PATHOGENS

The risk assessment for airborne pathogens adheres to the **Center for Disease Control's Protocol for Conducting a Tuberculosis Risk Assessment in a Healthcare Facility**.

Guided by the assessment algorithm, the following is the review of each protocol element and the resulting assessment for our operations.

CDC PROTOCOL ELEMENT	Assessment
1. Review of community TB profile from the Department of Public Health.	The Commonwealth of Massachusetts was considered in reviewing the "community TB profile". Although there are pockets of higher incidence, the occurrence of TB in the New England community as a whole is relatively low with an average of 1.96 per 100,000 compared to the US average of 3.8: • Massachusetts had a highest case rate of 3.7cases per 100,000 which is just about even with the National rate of 3.8 per 100,000 (2009). • Other rates for the same time period in the New England states are: Connecticut – 2.7, Maine – 0.7; New Hampshire – 1.2; Rhode Island – 2.3; and Vermont – 1.1 • New York was also considered because of the large border and visitor populations. NY's Rate was 5.1
2. Analyze PPD test data by area and occupational groups: a. determine if PPD conversions rate is significantly higher than rates for area or group where occupational exposure is unlikely, (or) is higher than previous rate.	All company employees who are classified as health care workers and are subject to PPD testing are in the same "area and group", providing medical transportation. a. This data has not been tracked for this Company but will be with the reinvigoration of the Health & Safety Programs and specifically the Infectious Control Program.
CDC PROTOCOL ELEMENT	ASSESSMENT
b. determine if there is a cluster of person-to-person transmission.	b. There have been NO clusters of PPD conversions for any 3 month period for the group.
c. determine if there is evidence of person-to-person transmission.	c. There is No evidence of person-to-person transmission of TB since the revitalization of this program

3. Analyze number of TB patients treated by area and occupational groups: a. No TB patients = very low risk b. Fewer than Six TB patients = low risk c. Six or more TB patients = moderate / intermediate risk	The number of TB patients transported in company vehicles may total up to as many as 25 per year, but usually averages less than 10 per year. This is based on reporting from DICO at receiving hospitals.
4. Analyze other risk factors by area and occupational groups.	An additional risk factor to be considered for a sub-group of employees would be certain airway procedures performed by ALS personnel. Based on this factor, the employees in this sub-group will be subject to PPD testing at a more frequent interval, 6 months instead of 12 months. At this time the ALS staff are NOT performing skills that would necessitate an increase in PPD testing.

RESULTS OF RISK ASSESSMENT

Based on the analysis of each element in the CDC protocol algorithm as discussed above, the "area and occupational group" that includes our patient care and transportation personnel is assessed as MODERATE / INTERMEDIATE RISK. This conclusion is in accordance with the CDC guideline which states as follows:

"Intermediate-risk" areas or occupational groups are those in which a) the PPD test conversion rate is not greater than that for areas or groups in which occupational exposure to M.Tuberculosis is unlikely or than previous conversion rates for the same area or group, b0 no clusters of PPD test conversions have occurred, c) person-to-person transmission of M. Tuberculosis has not been detected, and d) six or more patients with active TB are examined each year. Survey data suggest that facilities in which six or more TB patients are examined or treated each year may have an increased risk for transmission of M. Tuberculosis (CDC unpublished data); thus, areas in which six or more patients with active TB are examined or treated each year (or occupational groups in which HCWs are likely to be exposed to six or more TB patients per year) should be classified as "intermediate risk."

Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Facilities, 1994; CDC, MMWR October 28, 1994/Vol.43/No.RR-13

CHAPTER B: EXPOSURE DETERMINATION
SECTION 9 – BLS WORK ACTIVITIES INVOLVING AIRBORNE PATHOGENS

This list includes Basic Life Support skills, tasks, and procedures within the company's operation where employees may come in contact with respiratory droplet and/or oral/nasal secretions, or other potentially infectious materials which may result in exposure to airborne pathogens:

A. Patient Assessment

B. Airway Care
   1. Opening the airway
   2. Clearing the airway
   3. Suctioning the airway
   4. Insertion of oral or nasal airways (OPA/NPA)
   5. Insertion of airway control devices to include but limited to LMA's, King-Tubes, or Combi-Tubes

C. Procedures to Assist Patient Breathing
   1. Mouth-to-mask
   2. Bag-Valve-Mask
   3. Positive Pressure Device

D. Oxygen Therapy & Administration
   1. Nasal Cannula
   2. Simple Mask
   3. Partial Non-Rebreather Mask
   4. Non-Rebreather Mask
   5. Humidification

E. Cardiopulmonary Resuscitation

F. Handling Patient with Respiratory Symptoms
   1. Lifting, Moving, and Carrying Patients
   2. Contact with Patient in Confined Spaces
      -Small Rooms
      -Elevators
      -Inside Ambulance or Chair Car Van

G. Ambulance Cleaning, Disinfection and Maintenance

H. Equipment Cleaning, Disinfection and Maintenance

I. Medication administration or assistance with involving Intranasal, Oral, Sublingual, or Nebulized routes

CHAPTER B: EXPOSURE DETERMINATION
SECTION 10 – ALS WORK ACTIVITIES INVOLVING AIRBORNE PATHOGENS

This list includes Advanced Life Support skills, tasks, and procedures within the company's operation where employees may come in contact with respiratory droplet and/or oral/nasal secretions, or other potentially infectious materials which may result in exposure to airborne pathogens:

A. Administration of Medications
   1. Sublingual
   2. Oral
   3. Endotracheal
   4. Nebulizer
   5. Intranasal

B. Advanced Airway Management Procedures
   1. Endotracheal Intubation
   2. Nasotracheal Intubation
   3. EOA/EGTA
   4. Cricothyrotomy
   5. Deep Tracheal Suctioning - Adult and Neonate
   6. Removal of Foreign Object via Magill Forceps
   7. Care of Patient with Tracheostomy Tube

C. Chest Decompression

D. Insertion of Nasogastric Tube

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 1 – UNIVERSAL PRECAUTIONS / BODY SUBSTANCE ISOLATION

In the pre-hospital care setting medical history and examination cannot reliably identify all patients infected with both bloodborne and airborne pathogens. During emergent or acute care calls, there exists an increased risk of exposure to pathogens and the infection status of the patient is usually unknown, therefor:

- Blood and body fluid precautions shall be consistently followed for ***ALL*** patients.
- Respiratory precautions shall be followed for ***ALL SYMPTOMATIC*** respiratory patients.

UNIVERSAL PRECAUTIONS / BODY SUBSTANCE ISOLATION

Universal Precautions shall be followed for every patient where there is the possibility of contact with their body fluids, including blood, respiratory secretions or any other discharge, regardless of whether diagnosis is known or not. This includes but is not limited to starting IVs / IO's, Intubation, Airway adjunct insertions, suctioning, caring for trauma patients, or assisting with OB-GYN emergencies.

Body fluids include:

- Saliva
- Gastric Secretions
- Feces
- Sero-Sanguinous Fluid
- Breast Milk
- Amniotic Fluids
- Sputum
- Urine
- Cerebral Spinal Fluid (CSF)
- Semen
- Thoracic Cavity Fluids
- Any Other Drainage

PROCEDURES

- GLOVES: Non-sterile gloves shall be worn if contact with any type of body fluids may occur.

- GOWNS: Shall be worn if soiling of clothing with blood or body fluids may occur. The protection shall be impervious to blood or body fluids particularly in the chest and arm areas.

