

Court Services and Offender Supervision Agency (CSOSA)



Exposure Control Plan

OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS AND TUBERCULOSIS

September 3, 2004

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SCOPE

The Federal Occupational Health (FOH) office of the Department of Health and Human Services conducted an assessment of the Court Services and Offender Supervision Agency's (CSOSA) staff responsibilities and work environments. FOH identified several positions within CSOSA that are at a very "low risk" for exposure to Tuberculosis (TB), an airborne transmissible disease. In addition, FOH determined that CSOSA employees are not involved in job responsibilities that may place them at risk for direct contact with blood and other potentially infectious materials (OPIM). The primary individuals deemed at risk for exposure to bloodborne pathogens are contract employees who work in the DNA blood collection and acupuncture labs.

In an effort to reduce or eliminate the risk of employee exposure to infectious diseases in the workplace, FOH recommended the development of an exposure control plan for bloodborne pathogens and TB.

It is the goal of CSOSA to reduce the possible incidence of exposure and to ensure its employees, contractors and clients are safeguarded from infection. This Exposure Control Plan (ECP) addresses bloodborne pathogens and TB.

A definition of terms from the Occupational Safety and Health Administration, U.S. Department of Labor is provided to clarify the terminology used in this document. See appendix A.

GENERAL STATEMENT

This Exposure Control Plan shall be:

1. Posted on CSOSA website;
2. Accessible to employees within 15 working days of their request;
3. Reviewed and updated at least on an annual basis by the contractor for Federal Occupational Health (FOH); and,
4. Reflective of all current Centers for Disease Control (CDC) recommended practices for protection of clients and staff.

This plan was developed in accordance with Policy Statement 5000, Exposure Control Policy for Tuberculosis and Bloodborne Pathogens and represents the minimum level of practices that must be adhered to. Failure to comply with the requirements of this plan may result in disciplinary action.

RISK ASSESSMENT FOR EXPOSURE TO TUBERCULOSIS

2001/2002/2003

As a part of CSOSA's risk assessment, the FOH representative contacted the District of Columbia Department of Health (DOH), Office of TB Control to obtain the number of cases reported in the general agency area for 2001-02. There were 51 active cases reported District-wide in 2001. No cases were reported in 2002. No new cases were reported to the CDC for 2003 as well.

On a national level there was a decrease in the number of TB cases in 2001-2002. In 2001, there were 16,377 cases, reported nationally. This represents a 7% decrease since 1997 and a 43.5% decrease since 1992. During 1997, the cases reported were primarily in foreign-born persons. Also during 1997, the number of cases in U.S. born persons decreased in all age groups. The most significant decrease was noted in persons between the ages of 25 - 44 years. In 2002 there were 12,120 cases reported nationally. This number combines typical, atypical and extra-pulmonary cases.

Based on the 2001-02 caseload, the areas serviced by CSOSA, fall in the "very low risk" category using the CDC's 1994 TB Guidelines, which OSHA is currently enforcing. Under the "very low risk" heading, the implementation of a respiratory protection program is not recommended or required. Additionally, CSOSA has not been notified by area hospitals of any potential exposures. Notification is required under the Ryan White Emergency Notification Law.

Considering the above information, CSOSA is not required to implement a Respiratory Protection Program based on the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, (October 1994).

Employees will be trained to screen offenders for active TB and any offender suspected of having active TB may be asked to wear a surgical mask. When possible, the windows in the office should be opened for risk reduction. Data will be monitored closely to determine the need to alter this risk determination.

EXPOSURE DETERMINATION

This Plan identifies CSOSA positions that are deemed to be at risk for exposure. This determination is assigned without the consideration of the use of personal protective equipment.

TUBERCULOSIS

Below is a list of CSOSA staff deemed at risk for exposure to TB. This determination was made by considering what positions might have the occasion to spend an extended period of time with clients in an unventilated room.

- Community Supervision Officers
- Treatment Specialists
- Addiction Assessors
- Intake Staff
- Residential Assessment & Orientation Center Staff

BLOODBORNE PATHOGENS

The exposure determination for personnel was made based on if it could be "reasonably anticipated" that an employee would come into contact with blood or other potentially infectious materials (OPIM). CSOSA employees are **not** at risk for exposure to bloodborne pathogens. FOH conducted a review of needle stick injuries on CSOSA employees for 2001-2002 and determined that CSOSA employees do not directly handle sharps. As a result of this review CSOSA employees are in a low-risk category for needle-stick or other sharps injuries.

The only individuals deemed at risk for exposure to bloodborne pathogens are contract employees. Several contractors employed by CSOSA who provide services that involve the use of needles or they may possibly have contact with sharps are at risk for exposure to bloodborne pathogens. The following contractors groups were reviewed for the purpose of exposure determination and have been deemed at risk are covered by this plan.

