




Brighton Ambulance

EXPOSURE CONTROL PLAN

	THE AGENCY, INC.	Original	8/1/2005
	EXPOSURE CONTROL PLAN	Revised	3/15/2019

PURPOSE

The purpose of the Exposure Control Plan (ECP) is to reduce the risk of hazardous exposures at the agencies (the agencies) to potential infection disease(s) and to define appropriate exposure control procedures, preventative measures, and medical treatment follow up as needed, as within OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens" .

CONTEXT

The ECP is part of the overall Health and Safety Program that begins at the point of pre-employment health screenings, and is both maintained and ongoing throughout the agency's health and safety programs. ECP parameters apply to all the agencies field providers, office staff, and adjunct the agencies personnel associated with the agencies operations.

DEFINITIONS

AIDS	Acquired Autoimmune Deficiency Syndrome	BCG	bacillus/calmette/guerin: TB vaccine rendered anti virulent
ALS	Advanced Life Support	BLS	Basic Life Support
BSI	"Body Substance Isolation"		
CDC	Center for Disease Control	Crew	Emergency medical technicians commonly assigned to an ambulance.
DOH	Department of Health	ECP	Exposure Control Plan
EMS	Emergency Medical Services	EMT	Emergency Medical Technician
HCP	Hazard Control Plan	HEPA	High efficiency particulate air filter
HIV	Human Immunodeficiency Virus	IAW	"In accordance with"
IMA	"Independent Medical Authority"	PCR	Prehospital Care Report
PPD	Purified Protein Derivatives (TB testing material)	PPE	Personal Protective Equipment
OSHA	Occupational Health and Safety Administration	QA	Quality Assurance
SARS	Severe Acute Respiratory Syndrome	SOP/SOG	Standard Operating Procedure/Guideline
TB	Tuberculosis	Td	Tetanus



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Section 1	Pre - Employee Health Screening
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All staff must have a complete physical examination prior to the start of his/her relationship with the agencies. This examination will be conducted after a member has been interviewed and approved for hire.

Exams will be conducted by an independent contracted medical agency, and must include at least:

- A review of medical history
- Head to Toe physical exam
- General statement of employees capability to work
- Urine Glucose
- General drug screening
- Immunization Status
- Lifting assessment
- PPD placement/testing

After the completion of all required testing the contracted medical agency will provide the agencies with verification of completion, and all complete medical records. Should any concerns be raised, or infractions noted, the Health & Safety Officer (HSO) and agency medical director (or approved designee) will discuss if the candidate is capable of performing the membership roles without modification or assistance.

All information will remain confidential under the guidelines of the ECP, and will be only disclosed to the HSO and the agency's Human Resources Department. All medical documents will be secured within a locked cabinet located at the agency's base (1551 S. Winton Road Rochester NY, 14618).

Ongoing records will be retained in accordance with DOH Part 800.21K.

Section 2	Retroactive Health Services
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Every member of the agencies regardless of membership/employment status employed prior to the implementation of this policy, shall complete a health screening as outlined in **Section 1 : Pre-Employee Health Screening.**


Section 3	Ongoing Health Record Maintenance
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Membership health records will be maintained and stored by the agency's human resources department and HSO.

Filed information will include but not limited to:

- General Health Screening
- Immunization Record
- Infectious Disease/Injury Reports (all exposure records/log)
- Results of all/any the agencies required lab work, physical exams, or diagnostic procedures
- Any additional medical documentation deemed necessary for continuous membership to the agencies and general health and safety

the agencies cannot mandate the immunization of any member. Members must authorize or refuse immunization annually.

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Section 4	At Risk Individuals
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Employees Identified in the Exposure Risk Determination.

The agency's members/employees identified in the Exposure Risk Determination are required to comply with all aspects of the ECP whenever feasible and with no detriment to patient care. These requirements include: attending annual training, performing procedures in accordance with the ECP, developing and maintaining good personal hygiene habits, performing proper equipment disinfecting/decontaminating on a "per call" basis, reporting all incidents of exposure to blood/body fluids and/or bloodborne pathogens to the HSO and ensure that the proper incident paperwork is initiated and completed. Persons deemed **At Risk** may be, but are not limited to: EMT-B, EMT-B Trainee, EMT-P, EMT-P Trainee, EMT-B/P Students, and authorized observers. Some activities or duties performed, may be of higher risk than others. Specific "At Risk" tasks, may include but are not limited to:

- Patient Care, general, and specific, when exposed to body fluids.
- Airway preservation and maintenance.
- Suctioning
- Intravenous access and therapy initiation and maintenance.
- Hemorrhage control.
- Patient transport or handling equipment
- Childbirth

Secondary exposures can also occur and place the agencies members at risk:

- Contact with contaminated equipment or surfaces.
- Contact with the patient compartment or cab.
- Contact with bags, linens, or containers that are contaminated.
- Contact with contaminated materials/surfaces on scene.
- Cleaning equipment.

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Methods Of Compliance

Herein are the methods of compliance, and procedures to be followed to minimize the risk of occupational exposure to bloodborne pathogens. There are four basic components to this approach:

- Universal Precautions
- Engineering and work practice controls
- Personal protective equipment
- Housekeeping Practices

The methods of compliance are written broadly to apply to all the agency's member positions that have the potential for exposure to blood/body fluids and/or bloodborne pathogens. For other sources of approved, specific, local protocols and procedures regarding compliance, please refer to the following; the agency's Standard Operating Guidelines (SOG's), and professional training required of different member positions such as: First Aid, EMT-B, EMT-P training.