- MASK: Shall be worn if aerosolization of blood or body fluids may occur (examples of when to wear include: suctioning, insertion of Endotracheal tubes, insertion of airway adjuncts, patient who is coughing excessively and other invasive procedures). In the event that any patient displays signs and symptoms suggestive of an infection with and airborne, droplet or respiratory route of transmission or you are notified that a patient has an infection with a respiratory component, masks shall be worn by all personnel, (see also C.02).

- GOGGLES: Shall be worn when splattering of blood or body fluids may occur.

- HANDWASHING: Shall be done before and after contact with patients regardless of whether or not gloves were used.

- MOUTH-TO-MOUTH: CDC recommends that EMS personnel refrain from having direct contact with patients whenever possible, and that adjunctive aids be carried and utilized. These include pocket masks, face shields, BVM or demand valves.

- CLOTHING: If clothing does become contaminated, personnel shall shower either at the hospital or upon return to the station. If at the hospital, request to borrow a "scrub suit" until a replacement uniform is obtained. Personnel must not wear contaminated clothing home. The soiled or contaminated clothes shall be placed in a plastic bag until it is possible to wash them in hot water (160 degrees and detergent for a minimum of twenty-five (25) minutes). It is recommended that personnel keep a complete, spare change of clothing at the work place, either in the station or in their vehicle. Trinity EMS does provide a Washer and Dryer at the Lowell Westford Street and Haverhill Stewart Street Base locations that is capable of the temperatures and times necessary to address contaminated clothing. Specific instructions for use are posted at each location.

- SHOES: It is recommended that personnel leave their work shoes in the workplace and wear other footwear to and from work.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 2 – SPECIAL RESPIRATORY PRECAUTIONS

Universal precautions / Body substance isolations can provide protection from direct skin contact with respiratory secretions, but they do not afford adequate protection from all airborne pathogens. Therefore additional precautions are required for patients with respiratory symptoms.

RESPIRATORY PRECAUTIONS

Respiratory precautions shall be followed for every symptomatic patient if contact with respiratory droplets and /or oral/nasal secretions is possible, regardless of whether diagnosis is known or not. This includes but is not limited to Intubation or any type of airway and ventilation care, suctioning, administration of oral, intranasal, or inhaled/nebulized medications, chest decompression and transportation and handling procedures in confined spaces such as ambulances or chair cars/vans.

PROCEDURES

As noted, C.01 Universal Precautions / Body Substance Isolation, is designed to protect against both bloodborne and airborne pathogens, that the employee may come in direct, indirect or through inhaled contact with infectious materials. Proper use of protective equipment will include gloves, gowns, handwashing, etc. However, the following additional procedures are required when dealing with respiratory symptoms:

- MASK: Appropriate respiratory protective equipment, specifically a type N-95 respirator shall be worn during the following patient transport and handling situations:
    - patients diagnosed with tuberculosis
    - patients symptomatic of tuberculosis who display signs and symptoms suggestive of an infection with an airborne, droplet or respiratory route of transmission
    - see policy D.07 Respiratory Protective Equipment for additional information on type N-95 respirators.

- GOGGLES: Shall be worn when performing any invasive procedure requiring visualization of the airway on a symptomatic patient.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 3 – ENGINEERING CONTROLS

Engineering Controls are initiated to reduce or eliminate the employee's chances of exposure to pathogens. When properly utilized during patient contact and clean-up, they will prevent in most cases contact with body fluids or other potentially infectious materials.

The Safety/Exposure Control Committee will periodically work with management to review tasks and procedures that lend themselves to engineering controls to assure that controls are:

- Being employed correctly and effectively
- Appropriately updated as necessary
- Not currently employed but where trial and evaluation could develop beneficial engineering controls

REQUIRED CONTROL MEASURES

The following engineering control measures must be utilized throughout the company:

- Handwashing facilities (antiseptic hand cleansers) must be stocked in all ambulances, readily accessible to all employees who have the potential for exposure.

- Containers for contaminated sharps must have the following characteristics:
    - Leak Proof
    - Color-coded or labeled with a Bio-Hazard warning label
    - Puncture Resistant

- Specimen containers must have the following characteristics:
    - Leak Proof
    - Color-coded or labeled with a Bio-Hazard warning label
    - Puncture Resistant, when necessary

- Secondary Containers must have the following characteristics:
    - Leak Proof
    - Color-coded or labeled with a Bio-Hazard warning label

- Safe Needle Devices (Needle-stick Safety and Prevention Act 2000):
    - Protecta-Caths or similar style IV catheter with a self-sheathing device is now mandated for all IV starts
    - Needleless systems will be utilized when available to facilitate the administration of medications

ENGINEERING CONTROLS / RESPIRATORY PATIENTS

The following items relate to the control of airborne pathogens when transporting a tuberculosis or patient symptomatic of tuberculosis within an enclosed vehicle:

- Air Ventilation - Air exhaust fans in vehicles shall be used on a high setting so as to move a high volume of air and to exhaust potentially infectious droplets from the vehicle.

- Air Conditioners - Air conditioners must not be operated as they recirculate contaminated air. An exception would be air conditioning systems with installed HEPA or Type N-95 filtration systems and which are clearly labeled as such.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 4 – WORK PRACTICE CONTROLS

Work Practice Controls are initiated to either minimize or eliminate potential exposure to pathogens.

The following list of Work Practice Controls are currently required to be utilized in all operations of the company:

- Employees must wash their hands before and after contact with patients regardless of the use of gloves. This must be done immediately or at least as soon as possible after the removal of potentially contaminated gloves or other personal protective equipment (PPE).

- Following any contact of body surfaces with blood, respiratory droplets and/or oral/nasal secretions or any other potentially infectious materials, employees will wash their hands and any other exposed skin with soap and water, as soon as possible. They will also flush exposed mucous membranes with water.

- Contaminated needles and other contaminated sharps will be handled in accordance with the Sharps/Hypodermic Disposal Policy C.05.

- Smoking is prohibited at all times in any company vehicle, building, or garage.

- Eating, drinking or the transportation of food and drink is prohibited in the back of the ambulance. The application of cosmetics, lip balm or the handling of contact lenses, combs or other personal items is also prohibited in the work area.

- Food and drink are not to be kept in refrigerators, freezers, on counter tops or in storage areas where blood or other potentially infectious materials are present or stored.

- Mouth suctioning or pipetting of any body fluid specimens or other infectious materials is prohibited.

- All procedures involving blood, respiratory secretions or any body fluids are performed in a manner that will minimize splashing, spraying or other actions that may generate droplets of the material.

    - Specimens of blood, respiratory secretions or other materials are placed in leak-proof containers, appropriately labeled for handling and storage.

- If outside contamination of a primary specimen container occurs, that container must be placed within a second container that is leak proof. It must be appropriately labeled, for handling and storage. If the specimen can puncture the primary container, the secondary container must be puncture-resistant, as well.

- Contaminated equipment which requires servicing is examined and decontaminated as necessary, prior to servicing or shipping unless it can be demonstrated that decontamination is not feasible.

- An appropriate Bio-Hazard Warning label is attached to any contaminated equipment, identifying the contaminated portions/items.

- Information regarding the remaining contamination is conveyed to all affected employees, the equipment, manufacturer and the equipment service representative PRIOR to handling, servicing or shipping.

- New employees or employees changing positions within the company are subject to the following process to ensure that they are trained in the appropriate work practice controls:

    - The employee's job classification and the tasks and procedures that they will perform are checked against the Job Classifications and Task Lists identified in the Exposure Control Plan as those in which occupational exposure occurs.

    - If the employee is transferring from one position to another within the company, the position classifications and tasks/procedures pertaining to their previous position are also checked against these lists.

    - Based on this "cross-checking" the new position classification and/or tasks and procedures which will bring the employee into occupational exposure situations are identified.