- FOH staff who conduct DNA collection
- Acupuncturist
- Protective Security Officers

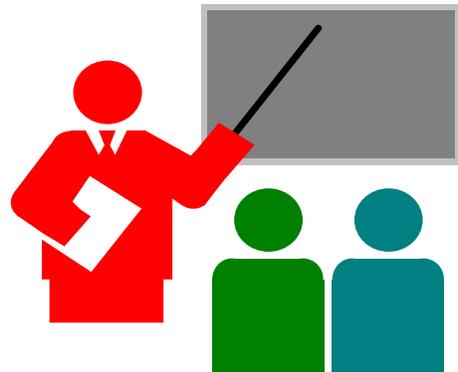
It should be noted, however, that should any CSOSA employee (or contracted employee) sustain a needle stick injury or an exposure to bloodborne pathogens or OPIM, they are covered under the Agency's policy for post-exposure management. All Procurement Contracting Officers are to ensure that all contracts for contractors identified in the ECP as "at

risk” for possible exposure to bloodborne pathogens, Tuberculosis (TB) or other potentially infectious materials, contain language that hold the contracted entity, or themselves, if self-employed, responsible for complying with the CSOSA ECP and the OSHA Act of 1970 with regards to their employee’s duties and responsibilities at CSOSA.

RATIONALE FOR EXCLUSION

The removal of positions from the “at risk” determination is based upon a review of job duties outlined in the job description and the requirements of the application for the position. Consideration was also given to the aspect of "reasonably anticipated" risk. The final decision regarding risk was determined by interviewing Agency personnel. However, in the event an individual not in the “at risk” group is exposed, they are covered under the post-exposure management protocol.

EDUCATION AND TRAINING



GENERAL GUIDELINES FOR EDUCATION AND TRAINING

On or before the end of July 2004, the FOH representative will train several CSOSA employees to conduct future annual updates of information provided to the agency by FOH in support of the plan and policy. All training will be provided during normal working hours.

General training will be provided to at risk employees before their initial assignment and on an annual basis. All other employees will receive training before or within six months of their initial assignment and on an annual basis. The Associate Director of Human Resources reserves the right to require additional training, as needed. Annual training for current employees identified in the “at risk” group will be completed within one year of their previous training. Training will update personnel on the diseases and changes in the policy, procedures or exposure rates. All training content will be reviewed on a continual basis and additional training will be scheduled.

Training will include:

1. A presentation of the Agency Exposure Control Plan;
2. Providing employees access to a copy of the appropriate OSHA standard and the Agency Exposure Control Plan;
3. A general explanation of the epidemiology of bloodborne disease and their symptoms, to include: HIV, Hepatitis B, Hepatitis C and Syphilis;
4. Education on the epidemiology and symptoms of tuberculosis;
5. A review of tasks that each employee performs and how they might be at risk for exposure;
6. A review of the use of personal protective equipment (PPE) and the limitations of PPE in certain circumstances;
7. The type of PPE that is available and why that type was selected;
8. Information on how to report and document an exposure;
9. Information will be provided on what action will be taken in an exposure situation, and how to seek medical attention;
10. Information on what options are available for medical follow up after an exposure;
11. Explanation of the signs and labels to be used in the handling and storage of medical waste;
12. Access to medical records upon request;
13. Latex Glove Allergy/Sensitivity Issues; and,
14. Hand washing techniques.

Training will allow for interactive questions and answers with a knowledgeable instructor. The instructor will be knowledgeable in communicable diseases and infection control and should be able to relate this information to each specific work area.

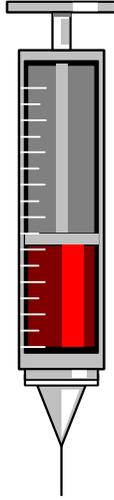
TRAINING RECORDS

Training records will include:

1. Dates of the training session;
2. The content (outline) or summary of the material presented;
3. The name and qualifications of the instructor;
4. The names and job titles of all persons attending the training session; and
5. The employees' signature.

All training records will be maintained for three (3) years. Training records are not confidential and will be provided upon request to the employee or the employee's representative within 15 days of the request. If the Court Services and Offender Supervision Agency should cease to do business, it shall notify the Director of the District of Columbia OSHA office at least three months prior to the end of business. The Director may require that all training records be transferred to the OSHA office before the end of the three-month period.

TB SKIN TESTING PROGRAM



TESTING FOR EXPOSURE TO TUBERCULOSIS

“AT RISK” PERSONNEL: The following personnel have been identified in the “at risk” category for exposure to Tuberculosis:

Community Supervision Officers
Intake Processing Staff
Treatment Specialists
Addictions Assessors
Assessment and Orientation Center Staff

Employees listed in the “at risk” group for possible exposure to tuberculosis (TB) will be offered baseline PPD skin testing and annual skin testing. (Employees may opt to have baseline and annual testing done at a medical facility of their own choice at their own cost and risk.) PPD administration for baseline and annual testing will be administered at the office of the FOH Unit located at 555 4th Street, NW, Level B1. An accredited laboratory will conduct the established FOH program for blood testing and medical follow-up. All laboratory tests will be conducted through a designated physician at the FOH Health Unit. Medical records of exposure medical management will be confidential.