Universal Precautions


As Identified by OSHA, Universal Precautions is an approach to infection control that assumes that **ALL** human blood and body fluids are known to be infectious with bloodborne pathogens, which may include Human Immunodeficiency Virus, Hepatitis-B Virus, Hepatitis-C Virus and Tuberculosis as well as other infectious agents. Infection may occur through four types of occupational exposure to blood or other infectious body fluids:

- Parenteral exposure - contaminated needle stick, cuts, injection.
- Mucous membrane absorption - eyes, mouth
- Inhalation of droplet saliva - lungs
- Non-intact skin exposure - abrasions, previous cuts, dermatitis, wounds

Precautions are to be applied universally to all patients; all blood/body fluids and all potentially infectious materials without regard to the individual person who may be the source of the potentially infectious material. A description of universal precaution procedures applied to the agency's operations is listed in the PPE section of the ECP. Additional precautions may be applied to patients with diseases, or symptoms of diseases, that are readily transmitted through air or direct contact and are described in the Face Protection, and TB Protection Plan sections of the ECP.

Potentially Infectious Materials:

- Human blood/blood products
- Semen and vaginal secretions
- Cerebrospinal fluid, synovial fluid
- Peritoneal fluid, pericardial fluid, amniotic fluid
- Body fluid visibly contaminated with blood
- Saliva, sputum or aerosolized droplets expelled while coughing
- Any unfixated or exposed human organ
- HIV-containing cell, tissue, or organ cultures or solutions, and blood,
- Organs, blood, or other tissues and fluids from experimental
- Animals infected with HBV, HCV, and HIV.

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Engineering and Work Practice Controls

Engineering and work practice controls are designed to minimize or eliminate occupational exposure to bloodborne pathogens and other infectious agents. Physical means to isolate hazards, such as sharps disposal containers, are called engineering controls. Altering the way a task is performed, such as donning gloves, gowns or N95 masks, or prohibiting re-capping of contaminated needles, are examples of work practice controls. In order for engineering and work practice controls to be effective, each corps member/employee must employ good habits, utilizing both controls.

Hand Washing

Hand washing is the single most effective method of preventing the spread of infection in the pre-hospital care setting. Therefore, it is important to know where and how to wash your hands. When hand washing is not available, hospital grade hand sanitizer may be utilized, until hand washing becomes available. Hands should be washed:

- When reporting for duty
- Before and after every patient contact
- After using the restroom
- Before eating
- After using a tissue
- Before an invasive procedure
- After decontaminating surfaces and equipment
- Even if gloves are worn
- Immediately following any bare/broken skin exposure

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Sharps Disposal

As an ALS level agency, the agency's members handle contaminated and potentially infectious needles or "sharps" regularly. Members/employees identified in the Exposure Risk Determination may, on a regular basis, be in contact with used, contaminated sharps which may contain infectious materials. Any needles, scalpels, broken/contaminated glass or any other contaminated material or object likely to puncture a simple bag must be disposed of in an approved sharps container.


- All the agencies active road members/employees are responsible for the proper disposal of sharps.
- Used and contaminated sharps are not to be left on floors, benches, counters or in any cabinet or equipment storage or storage compartment and may NEVER be disposed of in regular trash receptacles.
- Bending, breaking, disassembling or re-capping, used, contaminated sharps is prohibited.
- Approved sharps containers will be made of hard, puncture resistant plastic, leak proof on the side and marked "biohazard". Sharps containers will be mounted in the ambulances, and portable, single use sharps containers will be present in ALS IV kits.
- Single use sharp shuttles may be disposed of within a larger, mounted or floor standing sharps container.
- Wall mounted sharp containers must be replaced when filled to the indicated fill line ($\frac{2}{3}$). The safety slot must be closed and secured shut with adhesive tape covering the entire front opening of the sharp container.
- Replacement sharps containers and shuttles will be made readily available for all ALS providers, and BLS providers upon request.
- Any needle utilized for IM injection or administration should have a deployable safety cap.
- When securing a used IO needle, the safety block must be placed flat on a surface (floor, counter, ground), allowing the device to stand alone, and the needle inserted into the safety block. At **NO TIME** shall the safety block be held by a provider, while securing the IO needle. Once secured, dispose of the IO needle in a sharps container.
- IO needles may also be disposed of in a sharps container, without utilizing the safety block.

Sharps Injury Log

The agency's Health and Safety Officer maintains a confidential sharps injury log. The Log must include information regarding the type and brand/serial number of the device involved, the method and area in which the exposure occurred, and a description of the entire incident. For accidental "sticks" and potential exposures see Section 7.

Vaccination Program

The agency offers immunization against most infectious agents: Measles, Mumps, Rubella, Tetanus, Diphtheria, Hepatitis A and B, Influenza, Pneumococcus, and Varicella through the occupational medicine health screening program. The agency also offers post exposure prophylactic antiretroviral therapy.

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Regulated Medical Waste (RMW) Defined

The Bloodborne Pathogens Standard uses the term, "regulated waste," to refer to the following categories of waste:

- Liquid or semi-liquid blood or other potentially infectious materials (OPIM);
- Items contaminated with blood or OPIM and which would release these substances in a liquid or semi-liquid state if compressed;
- Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling;
- Contaminated sharps; and
- Pathological and microbiological wastes containing blood or OPIM."-(OSHA standards for BBP).

Feces, or materials saturated with feces is not RMW. Urine or materials saturated with urine is not considered RMW unless blood is visibly present in the stool or the patient is known to have a disease which may be transmitted through stool.