    - The employee is then oriented to any work practice controls in which the employee lacks experience.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 5 – SHARPS / HYPODERMIC DISPOSAL

- Needles and syringes shall be disposed of in the vehicle's rigid, puncture resistant container which is properly labeled as a "CONTAMINATED SHARPS" container.

- When the container becomes two-thirds full, it must be disposed of appropriately.

    - Whenever possible, disposal should take place at the receiving hospital and a sharps container exchange made.

    - If it is not convenient to dispose of sharps at the hospital, the individual sharps container can be placed in a station Bio-Hazard container. The secondary container must then be marked as containing a sharps container.

- Contaminated needles and other contaminated sharps will not be bent, broken, recapped or removed unless:

    - It can be demonstrated that there is no feasible alternative.

    - The action is required by specific medical procedure.

    - In the situations above, the recapping or needle removal is accomplished through the use of a one-handed technique or use of a medical device (i.e. forceps or hemostat).

- Reusable sharps are prohibited.

- Potentially contaminated broken glassware will only be picked up using mechanical means (such as dust pan and brush, tongs, forceps, etc.). The broken material must then be disposed of in a sharps container.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 6 – PERSONAL PROTECTIVE EQUIPMENT

AVAILABILITY OF EQUIPMENT

The company will provide, at no cost to the employee, the personal protective equipment necessary to protect them against exposure to pathogens. This equipment will include, but is not limited to:

- Gloves
- Fluid shields / masks
- Goggles
- Respiratory protective equipment
  - Surgical masks, or as necessary
  - Type N-95 respirators approved by NIOSH for TB protection
- Ventilation devices
  - Bag-valve-mask
  - Demand valve device
  - Ventilation barrier device
- Contamination kits
  - Gowns
  - Boot coverings
  - Gloves
  - Masks

Hypo-allergenic (latex-free) gloves and supplies are available for those cases where employees or patients have latex allergies. See C-10.

Materials Management, working with management is responsible for ensuring that all vehicles and work areas have the appropriate protective equipment available to all employees.

TRAINING IN USE OF PERSONAL PROTECTIVE EQUIPMENT

All employees are trained in the use of the appropriate person protective equipment for their job classification and tasks/procedures they perform. Initial training is provided during orientation and additional training is provided when necessary, i.e. when employees change job classifications or if new tasks, procedures, or equipment is introduced.

MAINTENANCE AND USE

To ensure that all personal protective equipment is not contaminated and that it is in appropriate condition to protect employees from potential exposure, the following practices are mandated:

- All personal protective equipment is inspected periodically and repaired or replaced as needed to maintain its effectiveness.

- Re-usable personal protective equipment is cleaned, laundered and decontaminated as needed.

- Single-use personal protective equipment or equipment that cannot be decontaminated is disposed of at a receiving facility in their prescribed manner or by disposing of the PPE in the appropriate manner at the ambulance station.

- Any garments penetrated by body fluids or other infectious materials are removed immediately, or as soon as feasible.

- All potentially contaminated personal protective equipment is removed from work areas or accident/incident sites. If possible, this should be done prior to patient transport and leaving the site or as soon as feasible.

- Gloves MUST be worn in accordance with the policy on Universal Precautions (C.01) and must be replaced immediately if they are torn, punctured or otherwise lose their ability to function as an “exposure barrier” and as soon as practical whenever they become grossly contaminated.

- Utility gloves are decontaminated for re-use unless they are cracked, peeling, torn or exhibit other signs of deterioration, at which time they are disposed of in the proper manner.

- Masks and fluid shields are used whenever splashes or sprays may generate droplets of blood or other body fluids.

- Type N-95 respirators are used during the handling and transportation of patients diagnosed with or symptomatic of tuberculosis.

- Protective coverings, i.e. gowns are worn whenever gross contamination is anticipated which exceeds the protection afforded by gloves.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 7 – HOUSEKEEPING / SANITATION PROCEDURES

PROCEDURE TABLES

For detailed and specific information on the handling of individual pieces of equipment, a table of procedures has been established for cleaning, decontamination or disposal of equipment. The tables are located in Appendix - E.02 TABLE OF PROCEDURES - CLEANING/DISINFECTION and provide the following information:

- Equipment or area to be cleaned / decontaminated.

  - frequency of cleaning / decontamination procedure

  - cleaning / decontamination methods to be used.

- Any special instructions that are appropriate.

OVERALL SANITARY STANDARDS

- All equipment and surfaces will be cleaned and decontaminated after contact with blood, respiratory secretions or other potentially infectious materials:

  - immediately after or as soon as feasible, when surfaces are overtly contaminated

  - After any spill of body fluids or infectious materials

  - At the end of the work shift if there is any potential that the surface may have been contaminated during that shift.

- Unused supplies, equipment, medications need not be discarded unless they have been opened, used or contaminated with blood, body fluids, or other potentially infectious materials.

  - Extra precautions should be taken to avoid contaminating unused or clean items, if there is any doubt, consider them contaminated

  -Protective coverings on unused equipment or supplies, i.e. linens, plastic covers/wrappers foil wrappers or absorbent paper, will be grossly contaminated or by the end of the work shift if they may have been contaminated during the shift.

WASTE HANDLING

Extreme care is required in the handling of trash and regulated waste. All employees will adhere to the following minimum standards regarding trash disposal or the proper handling of medical waste:

- All trash containers, pails, bins and other receptacles will be inspected,

cleaned and decontaminated, as soon as possible, if visibly contaminated.

- Waste containers will be maintained in an upright position and routinely replaced and not allowed to over fill.

- Contaminated laundry will be handled as little as possible and will not be sorted or rinsed where it is used.

- All medical waste will be discarded or "bagged" utilizing containers that are:
  -red in color or labeled with appropriate Bio-Hazard warning label.
  -closable, sealable.
  -puncture-resistant if the discarded materials have the potential to penetrate the container.
  -leak-proof, if there is a potential for fluid spill or leakage.

- Potentially contaminated broken glassware will be handled in accordance with the Sharps/Hypodermic Disposal policy C.05.

- Whenever possible, Bio-Hazardous material should be disposed of right after it is generated by leaving it at the hospital at the same time the patient is delivered.

- Whenever employees move containers of regulated waste from one area to another the containers are immediately closed and placed inside an appropriate secondary container if leakage is possible from the first container.

HAZARDOUS WASTE REMOVAL CONTRACTOR

A service licensed to remove Bio-Hazardous waste is under contract to remove materials as requested. The waste remover is required by law to leave a manifest at the pickup site. The pick-up manifest will be matched with the second manifest which the contractor supplies after waste is delivered to the final disposal site.

This vendor contract is managed by the Vice President or his/her Designee

DOCUMENTATION / NOTIFICATION

- An "UNPROTECTED EXPOSURE FORM" must be completed and submitted to the appropriate agency.
    - This may be the receiving facility if the patient is being transported to an acute care hospital.
- If there is any question as to where the form is submitted, it should be forwarded to the DICO at Headquarters.
- An Employee Injury Packet must also be completed and forwarded to the Human Resource Director at Headquarters.
    - "*First Report of Injury*" can be completed per Workman's Compensation requirements.
- All Needlestick / Sharp Unprotected Exposures MUST be documented on the appropriate documentation/tracking form as required by the Needlestick Safety and Prevention Act of 2000

INFORMATION REGARDING SOURCE INDIVIDUAL

Unless prohibited by law or otherwise unobtainable, identification of the source individual will be made.

When identification is possible of a source individual for a bloodborne exposure, attempts will be made to have that individual's blood tested to determine HBV and HIV infectivity.