New employees hired in positions deemed to be at risk for exposure to TB will be offered skin testing upon hiring to establish a baseline and then tested on an annual basis. If the rate of TB conversion appears to increase in employee population, testing may be recommended on a more frequent basis.

Testing for TB will be done using the Mantoux test - administration of PPD given by the intradermal method. This test will be read by a trained health care professional from FOH. Each employee should sign a consent or denial form. Employees who have not previously tested positive or have not been tested in the last 12 months will be offered a two-step test. A two-step test is required when a person has not previously tested positive or has not been tested in the last 12 months. The Mantoux test is performed and then redone within one or two weeks for definitive results. This is done to address the “booster phenomenon” and is in keeping with the current recommendations of the CDC. Consent or denial forms will be requested and kept on file in the employee medical records file. Examples of the following forms used by the employees for testing are located in Appendix B, Consent, Informed Denial, and Tuberculosis Surveillance for Annual Screening.

TEST RESULTS / WORK RESTRICTIONS

Individuals who test positive from the Mantoux skin testing but have negative chest x-rays are not contagious and may work.

Individuals who test positive from the Mantoux skin testing and have a positive chest x-ray or signs and symptoms of TB will be placed according to the work restriction guidelines.

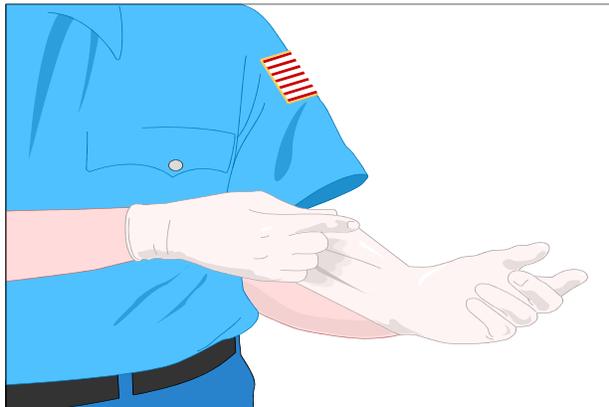
Their physician shall implement the restrictions in accordance with the guidelines set forth by the CDC in conjunction with a medical evaluation. Employees may not return to work until their personal physician provides clearance and information to the FOH unit regarding their readiness to return to work. The FOH unit is located at 555 4th Street, N.W., Level-B1, telephone number (202) 307-0014. If the disease is the result of an on the job exposure, CSOSA requires FOH physicians to provide all medical evaluation and follow-up services to ensure quality and continuity of care in compliance with CDC/OSHA reporting and treatment requirements. Should the employee choose to obtain services from their private physician/HMO, it will be at their own expense and at no cost to CSOSA.

FITNESS FOR DUTY CERTIFICATION

Newly-hired CSOSA employees will not be assigned clients until he/she has completed the required ECP training.

1. Newly-hired employees must provide written proof of any previous TB skin test results, if available, within two weeks of hire.
2. Newly-hired employees will be offered TB skin tests, infection control education and training immediately after hiring and/or after the completion of the Basic Skills Course if the employee is a CSO.
3. Newly-hired employees must complete and submit the Communicable Disease Health History and the Immunization Record (Appendix B). These are confidential forms and will be forwarded to and maintained by FOH.

ENGINEERING CONTROLS AND WORK PRACTICES



ENGINEERING CONTROLS/ WORK PRACTICES

Engineering controls include the redesigning of equipment to ensure employee risk reduction procedures that serve to reduce exposure such as the cleaning of equipment or areas that have been contaminated, and the use of barrier techniques to reduce direct contact with blood and OPIM.

CSOSA employees will follow the enclosed protocols in the course of their daily work to assist with risk reduction. Also, CSOSA will ensure that contractors comply with these workplace safety protocols/procedures. These protocols are in accordance with the documents published by the CDC, Infection Control and OSHA.

WORK PRACTICES

All employees will adopt the practice of Universal Precautions, as defined by OSHA, to reduce the risk for exposure to blood and OPIM.

Listed below are body fluids that are categorized as OPIM:

- Cerebrospinal Fluid
- Synovial Fluid
- Amniotic Fluid
- Pericardial Fluid
- Vaginal Secretions (sexual contact)
- Semen (sexual contact)
- Pleural Fluid
- Peritoneal Fluid
- Saliva in Dental Procedures
- Any body fluid containing Gross Visible blood

HAND WASHING PROCEDURES

Hand washing is the single most important means of preventing the spread of infection. Employees must wash their hands before and after client contact. CSOSA will ensure that soap or other hand washing solutions will be readily available at all CSOSA work sites for employee use. The following procedures should be used when washing hands:

- Scrub hands for at least 15 seconds;
- Use a friction rubbing motion after the soap is applied;
(Friction will assist in the removal of dirt, bacteria and other organisms)
- Rinse hands well under running water;
- Dry hands with a paper towel and use a paper towel to turn off the water faucet;
- The use of a waterless hand washing solutions is recommended when running water is not available, (i.e., Alcare, Hibistat and Cal-Stat). CSOSA will equip government vehicles with the recommended waterless hand washing solutions.

