PORT WASHINGTON FIRE DEPARTMENT

INFECTION CONTROL

POLICY

REVISED

FEBRUARY 2018

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Revised-1993

Revised-2018

PORT WASHINGTON FIRE DEPARTMENT
PORT WASHINGTON, NY

FEBRUARY 2018

STANDARD OPERATING PROCEDURE
SUBJECT: INFECTION CONTROL
APPLICABLE TO: ALL P.W.F.D. PERSONNEL

SCOPE: This policy applies to all personnel (members) who have a potential for occupational exposure to blood or other infectious materials.

PURPOSE: The purpose of this policy is to minimize or eliminate member exposure to communicable diseases.

AUTHORITY: 29 Code of Federal Regulations, Part 1910.103
29 Code of Federal Regulations, Part 1910.20
OSHA Instruction CPL 2-2.44C

POLICY STATEMENT

The Port Washington Fire Department has established a written Exposure Control Plan that has been approved by the PWFD Fire Officers Board and Board of Directors and is distributed to every member of the Port Washington Fire Department. The Chief of Department is the Infec tion Control Coordinator for this program. When the Chief or Assistant Chiefs are absent the following persons are responsible
for administering the program:

* Captains
* Lieutenants
* Safety Officers
* Senior on-duty EMT-P, EMT-CC or EMT-Basic

The Port Washington, NY Fire Department is committed to full compliance with applicable laws and policies dealing with infection control. The Department will develop plans leading to compliance for any deficient areas identified by this program.

EACH MEMBER IS RESPONSIBLE FOR FOLLOWING THE POLICIES AND PROCEDURES OUTLINED IN THE INFECTION CONTROL MANUAL.

The Infection Control Program will be reviewed and updated at least annually and as necessary to reflect significant changes in tasks or procedures

The Infection Control Manual contains guidelines as follows:

1. Precautions and Prevention
2. Personal Protective Equipment
3. Scene Management
4. Cleaning and Disinfection
5. Infectious Waste Disposal
6. Immunizations
7. Exposure Determination
8. Post-Exposure Evaluation and Follow Up
9. Medical Surveillance
10. Record Keeping
11. Training Requirements

The Port Washington Fire Department requires that the guidelines for the following areas be strictly adhered to:

1. PRECAUTIONS AND PREVENTION

A. That members wash their hands or use an alcohol-based hand sanitizer as soon as feasible after removal of gloves or other personal protective equipment that have contacted blood or other potentially infectious materials.

B. Removal of personal protective equipment as soon as possible upon leaving the emergency scene; and placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

C. That all members performing procedures involving blood or other body fluids use caution so that they minimize splashing, spraying, or aerosolizing of these substances.

D. That all used needles and other sharp objects are not sheared, bent, broken, recapped, or re-sheathed with two hands. Needles should be covered using their built in safety device as soon as possible. Used needles will not be removed from disposable syringes. All used sharps will be placed directly into a sharps container as soon as possible after use.

2. PERSONAL PROTECTIVE EQUIPMENT

A. Provides, and assures that members use, appropriate personal protective equipment where biomedical hazards are likely to exist.

B. Assures that the appropriate personal protective equipment in the equipment is readily accessible at the worksite, in the vehicle, or individually issued to the member.

3. SCENE MANAGEMENT

A. Uses the Port Washington Fire Department Incident Command System to manage emergency scenes effectively.

B. Members must follow infection control measures at all emergencies, scenes, in the hospital or other receiving facility.

C. Members consistently and correctly answer infection control questions arising from contact with the public while maintaining compliance with HIPPAA. (The Health Information Portability and Accountability Act)

4. CLEANING AND DISINFECTION

A. Provides for the cleaning, laundering or disposal of required personal protective equipment at Fire Medic Company no.1 or Department Headquarters.

B. Repairs or replaces personal protective equipment as needed to maintain its effectiveness.

C. Establishes a schedule for the cleaning of medical equipment and provides methods for disinfecting same, based on the location, type of surface to be cleaned, type of contaminant present, type of cleaner needed, and tasks or procedures done.

5. INFECTIOUS WASTE DISPOSAL

A. Assures that members place all infectious waste needing disposal in a closable, leak proof container or red bag that is marked, color coded, or labeled, as required by law.

B. Equips all EMS vehicles with puncture resistant biohazard containers for proper disposal of needles, disposable syringes, and other sharp surface instruments.

C. Assures that members dispose of infectious waste according to applicable federal, state, and local regulations.

6. Immunizations

A. Makes available Hepatitis B vaccination to all members who have a potential for occupational exposure.

B. Will provide a booster dose(s) for Hepatitis B at a future date, according to standard recommendations for medical practice at no cost to the employee.

C. Recommends that members obtain other vaccinations recommended for health care workers by the Center for Disease Control such as flu shots and Tdap

7. EXPOSURE DETERMINATION

A. Establishes an Occupational Exposure Incident as one of the following:

- contaminated needle-stick injury
- blood or body fluid contact with mucous membrane of eyes, nose, or mouth
- blood or body fluid contact with open skin (non-intact skin)
- cuts with sharp objects covered with blood or body fluid
- injury sustained while cleaning contaminated equipment
- direct contact with draining wounds, rashes, fecal material or bugs

B. Provides members with a method for the reporting of occupational exposures.

8. POST-EXPOSURE

A. Provides post-exposure and follow up for all members with an occupational exposure per Port Washington, NY Fire Department Exposure Control Plan.

B. Assures that a licensed physician does, or supervises, all medical evaluations and procedures.

c. Assures that the member is informed of the results of the medical evaluation; and that the member is told about any medical conditions resulting from exposure to blood, or other potentially infectious materials, that require further evaluation or treatment.