This information will also be made available to the exposed employee, if it is obtained. At that time, the employee will be made aware of any applicable laws and regulations concerning disclosure of the identity and infectious status of a source individual.

MEDICAL FOLLOW - UP OF EMPLOYEE

Employees with possible exposure to bloodborne pathogens will have their own blood tested to establish a new baseline status for HBV and HIV. This will be done through area occupational health centers, hospital emergency departments, or other contracted facilities and/or agents.

Once these procedures have been completed, a consultation is arranged for the exposed employee with a qualified health care professional to discuss the employee's medical status. This includes an evaluation of any reported illnesses, as well as any recommended treatment.

To facilitate the consultation, the following information is forwarded to the healthcare professional:

- Copies of pertinent sections of the Exposure Control Plan

- A description of the exposure incident
- The exposed employee's relevant medical history
- Other pertinent information

HEALTHCARE PROFESSIONAL WRITTEN OPINION

After consultation, the healthcare professional provides a written opinion evaluating the exposed employee's situation. This in turn, is furnished to the exposed employee.

In keeping with the emphasis on confidentiality for this process, the written opinion will contain only the following information:

- Whether Hepatitis B vaccination is indicated for the employee.
- Whether the employee has received the Hepatitis B vaccination.
- Confirmation that the employee has been informed of the results of the evaluation.
- Confirmation that the employee has been told about any medical conditions resulting from the exposure incident which require further evaluation or treatment.

Any other findings or diagnoses will remain confidential and will not be included in the written report.

NOTE: See D.05 and D.06 for Mantoux re-testing and follow-up procedures for possible exposure to tuberculosis.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 9 – HEPATITIS B VACCINATION

Despite the efforts of the company and employees in regards to exposure prevention practices, exposure incidents can occur. Therefore, a vaccination program has been implemented to protect employees as much as possible from the possibility of Hepatitis B infection.

INFORMATION AND AVAILABILITY

The program is available at no charge to all employees who may have an occupational risk of exposure to Hepatitis B.

To ensure all employees are aware of the vaccination program it is discussed during the bloodborne pathogens training session during new employee orientation and during the annual re-training sessions. Employees will receive information regarding the vaccination program regarding its safety and effectiveness.

"Vaccination Program Notices" are also posted annually in prominent places at company facility(s), a sample notice is included in Appendix Section, E.05 - Hepatitis B Vaccination Notice. The posting serves as a reminder to those employees that declined the vaccination of the program's ongoing availability.

ADMINISTRATION OF THE PROGRAM

Vaccinations are performed under the supervision of a licensed physician or other healthcare professional. The program consists of a series of three (3) inoculations over a six-month period.

Employees who have declined to take part in the program must sign a "Vaccination Declination Form" a sample of the form is included in the Appendix Section, E.06 - Hepatitis B Vaccination - Status Form / Declination Form.

The DICO in collaboration with the Human Resource Director is responsible for administrative supervision and monitoring of the vaccination program, which became effective on April 22, 1998.

CHAPTER C: EXPOSURE CONTROL PROCEDURES
SECTION 10 – HYPO-ALLERGENIC (LATEX-FREE SUPPLIES)

PURPOSE

Universal blood and body fluid precautions must be consistently used for all patients since medical history and examination cannot reliably identify all patients infected with HIV and other bloodborne pathogens. However, hypo-allergenic supplies must be available to prevent allergic reactions in both patients and employees who may have sensitivities to latex. The most common reaction is to gloves worn by employees, but there has been an effort to identify all products that contain latex and how they are used in the pre-hospital setting. As a result, a latex-free kit has been developed and placed in all vehicles.

IDENTIFIED ITEMS CONTAINING LATEX

- Gloves
- Tourniquets (Penrose tubing)
- Nasopharyngeal Airways
- Bulb Syringes
- Band-aids
- Y-Ports of IV Tubing
- Stethoscope Tubing
- B-V-Ms and masks (some brands)
- Elastic bands on oxygen delivery masks and respiratory protective equipment (some brands); most manufacturers are now covering with non-latex material)

LATEX FREE GLOVES

Employees who are subject to latex reactions will be provided with a supply of latex free gloves. These can be obtained through Material Management.

LATEX FREE KIT

A labeled kit containing latex free supplies is to be kept on board each vehicle and utilized whenever a latex sensitive patient has been identified. The contents include:

- Non-Latex examination gloves - 2 pairs each of small, medium, and large
- Latex Free Tourniquet
- Latex Free Bag-Valve-Mask
- Towels from the vehicle linen stock must also be available

PROCEDURES

When a latex sensitive patient has been identified, the crew on scene shall retrieve the LATEX FREE KIT from the vehicle and take the following steps to ensure the safety of the patient:

GLOVES	Assure that latex free gloves are worn by all pre-hospital care providers who may come in contact with the patient.
TOURNIQUETS	Advanced Life Support providers will use only latex free tourniquets while

	establishing IVs (or use a latex free glove as a tourniquet).
AIRWAY	Should the patient need airway support; - DO NOT use Nasopharyngeal Airways, Oral airways can be used.
STETHOSCOPES	Cover/wrap stethoscope tubing with face cloth or do not use, if necessary, perform blood pressures by palpation.
BLOOD PRESSURES	When taking B/P, assure that the bladder and tubing do not come in contact with the patient as they contain latex. If necessary, place a towel or face cloth between the B/P apparatus and the patient's arm.
BULB SYRINGES	Do not utilize bulb syringes that contain latex, utilize instead a rigid, non-latex flexible suction catheter, adjust suction vacuum to an appropriate level.
BAND-AIDS	Do not use, instead utilize sterile dressing with plastic tape or nylon hypoallergenic tape.
IV Y-PORTS	Must be covered with tape and not used, utilize a stopcock to inject meds, flush IV tubing before use.
B-V-M	Use only the latex free BVM that is supplied in the kit
MATTRESS / SEAT COVERING	Wrap patient in sheet-"Papoose Style" to prevent casual contact

NOTIFICATION / DOCUMENTATION

- The receiving facility must be notified of the impending arrival of a patient who is sensitive to latex so that the appropriate supplies are on hand. Notification should be made prior to arrival by contacting the facility via radio or landline.

- Upon arrival at the receiving facility, it is the responsibility of the pre-hospital care providers to re-confirm the notification by informing the nursing and physician staff that the patient has a sensitivity to latex and what precautions have been taken in the pre-hospital setting during patient care.

- All patient documentation must make note of the sensitivity to latex and what precautions were taken during patient care.

RE-STOCKING

The re-stocking of the LATEX FREE KIT on the vehicle must be a completed as soon as possible. Notify Material Management that additional supplies are needed through your supervisor.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 1 – TRANSPORT OF SUSPECTED OR KNOWN TB PATIENTS

Personnel transporting or otherwise involved with the care and handling of suspected or known TB patients must adhere to the exposure control procedures mandated for respiratory precautions specific to TB patients. Each procedure of the TB protection program is explained in detail in this section of the Policy and Procedures manual but can be summarized as follows:

- Personnel are required to wear appropriate respiratory protective equipment while caring for or transporting the patient or at any time they are in confined quarters with the patient (rear of the ambulance, entering the patient's room etc.)

- Appropriate respiratory protective equipment would be a type N-95 respirator approved by NIOSH for TB protection.

- Respirators must be donned prior to patient contact whenever a healthcare facility or information is provided by the patient or patient's family confirms the patient is infectious.

- In unknown situations, personnel must take immediate precautions whenever circumstances indicate that a TB potential exists. These circumstances are explained I detail in the next policy D.02 and can be summarized as follows:

    - Patient is from a population known to have a high prevalence of TB

    - Patient has another medical condition that puts them at greater risk of having clinical tuberculosis.