The routine use of antibacterial soap is not recommend. Proper hand washing procedures will be reviewed during training.

GENERAL PERSONAL PROTECTIVE EQUIPMENT

On or before January 2004, appropriate personal protective equipment will be provided to the employees with potential occupational exposure. Personal Protective Equipment (PPE) will be made available to all CSOSA facilities with positions classified as “at risk.” Issuance of PPE will be based on the needs of each particular work group and the anticipated exposure. PPE for personnel will include, but is not limited to: disposable gloves, protective eyewear and mask (surgical), waterless hand washing solution (alcohol based), and a biohazard bag.

1. An employee may decline the use of PPE in an emergency situation. This is in keeping with the OSHA Bloodborne Pathogens Regulation.
2. If clothing becomes contaminated with blood or OPIM then it shall be removed as soon as possible.
3. When disposable PPE is removed, it shall be placed in a designated container in an appropriate area for disposal.
4. PPE will be issued in appropriate sizes, and will be readily accessible at the worksite or will be issued directly to the employee.

The table listed below is to be used as a guide by CSOSA employees identified in the “at risk” group on the type of Personal Protection Equipment (PPE) required for performing the duties as listed. Information concerning the proper use of this equipment will be provided by the FOH representative during the initial training and update information concerning the use of this equipment will be provided annually.

Task	Gloves	Eyewear/ Mask	Lab Coat
Acupuncture	Required	Not required	Required
CPR	Required	Not required	Not required
Drug testing	Required	Not required	Not required
DNA Testing	Required	Not required	Required
Interview with client (suspected for active TB)	Not required	Place surgical mask on the client	Not required
Cleaning of Equipment	Heavy-duty utility required	Available but not required	Available but not required

The following PPE will be available to employees with the potential risk of occupational exposure.

GLOVES

All contractors and staff in the performance of duties in which they may have contact with blood, contaminated items/surfaces or other OPIM shall wear gloves. Gloves will be available for employee use at all CSOSA sites.

In an effort to comply with the National Institute of Occupational Safety and Health (NIOSH) Alert, CSOSA will move toward a latex free workplace.

- Disposable gloves shall be replaced as soon as practical when they become contaminated, torn or ripped.
- Disposable gloves shall not be washed for reuse. Following glove removal, hands should be washed
- Heavy-duty utility gloves should be used when cleaning contaminated equipment and surfaces.
- Heavy-duty utility gloves can be washed and reused as long as they are not torn or cracked.

MASKS

Surgical masks, which are molded and fitted, are required for offenders when there is a suspicion that the individual may have TB or an airborne transmissible disease. Masks will be available for employee use at all CSOSA sites.

PROTECTIVE CLOTHING

Appropriate protective clothing such as lab coats or aprons or similar outerwear shall be worn in exposure situations. This is appropriate for contract staff in “at risk” positions.

POCKET MASKS

All personnel trained in the administration of cardiopulmonary resuscitation (CPR) will be trained in the use of either a bag/mask device or a pocket mask. Training will include the proper method for disposal or cleaning.

CLEANING SCHEDULE

Contaminated areas of the urine collection lab and DNA collection room will be cleaned at the end of the day. All areas that are contaminated with blood/body fluids will be cleaned immediately after contamination occurs. A cleaning log for all labs and DNA collection rooms shall be maintained by the supervisor at each site.

CLEANING SOLUTION

The stock cleaning solution will be a bleach/water solution or Lysol. Bleach/water will be used for all blood cleaning activities. Cleaning blood-covered areas will be done with a bleach/water solution at 1:100 dilution = $\frac{1}{4}$ cup bleach per gallon of water. Lysol is mixed at 2 $\frac{1}{2}$ teaspoons per gallon of water. This can be used for 24 hours. Diluted bleach solution must not be stored in glass bottles.

ROUTINE CLEANING

A weekly cleaning schedule will be posted in the designated areas to be cleaned. Variance from the standard will be set by the supervisor and will be based upon the volume of offenders served. See appendix A for a sample of the cleaning log.

CLEANING NON- DISPOSABLE BAG MASK VENTILATION DEVICES

PROCEDURE

All non-disposable mask ventilation devices with bags should be sterilized after each use. Cleaning the bag after each use is a CDC requirement. When cleaning the device, sterile gloves and water should be used. To reduce the incidence of cross infection disassemble the device and follow these steps:

1. While wearing utility (dishwashing) gloves, disassemble the device;
2. After disassembling, wash the bag thoroughly with soap and water;
3. Rinse away the soap and allow the bag to air dry on a clean dry surface;
4. Soak the other parts of the device in a high-level disinfectant solution for at least 30 minutes or the amount of time recommended by the solution product manufacturer.
5. Rinse all parts of the device thoroughly with sterile water and allow them to air dry;
6. Check the manufacturers label for additional cleaning tips;
7. Thoroughly dry all of the parts before reassembling; and,
8. Reassemble and place the device in packaging to protect it until the next use.