9. MEDICAL SURVEILLANCE

A. Provides all evaluations, procedures, vaccinations, and post exposure management to the member at a reasonable time and place, and according to standard recommendations for medical practice at no cost to the member.

10. RECORD KEEPING

A. Maintains accurate medical records for each member for at least the duration of employment plus thirty years.

B. Keeps all member medical records confidential, and does not release them to any person within, or outside the work place, except as required by law.

c. Maintains all training records for three years in compliance with Section 29, Code of Federal Regulations, 1910.20.

11. TRAINING REQUIREMENTS

A. Assures that all emergency response personnel who are at risk for potential occupational exposure participate in a training program.

B. Provides training at the time of initial membership), and at least annually after that. provided within fifteen (15) days of assignment response duties. employment (or This training is to emergency

C. Assures that the training program contains those elements required by law.

DATED: April 25, 2018

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PORT WASHINGTON FIRE DEPARTMENT
STANDARD OPERATING PROCEDURE

SUBJECT: INFECTION CONTROL

2018

PORT WASHINGTON FIRE DEPARTMENT

EXPOSURE CONTROL PLAN

MANUAL

PURPOSE

This manual has been produced to elaborate on the infection control policies of the Port Washington, NY Fire Department and to educate its emergency response personnel about infection control in the work place.

The goal of infection control is to prevent infection from occurring in the patient, emergency response personnel, and their families. The dangers faced by emergency response personnel are not always obvious. The occupational hazards of AIDS, hepatitis, and other communicable diseases are unseen but real. An effective Infection Control Program provides the means to minimize, but not eliminate, occupational health risks. This Exposure Control Plan is an integral part of that program.

P.W.F.D RESPONSIBILITIES

Port Washington Fire Department provides policies that exist to:

1. Designate the Chief of Department as the Infection Control Coordinator for the Department.

2. Teach all potentially exposed members about the epidemiology, modes of transmission, and prevention of HIV and other blood-borne infections.

3. Emphasize the need for routine use of universal blood and body fluid precautions for all patients.

4. Provide personal protective equipment and supplies necessary to minimize the risk of infection from a patient exposure with HBV, HIV and other blood-borne pathogens.

5. Monitor member adherence to recommended protective measures. When monitoring reveals a failure to follow recommended precautions, appropriate counseling, education, or retraining will be provided. If these measures are unsuccessful, Appropriate disciplinary action will be considered.

6. Review and update this document whenever necessary to reflect new or modified tasks or procedures which affect occupational exposure and to reflect new or revised positions with occupational exposures.

MEMBER RESPONSIBILITIES

The member must learn the basics of infection control, including modes of disease transmission, and exposure risks. Each member is responsible for ensuring compliance with the policies and procedures outlined in the Exposure Control Plan manual.

EXPOSURE DETERMINATION

A. The following tasks are reasonably anticipated to involve exposure to blood, body fluids or other potentially infectious materials:

- Provisions of emergency medical care to injured or ill patients;
- Rescue of victims from hostile environments, including burning structures or vehicles, water contaminated atmospheres or oxygen deficient atmospheres;
- Extrication of persons from vehicles, machinery or collapsed excavations or structures;
- Recovery and or removal of bodies from any situation, Including those cited above:
- Response to hazardous materials emergencies, both transportation and fixed-site, involving potentially infectious substances.

B. The following job classifications are reasonably anticipated to involve exposure to blood, body fluids or other potentially infectious substances in the performance of their duties:

- Chief
- Company Officer
- Firefighter
- First responder
- Emergency medical technician
- Paramedic
- Driver/Operator
- Other emergency response personnel not otherwise classified

DEFINITION OF TERMS

COMMUNICABLE DISEASE

A communicable disease is a disease that can be transmitted from one person to another. It is also known as a contagious disease.

INFECTION CONTROL OFFICER

A member of the Fire Medic Company No. 1 of the Port Washington Fire Department with the following minimum qualifications:

-Off 2 year probation
-An Emergency Medical Technician
-Thoroughly familiar with the PWFD Infection Control Plan.
-Approved by the Chief of Department and Captain FMCO

INFECTIOUS DISEASE

An infectious disease is an illness or disease resulting from invasion of a host by disease-producing organisms such as bacteria, viruses, fungi, spores, molds, insects, animal bites or parasites.

OCCUPATIONAL RISK

Occupational exposure may occur in many ways, including needle sticks, cut injuries, or aerosols of body fluids. Health care workers are at high risk for blood-borne infections due to routinely increased exposure to body fluids from potentially infected patients, or contaminated equipment or surfaces. Any exposure to a communicable disease carries a certain amount of risk. Emergency response personnel are in an occupation that directly exposes them to body fluids and must be considered at substantial risk of occupational exposures.

BODY SUBSTANCE ISOLATION

The Centers for Disease Control (CDC) recommends the use of "Body Substance Isolation" when emergency response personnel work with blood or body fluids from any patient. This precaution says that emergency response personnel must consider all body substances from any patient as potentially infectious. Body Substance

Isolation exceeds Universal Precautions which states that blood or certain body fluids from any patient may be potentially infectious.

MODES OF TRANSMISSION

A communicable disease can be spread through two means: direct and indirect transmission. Blood-borne diseases spread through direct blood-to-blood contact. blood is the single greatest source of HIV and HBV in the work place setting. Airborne diseases spread via droplets expelled into the air by a productive cough or sneeze. For other definitions related to infection control, personnel can consult the publication, ••Infectious Disease Handbook for Emergency Care Personnel." This book, written by Ms. Katherine H. West, R.N., an authority in the infection control field, is an excellent resource book.