    - Patient is exhibiting various symptoms associated with TB infection

- While in the vehicle, the rear compartment exhaust fan must be turned on. However, environmental control systems which recirculate compartment air (i.e. air conditioner) must be turned off so the system will not be contaminated.

- Exposed interior surfaces must be cleaned/disinfected and contaminated items appropriately disposed of in accordance with the housekeeping and sanitation guidelines previously outlined.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 2 – EVALUATING POTENTIAL OF TB

Rapid identification of patients with suspected TB must be undertaken to prevent unprotected exposure. The CDC provides guidelines regarding high prevalence populations, medical conditions with increased risk and identifiable symptoms.

POPULATIONS WITH HIGH PREVALENCE OF TB

- Persons with HIV infection and those at high risk of HIV infection
- Persons who have resided with or had close contact with tuberculosis patients
- Persons with medical conditions which increase the risk of tuberculosis if exposure has occurred (see medical conditions listed below).
- Foreign-born persons from high prevalence countries (Asia, Africa, Central America, South America).
- Medically under-served, low-income populations including high risk racial or ethnic minority populations.
- Alcoholics and intravenous drug users.
- Homeless persons.
- Residents of long-term care facilities, correctional facilities, and mental health institutions.
- Populations identified locally as being at increased risk for tuberculosis because of repeat contact with infected persons, e.g. health care workers, prison guard, persons working in homeless shelters, or drug treatment centers.

HIGH RISK MEDICAL CONDITIONS

Individuals with the following medical conditions have a higher risk of developing clinical tuberculosis once tuberculosis exposure and infection has occurred.

- Abnormal chest radiograph showing fibrotic lesions which may represent old, healed TB.
- Weight of 10% or more below ideal body weight.
- Chronic Malabsorption syndromes
- Conditions requiring prolonged high-dose corticosteroid therapy or other immunosuppressive therapy.
- Hematologic disorders, especially leukemia and Hodgkin's diseases.
- Other malignancies, especially carcinomas of the oropharynx and upper GI tract
- HIV Infection
- Silicosis
- Gastrectomy
- Jejunoileal bypass
- End-stage renal disease
- Diabetes mellitus

IDENTIFIABLE SYMPTOMS OF TUBERCULOSIS

- Persistent cough
- Productive cough (i.e. mucus, blood)
- Experience of chest pain when coughing

- Weight Loss
- Anorexia (loss of appetite)
- General lethargy, weakness
- Fever
- Night Sweats

NOTE: Tuberculosis may be difficult to diagnose among persons with HIV infection because of a similar clinical or radiological presentation and/or the simultaneous occurrence of other pulmonary infections.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 3 – TB TESTING / SCREENING

TESTING METHOD

The screening method for tuberculosis is accomplished using Purified Protein Derivative (PPD) via the Mantoux method. All personnel with previously non-significant PPD reactions are eligible for skin testing.

TESTING REQUIREMENTS

- To be in compliance with the Federal mandates of OSHA, periodic skin testing is required of all personnel whose jobs have been classified as being at risk for occupational exposure to airborne pathogens. This would include all personnel engaged in medical transportation and treatment and therefore having patient contact.

- See Exposure Determination, Section B of this plan for complete job classification lists and work activities involving airborne pathogens.

FREQUENCY OF TESTING

- ANNUAL TESTING - BLS PERSONNEL

    - At a minimum, all employees, whose job classification involves patient contact will be screened for TB infection every twelve (12) months.

- ANNUAL TESTING – ALS PERSONNEL

    - Employees who additionally perform certain Advanced Life Support airway procedures will be screened for TB infection every twelve (12) months.

        - The specific medical procedures would include Endotracheal Intubation, insertion of EOA/EGTA, deep tracheal suctioning, administration of aerosolized medications.
        - Employees included in this category are EMT-Paramedics and Intermediates.

CONTRAINDICATIONS FOR SKIN TESTING

- Exclusions - the only allowable exclusions from skin testing are individuals with prior documented:

    - Significant reaction to PPD (Mantoux) testing
    - Adequate treatment for TB disease
    - Completion of adequate preventive therapy

- Those excluded from skin testing due to a prior positive PPD or past disease must be evaluated for active disease similar to employees with a newly discovered significant reaction. (See D.05).

- NOTES:

    - People with a history of BCG vaccination should undergo PPD (Mantoux) testing. Prior BCG vaccination is not a contraindication for PPD testing unless history of a previously positive reaction is reported.

    - Pregnancy is not a contraindication for PPD testing unless history of a previously positive reaction is reported.

TESTING METHODOLOGY

Application of the PPD (Mantoux), including administration, reading and interpretation, is in accordance with the recommendations of the American Thoracic Society and the Centers for Disease Control.

- Administration:

    - Skin tests will be administered by Occupational Health Consultants contracted by the company. The Mantoux method will involve the intradermal administration of 0.1 ml of stabilized PPD containing 5 TU into the volar surface of the forearm.

- Interpretation:

    a. Test reading and interpretation will be conducted by contracted Occupational Health Consultants.
    b. Test must be interpreted at 48-72 hours after administration.
    c. The presence and measurement of induration is used as the basis for reading a test as positive.
    d. The amount of induration measured in millimeters at the time of reading is recorded.
    e. Any Mantoux skin test that appears to have a reaction of 5 millimeters or more if induration or which the test reader finds unusual in any way will be immediately referred to the Occupational Health Consultant for interpretation.

- Recording Results:

    - Skin testing must be documented in the employees' medical record, including the date tested, testing material used, size of the reaction to the test in millimeters, and interpretation. Information of newly positive PPDs or a case of nosocomial tuberculosis following initial employment must also be recorded on the OSHA 200 log.

- It is the responsibility of the employee to have the test read/interpreted within the prescribed time limits. Failure to have the test read will require additional Testing.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 4 – PRE-EMPLOYMENT / TWO STEP TB TESTING

REQUIREMENT

After the offer of employment is tendered, potential employees are subject to a two-step baseline screening test for tuberculosis infection by an Occupational Health Consultant or their private physician.

- Test results must be read and interpreted as a final condition of employment

- Potential employees testing positive must seek medical follow-up and evaluation from their own private physician. To be employed, these individuals must provide documentation, which is subject to review by the company, certifying that they are not infectious.

PURPOSE OF TWO-STEP TESTING METHOD

The two-step method is to reduce the likelihood that a "boosted reaction" is misinterpreted as a new infection. For example, if tested with PPD, adults who were successfully treated for a childhood infection may have a negative reaction. However, the PPD test could boost the hypersensitivity, and the size of the reaction could be significant on a subsequent test. This boosted reaction may be misinterpreted as a PPD conversion from a newly acquired infection. This may result in unnecessary prescription of preventative therapy and source investigation.

- The CDC recommends two-step testing on all newly employed healthcare workers who:
    - have an initial negative PPD result at the time of employment; and
    - who have not had a documented negative PPD during the preceding twelve (12) months.

- The second test should be performed one to three (1-3) weeks after the first test:
    - if the second test result is positive, this is most likely a boosted reaction and the person should be classified as previously infected;
    - if the second test remains negative, the person is classified as uninfected and positive reactions to any subsequent testing represents a new TB infection.