CPR MANNEQUIN CLEANING AND TRAINING ISSUES

CSOSA will ensure that CPR Training provided by the American Redcross will adhere to the following procedures and guidelines:

BASIC CONSIDERATIONS

All persons responsible for CPR training should be thoroughly familiar with good hand washing procedures and the proper cleaning of mannequins.

If more than one cardiopulmonary resuscitation (CPR) mannequin is used, students should be assigned in pairs, with each pair having contact with only one mannequin.

Mannequins should be inspected routinely for cracks or tears in the plastic surfaces that could make cleaning more difficult.

The clothes and hair of the mannequin should be washed monthly or whenever visibly soiled.

CLEANING AFTER EACH PARTICIPANT

After each participant, the manikin's mouth and lips should be wiped with a 2X2-gauze pad wetted with a solution of 1:100 bleach and water solution or 70% isopropyl alcohol. The surface of the mannequin should remain wet for at least 30 seconds before it is wiped dry.

When a protective face shield is used, it shall be changed for each student.

TWO-RESCUER CPR

During the two-rescuer CPR, each student should have his/her own CPR mask, as there is not time to disinfect between students. The second student to practice ventilation should "simulate ventilation." This recommendation is consistent with the current training recommendations of the American Heart Association.

Training in the "obstructed airway procedure" involves the student using his/her finger to sweep foreign matter out of the mannequin's mouth. This action could contaminate the student's finger, if there is an open area, with saliva from the previous student. The finger sweep should be either simulated, performed on a mannequin that has been decontaminated, or done using a finger cot or glove.

CLEANING OF MANNEQUINS

1. Rinse all surfaces with fresh water;
2. Wet all surfaces with a mixture of bleach and water at a 1:100 dilution (1/4-cup bleach per gallon of water). This solution must be mixed fresh for each class; and,
3. Rinse with fresh water and dry all surfaces. (Rinsing with alcohol will aid drying time of internal surfaces and will prevent the survival and growth of bacteria and/or fungus.)

MEDICAL WASTE

Medical waste is defined by the District of Columbia in D.C. Act 12-263 (D.C. Official Code § 8-901), a copy of which is included in this document in Appendix C. Medical waste includes but is not limited to dressings, contaminated medical equipment, and contaminated protective (non-cleanable) clothing.

All medical waste will be contained in accordance with District of Columbia (D.C.) Code and the Environmental Protection Agency.

All sharps will be placed directly into a rigid container that is leak-proof, puncture-resistant and exhibits the universal biohazard symbol.

All items meeting the D.C. definition for medical waste will be placed into red biohazard waste bags. When bags are $\frac{3}{4}$ full, they will be placed into a cardboard box and prepared for pick up by the CSOSA contractor responsible for the disposal or reprocessing. Full containers awaiting pick up should be stored in the secured designated area with a biohazard label on the door. This is in accordance with D.C. Code and OSHA regulations.

Please note, urine cups and gloves used by the collection labs are not medical waste as defined above and do not require biohazard disposal methods. Urine cups should be emptied in a toilet and disposed in a plastic lined waste container. Gloves should be discarded after each use and disposed in a plastic lined waste container.

POST - EXPOSURE MANAGEMENT

PROTOCOLS AND RESPONSIBILITIES



POST EXPOSURE MANAGEMENT

Post exposure management protocols are set in accordance with OSHA 1910.1030. Protocols have been developed for both bloodborne and airborne pathogens. They provide specific instructions for response and reporting requirements.

In general, employees will be instructed to contact the Designated Health Officer (DHO) immediately, if they feel they have been involved in a possible exposure situation. Exposure reporting will be done with regard to bloodborne and airborne transmissible diseases. If necessary, the (DHO), will refer the employee directly to the FOH Unit and conduct the initial investigation of the incident. No referral will be made until the DHO has confirmed that an exposure occurred.

CSOSA will make immediately available to all exposed employees, evaluation, counseling and follow-up services by a health care professional at FOH, who is familiar with the OSHA standard, the CDC medical follow up guidelines, and the criteria for pre- and post- exposure counseling. Employees that seek counseling or testing medical treatment through a physician or organization other than FOH, do so at their own risk and cost. When employee's decline FOH evaluation and follow up, they must sign a Post Exposure FOH Declination Form (Appendix B).

An accredited laboratory will conduct the established FOH program for blood testing and medical follow-up. All laboratory tests will be conducted through a designated physician at the FOH Health Unit. Medical records of exposure medical management will be confidential.