ALL Regulated Medical Waste MUST be disposed of in the appropriate Biohazard waste receptacle either at the receiving facility, or the agency's base.

Contamination/De-contaminating

Soiled linens suspected of being contaminated with a bio-hazardous waste will be placed in the appropriate linen bins in the hospital. Soiled linens returned to or present at base must be placed in the appropriate linens bin to be washed in warm water with a diluted Clorox solution in the garage laundry machines **only**. Linens that **cannot** be decontaminated, and qualify as regulated waste, shall be placed in red biohazard bags and disposed of properly either at a hospital or the the agencies contracted regulated medical waste disposal company, these may be linens that are: saturated with blood, saturated with blood laden vomit, sputum, amniotic fluid. If items are not **saturated**, meaning incapable of absorbing any more liquid, decontaminating may be feasible.

Equipment used and brought in contact with a patient, regardless of signs/symptoms, shall be decontaminated after **every** encounter. This includes but is not limited to: gurney rails, pads and straps, manual or automated blood pressure cuffs, SpO2 finger probes and ECG lead cables. Items visibly contaminated should receive special attention to ensure effective decontamination.

When decontaminating with antimicrobial wipes or a pre-made solution, be sure to follow the manufacturer's recommendations. "Fanning" surfaces to expedite evaporation reduces effectiveness of disinfectants and renders decontamination inadequate. Equipment that cannot be decontaminated in this fashion shall be placed in an appropriately sized red biohazard bag and returned to base where it will be soaked in a 1:10 bleach solution for 10 minutes, wiped, then air dried. Items that still cannot be decontaminated in this fashion are considered regulated medical waste and shall be placed in an appropriately sized red biohazard bag and disposed of properly by either, disposing of the waste at the receiving facility, or the red biohazard waste bin in the ambulance bay, to be disposed by the the agencies contracted regulated medical waste disposal company. Red Biohazard bags containing regulated medical waste must **NEVER BE DISPOSED OF IN REGULAR TRASH RECEPTACLES.**

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General Cleaning Practices

Equipment and apparatus should be washed and decontaminated at the end of each shift and made sanitary for the oncoming crew. This cleaning should apply to all large surfaces, handles, and controls, dials or buttons. All vehicles will be regularly supplied with items to facilitate disinfection: antimicrobial wipes, lysol spray and towels. Monthly detailed cleaning of cabinet interiors will be performed as part of regularly scheduled equipment care and maintenance. High traffic work areas and equipment such as computer stations and surface areas should also receive routine cleaning and sanitization.

Contaminated Uniforms

- Work uniforms, contaminated or not, should not be washed with regular laundry.
- Work uniforms should always be washed and dried according to manufacturer specifications.
- Employees are encouraged to keep a spare uniform either at base or in their vehicle
- Contaminated uniforms are to be washed at work, in the garage bay laundry, prior to use of the base laundry machines.
- Contaminated boots and leather goods may be soap and brush scrubbed with warm water to remove contamination.

Personal Protective Equipment


The use of Personal Protective Equipment (PPE), places a barrier between the employee/member and the potentially infectious material to which they may be exposed. In accordance with Universal Precautions, blood, body fluids and tissues of ALL persons are presumed to be potentially infectious. PPE must be utilized based on the particular task to be performed, regardless of the patient involved or the source of blood or other potentially infectious material. Appropriate PPE will not allow blood or other potentially infectious materials to pass through it or reach the provider's bare skin, eyes, mouth, lungs, mucous membranes or duty uniform under normal conditions of use.

PPE Use Directives

PPE **must** be worn in all cases where there is potential for exposure to blood, body fluids, airborne droplets and other potentially infectious materials. The exemptions from the use of appropriate PPE are rare and require extraordinary conditions to which donning the appropriate PPE would place the employee/member at increased hazard of personal injury. A member's decision to not use PPE shall be made on a case by case basis, prompted by legitimate and truly extenuating circumstances. In these cases, whether or not an exposure occurred, a special report must be filed under "infectious exposure", explaining the event, as well as an Exposure Report. This may be completed with the assistance of the on duty Ops Officer, and should contain details surrounding and leading up to the event as well as the specific identifying number associated with the Patient Care Report. Additional precautions, directives or patient care standards may be issued by the agencies, NYS DOH, MLREMS, and County Health Department etc. to meet increased protective standards during a public health emergency. These additions should be implemented as required per the directive and must be strictly adhered to.

PPE General Provisions

- PROVISION: the agencies will provide all appropriate PPE necessary for day to day EMS duties at no cost to employees/members. Any employee/member with special requirements in regards to PPE materials, i.e.: size, material, etc. shall bring these requirements to the attention of Operations and/or the HSO who will ensure appropriate PPE is provided at no cost to the employee/member.
- USE: Appropriate use of PPE will be demonstrated to members/employees to ensure proper donning, use, doffing and disposal of PPE. In the event PPE is not used when indicated, or fails during use, the HSO will investigate the matter and document any and all findings and submit an incident report to the Chief.
- ACCESSIBILITY: Each agency's Officer is responsible for ensuring appropriate PPE is accessible at base, on scene, and if necessary issued directly to the employee/member. If suitable PPE can not be located or provided, the HSO must be notified as soon as possible.
- UPKEEP: the agency is responsible for the cleaning, laundering, disposal, repair and replacement of PPE. These tasks shall be performed on an "as needed" basis and without unnecessary delay.

