

## **Infection Control**

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### **a. Infection Control Program**

Effective Date: 03/11/03
Revised Date:
Emergency Services:

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**Purpose:** Valencia County has established this program to comply with this OSHA regulation, while volunteers may or may not be exempt from this standard, it is Valencia County's intent that persons covered by disability, sickness or performance liability, comply with this guideline.

**Rationale:** The implementation of a guideline to protect service members from communicable diseases and comply with relevant regulations.

**Legal Requirements/Guidelines:** 29 CFR 1910.1020, NFPA 1521

**Guideline:** The Emergency Services Division recognizes that the potential exposure to communicable disease is an occupational health hazard and that in the performance of duty, there is a possibility of communicable disease transmission to service members. To minimize the risk of exposure, the county will implement an infection control program. This document should be reviewed not less than every two (2) years by the Medical Director and his/her designee.

- I. Job Classifications which have risk of exposure to Bloodborne Pathogens.
  - A. EMS First Responders
  - B. EMT-Basic, Intermediate, Paramedic
  - C. Corrections Department
  - D. Law Enforcement
  - E. Fire Fighters
  
- II. Job Classifications where some members have a risk of exposure to Bloodborne Pathogens.
  - A. Road Department
  - B. Solid Waste Disposal Department
  - C. Valencia County Communications Dispatcher

The Occupational Safety and Health Administration (OSHA) has set up a federal standard that all employers/services must follow. The Bloodborne Pathogens Standard is a comprehensive law that mandates specific requirements to prevent the transmission of bloodborne diseases to members. Employers/services must:

1. **Classify the exposure potential for each member.**

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- 2. Develop an exposure control plan.**
- 3. Train members on bloodborne pathogens hazards.**
- 4. Provide hepatitis B vaccination to applicable members.**
- 5. Provide protective equipment and mandate its use.**
- 6. Keep accurate records.**
- 7. Make available annual TB testing.**

The infection control program will include guidelines covering initial training and continuing education in infection control practices, a vaccination program, annual PPD screening program, the provision of proper infection control clothing and equipment, decontamination procedures for clothing and equipment, procedures for the disposal of medical waste, a system for reporting and managing exposures, policy compliance monitoring, and facility design.

The sustained health and welfare of each member of the services is the joint concern of the individual member, all service officers/supervisors and the Chief/Service Director. While each member is responsible for his/her own health, the county recognizes its responsibility to provide a safe and healthy work environment for its members.

**b. Employee Exposure to Infectious Disease:  
Rights, Reports, and Requirements**  
(See Appendix \_)

Effective Date: 03/11/03
Revised Date: _____
Emergency Services: _____
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**Purpose:** To ensure compliance with and proper implementation of the Ryan White Act for the benefit of employees experiencing exposure to infectious diseases.

**Rationale:** To provide guidelines for Designated Officers for the implementation of provisions of the Ryan White Comprehensive AIDS Resources Emergency Act.

**Legal Requirements/Guidelines:** Ryan White Act of 1990, 29 CFR 1910.1030

**Guideline:** The following information has been developed to serve as a general guideline and resource for Designated Officers. The presence of a total, comprehensive, all-inclusive document of responsibilities and authority is not intended. Therefore, each individual charged with the responsibilities of Designated Officer (DO) for the Ryan White C.A.R.E. Act is encouraged to develop knowledge of all laws (Federal, State, County, and Local) pertaining to this Act. Also, each DO should become familiar with OSHA Final Rule 29 CFR, Part 1910.1030, Federal Register, December 6, 1991, and all articles of The Ryan White Comprehensive Aids Resource Act, with particular emphasis on Part V.

**BACKGROUND**

Any emergency response employee (ERE) who aids a victim (source patient) of trauma and/or illness, and who experiences a significant exposure to airborne/ bloodborne pathogens may be subject to emotional trauma.

The possibility that such exposure could result in infection is stressful and anxiety-producing. The DO is responsible for developing follow-up procedures to determine, if in fact, the source patient is an active carrier of a listed disease to which the ERE has been exposed.

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The DO is responsible for communicating results of any request for medical testing or information from the receiving facility to the exposed ERE. All such results are subject to having been legally obtained (including consent to testing.)