Post Exposure Protocols Tuberculosis/Airborne Pathogens

Employee Protocol

If an employee, during their tour of duty, comes into contact with a client/offender who exhibits symptoms of active TB, (persistent coughing, fever [2-3 weeks duration], plus weakness, fatigue, coughing up blood or swollen lymph glands, the employee should take the following precautions:

1. Ask the offender if he/she have been tested for TB within the last three months.
 - a. If the offender has not been tested, the employee should refer the offender to the D.C. Department of Health, TB Testing Clinic. The offender may choose to be tested by his or her own physician. The employee should follow-up with the offender and the referral should be noted in the offenders file. If an offender is referred for TB testing the employee must follow the procedures listed below:
 - Notify DHO of suspected exposure incident; and,
 - Prepare the Employee Statement within 24 hours.
 - b. If the offender has been tested within the last three months, but the offender does not know the results of the test:
 - The offender should complete a medical release authorization form, (Form currently under revision by CSOSA's Office of the General Counsel. When final, form will be added to Appendix B.);
 - Notify DHO of suspected exposure incident;
 - Prepare the Employee Statement within 24 hours; and,
 - Obtain test results and inform the DHO of results.
 - c. If the results of the TB test are positive, the employee should follow the procedures below.
 - Contact the offender's medical provider or clinic and confirm if TB is active or dormant.
 - d. If active TB is present the employees should follow the procedures below:

- Notify the DHO immediately and submit the Employee Statement within 24 hours to the DHO.
 - If referral is approved by the DHO, the employee should report to FOH for evaluation, counseling and follow up. If employee declines referral to FOH they must sign the Post Exposure FOH Declination Form (See Appendix B) and he or she is not required to report to FOH.
 - Prepare and submit the appropriate forms to FOH: TB Screening Consent Form or Informed Denial Form, Exposure Report Form (to be completed by the DHO), Physician Counseling Documentation Form. (See Appendix B).
- e. If the offender refuses to cooperate, notify the DHO for follow up with the District of Columbia, Department of Health Tuberculosis Control Bureau, 202 698-4040, for offender testing information
 - f. If the employee has no documented negative test in the past three months, the Mantoux skin test should be given as soon as possible. If this test is negative the employee should be retested in 12 weeks (the incubation period is 4 – 12 weeks).
 - g. If the employee's test results are positive or they shows signs or symptoms of TB, a chest x-ray should be performed.
 - h. If the employee has previously tested positive, a Mantoux skin test is not required. A chest x-ray should be performed as soon as possible.
 - i. If test results are negative or TB is dormant, this information remains in FOH file and is not sent to the employer. It is confidential. No further action will be required. Healthy employees receiving prevention treatment for TB exposure will be allowed to continue to work.

Designated Health Officer (DHO)

When the DHO is advised of a possible exposure incident, the following steps should be taken:

1. Follow up with employee on results of offender's TB test.
2. If the offender's test is positive and active TB is present,
 - a. Obtain and review offender medical records (if possible),
 - b. Prepare the Exposure Report Form to determine if an exposure incident occurred; and
 - c. If determined an exposure did not occur, complete the Incident Report (Appendix B) and provide a copy to the employee.
 - d. Obtain and review Employee Statement.
3. If notified by the employee that the offender refuses to cooperate, contact the District of Columbia, Department of Health Tuberculosis Control Bureau, 202 698-4040, for offender

testing information. If there is no record of a test, proceed as if there is an exposure to active TB.

4. If an exposure incident occurred, immediately refer employee to FOH for evaluation and follow up as required. Request employee complete a medical release authorization form (Appendix B) and provide employee with the required forms (i.e., Exposure Report Form, TB Screening Consent Form or Informed Denial Form, and Physician Counseling Documentation Form. If employee declines referral to FOH they must sign the Post Exposure FOH Declination Form (Appendix B) and he or she is not required to report to FOH.
5. Forward Exposure Report Form and employee statement to FOH.
6. Contact FOH point of contact and request any additional instructions for reporting incident.
7. Conduct a follow up with employee for status of health.
8. If employee is tested, review Employee Protocols # 2 (d, e, f, g and h) for information; and,
9. If the offender's test results are negative or positive, but dormant, file test results, and the Exposure Report Form and employee's statement-in the confidential files.

Exposure Protocols - Bloodborne Pathogens

Post exposure protocols for bloodborne pathogens are similar to those for airborne pathogens in regards to the reporting process. Work related bloodborne exposures normally occur through sharps injuries or blood splatter/splash. If an exposure occurs, the employee, supervisor and DHO should follow the protocols for TB exposures as they relate to FOH referrals, completion and submission of forms and reporting requirements.

Contractors deemed "at risk" for bloodborne pathogens must follow the post exposure protocols set by their employer or company. If self employed, they can choose to follow the protocols set for CSOSA employees.

However, all injuries caused by sharps are **not** considered exposures. Some sharps injuries may be treated and remedied with first aid.