- All potential employees must have a pre-employment PPD administered and read as negative, immediately before beginning new employee orientation.
    - Those individuals who cannot document another negative PPD within the preceding twelve (12) months, must have a second PPD within one to three (1-3) weeks of beginning employment.
    - Those individuals who can provide documentation of another negative PPD within the preceding twelve (12) months have completed baseline testing. The pre-employment PPD will count as the second part of the baseline testing.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 5 – MANAGEMENT OF EMPLOYEES WHO TEST POSITIVE

FOLLOW-UP EVALUATION

- Employees with a skin test reaction of 5mm induration or greater will be referred to the Occupational Health Consultant for further evaluation which may include:

    - Referral for chest X-Ray
    - Complete medical history and physical examination to determine if any symptoms suggestive of active TB are present.

- An employee may elect to follow-up with a private attending physician:

    - The employee is responsible to notify the Occupational Health Consultant of the date of their initial appointment and further follow-up appointments.
    - Employees are also responsible for providing the Occupational Health Consultant with appropriate documentation attesting to the further evaluation and follow-up care.
    - If satisfactory follow-up care is not occurring, the employee may be required to establish a follow-up program with the company's Occupational Health Consultant.

RETURN TO DUTY

- An employee who tested positive must provide medical documentation that they are not contagious, i.e. latent state, post treatment, etc.
- The employee cannot return to duty until such documentation has been received by the company.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 6 – TB POST EXPOSURE RE-TESTING & EVALUATION

DOCUMENTATION / NOTIFICATION

- An "Unprotected Exposure Form" must be completed and submitted to the appropriate agency.
    - This may be the receiving facility if the patient is being transported to an acute care hospital.
    - If there is any question as to where the form is submitted, it should be forwarded to the DICO at headquarters.
- An Incident Report must also be completed and forwarded to the Operations Manager/DICO. The Operations Manager/DICO should also be notified by telephone as soon as possible so that a "First Report of Injury" can be completed per Workman's Compensation requirements.

EVALUATION

The employee must seek medical consultation / care, preferably at one of the company's contracted Occupational Health Service locations. An employee may also elect to follow-up with a private attending physician.

- Additional PPD skin testing will be required for employees who are exposed to infectious TB patients for whom adequate infection control procedures have not been taken.
    - Unless a negative skin test has been documented within the preceding three (3) months the exposed employee (except those already known to be positive reactors) will receive a PPD as soon as possible.
    - If the PPD is negative, the test will be repeated 12 weeks after the date of last exposure.
- Employees with a skin test reaction of 5mm induration or greater, or with symptoms suggestive of active TB, will be subject to further evaluation and possible therapy.
- If preventative therapy is required, I will be provided along with additional counseling about the drug and its side effects.
- Persons with previously known positive skin test reactions who have been exposed to an infectious patient will be evaluated for active TB:
    - They do not require a repeat skin test or chest X-Ray examination, unless they have symptoms suggestive of active TB.
    - If a chest X-Ray is obtained and is abnormal, the employee will be subject to further evaluation and possible therapy as noted previously.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 7 – RESPIRATORY PROTECTIVE EQUIPMENT

DEFINITIONS

Type - N-95 respirators refer to those with a filtration system that is 95% efficient in its rate of filtering particulate matter. NIOSH has determined that a 95% filtration rate is effective in filtering out Mycobacterium tuberculosis.

National Institute of Occupational Safety and Health, (NIOSH) is the federal agency whose responsibilities include the testing and approval of respiratory protection equipment

SELECTION OF TYPE N-95 RESPIRATORS

The N-95 respirators selected for use by the company have been determined to meet the following criteria:

- Manufacturers have provided evidence of the devices' effectiveness. U.S. government testing – (NIOSH serial numbers and designation as HEPA type respirators)
- Selection of the devices provides for the range of sizes to assure fit to the maximum number of employees as per OSHA standards.
- Size and shape of the devices provide for ease of use and for sanitary packaging and storage as per OSHA standards.
- The devices have a clinical appearance that makes them more appropriate for use in patient care.

RESTRICTIONS FOR USE

Type N-95 respirators are for use by EMS personnel or healthcare workers only, they are not to be worn by the patient.

- The ultra-fine mesh of the filter elements in these respirators reduce air flow and may cause further breathing difficulty for a patient with respiratory symptoms.
- Because of the restricted air flow through N-95 masks, employees are subject to a medical evaluation before using the device.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 8 – MEDICAL EVALUATION FOR USE OF RESPIRATORS

REQUIREMENTS

All personnel whose duties may require the use of respiratory protective equipment are subject to medical evaluation.

- The evaluation is to determine if the employee is physically able to perform the duties associated with their job while wearing type N-95 respirators.
- A medical determination will be completed as part of the hiring and orientation process.
- The medical status of all respirator users is subject to annual review.
    - The evaluation is the responsibility of the company, should there be a question whether the employee is suitable to use a respirator, a physician will determine what health and physical conditions are pertinent. This physician will be assisted by the DICO.
    - All records will be considered as confidential employee medical records (see A.10)

EVALUATION PROCESS

The evaluation process will include the following steps at a minimum:

- Questionnaire:
    - Employees will complete a medical questionnaire to initially screen for any health or physical conditions that may be effected by wearing a respirator.
- Review:
    - Questionnaires will be reviewed by the physician and employees with pertinent health or physical conditions will be scheduled for interview and/or physical examination by the physician or his designee.
- Physical Exam:
    - A physical examination by the physician or his designee may determine that the use of respiratory protective equipment will adversely effect the health of an employee or reduce their ability to perform job functions.
        - If such a determination is made, the physician would next subject the employee to a pulmonary function test administered by the company.
        - If pulmonary function testing results still indicate an inability to perform duties while wearing respiratory protective equipment, the employee

would be counseled regarding reassignment to an available position not requiring the use of such equipment.

- Employees may also seek further medical evaluation and testing at their own expense from clinical specialists or their personal physician familiar with their medical history. Further evaluations that seek to establish the employee's ability to function with respiratory protective equipment are subject to final review and approval by the company and their physician.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 9 – RESPIRATOR TRAINING & FIT TESTING

REQUIREMENTS

- All employees whose duties may require the use of type N-95 respirators are subject to annual training and fit testing of the device.
- The purpose of annual re-training is to ensure current knowledge regarding airborne pathogens and the use of the Type N-95 respirators.
- Initial fit testing is a minimum requirement, additional fit testing sessions are required whenever an employee experiences the following:
    - Weight gain or loss of fifteen (15) pounds or more;
    - Any type of facial disfigurement or scarring has occurred on or about the area where the mask seal takes place;
    - Employees had facial or dental surgery which may have altered the facial structure.

METHODOLOGY

Each employee will be fitted with a mask in accordance with the procedures established by the manufacturer.

- Employees will be sized with the appropriately sized respirator
- Conductor of test will utilize a fit test record and note conditions which may affect respirator fit
- Employee will sign the record to acknowledge respirator user instructions and limitations.
- A qualitative fit test will then be conducted utilizing a Bitrex taste challenge.
- Employees will complete test exercises in accordance with test kit manufacturer instructions
- Employee will again sign the record to acknowledge fit test results.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 10 – RESPIRATOR MAINTENANCE & STORAGE

Type N-95 respirators are considered “semi-disposable” and can be re-used, but only by the same person.

- Re-use of the N-95 respirator by the same person is possible provided that:
    - The device has not become wet or soiled;
    - The device maintains its shape and has not been crushed or torn;
    - The latex/vinyl face seal area is wiped clean with alcohol or other skin safe antiseptic;
    - If necessary, the device is then allowed to dry.
        - To allow ventilation while preventing contamination by dust o other material, the drying should take place inside a paper bag;
    - The device is then stored inside a plastic zip-lock bag for further use by the same individual only.
- Used devices cannot be stored with un-used masks - they must be kept separate for use by the same employee.
- Devices must be kept stored in their kits on board the vehicle until needed - sealed inside plastic zip-lock bags.
- Each vehicle must maintain a total inventory of nine (9) devices: three (3) each of small, medium, and large.
- Devices must be disposed of as soon as breathing becomes difficult due to clogging by retained particles in the filter element of the respirator, or if odor or irritation is detected.