MEASURES FOR PREVENTION

HEALTH HISTORY

A complete and detailed health history for each member is a critical preventive measure. Although a health history is not a requirement of law, an individual's health history helps to identify potential high-risk areas that may require special attention. All emergency response personnel will participate in a pre-membership physical. Emergency response personnel will receive periodic examinations as recommended in post exposure situations and current Department guidelines. This includes a yearly physical and clearance by the Department Surgeon.

IMMUNIZATIONS/VACCINATIONS

Due to the nature of emergency service work, all emergency response personnel are required by law to be offered hepatitis B vaccinations by their employer. Immunizations reduce the risk of contracting a communicable disease. This protects the health of the members and their families. The CDC highly recommends that all personnel maintain immunizations against:

- measles, mumps, and rubella (MMR)
- diphtheria, pertussis, and tetanus (Tdap)
- influenza (yearly)
- hepatitis B

The member is responsible for ensuring that all recommended immunizations/vaccinations are up to date. The PWFD complies with the OSHA mandate by providing the hepatitis-B vaccination free of charge to all emergency response personnel at a convenient time and place for the member. Although the Port Washington Fire Department cannot require anyone to receive the immunization, it strongly recommends it. Any PWFD emergency responder who declines the hepatitis B vaccination must complete and sign a waiver. Such an individual may change their mind at any time and receive the vaccination free of charge. Hepatitis B vaccines are available for all personnel at the Department Sur geons Office. Any prospective member must complete the Hepatitis B form before he/she can be eligible to join. Contact the Infection Control Coordinator for details about the hepatitis-B vaccination series. (Sample copy contained in Appendix I.)

PERSONAL PROTECTIVE EQUIPMENT

Emergency response personnel often work in unpredictable and uncontrolled situations. To minimize the risk of exposure, safe work practices and appropriate protective equipment must be used. Personal protective equipment includes protective equipment for eyes, face, head, and extremities. The Port Washington Fire Department will provide, AND emergency response personnel must use, personal protective clothing to reduce personal exposure to infected blood or body fluids. Personal protective clothing must be maintained in a sanitary and reliable condition. Such clothing must be properly used when necessary because of hazard or environment. Emergency response personnel must ensure that any personal cuts, abrasions, wounds, etc., are always properly dressed for their own protection and that of their patients.

GLOVES

Disposable single-use gloves are a standard component of emergency response equipment in the Port Washington Fire Department. Gloves must be donned by all personnel before initiating any emergency care tasks involving delivery of patient care. Gloves must be of appropriate material, usually intact latex or intact vinyl, of appropriate quality for the procedures done, and of appropriate size for each emergency response personnel. Gloves should be changed after contact with each patient. Members should replace a torn glove as soon as pos sible. Apparatus drivers must change gloves before entering the driver's compartment. This will prevent contamination of the steering wheel, radio, seats, etc.

MASK AND EYE PROTECTION

Personnel are required to use masks and protective eyewear, or face shields, when there exists a possibility for exposure to contaminated body fluids from the following:

- mucosal membranes
- eyes, mouth, or nose
- open wounds
- where splashes or aerosols of material are likely to occur

Such protective equipment is mandatory when providing emergency care to a patient's airway and during emergency childbirth. Masks may be placed on a patient when the potential for airborne transmission of disease exists. Routine care does not require the use of masks.

HAND-WASHING

Hand-washing is the single most important means of preventing the spread of infection. After removing gloves, hands and other skin surfaces will be washed thoroughly. Personnel should scrub hands briskly for 15-30 seconds with warm water and soap. Hand-washing signs will be posted in all fire station restrooms. (Copy of the PWFD hand-washing procedure is contained in Appendix II.)

Emergency response personnel must NEVER wash their hands in food preparation areas. When hand-washing facilities are not available, personnel should use a waterless hand cleaner according to manufacturer's directions. Waterless micro-bacterial hand cleaner is available on all response vehicles. When this method is used, the members must wash their hands according to the department hand-washing procedure as soon as possible.

SHARP INSTRUMENTS

To prevent needle stick injuries, contaminated needles will not be:

- recapped with two hands
- purposely bent or broken by hand
- removed from disposable syringes
- otherwise manipulated with two hands

All EMS vehicles are equipped with puncture resistant containers (sharps container) to dispose of needles, disposable syringes, and other sharp surface instruments. All needles and lancets on PWFD apparatus have safety caps or retractable needles for member safety.

RESUSCITATION EQUIPMENT

Mechanical respiratory devices are available to all emergency response personnel that respond, or potentially respond, to medical emergencies or victim rescues. Disposable resuscitation equipment should be the primary means of artificial ventilation. Mouth-to-mouth ventilation and the use of CPR micro-shields are not approved methods employed by the Port Washington Fire Dept.

SCENE MANAGEMENT

INCIDENT COMMAND

Emergency response personnel will use the Port Washington Fire Department Incident Command System to manage the emergency scene effectively. This includes the following infection control measures, but is not limited to:

- proper use of PPE (gloves, masks, eye protection, etc.) for patient care vs. extrication
- proper packaging and disposal of contaminated equipment.

PUBLIC RELATIONS

The Incident Commander will assure that personnel answer infection control questions arising from contact with the public consistently. Citizen inquiries about the use of PPE will be answered as follows:

"Our use of personal protective equipment is as much for the patient's safety as ours. Wearing such equipment assures your safety, and ours from any contaminants that may be present."

CARE AND CLEANING

EQUIPMENT CATEGORIES

There are three distinct levels of patient care equipment, each of which requires a different level of cleaning/decontamination.