If the results support the possibility of exposure with the risk of subsequent infection, the DO will need to communicate that information appropriately, with sensitivity and compassion, guiding the exposed ERE to appropriate resources for medical and psychological management.

### ***APPOINTMENT AND ROLE OF DESIGNATED OFFICER***

Organizations whose employees or volunteers are trained to respond to emergency situations must appoint an individual who is responsible for carrying out the duties of the Designated Officer in accordance with The Ryan White C.A.R.E. Act Provisions for the EREs. Ideally, although not mandated, this person should have a medical background which has prepared the individual to address clinical issues with a professional and common-sense approach.

Selection of the DO: Valencia County EMS Board designate the responsible individual.

The identity of the Designated Officer should be readily known to all EREs within the service. It is recommended that the identity and phone number or pager number be visibly posted and communicated. Also, the DO (or alternate) should be accessible on a 24 hour, 7-day basis. The service should notify all receiving facilities (hospitals) with which it routinely do business of the Designated Officers name and how to contact them. The service must also update receiving facilities when name changes occur. In addition, EMS organizations may wish to consider stamping the phone number of its DO on all infectious disease reports.

### ***DUTIES OF DESIGNATED OFFICER***

1. Responsible for establishing a procedure to request information or consent for medical testing on the source patient by the receiving facility. This applies when an ERE suspects exposure to a blood borne/airborne pathogen. These requests should be initiated only when there has been an exposure event that would constitute a significant risk to the ERE (HIV, Hepatitis B, or others.)
2. Responsible for assuring the EREs employed by their service receive appropriate exposure evaluation and information about the exposure.

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3. Serve as point of contact for receiving reports of possible exposure from EREs and from hospitals which identify that an ERE transported a patient with an airborne or other high-risk communicable disease.
4. Must assess available information to determine whether a possible exposure occurred.
5. Must initiate a request for information and evaluation with the medical facility receiving the source patient and communicate directly with the receiving facility and with the ERE to assure appropriate follow-up.
6. Must have at their disposal as necessary, expert back-up counsel (preferably Physician or Epidemiologist) when information may be insufficient to determine whether exposure has occurred.
7. Must communicate the findings received from receiving facility Infection Control Nurse (I.C.N.) resulting from a request for information and advise the ERE on the appropriate medical follow-up.
8. Shall immediately determine identity of EREs who may have had contact with, or transported a patient subsequently found by the health care facility to have uncommon or rare diseases such as: Infectious diphtheria, tuberculosis, meningococcal meningitis, plague, a hemorrhagic fever, rabies, etc., and initiate appropriate follow-up as soon as possible.
9. Must determine the Public Health Officer for their particular geographic location. Under the C.A.R.E. Act, may request assistance of the Public Health Officer in contested requests for information covered under the Act that require arbitration.
10. Inform the ERE that it is unlikely that the incident would put the employee at risk for that particular disease and does not meet established criteria.
11. Refer the ERE to their health care provider for further follow-up in the case of the DOs determination of exposure being questioned by the exposed ERE.
12. Must at all times maintain the confidentiality of all information acquired in the course of fulfilling their responsibilities as Designated Officer.

**c. Infection Control for Scene Operations**

Effective Date: 03/11/03
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Emergency Services: _____
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**Purpose:** To establish policy and scene operation procedures eliminating or minimizing employee exposure to infectious diseases.

**Rationale:** To ensure the safety and well-being of service employees and to comply with necessary requirements.

**Legal Requirements/Guidelines:** 29 CFR 1910.1030, NFPA 1581.

**Guideline:**

- A. Universal Precautions
  - 1) Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.
  
- B. Procedures
  - 1) Non-sterile **gloves** shall be worn if contact with blood or body fluids may occur. The protection shall be impervious to blood or body fluids.
  - 2) **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.
  - 3) Masks with **Eye Shields** shall be worn if aerosolization or splattering of blood or body fluids may occur (i.e. - suctioning, insertion of endotracheal tubes, patient who is coughing excessively and certain invasive procedures).