Some injuries can be treated accordingly:

First Aid	Medical Treatment
<ul style="list-style-type: none"> <input type="checkbox"/> Antiseptics during first visit <input type="checkbox"/> Application of bandage <input type="checkbox"/> Use of non-prescription medications <input type="checkbox"/> Single dose of prescription medication <input type="checkbox"/> Administration of tetanus shot or booster <input type="checkbox"/> Lab test or x-ray that shows no injury or infection from that injury 	<ul style="list-style-type: none"> <input type="checkbox"/> Treatment of infection <input type="checkbox"/> Application of antiseptics at 2nd and 3rd visits <input type="checkbox"/> Administration of >1 dose of prescription medication <input type="checkbox"/> Administration of hepatitis vaccination <input type="checkbox"/> Lab test or x-ray that shows injury or infection

In all cases the following steps should be taken immediately for the stated injuries.

1. If the exposure is a sharps injury:
 - A. Let the area bleed freely;
 - B. Wash the area with soap and water or use a waterless hand washing solution; and,
 - C. Notify the DHO.

2. If the exposure was a splash to the eye, nose or mouth:
 - A. Flush the area with water for 10 minutes and,
 - B. Notify your supervisor who will notify the DHO.

Sharps injuries should be reported and handled like all other work-related injuries. Additionally, all contaminated sharps injuries must be recorded in the Sharps Injury Log (Appendix B), and if warranted FOH will record injury in the OSHA FORM 300.

The following are potential injuries that may cause an exposure and should be recorded in the log, and reported to the DHO immediately:

1. A contaminated needle stick injury;
2. Blood/OPIM in direct contact with the surface of the eye, nose, or mouth;
3. Blood/OPIM in direct contact with an open area of the skin; and,
4. Cuts with a sharp object covered with blood/OPIM.

Other work-related sharps injuries that are recordable in the log, (if contaminated or not), are injuries that;

1. Cause a death;
2. Cause an illness;
3. Requires medical treatment beyond first aid (even if treatment is offered and refused);
4. Sharps injury equals exposure.

Sharps-related exposure information may be recorded on a separate document or may be included in the data you collect following an exposure investigation. It is acceptable to maintain the information in computer files if you are able to sort the report for sharps injuries only and access it in a timely manner for OSHA if requested. This information is also confidential and subject to the same requirements and restrictions of other confidential medical information.

POST EXPOSURE RESPONSIBILITIES

FOH

Counseling and baseline testing of the employee will be done in the FOH Health Unit for employees who consent to receive treatment at FOH.

In case of exposures, if the exposure was a needle stick injury or an exposure to TB resulting in a positive skin test, FOH will also complete an OSHA 300-report form and the Sharps Injury Log. The physician at FOH will issue a letter of written opinion within 15 business days of the exposure event.

FOH will maintain all employee medical records for the duration of employment plus an additional thirty years as set forth in the OSHA regulation. All employee medical records will be kept confidential. The files will be locked and located in the FOH Health Unit. Contents will not be disclosed or reported to any person within or outside the workplace without the employees express written consent, except as required by law or regulation.

In the District of Columbia, consent of the tested individual is required to obtain medical information if there has been an actual exposure. Employees who wish to obtain a copy of their medical record, must fill out the request form and FOH will make a copy available within fifteen business days at no cost.

CSOSA

CSOSA will furnish any and all relevant medical information to the FOH office.

On or before December 2004, CSOSA will insure that an accurate medical record will be established and updated for each employee deemed to be at risk for exposure. The records will be held and maintained by the FOH Health Unit and can be accessed upon written request by the employee or third party authorized by the employee. (In accordance with the appropriate laws and regulations.

Information contained in the medical records will include:

1. Name and social security number of the employee;
2. A copy of the Immunization Record, titer test results, and PPD test result/status;
3. Consent/Denial forms;
4. A copy of results of examinations and follow up procedures as required by the OSHA regulation;
5. A copy of the healthcare providers written opinion(s) following an exposure;
6. A copy of the information provided to the healthcare provider as required, to assist with medical follow up; and,
7. Documentation of the route of exposure, and the circumstances under which the exposure occurred.

COMPLIANCE MONITORING



COMPLIANCE MONITORING

The Court Services and Offender Supervision Agency recognizes its responsibility to provide personal protective equipment, education and training, and post exposure reporting/follow-up for its employees at risk for exposure. It also notes the responsibility of the employees to comply with the established policy/procedures set forth in the Exposure Control Plan. Thus, supervisors with employees identified as having job responsibilities that place them at risk, will conduct compliance monitoring activities on a regular basis. The time frame between monitoring will be decided by the Designated Health Officer. (A sample Compliance Monitor Chart is located in Appendix B for your reference.)