1. NON-CRITICAL EQUIPMENT - such as stethoscopes and blood pressure cuffs. This level of equipment requires cleaning.

CLEANING- Cleaning is the physical removal of dirt and debris. Personnel should use soap and water, combined with scrubbing ac tion. The scrubbing action is the KEY to rendering all items safe for patient use. Cleaning is generally sufficient for non critical equipment. However, if non-critical equipment has become contaminated with blood or body fluids, they also must be disinfected.

2. SEMI-CRITICAL EQUIPMENT - such as stretchers, vehicle walls and floors, communication headsets, defibrillators, and drug boxes. This level of equipment requires disinfection.

DISINFECTION-Disinfection is reducing the number of disease producing organisms by physical or chemical means. Personnel should clean the item with soap and water, then apply a disinfect ing solution. Solutions such as chlorine bleach and water at a 1:10 dilution ratio are acceptable disinfectants. A fresh disinfectant solution must be made every day. Germicidal wipes or sprays with paper towels should be used. Bleach should be reserved only to decontaminate specific organism, such as C-*difficle*. DO NOT use bleach solution in the cleaning of electronic equipment. Refer to the MSDS for each disinfectant solution to decide what personal protective equipment may be needed. Remember, disinfectants can be toxic or caustic. Disinfection solutions should have an EPA registry number and show that they are effective against mycobacterium tuberculosis. Routine disposal of the germicidal cleaning water in the septic drainage system is acceptable.

3. CRITICAL EQUIPMENT - such as resuscitation equipment and intubation equipment. This level of equipment requires sterilization or high-level disinfection.

STERILIZATION/HIGH-LEVEL DISINFECTION- (Most of these items have been replaced with disposable equipment that should be discarded and replaced at the hospital or at FMCo.) However, High-level disinfection is the use of chemical liquids for sterilization. Personnel should clean the items, then place the items in special solutions for a prescribed time. Items must then be rinsed with sterile water. Refer to the Material Safety Data Sheets for each disinfectant solution to learn what personal protective equipment may be needed. Remember disinfectants can be toxic or caustic. Cidex (a chemical sterilization agent) or equivalent is an acceptable high-level disinfectant when used according to the manufacturer's directions. Routine disposal of the germicidal cleaning water in the septic drainage system is acceptable. Sterilization is the complete destruction of all microorganisms usually by steam or gasification.

CLEANING / DISINFECTING AREAS

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THE DESIGNATED CLEANING/RED BAG STATION FOR THE PWFD IS FIRE MEDIC COMPANY NO. 1 AT 65 HARBOR ROAD.

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Used equipment from an emergency incident should be placed in a leak-proof and labeled bag and transported DIRECTLY to the desig nated cleaning station for the PWFD. Biohazard waste containers
provided for contaminated equipment will have the biohazard symbol. A sample of a biohazard symbol is contained in Appendix

III. Each Company will transport their contaminated equipment to the specific area for cleaning contaminated equipment without stopping anywhere else first (other than the ambulance responding to the hospital with a patient):

- The area must only be used for cleaning contaminated equipment
- This area MUST NOT be used for the cleaning of SCBA facepieces
- This area must to be away from the station living quarters
- The area must be conspicuously marked with limited access to prevent accidental exposures.

Medical equipment must never be cleaned or disinfected in the station's living quarters, especially food preparation or eating areas. MSDS sheets for each disinfectant will be posted at a prominent place in the designated cleaning area.

LAUNDRY

Some fire stations are equipped with a clothes washer and dryer. The Port Washington Fire Department recommends that all members wash their outer garments involved at a call at the fire station to minimize the potential of spreading infection. Members who wear their on-duty outer garments between work and home should routinely change into a freshly laundered uniform before leaving the fire station. At a minimum, members should maintain a fresh change of clothing at the fire station so that in the event their work clothes become soiled, they may change into clean clothes before returning home. This minimizes the risk of carrying unknown infectious agents or disease producing micro organisms home on a dirty uniform to their family members.

> [Companies that do not have the ability to launder soiled garments in the fire station and do not plan to do so may opt to contract with an approved laundry service or replace the garments. In some cases, it may be more economical to have a total garment replacement policy if the number of occupational exposures anticipated is small in number.]

Outer garments that are grossly blood soiled should be disposed of as regulated biomedical waste. Department issued outer gear should be placed in a large clear biohazard bag and be brought to department headquarters, so it can be sent out for professional cleaning.

LINENS

Linen exchange with the receiving hospital is acceptable.
Linen soiled with body fluids will be handled with minimum agitation to prevent contamination of the person handling the linen.
All soiled linen will be dealt with according to the receiving hospitals' infection control guidelines.

CARE OF SPECIFIC CONTAMINATED EQUIPMENT

CLEANING KEY

1) Dispose
2) Cleaning (Multipurpose household or industrial cleaner)
3) Disinfection (1:10 Bleach & water solution) Germicidal wipes / spray
4) High-level Disinfectant (Cidex)
5) Launder

ARTICLE	CLEANING PROCEDURE
Airways (including ET tubes, Oropharyngeal, Nasopharyngeal	1
B/P Cuffs	2
Backboards	2
Bag Valve Masks	1
Bite Sticks ETT securement device	1
Bulb Syringe	1
Cannulas, Jv1asks	1
Cervical Collars	1 or 2
Dressings and Paper products	1
Drug boxes	3
Electronic Equipment	3
Emesis Basins	1
Firefighter Protective Equipment	5

	2
Humidifiers, Regulators, Tanks	3
KED	4
Laryngoscope handles /blades	1 or 5
Linens	3
MAST Suit	1
Needles/Syringes	1 or 2
Penlights	1 or 4
Pocket Masks	2
Restraints	1 or 4
Resuscitators (BVM) Scissors	3
Splints	2
Stethoscope	2
Stretcher Stylets	3
Suction Catheters	1 or 4
Suction Unit (collection jars)	1
Uniforms	5

In cases where the level of contamination is relatively low, i.e., blood or vomitus is present on the mechanical resuscitator's equipment's exterior, it should be cleansed and disinfected. Personnel should take care to make sure that all medical devices are still materially sound before placing them back in service whether they were used during the emergency operation or not.
Disposable items are more susceptible to wear than non-disposable items. Repeated non-emergent handling of these items may cause their failure. When contaminants such as blood or vomitus get into the interior of medical equipment it should be cleaned and disinfected or if this is not possible discarded and reordered.