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- 4) **Hand washing** shall be done before and after contact with patients regardless of whether or not gloves were used. Hands contaminated with blood or body fluids shall be washed as soon as possible and a report of possible exposure made to the Immediate Supervisor.
- 5) **Mouth to mouth** resuscitation: CDC recommends that EMS personnel refrain from having direct contact with patient wherever possible, and that adjunctive aides be carried and utilized. These include pocket masks, face shields or use of BVM or demand valves.
- 6) **Contaminated Articles**
  - a) Bag all non-disposable articles soiled with blood or body fluids and handle according to contaminated equipment policy. Wear gloves when handling soiled articles. Bloody or soiled non-disposable articles shall be rendered safe for handling prior to being placed back into service. Laryngoscope blades and Magill forceps should be sterilized prior to reuse.
  - b) Bloody or soiled disposable equipment shall be carefully bagged and discarded according to bio-hazardous waste guidelines.
- 7) Non-disposable **linen** should be placed in a appropriate receptacle if the destination facility participates in the linen exchange program (all Presbyterian and Sandia Healthcare hospitals currently participate). Otherwise, linen should be bagged and appropriately identified for drop off at one of the above facilities at the earliest opportunity. Gloves should be worn while handling soiled linen.
- 8) **Needles and syringes** shall be disposed of in a rigid, puncture resistant container and labeled as "Contaminated Sharps". When full, sharps containers should be placed in bio-hazardous waste containers located by the wash bay.
- 9) **Blood spills** should be cleaned up promptly with a solution of 5.25% sodium hypochlorite (household bleach), diluted 1:10 with water or other approved cleaning solution. Always follow manufactures guidelines for cleaning and disinfection. Remember

that bleach is corrosive on metals, can damage electrical equipment and decolorize certain fabrics.

- 10) **Needle sticks or blood exposures:** When a needle stick or blood exposure occurs, the employee should immediately cleanse the wound or wash off blood. Exposure should then be immediately reported to the Immediate Supervisor and necessary paperwork completed. The employee should then be referred for appropriate evaluation, counseling, testing and treatment.
- 11) Routine **cleaning of vehicles**, fire suppression equipment should be cleaned by the service with an EPA registered disinfectant.
- 12) **Fire Suppression/Extrication:**
  - a) If protective clothing or uniform becomes contaminated by body fluids it shall be handled as described in Infection Control, post-Response guideline.
  - b) Latex gloves shall be worn under protective gloves during extrication activities.
  - c) During extrication, contaminated jagged edges should be covered to prevent exposure from puncture injury.
- 13) Patients with suspected **airborne communicable diseases** will be transported wearing a face mask or particulate respirator whenever possible. Ambulance windows should be open and ventilation systems turned on full whenever possible.

**d. Guidelines for Determining a Possible Significant Exposure**

Effective Date: 03/11/03
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Emergency Services: _____
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**Purpose:** To ensure adequate procedures are followed to determine and fully document a significant exposure to infectious disease.

**Rationale:** To provide guidelines for designated officers for the implementation of provisions of the Ryan White Comprehensive AIDS Resources Emergency Act.

**Legal Requirements/Guidelines:** Ryan White Act of 1990, 29 CFR 1910.1030

**Guideline:**

1. Bloodborne Exposures: Bloodborne pathogens (HIV, HBV) may be transmitted when an infectious fluid, usually but not limited to blood, is able to bypass the skin or a mucous membrane and gain entry into the body. The following are considered significant exposures requiring a follow-up by the Designated Officer:
  - a. Exposure to body fluids such as: blood, semen, vaginal secretions, pleural, amniotic, peritoneal, cerebrospinal, synovial, or any other body fluid contaminated with blood, or exposure to a body fluid under circumstances when it was difficult or impossible to distinguish the fluid type (or presence of blood).
  - b. The type or exposure injury provided a portal of entry:
    - i. Percutaneous exposure (e.g., a penetrating injury with a contaminated implement that went through the skin, such as a needlestick.)
    - ii. Mucous membrane entry, such as eyes or mouth.
    - iii. Non-intact skin, such as cuts, abrasions or dermatitis.
    - iv. Blood or body fluid exposure to intact skin generally poses no risk of bloodborne disease transmission. However, if there has been prolonged contact with intact skin and/or there is a massive blood exposure, it is prudent to initiate a follow-up.
    - v. If the skin is broken, human bites may pose a risk for Hepatitis B Virus transmission. Human bites generally do not require follow-up unless the patient was bleeding from the mouth and the bite penetrated the skin.