CHAPTER D: TUBERCULOSIS PROGRAM
SECTION 11 – PROHIBITIONS ON BEARDS / FACIAL HAIR

FEDERAL REGULATORY REQUIREMENTS

The Occupational Safety and Health Administration (OSHA) mandates the use of respiratory protection equipment for health care workers who may be at risk of exposure to airborne pathogens. The standard in regards to protection against tuberculosis requires a respiratory protection program, that includes fit testing of employees for Type N-95 respirators at a minimum, in accordance with 29 CFR 1910.134.

EFFECTIVENESS OF FACE SEAL

The OSHA standard addresses the fact that face seal leakage compromises the ability of a respirator to protect the healthcare worker:

> *"A proper seal between the respirator's sealing surface and the face of the person wearing the respirator is essential for effective and reliable performance of any negative pressure respirator.*

The OSHA standard further specifies that regulatory standards are not being met and that respirators shall not be worn when conditions prevent a good face seal. Conditions are listed as:

> *"a growth of beard, sideburns, a skull cap that projects under the face piece or temple pieces on glasses."*

COMPANY STANDARD

See also Company Policy - *Dress Code: Personal Appearance and Uniform*

To be in compliance with federal regulations, the company standards will require the following:

- Respirators are not considered effective and will not be worn if facial hair comes between the sealing surface of the face piece and the employee's face.
- The employees who cannot pass a respirator fit test are not eligible for field assignments.
- Employees who are ineligible for fit testing due to facial hair are expected to shave as necessary to become eligible for fit testing and proper wearing of respiratory protective equipment.

CHAPTER E: APPENDIX
SECTION 1 – MEDICAL WASTE DISPOSAL CHART

ITEM	DESCRIPTION	RED Bi0-BAG	REGULAR TRASH BAG	SEWER	SHARPS
Blood or Body Fluids	Any item saturated with liquid blood or bloody fluid; or caked with dried blood.	x			
	Blood or bloody fluid collected in a container that can be emptied.			x	
	Blood or bloody fluid collected in a container that **cannot** be emptied (such as suction containers and chest tube drainage setup)	x			
Containers	Containers that **have been** emptied (such as Foley bags)		x		
	Suction containers and tubings	x			
Diapers/Chux Peripads	Disposable diapers, chaux pads, peripads (unless dripping wet with blood)		x		
Dressings	Dressings, chaux pads, and other absorbent items **saturated** with blood or bloody fluid, or caked with dried blood.	x			
	Dressings, chaux pads, and other absorbent items **soiled** but not saturated or caked with blood or bloody fluid		x		
	Dressings, chaux pads, and other absorbent with non-bloody fluids (such as feces, urine, saline, water).		x		
Feces	Feces			x	
Foley Bags	Emptied foley bags		x		
Glass	Glass items contaminated with body substances (such as blood vials, pipettes)				x
Human Tissue	Human Tissue-incidental residual only. If recognizable as human remains, handle as pathological waste.	x			
IV's	I.V. catheter--short, peripheral		x		
	I.V. catheter--long, central (visibly bloody)	x			
	I.V. catheter--long, central (not visibly bloody)		x		

	I.V. tubing and bags used in blood or blood products delivery	**X**			
	I.V. tubing (visibly bloody)	**X**			
	I.V. tubing (**not** visibly bloody)		**X**		
	I.V. solutions (unused remainder ***except*** Chemotherapy IV's)			**X**	
	I.V. bags (empty or drained)		**X**		
Microbiology	Microbiology cultures	**X**			**X if glass or sharp edge**
Needles, Sharps, and Syringes	Needles; other sharps				**X**
Trash	Trash at bedside (from **any** patient; even those in isolation)		**X**		
Ventilator	Ventilator tubing condensate			**X**	
	Ventilator circuit tubing		**X**		

CHAPTER E: APPENDIX
SECTION 2 – EXPOSURE INCIDENT INVESTIGATION

Date of Incident	**Type of Incident**	**Date of Investigation**
Location of Incident		
POTENTIALLY INFECTIOUS MATERIAL INVOLVED (Blood, Urine, Saliva, Etc.)		
TYPE / BRAND:	**SOURCE (bandages, spill, patient, etc.):**	
CIRCUMSTANCES (Work being performed, etc.)		
CAUSE OF INCIDENT (accident, equipment malfunction, etc.)		
PERSONAL PROTECTIVE EQUIPMENT UTILIZED		
ACTIONS TAKEN (decontamination, clean-up, reporting, etc.)		
RECOMMENDATIONS FOR AVOIDING REPETITION		
INVESTIGATOR (print)	(sign)	

CHAPTER E: APPENDIX
SECTION 3 – POST EXPOSURE EVALUATION & FOLLOW-UP CHECKLIST

The steps indicated must be completed and documentation forwarded appropriately following any incident involving an employee's unprotected exposure.

	ACTIVITY	DATE
1.	UNPROTECTED EXPOSURE FORM TO BE FILLED OUT AND FORWARDED APPROPRIATELY	
2.	REQUIRED DOCUMENTATION RECEIVED COPY OF UNPROTECTED EXPOSURE FORM & INCIDENT REPORT	
3.	EMPLOYEE SENT FOR EVALUATION BY HEALTHCARE PROFESSIONAL FACILITY: PHYSICIAN EVALUATION RESULTS/TREATMENT PLAN	
4.	FOLLOW-UP IF INDICATED PHYSICIAN REQUIRED FOLLOW UP:	
5.	DOCUMENTATION FORWARDED TO HEALTHCARE PROFESSIONAL ☐ Exposure Control Standard ☐ Description of Exposed Employee's Duties ☐ Description of Exposure Incident Including Routes of Exposure ☐ Results of Source Individual's Blood Test (if Available) ☐ Information Regarding Source Individual's TB Status ☐ Exposed Employee's Medical Records ☐ Other:	
6.	Written Opinion Received FROM HEALTHCARE PROFESSIONAL (WITHIN 15 DAYS)	

CHAPTER E: APPENDIX
SECTION 4 – HEPATITIS B VACCINATION NOTICE

TO: **ALL STAFF WHO MAY COME IN CONTACT WITH BLOOD, BLOOD PRODUCTS, OR BLOODY WASTE WHILE PERFORMING THEIR JOB FUNCTIONS**

SUBJECT: **HEPATITIS VACCINATION AVAILABILITY**

As required under 1910-1030 any employee who may come in contact with blood, blood products, or bloody waste during the performance of their job functions are provided at no cost to the employee the Hepatitis B Vaccination Series. We covered this information during our 2011 Mandatory Training Sessions and we have included this information in our New Hire Orientation Process to ensure all new staff are educated on their risks and risk reduction practices. It will also be reiterated during our Annual Required Knowledge Programs.

Trinity EMS, Inc. has gone an extra step in that we are offering to all our new staff and any staff that have not had the Hepatitis B vaccine the TwinRix® Product which is a combination Hepatitis A & Hepatitis B vaccination. This is at no cost to the employee.

For employees who have had the Hepatitis B Vaccination and would like the Hepatitis A Vaccination, we will provide that at no cost to the employee.

For any employee who chooses to not have the Hepatitis B vaccination, they must sign a declination form which will be maintained in their Employee file in Human Resources. If at any point during their employment with Trinity EMS, Inc. the employee may change his/her mind and we will provide this to him/her at no cost.