For information about cleaning/disinfecting equipment not listed above, contact the Department Infection Control Officer.

BIOHAZARD WASTE

BIOHAZARD WASTE CONTAINERS
The Department of Environmental Conservation mandates the proper disposal of biohazard waste. Port Washington Fire Department supplies biohazard containers that meet, or exceed, OSHA and EPA specifications. When personnel generate biohazard waste at an incident, it is their responsibility to dispose of that material in a properly marked biohazard container.

When transporting biohazard waste aboard emergency response vehicles, the members will place such waste in appropriately marked leak-proof containers. Each emergency response vehicle will have at least one biohazard container available for their use. The Fire Department Biohazard collection station at Fire Medic Company will have at least one large container with a designated area for the storage of and pick up of biohazard waste. When preparing a biohazard container for disposal, personnel will wear both gloves and eye protection. This area must be away from the fire station living area and clearly marked with the biohazard symbol.

CONTAMINATED GLOVES

When gloves become contaminated they should be removed as soon possible taking care to avoid skin contact with the exterior of the gloves. All gloves will be considered contaminated and must be disposed of in an approved biohazard container. Personnel should never leave contaminated gloves on scene or throw them in an ordinary waste receptacle.

BIOHAZARD BAGS

Objects contaminated with potentially infectious materials must be placed in an impervious bag. If outside contamination of the bag is likely, a second bag will be added. The bag will have the signal word "BIOHAZARD" or other biological hazard symbol and, in

most cases, be red in color. The items may then be transported to an approved area for disposal or appropriate cleaning.

SHARP INSTRUMENTS

Disposable syringes, needles, lancets, scalpel blades, and other sharp items must be placed in the provided puncture-resistant containers for disposal. All patient care vehicles will have puncture-resistant containers on board.

OCCUPATIONAL EXPOSURES

The following is a quick reference guide concerning the different levels of exposure that personnel may encounter:

Occupational Exposure
Reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of a member's duties.

POST EXPOSURE INCIDENT PROTOCOL

I. Any member exposed to potentially infectious material will immediately wash the exposed area with appropriate cleaning agents or saline eye wash if the eyes are involved.

2. Any member having an occupational communicable disease exposure will immediately report the exposure to his or her super visor. Needlestick injuries will be reported to the Infection Control Officer immediately. Injuries involving unused, sterile needles should also be reported to the Infection Control Officer.

3. Care at the time of injury should consist of: A. Local wound care.
Local wound care will include washing the affected area with a germicidal soap and copious amounts of running water. The injury site should then be dressed as any other wound. Consideration of need for tetanus-diphtheria toxoid.

4. Occupational Exposures with a SUSPECTED contamination source should be handled as follows:

A. The member will fill out a communicable disease exposure report before being released from the emergency response activity for any of the following exposures:
- needlestick injury
- break in the skin caused by a potentially contaminated object
- splash of blood or other potentially infectious material into the eyes, mucous membranes, or no-intact skin
- other exposure that the member may feel is significant.

The report will include the details of the task being per formed, the means of transmission, the portal of entry and the type of PPE in use at the time.

The highest ranking FMCO Medical Duty Officer will review the communicable disease report with the Infection Control Officer and the Chief for exposure hazards. If a possible exposure oc curred, medical evaluation by the Department Physician or designee will be arranged no later than 48 hours post-exposure. If no exposure took place, the Infection Control Officer and the senior FMCO Medical Duty Officer will counsel the member on ex posure hazards. The Infection Control Officer will complete the communicable disease exposure report, indicating disposition of medical management, and file the report in the office of the Department Physician.

The member will be referred for infection control retraining or to stress counseling if necessary.

FORMS FOR EVALUATION OF EXPOSURE INCIDENTS

COMMUNICABLE DISEASE EXPOSURE FORM A sample copy of this form may be found in Appendix III. Notify the Chief, FMCO Medi cal Duty Officer, or the Infection Control Officer. Follow the procedure outlined in the Exposure Incident Protocol contained in this document.

POST EXPOSURE FOLLOW-UP

DOCUMENTATION

When a member experiences an Exposure Incident to a communicable disease, the incident must be documented within twenty-four hours of the suspected exposure on a "Communicable Disease Exposure Form." This documentation protects both the member and the department. Proper documentation is essential for insurance and compensation claims, and is useful for quality assurance and compliance monitoring.

All member medical records, including communicable disease exposures, are strictly confidential. The Communicable Disease Exposure Form will be forwarded to the senior FMCO Medical Duty Officer who will investigate the incident further.

NOTIFICATION

The Ryan White Comprehensive AIDS Resources Emergency Act of 1990 requires the receiving hospital's Infection Control Practitioner to notify the Fire Department's Infection Control Coordinator within forty-eight hours of a communicable disease diagnosis in a patient treated by a prehospital team member.