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2. Airborne Exposures: Determining whether a follow-up is required when an Emergency Response Employee reports a tuberculosis exposure depends on the following factors. First, the Designated Officer must ask the ERE the following questions:

- a. Did the ERE spend time in an enclosed space with the patient?
- b. Did the ERE ride in the ambulance with the patient?
- c. Was the patient symptomatic?

If the answer is yes to any of these, then a potential exposure occurred. To confirm, ask the ERE:

- a. Did the patient wear a mask?
- b. Did the ERE wear a mask?
- c. Was the space sufficiently ventilated?

If the answer is yes to any of these questions, then exposure is probably not significant. If the answer is no, then a baseline skin test with a subsequent follow-up test three months later and counseling by a licensed medical practitioner is advisable.

Since knowing anyone's disease status is very difficult, if not impossible, precautions should be followed to protect employees from any persons treated in close quarters and those who show evidence of TB symptoms: coughing, hemoptysis, unexplained weight loss, long term fever, weakness, night sweats. Wearing a high efficiency protective air (HEPA) respirator, ventilation (opening doors and windows in enclosed spaces), diluting (operating vent fans on non-recirculating mode) and masking patients who cough will help reduce the likelihood of tuberculosis infection. A TB control program will assist in maintaining awareness among employees and provide early warning for prophylactic treatment. An exposure follow-up is essential in protecting responders.

The Designated Officer should be aware of the two major mandates impacting airborne exposures to tuberculosis: Ryan White Act & OSHA enforcement guidelines dated October 8, 1993. The former outlines reporting and follow-up

procedures while the latter requires the use of high efficiency protective air (HEPA) respirators.

Reported exposures may come from a member or the medical facility which determined that the source patient had an active case of tuberculosis. If the member reports the exposure, the patient's disease status must be determined. This is accomplished primarily by contacting the local county health service's TB nurse. If the patient is on medication, the TB nurse should know about it and be able to provide information on when medication was begun. If the patient is not on medication or suspected to have been exposed to TB, the member may request that the patient be tested/examined for potential infection with mycobacterium tuberculosis.

Whenever there is any doubt about the patient's disease status, have the member get a baseline skin test as soon as possible (within two weeks is best). If the member was exposed to a person whom they treated in an enclosed space, or the person was symptomatic, then a baseline skin test is suggested. The key issue to determining exposure to an active contagious case of tuberculosis is knowing that the patient was symptomatic at the time and either not medicated or inadequately medicated. Once adequate medication is begun, the time for an active case of tuberculosis to become non-contagious varies from 2-10 weeks. Therefore, if a person states they are on medication for tuberculosis, their starting date of medication becomes critical, as does the person's following the prescribed regimen. If the active case is multi-drug resistant TB, then typically prescribed medication may be inadequate and the person may be highly infectious.

Pulmonary and laryngeal TB are spread by persons with active disease when they cough, sneeze, speak, or sing. As the droplets are expelled, they quickly dry, forming droplet nuclei which are .1-.5 microns in size. Infection may occur when a susceptible host inhales the tiny droplet nuclei. Conventional Epidemiology standards dictate six months of prolonged exposure, such as living together or working in the same enclosed space, as the most likely situations to produce the possibility for infection. However, a recent study published in the June 16, 1994 New England Journal of Medicine by Dr. Small, et al, proposes new findings. As a result of DNA fingerprinting and conventional epidemiological investigation, Dr. Small showed that patients with no epidemiological relation were infected with the same strain of tuberculosis. He goes on to say that Tuberculosis can be transmitted during brief contact between persons who do not live or work together.

**e. Infection Control Post Exposure Procedures**

Effective Date: 03/11/03
Revised Date: _____
Emergency Services: _____
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**Purpose:** To establish policy and procedures for reporting, documenting, and investigating all circumstances pertaining to an exposure to a communicable disease incident.

**Rationale:** It is the intent of the service to provide a comprehensive infection control program which will employ the highest possible protection against communicable diseases for all employees of the service.