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PPE Disposal

- All PPE shall be removed and properly stored/disposed of immediately following leaving the area of potential exposure. Unless absolutely necessary, gurneys, gear bags, monitors and all exterior ambulance doors and compartments shall not be carried, operated or opened while potentially contaminated PPE such as gloves and gowns are still being utilized. In the event of an ongoing exposure such as a patient with a confirmed infectious disease the employee/member providing care during transport shall continue to wear all appropriate PPE throughout patient contact. Members/employees not responsible for patient care during transit MUST drop all potentially contaminated PPE prior to initiating transport and don appropriate, uncontaminated, new and or sterile PPE upon arrival at the receiving facility.

In the event the appropriate PPE is not utilized or fails to provide sufficient barrier and duty uniform garments become contaminated, these garments shall be removed as soon as reasonably possible. For this reason it is the responsibility of each employee/member to ensure they have a spare duty uniform either kept at base or in their personal vehicles. Any duty uniform that cannot be decontaminated after an exposure will be properly disposed of and documented, the member/employee will receive timely reimbursement of said article.

Gloves

-Gloves shall be worn on all calls as a standard of care and necessity to practicing Universal Precautions in a prehospital setting.


-Gloves shall be worn when handling items or surfaces suspected to be contaminated with blood or any other potentially infectious material.

-Gloves must be worn during all clean-up of blood/body fluids during decontamination of instruments, equipment and ambulances.

-Gloves shall be replaced as soon as practical when contaminated or as soon as feasible when torn or punctured or their ability to function as a barrier is compromised.

-Gloves are to be worn only in the area of suspected exposure and must be discarded prior to operating the gurney, entering the front compartment of the ambulance or operating other electronic devices such as laptop computers or ambulance radios.

-Disposable/single use gloves are to be disposed of in an appropriate waste bin after each use. Washing/reusing disposable gloves is never appropriate.

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Section 5

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Face Protection

While BBP is a major concern, there are a wide variety of other pathogens that can cause serious infection and illness and are easily communicable, particularly respiratory illnesses. These can include but are not limited to:

- Pneumonia
- Influenza
- Pertussis
- Measles
- Streptococcus
- Coronavirus infections (SARS, MERS, Covid-19)
- Mumps, etc.

-The three primary lines of defense against contracting and spreading these diseases are good sanitation, decontamination practices, and donning face masks. Any patient presenting with respiratory symptoms should be considered a candidate for a droplet mask. Any provider near or providing care for any of these patients should consider, at a minimum, donning a droplet mask themselves, or opt to wear an N95 respirator.

-Masks covering both the nose and mouth must be worn whenever splash, spray, splatter or aerosol droplets of blood or body fluids may be generated and contamination of the mouth, face or lungs can be reasonably anticipated. During all obstetrical procedures and when rendering care of wounds with the likelihood of large amounts of blood exposure.

-Appropriate masks to be utilized should be determined on a case by case basis. Caring for patients with no known history of TB and not suspected of any respiratory disease more severe than pneumonia or influenza but have an active cough indicate use of a droplet mask for the provider and patient. Patients with suspicion of more serious infectious diseases such as TB, SARS, and Ebola etc. indicate the use of an N95 particulate respirator.

-Masks must be worn correctly to be effective. The metal band must be contoured to the bridge of the nose and the bottom of the mask should cover the entire front area of the chin. All loops, ties or elastic bands shall be properly adjusted and fastened to ensure an effective barrier is created and maintained.


-Masks should be changed if they become dampened or saturated regardless of time frame worn.

-Used masks must be discarded in the appropriate receptacles and removed prior to entering the front of the ambulance.

-A mask is either on or off. Masks cannot be allowed to dangle from the neck or be placed resting upon the provider's forehead. Inappropriately worn masks can become heavily contaminated and even increase the likelihood of exposure.

-N95 mask fit testing will be performed annually and is required of all members/employees identified in the Exposure Risk Determination. Members may sign an informed declination form in lieu of fit testing.

-PPD placement and testing will be performed annually and is required of all members/employees identified in the Exposure Risk Determination. PPD testing may be performed at quarters by providers approved to administer PPD tests under ALS Chief Approval and the agency Medical Director. PPD tests may also be performed at a clinic or facility of the agency's choice at no cost to the member/employee. If an employee/member elects to have the annual PPD test performed elsewhere, he or she does so at their own expense and will be required to provide official documentation asserting the placement and results of the PPD test.

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Eye Protection

-Eye protection includes goggles or safety glasses with a solid side shield. Ordinary reading, prescription or sun glasses do not offer an acceptable level of eye protection to qualify as PPE.

-Protective eyewear should be worn in conjunction with an appropriate mask whenever splash, spray, aerosol droplets of blood, body fluids or tissue/bone particles may be generated, and contamination of the eyes or face can be reasonably anticipated.

-Whenever protective eyewear is deemed appropriate then an appropriate mask should also be worn.

-When soiled or contaminated, protective eyewear shall be cleaned and disinfected per manufacturer's specifications. In the event the eyewear cannot be decontaminated, the eyewear is to be placed in the appropriate receptacle for disposal.

-Protective eyewear shall be discarded if broken, defective or irreparably damaged.

Face shields are an acceptable alternative to goggles or safety glasses. Face shields combine eye, face, mouth, and nose protection. Face shields must be at least chin length and may be worn over prescription glasses. Face shields are not an appropriate alternative when the use of an N95 respirator mask is indicated but may be used in conjunction over top of a properly donned N95 respirator.

Gowns and Aprons


Regular uniforms, work clothes or surgical scrubs are not considered protective attire.