Upon notification, the Chief will notify the Senior FMCO Medical Duty Officer who will notify the involved member(s) and initiate any necessary follow up. It is the responsibility of the Infec tion Control Coordinator and the Senior FMCO Medical Duty Officer to document the incident and coordinate any follow-up activities with the Department Surgeon.

If the member suspects that a patient he may have attended may have an communicable disease that is transmitted by means other than aerosol, and that such member may have experienced an Exposure Incident, the Department Infection Control Coordinator will request, in writing, that the receiving medical facility make a determination of whether, on the basis of the information possessed by the medical facility, the member was exposed to an communicable disease.

By law, the receiving medical facility must notify the Department Infection Control Coordinator of the determination, in writing, within 48 hours whether or not the member was exposed. The Infection Control Coordinator will then notify the member and, if appropriate, the Department Surgeon.

VERIFICATION

Verification is the process of deciding if a reported exposure poses a real health risk to the member. The Infection Control Officer and the senior FMCO Medical Duty Officer will advise the member of any required follow up treatment. The Operational Medical Director and/or the Epidemiologist at the receiving hospital will determine the appropriate follow up treatment. The member will be verbally notified of any treatment within twenty-four hours, with written documentation to follow within forty-eight hours. If an exposure requires follow up treatment, follow the procedure in this Exposure Control Plan.

TREATMENT

Treatment is medical care given to reduce the chance of contracting a communicable disease after exposure. The type and timing of treatment varies with different diseases. Depending on the disease, treatment may be short- or long-term. Diseases that usually require post-exposure treatment include, but are not limited to:

- HIV
- hepatitis B
- non-A, non-B hepatitis
- meningitis
- tuberculosis

All post-exposure testing will be performed at the office of the PWFD Department Surgeon. The exception would be when the exposure is in conjunction with an injury, such as a laceration,

that requires prompt emergency care. In such cases the initial testing and treatment should be done simultaneously at the medical facility providing treatment. Emergency response personnel will be informed of the results of medical evaluation. They must be told about any medical conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment.

Serologic testing is available through the Department Surgeons Office. This is available to all emergency response personnel with concern about a possible communicable disease exposure, provided that they have documented the potential exposure. All testing and any required follow up treatment will be provided at no cost to the member.

B. The Department Surgeon will contact the Infection Control Director at the receiving medical facility to determine whether or not the patient has an infectious disease. Determination of risk will be based on medical information possessed by the medical facility treating the patient. The medical facility must respond to the Department's request in writing as soon as practical but not later than 48 hours after receipt of such request.
Although every attempt will be made to secure permission from the suspected source to perform appropriate blood tests, New York State law does not permit testing for infectious disease without the permission of the patient.

C. The injured member should be interviewed regarding any history of hepatitis, risk factors for exposure to hepatitis B, and hepatitis B immunization status. The following blood tests will be requested:

1. Anti-Hep BsAg (antibody to Hepatitis B surface antigen)
2. HIV antibody

Any personnel receiving an occupational exposure from a HIV positive patient should have an additional HIV antibody test done six weeks post-exposure. The HIV anti-body test must be repeated at 3, 6, 12 month intervals.

The results of these tests will be provided to the member with counseling from a physician. The results of these tests will remain in strict confidence between the firefighter/EMS provider and the attending physician. These tests will be done at the expense of the Port Washington Fire Department. The member will provide the Department Infection Control Coordinator with information necessary to comply with worker's compensation laws, and other department policies only.

CLINICAL ACTION REQUIRED FOR OCCUPATIONAL E X P O S U R E INCIDENTS

PATIENT TEST STATUS	DEPARTMENT MEMBER STATUS	ACTION REQUIRED FOR MEMBER
Hepatitis BsAg positive	Anti-Hep BsAg negative	Administer Hepatitis B immune globulin within forty-eight hours of the injury. This should be done even if they have received all of the Hepatitis B vaccine doses. Hepatitis B vaccine should be given within seven days of administration of the immune globulin. Repeat the anti-Hep BsAg one month post vaccination series.
Hep BsAg negative	Anti-Hep BsAg negative	Administer the Hepatitis B vaccine series. Repeat the anti-Hep BsAg one month post vaccination series.
Hepatitis B core antibody positive Hep BsAg negative	Not pertinent	The patient is not infectious; the patient is recover ing from an infec tion. No therapy needed.
Hepatitis B core antibody positive, Hep BsAg negative, and anti-Hep B negative	Not pertinent	Patient has an infection with Hepatitis B and is possibly infectious. Treat personnel with standard immune serum globulin.

Anti-Hep B positive	Not pertinent	Immunity to Hepatitis B is assured, or they have contracted Hepatitis B. In either case prophylaxis against Hepatitis B is not needed.
Elevated SGPT and SGOT levels	Not pertinent	Hepatitis-C is a possibility. Administer immune serum globulin.
Positive test for Hepatitis A	Not pertinent	Administer immune serum globulin.

III. Occupational Exposure Incidents from an UNKNOWN source should be handled as follows:

A. Test for anti-Hep BsAg.
B. The HIV anti-body will be tested at 3, 6, 12 month intervals post exposure.
C. If member tests anti-Hep BsAg negative:
    1. Receive hepatitis B immune globulin
    2. Repeat dose of Hepatitis vaccine at time of injury and test for anti-Hep BsAg one month post vaccination.
D. Prophylactic treatment for the presence of the HIV virus.

The Operational Medical Director, in consultation with the Department of Epidemiology at the Health Care Facility, will decide which agent is most appropriate.