The addition of the Hepatitis A vaccination is not a requirement. Trinity EMS has elected to offer this to our employees as an added health & safety benefit.

Please contact the DICO or the HR Manager for more information and instructions on how to obtain either of these vaccinations at no cost.

HEPATITIS B VACCINATION PROGRAM

EMPLOYEE NAME (PRINT)	EMPLOYEE NO.

√ and fill in ONE of the 4 boxes below indicating your HBV vaccination status:

☐ 1 COMPLETED VACCINATION PROGRAM

I have completed the full HBV Vaccination series. The dates of the injections are as follows:

HBV #1 _____ Booster if administered _____
HBV #2 _____ Titre if completed _____
HBV #3 _____

If exact dates unknown, give approximate or at least the date series completed.)

_____ _____
Signature of Employee Date

☐ 2 VACCINATIONS IN PROCESS

I am in the process of receiving my vaccinations. The following injections have been completed / scheduled:

HBV #1 _____ Facility where program
HBV #2 _____ is underway _____
HBV #3 _____

If exact dates unknown, give approximate.)

_____ _____
Signature of Employee Date

☐ 3 REQUEST VACCINATION PROGRAM

I have not completed a vaccination program for HBV and I request the vaccination program at this time. I have been instructed that I may begin the program at the following facility on the date indicated:

_____ _____
Facility where HBV series will be administered Date series

_____ _____
Signature of Employee Date

☐ 4 *DECLINE* VACCINATION PROGRAM

I understand that due to my occupation, which involves exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to receive the Hepatitis B Vaccination program 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 for Hepatitis, I can receive the Hepatitis B Vaccination program at no charge to myself.

_____	_____
Signature of Employee	Date
_____	_____
Signature of Company Representative	Date CAS-OSHA Comp.

FIT TEST RECORD • RESPIRATORY PROTECTIVE EQUIPMENT

EMPLOYEE TESTED	
Name	Emp. No.
Job Title	

CONDITIONS WHICH MAY AFFECT RESPIRATOR FIT **(Completed by Fit Tester √)**

☐ clean shaven	☐ 1-2 day growth	☐ 2+ day growth
☐ permanent beard moustache beyond corners of the mouth	☐ dentures absent ☐ facial scar	☐ glasses ☐ other:

COMMENTS:

FIT TEST PROCEDURE

Fit test was conducted in fulfillment of OSHA Fit Testing requirement of employees wearing Half Mask Respirators (29 CFR 1910.134 (e) (5) and in accordance with American National Standard Institute Practices for Respiratory Protection, ANSI Z88.2 - 1992.

RESPIRATORY BRAND: _____

FIT TEST TYPE: Qualitative **TEST AGENT:** Bitrix

√ TEST RESULTS:

☐ PASS	☐ FAIL	
SIZE REQUIRED:	☐ X-SMALL	☐ SMALL
	☐ MEDIUM	☐ LARGE
	☐ X-LARGE	☐ UNI-SIZE

EMPLOYEE ACKNOWLEDGEMENT OF INSTRUCTIONS, LIMITATIONS AND TEST RESULTS

"I have read and understood the USER INSTRUCTIONS of the respiratory protective equipment and will follow said user instructions every time I use the respirator. I acknowledge that this device will not provide adequate protection when used under conditions other than specified or when USER INSTRUCTIONS are not followed."

CONDUCTOR OF TEST	
Print Name	Title
Signature	Date

CHAPTER E: APPENDIX
SECTION 7 – MEDICAL EVALUATION FORM – RESPIRATORY PROTECTION

MEDICAL EVALUATION • RESPIRATORY PROTECTIVE EQUIPMENT

Name			Emp. No.	
Job Title		Age	Weight	Height

Do you have or have you ever had any of the following conditions or symptoms?	√ YES	√ NO	If answering YES to any questions, list date of last occurrence, treatments, medications, current status.
a. Asthma			
b. Congestive Heart Failure			
c. Deviated Septum			
d. Emphysema			
e. Perforated Ear Drum			
f. Persistent Cough			
g. Pneumonia			
h. Pneumothorax			
I. Pulmonary Hypertension			
j. Respiratory Allergies			
k. Surgery involving the Respiratory System			
l. Tuberculosis			

Have you resided with or had close contact with anyone in the past year who was diagnosed as having Tuberculosis? □ NO □ YES

Do you work for any other health care facility or service that provides medical care? □ NO □ YES

Have you been tested for Tuberculosis within the past year □ NO □ YES

Have you suffered from claustrophobia or would you otherwise experience difficulty wearing a mask that may feel confining? □ NO □ YES

Employee Signature — Date Form Completed

Medical Director Signature - (if interview required) — Date

TUBERCULOSIS SCREENING PROGRAM

EMPLOYEE NAME (PRINT) _____ EMPLOYEE NUMBER _____

The above named employee was administered a Mantoux Test to screen for Tuberculosis.

The test was administered as follows:

Date: _____ Time: _____

Testing Facility: _____

Administered By: _____

Lot / Expiration Date: _____

Injection Site: _____ left arm

_____ right arm

_____ alternate site _____

This test must be interpreted within 48 - 72 hours after implantation!

The test results are as follows:

_____ Negative: _____ mm _____ Positive: _____ mm

Authorized Signature & Credential :_____

Date:_____

CHAPTER E: APPENDIX
SECTION 9 – ACKNOWLEDGEMENT OF TRAINING FORM

ACKNOWLEDGEMENT OF MANDATED TRAINING

Employee Name	Employee Number

I acknowledge that I have been informed and trained with regards to hazards associated with my employment. Special attention was paid to the Hazard Communication Standard (OSHA's 29 CFR 1910.1200), the Bloodborne Pathogen Standard (29 CFR 1910.1030) and the CDC Guidelines on the prevention of transmission of airborne pathogens. Training included detailed information, questions and answers about the environment in which my job is performed.

SPECIFIC TRAINING TOPICS AT THIS SESSION INCLUDED THOSE CHECKED BELOW:

☐ 1. HAZARDOUS COMMUNICATION STANDARD
- Standard Overview
- Company HAZ-COM Program
  - hazardous chemical inventory
  - Material Safety Data Sheets (MSDS)
  - Access to MSDS
  - Program updating, how & who
  - labeling
- Chemical & physical safety

☐ 2. AIRBORNE PATHOGEN STANDARD
- Definitions & Transmission of airborne pathogens
- Precautions & Personal Protective Equipment
- Cleaning, decontamination & waste disposal
- Transport of suspected TB patients
- Post exposure management

☐ 3. BLOODBORNE PATHOGEN STANDARD
- Definitions & transmission of bloodborne Standard
- Precautions & Personal Protective Equipment
  - Cleaning, Decontamination & Waste Disposal
- Transport of suspected TB patients
- Post exposure management
- HBV vaccination program
- Care & cleaning of uniforms
- Access to replacements/soiled uniforms

☐ 4. LEGAL MANDATES & RECORD KEEPING
- Designated Infection Control Officer (DICO)
- Ryan White Act
- Reportable diseases, viruses, syndromes
- Required reporting forms
- Mantoux test (TB screening) requirements

☐ 5. EMPLOYEE QUESTIONS AND ANSWERS

I understand that the information presented during this training was to ensure my general knowledge about the possible exposures present in my work place and associated with my job. I was given ample opportunity to ask questions about procedures and equipment in the work area. I also understand that if any questions arise in the future, I am encouraged to ask any training representative, supervisor or member of management.

Employee Signature	Date of Training

PRINT Trainer Name	
Trainer Signature	Date of Training

CHAPTER E: APPENDIX
SECTION 10 – UNPROTECTED EXPOSURE FLOW CHART