-A water resistant cloth isolation gown shall be worn whenever splashing, splattering or spraying body fluids is anticipated or when blood/body fluid contamination of the arms or chest is anticipated.

-Disposable plastic aprons are to be worn if clothing is likely to become contaminated with blood or body fluids but isolation gown criteria is not met.

-Isolation or surgical gowns are to be worn during any obstetrical delivery.

-All protective clothing must be removed after each use, disposed of in appropriate receptacles and not worn in the front compartment of the ambulance. Gowns or aprons are not to be hung up for re-use; a new gown is to be used for each contact.

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Encountering Exposure Risk Patients

EMS personnel may be exposed to a number of pathogens, transmitted by a number of vectors and pathways. Direct and Indirect contact may be the source of an exposure of many pathogens that are not bloodborne. Many transmissible and communicable diseases may cause serious illness, and in some cases death. These diseases may be, but are not limited to:


- Bacterial, Viral and Fungal Meningitis
- Ebola
- Legionnaires disease
- Measles
- Malaria
- Creutzfeldt-Jakob disease
- Coronavirus (SARS, MERS, Covid-19)

Personnel should, as a medical professional in practice, be aware of the signs and symptoms of these diseases and take appropriate precautions regarding PPE and isolation/decontamination. Personnel exposed or believed to have been in contact with non-bloodborne pathogens, or are currently caring for a patient presenting symptoms indicative of these serious communicable diseases should:

- Don full PPE; Gown, N95 respirators, goggles/face shield, gloves. Consider placing a droplet mask on the patient.
- Notify the receiving facility as soon as reasonably possible while observing pertinent patient care duties. Limit patient care and contact to one provider. When possible, utilize disposable blankets as a barrier between equipment and patient.
- When in confined spaces such as the patient compartment of the ambulance, utilize the exhaust fan to reduce concentration of possible airborne pathogens.
- Cab dividers separating the patient compartment from the driver compartment should be utilized if present.
- The driver must remove ALL PPE and place it into an appropriate receptacle **BEFORE** entering the driver compartment.
- Upon arriving at the receiving facility, staff should be notified of the nature of the hazard and will direct EMS staff according to their decontamination and isolation protocols if they deem necessary.
- Personnel not believing to have been exposed shall return to quarters "Out of Service" for complete decontamination of all equipment and apparatus within direct contact of the patient or immediate vicinity such as the patient compartment of the ambulance. All hard surfaces shall be cleaned with a 1:10 bleach water solution, or pre-made commercial antimicrobial solution. Any items incapable of being decontaminated this way shall be soaked in a 1:10 bleach/water solution for no less than 30 minutes, wiped clean and air dried.

EMS Personnel believed to have been exposed during this patient contact should notify the receiving staff immediately following transfer of patient care. Exposed personnel should also take action to notify the agency's Operations Manager, Director of Operations or HSO. An exposure report must be filed within 24 hours of the exposure.

Personnel exposed, evaluated, and found to be at low risk, should monitor their health and wellbeing for signs of infection for the next 72 hours. Symptoms, which may include but are not limited to, fever, chills, body aches, shortness of breath, persistent cough, rash, nausea, vomiting and diarrhea. Personnel displaying any of these signs or symptoms should notify the agency's Operations manager immediately, and request further evaluation from the agency's appointed occupational health clinic or seek evaluation from their primary physician.

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Orientation

All new hire/membership orientation sessions will include a segment on infection control, and will include:

- the agencies ECP brief description and digital or paper copy distributed to the new hire
- Isolation Kit and overview, indications for use, and demonstration of proper don/doffing techniques.
- Vehicle and equipment decontamination techniques
- N95 Fit testing
- Signed documentation showing the candidate's understanding of the material.

Annual Training

- Annual training shall consist of, at a minimum, review of the agency's approved BBP training course.
- Signed documentation declaring a review of the agency's ECP by staff.
- Annual fit-testing and review of N95 respirator use and application or a signed declination form showing understanding of risks.

Update Training

All the agency providers listed in the risk assessment will be given training updates if/when new PPE equipment or decontamination products and or procedures are adopted or placed in service. This training may consist of in-service hands on instruction, e-mail reference material, or Quarterly training sessions giving an overview of said changes.

Any updates requiring revision and editing of the ECP shall merit a session in mandatory Quarterly training.


Quality Assurance

The HSO, with the assistance of the Chief's Office, shall share the responsibility for ensuring that all training, both orientation and annual, are completed in full satisfaction of the NYS DOH and US Department of Labor, as well as OSHA guidelines and regulations.

Exposure Investigations

All documented exposures shall be investigated by the HSO within 12-24 hours. The results of said investigation shall be submitted to the EMS Chief with recommendations as to corrective actions and preventive measures, including recommended disciplinary action, that can/should be taken as well as an assessment of staff adherence to the agency's ECP.

Failure of ANY of the agency's personnel, listed in the exposure risk determination, to STRICTLY comply with policies and procedures expressed in this Exposure Control Plan may face disciplinary action. The agency's personnel with lapsed PPD testing will be immediately suspended from active road duty until PPD test placement and reading can be performed.

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Direct Exposure

Any employee/member sustaining skin, mucous membrane or percutaneous contact with potentially infectious materials shall cleanse the affected areas as soon as possible, as follows:

- Intact Skin- wash the affected area with soap and water for no less than 15 seconds.
- Broken skin/needle sticks- wash with soap and water for no less than 15 seconds, then flush with Chlorhexidine, Prevodine or iodophor solution.
- Intra-oral exposure- rinse your mouth well with water.
- Eyes- rinse well with sterile saline, sterile water or tap water if necessary. Contact lenses should be removed prior to eye flush and disinfected per manufacturer’s recommendations.