REPORTING REQUIREMENTS

Employers have a responsibility under various federal and state laws and regulations to report occupational illnesses and injuries. Existing programs in the National Institute for Occupational Safety and Health (NIOSH), Department of Health and Human Services; the Bureau of Labor Statistics, Department of Labor, and the Occupational Safety and Health Administration receive such information for the purposes of surveillance and other objectives. State Health Departments report cases of infectious disease, including HIV and HBV, to the Centers for Disease Control. For the purposes of reporting such information, the Port Washington Fire Department will cooperate with the medical professionals treating its members for exposure to infectious diseases.

CONFIDENTIALITY OF PATIENT INFORMATION DISCLOSURES

All patient related information must be considered confidential. Generally, notification laws emphasize patient confidentiality, not full disclosure to the attending emergency response personnel.

The social stigma associated with AIDS, or testing positive for the virus that causes AIDS (HIV), is very strong in this country. Anyone can become a victim of this deadly disease, and not always through behavior on their part. No matter the means through which a person gets, the disease AIDS destroys their life. Beyond the killing effects of AIDS, these people suffer humiliation, harassment, neglect, and abandonment by our society. This is just as true for the hemophiliac that gets"AIDS from a blood transfusion as it is for the intravenous drug user.

EMS personnel learn things about patients through their patient care contact that the patient's most intimate friends, or relatives, don't know. They obtain this information because the patients trust them. Emergency services response personnel have a tremendous moral responsibility not to betray those confidences, as well as a legal one. On the federal level, there is legislation enacted in January 1992 designed to provide greater protection against discrimination to patients with HIV. The Americans with Disabilities Act classifies patients with AIDS or those who test HIV positive as handicapped citizens. This classification affords such patients the same protection against discrimination in our society as other handicapped citizens. This legislation will set the AIDS, or HIV positive, patient apart from patients suffering from other communicable diseases.

The Port Washington Fire Department emergency response personnel will use knowledge of a patient's communicable disease status for patient care only, not infection control purposes.

The same confidentiality standards apply to information regarding the communicable disease status of workers involved in emergency services response. This information is between the worker and the attending physician. The sharing of this information through any other means, including the "grapevine," is a violation of confidentiality standards. Appropriate disciplinary action will be taken towards individuals who violate these confidentiality standards.

HEALTH MAINTENANCE SYSTEM

The health maintenance system is designed to optimize the health of workers, and to minimize the risk of getting an occupational infection or injury. The health maintenance system includes: pre entry (or pre-employment) health assessment, periodic reassessment, yearly physicals, reporting of communicable disease exposures, and a member assistance program.

HEALTH ASSESSMENT

Sanford Ratner, M.D. has agreed to be responsible for guiding, directing, and advising personnel concerning their health, fit ness and suitability for various duties and has been designated as the Port Washington Fire Department Operational Medical Director. Health assessment examinations are available based on the PWFD Medical guidelines.

Members needing post-exposure follow-up care from an infectious disease exposure will receive follow-up care from a suitable Health Care Facility. If a need arises for medical exam informa tion contained in their physical conducted by the Operational Medical Director, members can authorize release of that information to the Health Care Facility.

DUTY RESTRICTIONS

Under certain circumstances, the supervising physician may prescribe duty restrictions or light duty assignment to members. These restrictions may be for infection control purposes or for other medical reasons. Members who are pregnant must provide the Department with written documentation from their private physician indicating the extent of any work limitations, i.e., full duty, light duty, etc.

Any emergency response personnel having a communicable disease, such as influenza, lesions with morbid oozing of fluids, or HBV, will be assigned to duty that does not require patient contact. This determination will be made through consultation with the member's private physician, and the Operational Medical Director. Members undergoing follow up for post-exposure reasons must keep medical appointments.

TRAINING

The Infection Control Coordinator in conjunction with the Senior FMCO Medical Duty Officer, Operational Medical Director and the Infection Control Officer will assure that all members receive education on precautionary measures, epidemiology, modes of transmission and prevention of HIV/HBV. Members will receive training regarding the location and proper use of personal protective equipment, work practices, and precautions to be used in handling contaminated articles and infectious waste prior to their assign ment to emergency response duties.

At a minimum, the training program will include the following:

1. An accessible copy of the Standard and an explanation of its contents.
2. A general explanation of the epidemiology and symptoms of blood-borne diseases.
3. An explanation of the modes of transmission of blood-borne pathogens.
4. An explanation of the Department's Exposure Control Plan and the means by which the members can obtain a copy of the written plan.
5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
6. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment.
7. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.
8. An explanation of the basis for selecting personal protective equipment.
9. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated and that the vaccine and vaccination will be provided at no cost to the member.
10. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
11. An explanation of the procedure to follow if an exposure occurs, including the method of reporting the exposure and the medical follow up that is provided to the member following an exposure.
12. An explanation of the signs and labels and/or color coding required by the Standard.
13. An opportunity for interactive questions and answers with the person conducting the training session.

The person(s) conducting the training will be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the members' work place. Training records will show the dates of training sessions, the

content of those training sessions, the names of all persons conducting the training, and the names of all who attended the training. Training records will be maintained for five years. All new members will receive this training before making any patient care contact.

APPENDIX I.

HEPATITIS B FORM

Recently OSHA enacted a law mandating that all agencies dealing in Emergency Medical Services or Fire Departments must offer all their "employees" (members) a series of 3 (three) Hepatitis B Vaccinations at no cost to the employee. For your own personal protection, I strongly recommend that you accept the P.W.F.D. 's offer to get the shots and have that extra margin of safety! The 3 shots to complete the series will be provided over a 6 month period and will be administered by the Department Surgeon. Under this program, you may refuse to receive the shots!