**Legal Requirements/Guidelines:** 29 CFR 1910.1030, Ryan White Act and NFPA 1581.

**Guideline:**

An exposure as defined by OSHA is a body fluid to body fluid contact. Any member who believes that he or she has had an exposure shall do the following:

1. Contact Designated Officer.
2. The DO or designee will evaluate the report.
3. The DO shall fill out the following forms:
  - a. The Valencia County Injury Report form.
  - b. The Valencia County Infectious Exposure Form.
4. The source patient will be traced to the receiving medical facility. The DO or designee will notify the receiving facility that a communicable disease exposure took place, and request an infectious disease determination.
5. The exposed individual shall be scheduled for a medical exam as soon as practicable at no cost to the individual (no later than 48 hours post-exposure).

6. Appropriate lab tests shall be performed to determine a base line.
7. Counseling shall be provided to the exposed individual at no cost.
8. The incident shall be reviewed by the County EMS Medical Director and a care program shall be developed for the exposed individual.
7. The needlestick, blood, or airborne exposure procedures shall be used as appropriate.
8. A record of such incidents will be kept in the members file and in the Infectious Disease Exposure File.
9. The Designated Officer will record all pertinent information including the Exposure Report, medical reports, etc., in a manner which guarantees limited access, as this information is considered confidential.

**Procedures:**

**NEEDLE STICK, BLOOD, OR BODY FLUID EXPOSURE**

**Hepatitis**

- I. Member who have not received Heptavax - Contact D.O.
  - a. Unidentifiable source
    1. ISG 2 cc's IM, 2 doses one month apart
    2. ADT booster if not in the past 5 years
    3. Start Heptavax series
  - b. Identifiable source
    1. If possible test patient for Hepatitis B surface antigen.

**If patient positive:**

      - a. Test personnel for Hepatitis B surface antigen and Hepatitis B antibody.
      - b. If personnel are negative for above give HBIG 0.07 cc per kilogram in one dose and begin Heptavax series.

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- c. If personnel refused Heptavax repeat HBIG dose in one month and document refusal.
  - d. Employees positive for Hepatitis B surface antibody, no treatment is necessary.
2. **If patient is negative** for Hepatitis B surface antigen no treatment is necessary other than tetanus if appropriate.
  3. If unable to test patient for Hepatitis B surface antigen, treat as an unidentifiable source unless patient has history of Hepatitis B or is at high risk (substance abuse or jaundice). If patient is at high risk treat as if patient is a positive case.
- II. Members who have received Heptavax series (3 Injections+titier)
- a. Unidentifiable source
    1. ADT booster if none in the past 5 years.
    2. Check antibody response and follow-up with D.O.
  - b. Identifiable source
    1. No hepatitis testing necessary if source is negative.
    2. ADT booster if none in the past 5 years.
    3. May check antibody response and follow-up with D.O.

**HIV**

- A. Personnel who sustain a needle stick or eye splash or exposure to blood from a patient will be offered HIV antibody testing at the time of exposure. The D.O. will document whether the person refuses or accepts the testing.
1. A member positive for HIV on initial exam will be offered counseling by the Medical Director and will be informed by the medical director of positive results.
  2. Any member testing negative on the initial exam will be offered to repeat HIV testing 6 weeks, 3 months and 6 months after the initial test.

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- a) A member negative at three (3) months will be informed of the results by the medical director.
  - b) A member positive will be informed of the positive results by the Medical Director.
- B. Personnel who sustain an exposure to blood from sources known to be HIV positive will be offered the above HIV testing and will be counseled by the Medical Director.
- C. This testing will be ordered by the Medical Director and is to be arranged at the county designated healthcare facility.

**AIRBORNE PATHOGEN EXPOSURE**

**Tuberculosis**

- 1) Consider personal protection if a patient has a history of cough, fever, weight loss, hemoptysis, night sweats, or history of TB.
- 2) HEPA or appropriate filters should be worn if suspicion of TB.
- 1) Future routine TB testing will be done on a bi-annual or annual basis.