Post Exposure Procedures

YOU ARE OUT OF SERVICE ONCE TRANSFER OF CARE IS COMPLETED

The plan for post exposure evaluation and follow up will ensure that; appropriate measures are taken to minimize the risk of infection secondary to the exposure; the circumstances surrounding the exposure are investigated and documented; the affected employee receives medical consultation, follow up, and treatment if necessary in a timely and expeditious manner.

Any the agencies personnel who has had an exposure is required to:


- Contact the Shift Supervisor ***immediately*** following the event or ***as soon as is reasonably possible*** without causing undue delay in appropriate patient care.
- Contact Med Control at the receiving facility to inform them of your exposure.
- Fill out a Special Report.
- Complete an exposure report. This report shall include all facts and pertinent negatives such as:
 - o What PPE was utilized?
 - If PPE was not used, why?
 - Did the PPE fail or malfunction?
 - o Route of exposure (oral, ocular, mucosal, etc.)
 - o Type of infectious material (blood, amniotic fluid, droplet etc.)
 - o Events/tasks leading up to the exposure such as what procedures were being performed.
 - o Immediate measures taken to cleanse/disinfect the exposed area.
 - o Names of Officers contacted and informed of the situation.
 - o Identifying the number of the PCR associated with the exposure event.

Exposure information is collected and organized using the National Healthcare Safety Network: Exposure to Blood/Body Fluids and Bloodborne Pathogens Exposure Event form. This evaluation form was developed by the Centers for Disease Control and Prevention. No personal identification information will be disclosed through this report. Data collected here is utilized to form CDC policies and recommendations to prevent future exposures.

If necessary, the source individual’s blood shall be tested for HIV, HBV and HCV. Written consent is required for HIV testing.

If already at the emergency department the employee can ask to speak with an attendant regarding the situation and testing of blood and the source individual’s medical status according to the Ryan White Care Act. The exposed member/employee may also request prophylactic treatments, regardless of source individual testing or medical condition if prophylactic treatment is clinically indicated.

If necessary, the HSO or Operations Staff will follow up with the infection control nurses at the hospital according to the Ryan White Care Act regarding the medical status of the source individual.

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Section 7	Exposure Control Follow UP
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An employee/member who was exposed will be referred, as soon as possible, for medical evaluation. During regular business hours, the agency's appointed occupational health clinic will be the primary facility. After hours, the exposed individual shall receive initial evaluation at an emergency department of their choosing, and within 48 hours, receive follow up care with either the agency's appointed occupational health clinic or their Primary Care Physician. An employee may designate their Primary Care Physician or defer to the physician/clinic, selected by the Chief's Office, for post-exposure medical evaluation or follow up, providing said care, including blood analysis, can be conducted within 24-48 hours.

The healthcare provider providing exposure treatment, consultation and follow-up or post exposure consultation will be given access to the following, provided the exposed member/employee completes a patient Protected Health Information release approval form.

- A description of the employee/member's duties as they relate to the exposure incident.
- A copy of the Special Report and all subsequent exposure paperwork filed in regards to the incident.
- Results of the source individuals testing, if available, except as prohibited by law.
- All medical records relevant to the treatment of the employee/member including vaccination records.

The healthcare provider will advise and counsel the exposed employee/member with respect to risk of infection with bloodborne pathogens resulting from the exposure as well as appropriate treatments and testing.

The agency's HSO is responsible for following up with the exposed employee/member regarding care and continued support from the agencies as needed and for further documentation of any acquired illnesses as a result from the exposure.

During the follow-up period, the exposed employee/member should report any acute illnesses to the agency's HSO for documentation and is advised to seek medical evaluation from their chosen healthcare provider, especially during the first 12 weeks following the exposure.

Repeat follow-up testing will be offered at 6 weeks, 3 months, 6 months and 12 months, as appropriate per CDC recommendations if there is a documented or suspected exposure to HIV, HBV, and HCV.


TB Post Exposure Procedure

Personnel who have been exposed, or suspect exposure to TB and have not had a previously positive PPD reading and have not been tested within the past 3 months, the agencies shall provide a PPD skin test within 1 week of the suspected exposure at no cost to the employee/member.

Secondary PPD testing will be done within 8-10 weeks of the suspected exposure and will be provided by the agencies at no cost to the employee/member.

Should either of the post exposure PPD tests yield positive results, the agencies will provide, at no cost to the employee/member, further evaluation at either the agency's selected clinic or physician's office, or the personnel may elect to have their primary physician perform further evaluation.

If the infection is confirmed by further evaluation, the agencies will provide follow-up treatment and counseling, performed by either the agency's selected Physician or clinic, or the exposed employee/members Primary Care Physician at no cost to the employee/member.

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Tuberculosis Control Plan

TB should be suspected whenever a patient is encountered with the following symptoms: weight loss, night sweats, swollen glands, persistent cough, and bloody sputum. TB should also be suspected when a patient is on any of the following medications: Isoniazid (INH), Rifampin (RIF), Pyrazinamide (PZA), Ethambutol (ETH), and Streptomycin.