It is not mandatory that you get the shots, however if you choose not to do so, you must refuse in writing in the presence of a wit ness. The vaccination declination form for refusing the shots is on the bottom of this letter.

Whether or not you are going to have the shots, you must return this letter/form SIGNED to PWFD Headquarters.

Please check off the appropriate box below:

==========I DO WANT THE HEPATITIS B VACCINATION

==========I HAVE PREVIOUSLY HAD THE HEPATITIS B VACCINATION

DATE: BY WHOM:

==========I DO NOT WANT THE HEPATITIS B VACCINATION

(If you check this box, then sign the declination below)

Members Signature Date _ _ _ _ _

Witness Signature Date _ _ _ _ _

Must be a Company or Department Officer

(Either line or administrative)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Hepatitis B Vaccination Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of ac quiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I con tinue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccina tion series at no charge to me.

Members Signature _____Date _ _ _ _ _

Witness Signature Date _ _ _ _ _

Must be a Company or Department Officer

(Either line or administrative)

APPENDIX II.

HANDWASHING

PROCEDURE

Handwashing is the single most effective means of eliminating the spread of infection. Handwashing should be done before and after contact with the patient, after contact with body fluids and soiled items and after removal of gloves. Remove all rings because these harbor dirt and organisms. Wear your watch well above the wrist or place in a plastic bag if needed. Wet your hands and wrists with warm water and germicidal cleanser. Hold your hands below elbow level to avoid contaminating clean areas. For a routine handwashing, wash vigorously for approximately one minute under a stream of water; this removes most transient flora. Do not use bar soap. Avoid splashing water on yourself or the floor, because pathogens spread more easily on wet surfaces and slippery floors are dangerous. Avoid touching the sink or faucet which are considered contaminated. Work up a lather by rubbing your hands together vigorously. If you cannot remove your wedding band, move it up and down the finger to clean beneath the ring. Soap and water reduce organisms which wash away in the lather. The more vigorously you rub your hands when washing, the more contaminants remove. Pay special attention to the area under fingernails and around cuticles and the thumbs, knuckles, and sides of hands because organisms thrive in these protected or overlooked areas. Rinse hands and wrists well because running water flushes suds, soil and pathogens away. Keep your hand in the sink to prevent residue from running back up your forearm. Pat hands dry with a paper towel. Avoid rubbing which can cause abrasion and chapping. Turn off faucets by gripping them with a dry paper towel to avoid re-contaminating your hands. Discard paper towel in an appropriate receptacle.

APPENDIX III.

EXPOSURE CONTROL FORMS

COMMUNICABLE DISEASE EXPOSURE REPORT FORM

INFECTION CONTROL OFFICER EXPOSURE REPORT FORM

PORT WASHINGTON FIRE DEPARTMENT

COMMUNICABLE DISEASE EXPOSURE REPORT FORM

Incident Control # _____ Dept. I.D. # _____
Member: _____

Social Security #:_____ Company:_____
Phone Number: Home _____ _____
Work: _____Pager: _____
Type of Incident: _____
Date of Exposure: _____I I _____
Time of Exposure: _____
Describe how exposure occurred (be specific):
_____

_____
Were you exposed to:· Blood Tears · Feces Urine · Saliva
· Sweat · Vomitus Sputum
Other (specify)
_____

What part(s) of your body were exposed (check all that apply)? Arms · Legs
· Face · Hands Chest · Abdomen · Eyes
· Mouth
Other (be specific):

Did you have open cuts, rashes, etc. that became exposed (be specific):
_____
_____
Did you seek medical attention? Yes No If yes, location &
time: _____
Officer notified (name): _____ Date:
I I Time: _____
Infection Control Coordinator notified:
_____Date:_____I _____I _____ Time:
Name of Patient: _____
Male · Female
Address: _____
D.O.B: I I _ _ _ _
Suspected or Confirmed Disease:
_____
Transported to:
Transported by: _____
Member's Signature: Date: I l
Officer's Signature: Date: ---- ---- ----
Attach a copy of the Patient Care Report to this sheet ---- ----

PORT WASHINGTON FIRE DEPARTMENT

INFECTION_CONTROL_OFFICER'S_EXPOSURE_REPORT_FORM

Incident Control # _____

Member: _____Dept. I.D. #_____

Social Security #:_____ Company: _

_____

Phone Number: Home _____ _____

Work: _____ _____

Pager: ----------

Type of Incident: _____

Date of Exposure: _____/ _____/ _____

Time of Exposure: _____ _____

Date received: / _____/ _____

Hospital Contacted:

_____

Contact Person:

Check one of the following:

Patient has communicable disease

Name of disease:

_____

Patient tested; no communicable disease identified

Patient not tested; high suspicion of communicable disease

Patient not tested; low suspicion of communicable disease

Follow up by Operational Medical Director:

_____

Date of follow up: / / _____

Member contacted by: _____ Date:

/ / _____

I.C.C. name (typed or printed):

_____

I.C.C. signature: _____ Date: _

_____/ / _____

APPENDIX I V
REFEPENCES

- OSHA Instruction CPL 2-2.44C, Enforcement Procedures for Occupational Exposures to Hepatitis B Virus and Human Immunodeficiency Virus, March 6,1992
- 29 Code of Federal Regulations 1910.1030, Occupational Exposure to Blood-borne Pathogens
- National Fire Protection Association 1500, Standard for Fire Department Occupational Safety and Health Programs, 1987
- National Fire Protection Association 1581, Standard on Fire Department Infection Control Program, May 1991
- Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 38, No. S-6, 1989
- Guide to Developing and Managing an Emergency Service Infection Control Program, United States Fire Administration, June 1991

DISEASE.DOC