**Suspected or Confirmed Viral Meningitis**

- 1) Contact DO
- 2) DO will attempt to gain follow-up from Medical Facility to confirm case

**f. Infection Control, Post Response**

(See Appendix \_)

Effective Date: 03/11/03
Revised Date: _____
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**Purpose:** To establish guidelines for the cleaning, decontamination, Disinfection, or sterilization of any equipment used for EMS, rescue, or fire activities.

**Rationale:** To ensure the safety and well-being of members and to comply with necessary requirements.

**Legal Requirements/Guidelines:** 29 CFR 1910.1030, NFPA 1581.

**Guideline:**

1. Upon return to quarters, contaminated equipment will be removed and replaced with clean equipment. Contaminated equipment will be stored only in a decontamination area if it cannot be cleaned immediately. Supplies of safety clothing or items on response vehicles will be replenished.
2. Any damaged equipment will be cleaned and disinfected prior to being sent out for repair.
3. The manufacturer's guidelines will be used for the cleaning and decontamination of all equipment, unless otherwise specified.
4. Work surfaces will be decontaminated with an appropriate disinfectant after completion of procedures, and after spillage or contamination with blood or potentially infectious materials. Seats on response vehicles contaminated with body fluids from soiled safety clothing or items also will be disinfected as soon as possible upon return to station.
5. Contaminated boots will be brush-scrubbed with a hot solution of soapy water, rinsed with clean water, and allowed to air dry.
6. Contaminated work clothes (coveralls, T-shirts, uniforms, etc.) will be removed and exchanged for clean clothes. The employee will shower if body fluids were in contact with skin under work clothes.

**g. Infection Control Training**

Effective Date: 03/11/03
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Emergency Services: _____
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**Purpose:** To establish policy and procedures for required training in infection control.

**Rationale:** It is the intent of the service to set forth a comprehensive infection control program which will provide the highest possible protection against communicable diseases for all members.

**Legal Requirements/Guidelines:** 29 CFR Part 1910.1030, NFPA 1581.

**Guideline:**

1. All service members providing emergency services will be required to complete initial infection control training at the time of assignment to tasks where occupational exposure may occur, and receive refresher infection control training annually thereafter, or as needed.
2. All infection control training materials will be appropriate in content and vocabulary to the educational level, literacy, and language of members being trained.
3. Written records of all infection control training sessions will be maintained at the departments for three years after the date on which the training occurs.

## **h. Infection Control Engineering and Work Practice Controls**

(See Appendix \_)

<u>Effective Date:</u> 03/11/03
<u>Revised Date:</u> _____
<u>Emergency Services:</u> _____
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**Purpose:** To establish engineering and work practice controls to eliminate or minimize employee exposure to infectious diseases.

**Rationale:** Ensure the safety and well-being of employees and to comply with necessary requirements.

**Legal Requirements/Guidelines:** 29 CFR 1910.1030, NFPA 1581.

### **Guideline:**

- I. Review of the Work Practice will be done annually.
- II. Hand Washing
  - a. All personnel who perform a task where there is risk of exposure to blood or body fluids shall wash their hands as soon as it is feasible after removing personal protective equipment used while performing the task.
  - b. When it is not feasible to wash hands members are to use the antiseptic hand cleaner furnished in conjunction with clean paper towels which shall be provided in each appropriate vehicle.
    - 1) Hands will be washed with soap and water at the earliest practical opportunity after the use of antiseptic hand cleanser.
- III. Contaminated Sharps Handling
  - a. Needles or any other sharps shall not be bent, sheared or recapped unless no other alternative is feasible.

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- b. All sharps should be placed in appropriate sharps containers provided in all ambulances, rescue squads and other appropriate vehicles.
  - c. Sharps containers shall be:
    - 1) Puncture resistant.
    - 2) Labeled or color coded red as biological waste.
    - 3) Leak proof on sides and bottom.
    - 4) Kept in all appropriate vehicles and a portable container carried into scenes where invasive procedure may be performed.
    - 5) Should be maintained in an upright position at all times.
- IV. Restricted activity in work areas where there is risk of exposure to bloodborne pathogens.
- a) No eating, drinking, smoking, use of chewing tobacco or snuff or applying of contact lenses is permitted in contaminated vehicles or dirty utility areas.
  - b) This includes cab as well as the patient care compartment of vehicles.
  - c) Food may be kept in the cab if it is in a sealed container, however, it may not be consumed in a contaminated vehicle.
- I. All procedures involving blood or other possible infectious material (OPIM) will be performed in a manner that will minimize splashing, splattering or spattering.
- II. All blood samples, avulsed, amputated or expelled tissue recovered and transported to a hospital will be placed in an appropriate container and labeled. The container should be puncture resistant, leak proof and sealed to prevent spillage.
- VII. Cleaning and servicing of patient care equipment.