All members of the department shall be given the opportunity to be tested annually for TB. This test will be coordinated between the Safety Office, Management office, and/ or the Agency appointed Medical Provider. Trained and monitored the agencies personnel or the agencies appointed Medical Provider will perform the testing and recommend any necessary follow-up care. Any Personnel who has a reaction to the skin test of 10mm or more will be referred to the agency's appointed occupational health clinic, or if they chose, their Primary Physician for follow up. the agencies will provide all services, including any medication, at no cost to the exposed personnel. An employee/member, presenting with a positive test for TB infection must receive this follow-up evaluation in order to ensure there is no disease present. Members who have tested positive, yet display no active symptoms will not be restricted from work. These symptoms include: chronic cough, night sweats, fatigue and weight loss. The skin testing program is a required program. Persons performing active road duties involving patient care are required to participate, person's electing to not comply will be removed from active road duty.

All active duty road crew members will be fitted for an N95 TB Respirator or sign a declination form, stating they are aware of the risks of exposure, and possible lack of protection from the provided N95 respirators as a true fit was never documented.

The N95 respirator is designed to be used on any EMS call that involves a suspected or confirmed TB patient or any other contagious respiratory illness patient. These may include but not be limited to; Pneumonia, Influenza, Ebola, SARS, etc. All active duty road personnel will be qualitatively fit tested for the N95 respirator at the time of employment and annually thereafter. The fit testing will be repeated whenever the respirator design or facial changes occur that could affect proper fit of the respirator. Personnel not able to obtain a proper fit with the N95 disposable respirator will be fitted with an alternate N95 reusable respirator. These individuals will be issued a personal respirator that must be kept accessible for EMS responses. These members will be responsible for keeping the alternate respirator with them, clean and available for use whenever they are working.

The Health and Safety Officer will be responsible for overseeing the fit testing and training for the N95 respirator. Personnel are at a high risk of exposure when they are in proximity to the patient during any of the following treatments: airway placement (oral/nasal), artificial ventilation, intubation/laryngoscopy, suction (oral, nasal, tracheal), oxygen therapy, and nebulized breathing treatments. The N95 respirator must be worn in order to prevent the transmission of disease from these patients.

Two each of sizes Small, and Large or "one size fits all" N95 respirators will be kept with the isolation kits on each ambulance. These respirators will be used one time only and then disposed of. Replacement respirators will be available in the restock cabinets.

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PPD Testing Placement

Annual PPD placement testing will be required by all employees/members listed in the exposure risk determination. Annual PPD placement testing will be provided by the agencies to all members/employees listed in the exposure risk determination at no cost to them. PPD placement testing will be performed by selected and trained personnel, under the approval of the agency's medical director and ALS Chief, or if so chosen, the agencies may select a clinic or physician's office to provide PPD testing at no cost to the employee/member.

In house PPD testing may only be performed/read by the agency's Operations Staff. Operations staff selected to perform/read PPD tests must complete all training required by the ALS Chief and the agency's Medical Director, as well as follow any recommendations made by the agency's Medical Director, and any newly developed or adopted guidelines or laws as designated by State and Federal statutes or recommended by the CDC.

PPD placement testing must be performed in compliance with CDC approved methods and training provided. ie: An intradermal injection of 0.1mL Purified Protein Derivative, placed with a 1/4-1/2 inch 27ga short bevel needle, inserted at a 5-15 degree angle and at a depth of 3-5mm. Placement should be on either forearm, away from any scars, vasculature or skin blemishes. Testing sites shall be thoroughly cleaned with an alcohol swab prior to administration. Once placed, sites should be circled, dated and initiated by the placing personnel if the subject wishes to utilize digital confirmation methods. Readings must be performed between 48-72 hours of placement.


Failure To Read PPD's

Persons who fail to have an agency-provided PPD test read within the 48-72 hour period shall be required to have a repeat test performed within a 15 day period. The agencies may follow progressive disciplinary action against those who have failed to have PPD's read and repeated in a failed read situation, until a repeat PPD may be placed and read. Active road personnel may be sent "in service" to have this performed.

Alternative Testing Placement

- Members/employees may elect to have their Primary Care Physician perform their annual PPD testing, provided they surrender official, signed documentation from said provider documenting the test placement date, reading date, and results.
- If a member/employee has had a recent PPD test performed, they may present official, signed documentation showing placement date, reading date and results. This test **MUST** be performed no more than 1 year after a previous reading, and must have been read within the past 6 months. Official documentation of the previous test must also be presented in this case.
- Any Employee/member who has had a positive PPD test, and has received follow up care, may present copies of further evaluations, testing, treatments and x-rays in lieu of annual PPD placement.

Personnel who have a positive reading from a PPD test will be immediately referred to the agency's appointed occupational health clinic for further evaluation and treatment at no cost to the employee/member. Said employee/member may elect to have their primary physician provide evaluation and treatment, again at no cost to the employee/member. Said member shall be suspended from active road duty, pending the results of said follow up care.

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PPD Screening Interpretation

If the test results are negative, or 0-9mm induration, no further intervention is warranted unless the employee is known to be HIV positive or is otherwise immunocompromised. The latter conditions may require a 2 step "booster" PPD within 1 week of the original test and/or Mumps antigen energy testing as well.

If a skin test has an induration greater than 5mm in an employee who is known to be HIV positive or is immunocompromised, or greater than 10mm in any person who is not immunocompromised, this constitutes a positive reaction, requiring further evaluation.

If a prior negative results in a conversion to a newly positive, then the employee shall be treated as if active TB is present and CDC treatment guidelines shall be followed. This includes removal from active the agencies duties until treatment has been started and the individual is no longer considered contagious (after 3 weeks of therapy and HSO review)

If the employee is known to have had a positive test in the past, but did not verbalize this to the examiner, and full evaluation and/or treatment has been given, then no further intervention is necessary. Yearly chest x-rays are recommended to follow up with this individual, and they should not receive future PPD testing.