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- a. Procedures
  - 1) The exposed surfaces cots, cot mattress, floors of patient care areas, seat cushions shall be cleaned daily or as soon as feasible after a blood or OPIM spill. An approved cleaning solution or 1:10 dilution of sodium hypochlorite will be used.
  - 2) The walls, ceiling and shelf areas shall be cleaned as soon as feasible after a blood or OPIM spill or on an as needed basis.
- b. All equipment that is sent for servicing by outside service shops will be marked as equipment that has been used in a work area that is exposed to bloodborne pathogens. Personnel from that shop should take appropriate precautions when handling the equipment. The equipment should be inspected, cleaned and disinfected prior to being sent for servicing, but that due to the nature of its use, there is a slight risk of exposure to service personnel.

## VIII. Housekeeping

- a. To reduce the spread of infectious diseases to employees, patients and others the ambulance crew shall clean the interior of the ambulance, durable patient equipment used and dispose of single use patient supplies and equipment, after every patient contact.
- b. Supplies and equipment needed:
  - 1) One pair utility weight disposable or durable gloves.
  - 2) Clean, absorbent towels, rags or paper towels.
  - 3) Environmental Protection Agency registered germicidal/viricidal agents.
    - a) High level Disinfectants:
      - Glutaraldehyde - based formulation

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- Demand-release chlorine dioxide
- Stabilized hydrogen peroxide 6%
- b) Low level Disinfectants:
  - Ethyl or Isopropyl alcohol (70% to 90%)
  - Sodium hypochlorite (100 ppm available chlorine)
  - Phenolic germicidal detergent solution
  - Iodophor germicidal detergent solution
  - Quaternary ammonium germicidal detergent solution
- 4) Soap and water solution
- 5) Pail/bucket/basin
- 6) Appropriate bags and labels or tags
- c. Procedures
  - 1) Put on gloves
  - 2) Check the inside of the ambulance for discarded sharps and dispose of any found in an approved sharps container.
  - 3) Bag linen, supplies and equipment.
    - a) Contaminated single use linen, supplies and equipment shall be bagged at the location where it is used and proper information noted on the tag or label. The bag should then be placed in a designated container.
    - b) Contaminated reusable linen shall be bagged at the location where it is used and proper information noted

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on the tag or label. The bag should then be placed in a designated container.

- c) Contaminated reusable equipment and supplies shall be cleaned at the location here they are used whenever possible.
  - d) Contaminated reusable equipment that may not be readily cleaned shall be bagged at the location where it is used and proper information noted on the tag or label. The bag should then be placed in a designated container.
- 4) Spills should be cleaned up and the area disinfected with and EPA registered disinfectant/detergent.
  - 5) Wipe the floor after every patient transport.
  - 6) Clean the floor, ceiling and walls with soap and water on a regular basis or as needed (not necessary after every call).
  - 7) Laryngoscope blades, Magill forceps, resuscitator masks or any reusable item touches mucous membranes or non-intact skin shall be disinfected cleaned using a high level disinfectant after every patient use.
    - a) These items shall be bagged, labeled and returned to base for cleaning at the end of each shift.
  - 8) Stethoscopes, backboards, gurney mattresses or any other reusable item including handcuffs, restraints, etc., that touch intact skin should be cleaned using a low level disinfectant after every patient use.
  - 9) The gurney frame should be cleaned with a detergent - disinfectant product on a regular basis or as needed.
- d. All work surfaces contaminated with potentially infectious material shall be decontaminated after completion of a procedure,

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immediately or as soon as feasible and at the completion of the work shift.

- e. Protective coverings and linen should be replaced as soon as feasible once contaminated.
- f. Broken glass should be picked up by mechanical means, not by hand.
- g. Reusable sharps will not be used in any work area.

IX. Waste handling.

- a. Contaminated waste shall be placed in containers which are closeable, leak proof, red in color and labeled bio-hazard with the approved legend. In the event a container should develop a leak, the container should be placed and sealed in another container which meets the criteria listed above.
- b. Contaminated waste shall be placed in the marked receptacles at each facility designated. Under no circumstances shall contaminated waste be disposed of anywhere but these receptacles.

X. Laundry.

- a. Shall be handled as little as possible without agitation.
- b. Shall be bagged after use if not bagged at a recognized linen exchange facility.
- c. Shall be handled only when using Universal Precautions.
- d. All wet laundry shall be placed in a leak proof container.

**i. Use of Personal Protective Equipment/Safety Clothing**

(See Appendix \_)

Effective Date: 03/11/03
Revised Date:
Emergency Services:

**Purpose:** To establish guideline for the safety of members and to standardize the use of personal protective and safety equipment, while adhering to efficient standards of rapid response to emergencies.

**Rationale:** The service will provide appropriate personal protective equipment, safety clothing and training for the protection of members in hazardous situations and environments in accordance with applicable federal, state, and local laws and standards.

**Legal Requirements/Guidelines:** 29 CFR 1910.1030, and 1020, general duty clause, NFPA 1581.

**Guideline:**

- I. Personal Protective Equipment (PPE)
  - a) The following PPE will be provided to all employees at no cost.
    - 1) Disposable latex gloves.
    - 2) Disposable gowns.
    - 3) Masks with eye shields.
  - b) It is the policy of Valencia County that Universal Precautions be observed while working in the patient compartment of an ambulance, cell, vehicle or anywhere that there is exposure to blood or body fluids.
  - c) An exception report will be completed whenever Universal Precautions are not observed documenting the extraordinary circumstances that existed to justify the non-use of PPE. All occurrences will be reviewed by the Exposure Control Officer.
  - d) All PPE shall be readily available to employees and will be kept in the following locations:

- 1) Each County Fire/EMS station
  - 2) The medical supply room at the Sheriff's office.
  - 3) The designated storage room at the Sheriff's office.
  - 4) The Emergency Services Division
- e) Durable PPE will be issued to any employee prior to being assigned to work in an area where there is risk of exposure.
- 1) PPE will be replaced or cleaned and disinfected whenever needed.
- f) Any durable garment that an employee wears during the course of their duties that becomes contaminated will be appropriately cleaned at Valencia County expense. Such garments should be removed, bagged, labeled and turned into the Officer or Supervisor in charge as soon as feasible. At no time should employees or volunteers wear home contaminated clothing and further spread potential contagions.
- g) All PPE will be removed immediately after patient contact is discontinued.
- 1) The vehicle operator should not wear PPE while driving to the destination facility unless there is a high risk of exposure to blood or OPIM in the cab.
- II. Personal protective measures for specific clinical practices.
- a) Protective measures required for each task are outlined in the general text.
- III. Safety Equipment(i.e Bunker gear, helmets, coveralls, etc)
1. It shall be the responsibility of each member to maintain and care for safety clothing/equipment in line with safety and regulatory standards.
  2. It shall be the responsibility of each member to immediately report to his/her officer/supervisor if their safety clothing becomes lost or unserviceable. The officer/supervisor shall then immediately report to the Chief/Service Director of the need for equipment replacement.

3. To avoid emergency operation delays or accidental injuries, it is the obligation and responsibility of all members to wear the required safety clothing when responding to and working in a potentially hazardous situation.
4. Loss or damage of service issue safety clothing, caused by the member's negligence, will be replaced or repaired at the member's expense.
5. It shall be the responsibility of the Chief/Service Director to schedule an appointment for any department member who has missing or unserviceable safety equipment as soon as possible with the appropriate members to have the safety equipment repaired or replaced.
7. In general, department members and I/C should select safety clothing appropriate to the hazard potential and based on job duties. No policy or safety clothing ensemble can cover all situations. Common sense must be used. When in doubt, select maximal rather than minimal protection. Emergency response often is unpredictable and uncontrollable.

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