BCG vaccination does not preclude skin testing. Positive results should be treated as an active infection.

Positive Test Procedures


A positive skin test is reportable to the Monroe County Health Department. All employees shall be required either through the the agencies occupational health medicine physician, through the agencies HSO, or through the local Monroe County Public Health Department to obtain:

- Chest x-ray
- 3 sputum smears and cytology cultures for Acid Fast Bacillus through the respiratory therapy department at the hospital

Employees are not permitted to work in any capacity at the agency until the results of these tests are returned to the HSO for review. At the HSO's discretion, the employee may be returned back to active status if the 3 smears are negative.

Treatment

All employees with positive results are required to seek care through the agency's occupational health physician or their primary care physician and provide documentation that treatment is occurring. Documentation of negative sputum smears and/or cultures must be provided to the HSO before being allowed to return to active status in any capacity at the agencies. This typically will require 3 weeks of therapy. Due to the changing standards in appropriate therapy for TB, current CDC guidelines will be followed.

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Infestation Exposure

Infestations may be present on multiple scene types. EMS may regularly encounter infestations that may inadvertently contaminate the provider, equipment, and apparatus. Employees must be aware of signs of an infestation, and take steps to minimize potential spread of said infestations. Signs may include, but are not limited to:

- Patients presenting with small wheals, rashes, itching
- Patients complaining of “something biting them”
- Homes with visible animal feces
- Homes meeting hoarder conditions

Containment


When scene analysis raises suspicion of infestation, steps to contain said infestation shall be taken immediately. All non essential equipment shall be removed from the scene and placed next to the apparatus, regardless of weather conditions. When loading the patient, crews should utilize a sheet, wrapping the patient to minimize infestation contact with the gurney, and reduce spread to the apparatus. Once the patient is loaded, all gear having entered the scene shall be given a brief inspection for signs of infestation, and remove any gross debris if present.

Notification

Notification to the receiving facility of an impending infestation patient must be made. Charge RN or Med Control must be notified to prepare to accept a patient in need of decontamination. Failure to do so may cause further infestation at the receiving facility, and subsequently to their patients and staff.

Exposure

Upon suspicion of having become infested, crews must contact the on duty supervisor immediately, as well as inform the receiving facility. Once notified, the Operations Supervisor will retrieve spare uniforms, if suitable ones are on premises, and provide said replacements to the crew in question. Apparatus having transported a patient with a confirmed, or strong suspicion of infestation, will return to quarters immediately upon transfer of care, and remain out of service until a full decontamination and detailing can be performed. This will include removal and inspection of all cabinet and bench seat items, as well as any gear, and its contents, if it was present at the scene. The interior of the apparatus will receive a full cleansing with disinfectant, and all items replaced. The crew may then return to service.

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Synthetic Illicit Drugs

Synthetic illicit drugs and compounds have been believed to be causing opiate overdose like symptoms in first responders through suspected transdermal exposure. Despite several cases and reports, no positive test results have confirmed opioid exposure as a cause of the symptoms. As first responders and EMS are at an inherent risk for exposure to such substances on overdose calls, and the compounds are not classified or covered under Hazmat training, the HSO of the agencies has deemed it prudent to include these substances, and procedures for encountering them, in this ECP. Some of these compounds may be:

- U-47700
- Sufentanil
- Fentanyl
- Carfentanil

Exposure Risks

Exposure to high concentrations of these compounds are most likely to occur at locations participating in illegal drug manufacturing and distribution or residences where illicit drugs are used. Typically in powder form, these compounds pose a minimal risk in transdermal exposures, however, ocular or mucosal exposures may pose a significant risk to providers. Typically, when responding to calls of this nature, donning full isolation kits may not be practical.

PPE

N95 respirators and standard safety goggles or glasses are the recommended forms of PPE to prevent mucosal and ocular exposure. Used in conjunction with standard exam gloves the provider will be adequately protected.

Transdermal Exposure


Should a transdermal exposure occur, washing the exposed area with copious amounts of soap and water will greatly reduce the concentration of the compound and minimize absorption. If soap is not available, utilize copious amounts of water, sterile water, or saline. Alcohol based sanitizers are **NOT** recommended, many preservatives and alcohols found in hand sanitizers can act as a catalyst and expedite the absorption rate.

Mucosal/Ocular Exposure

Persons who believe to have suffered an ocular or mucosal exposure to these compounds should remove themselves immediately from the area, and flush the exposed area with copious amounts of sterile water or saline. The on duty supervisor shall be notified as soon as is practical. A special report as well as an exposure report shall be filed.

Persons exposed, experiencing symptoms, will be transported via ambulance to an emergency facility. These symptoms may include, but are not limited to:

- dizziness
- nausea
- lethargy
- slurred speech
- "heavy chest"
- decreased respirations
- tachycardia
- sleepiness

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Closing Statement

This ECP is written with the mutual interests of the Agency, and its members safety, success, and well being in mind. It has been written in accordance with current NYS DOH, OSHA, and CDC guidelines and recommendations. The agency's ECP will be reviewed annually and, if necessary, updated to reflect new recommendations and guidelines made by the aforementioned government entities. All members will be made aware of any changes to the ECP

the agencies, as an agency, will strive to always place the safety and health of its members as a forethought in all policies and procedures. With this approach, it is incumbent upon the members to ensure adherence to all policies and procedures made known to them. Failure to do so, whether willingly or through lack of understanding, may be detrimental to the efforts made by the agencies, to ensure a safe and healthy working environment.