The purpose of compliance monitoring is to verify that the program for reducing employee exposure is “on track.” It will also ensure the Agency is in compliance with all applicable laws, standards and guidelines. Additionally, compliance monitoring will serve to identify training needs or problems. Employees found not to be in compliance with this Exposure Control Plan will be subject to corrective measures, i.e. training, counseling, etc. Employee conduct that requires intervention will be noted and maintained by the supervisor on an Intervention Report (Appendix B).

DISCIPLINARY ACTION POLICY

The purpose of the exposure control plan is to reduce the risk for occupational exposure. This plan is effective if followed as written. Periodic and unannounced monitoring will be conducted to ensure that employees are complying with this plan.

Compliance with the exposure control plan is the responsibility of all employees. Intervention Reports will be made for each incident of non-compliance. This form will also be used to document information from any staff interviews regarding the incidents. Retraining and education will be offered. Disciplinary action may be taken according to the CSOSA personnel policy, when deemed necessary.

EXPOSURE CONTROL PLAN DEVELOPMENT

This Exposure Control Plan was developed by Katherine H. West, BSN, MS Ed, CIC; an Infection Control Consultant with Infection Control/Emerging Concepts, Inc.; in conjunction with the Offices of Management and Administration, Human Resources, and Community Supervision Services. Any questions regarding this plan should be addressed to the DHO in the Office of Human Resources at 220-5600, or Arla Scott, Management Analyst, Office of Management & Administration at 220-5433.

Implementation of this plan is the responsibility of the Court Services and Offender Supervision Agency.

DOCUMENTS USED IN THE PREPARATION OF THIS PLAN:

1. APIC Core Curriculum - Infection Control
2. 29 C.F.R. § 1910.1030 - Bloodborne Pathogens
3. 29 C.F.R. § 1910.20 - Medical Records
4. Centers for Disease Control and Prevention – 1994 Guidelines for Prevention and Control of Tuberculosis
5. Centers for Disease Control- 1989, Guidelines for Public Safety Workers
6. 42 C.F.R. Part 84 Subpart K, Volume 60
7. West KH: Infectious Disease Handbook for Emergency Care Personnel, ACGIH, 3rd Edition, 2001
8. NIOSH Alert, Latex Glove Sensitivity, June, 1997
9. CDC Guidelines for Health Care Worker Infection Control, Draft, Federal Register, September, 1998
10. Guidelines for Infection Control in Health-Care Personnel, 1998, AJIC, June, 1998
11. Medical Waste Regulations, District of Columbia
12. OSHA Instruction CPL 2-2.44D, Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, Nov. 5, 1999
13. NIOSH Alert, Preventing Needle stick Injuries in Health Care Settings, November, 1999
14. Needlestick Safety and Prevention Act, P.L. 106-430
15. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post exposure Prophylaxis, MMWR, June 29, 2001
16. OSHA Enforcement Procedure for Bloodborne Pathogens Regulation, CPL 2-2.69, November, 2001
17. Guidelines for Hand Hygiene in Healthcare settings: Recommendations of the Healthcare Infection Control Practices Committee, MMWR, October 25, 2002/51(RR16); 1-44

Definition of Terms
OSHA — Occupational Safety & Health Administration
U.S. Department of Labor

Bloodborne pathogens. - 1910.1030

Regulations (Standards - 29 CFR) - Table of Contents

- Part Number: 1910
- Part Title: Occupational Safety and Health Standards
- Subpart: Z
- Subpart Title: Toxic and Hazardous Substances
- Standard Number: 1910.1030
- Title: Bloodborne pathogens.
- Appendix: A

1910.1030(a) **Scope and Application.** This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

1910.1030(b) **Definitions.** For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Hand washing Facilities means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HCV means hepatitis C virus.

HIV means human immunodeficiency virus.

Needleless systems means a device that does not use needles for: (1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) The administration of medication or fluids; or (3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.

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

Other Potentially Infectious Materials means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Prophylaxis means the prevention of disease, preventive treatment.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research-laboratory-scale amounts of HIV or HBV. Research laboratories may produce high concentrations of HIV or HBV but not in the volume found in production facilities.

Sharps with engineered sharps injury protections means a non needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the

developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

In addition to the above OSHA defined terms, CSOSA references the terms below throughout this plan.

Active Tuberculosis: the contagious stage of Tuberculosis when the TB bacteria becomes active and starts to destroy lung tissue and may spread to other parts of the body via the bloodstream. Individuals with dormant TB bacteria may test positive for TB but are not contagious until the bacteria becomes active.

“At Risk”: CSOSA employees or contractors who are at risk for possible exposure to bloodborne pathogens, Tuberculosis (TB) or other potentially infectious materials based on the CSOSA exposure determination conducted by FOH.

Exposure or Exposure Incident: bloodborne pathogens means a specific mouth, non-intact skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. The terms “exposure and exposure incident” are used interchangeably for both bloodborne and airborne pathogens in the Exposure Control Policy and Plan.

Exposure or Exposure Incident: airborne pathogens means an exposure during the performance of duties, to persons with active Tuberculosis (TB), who sneeze, cough, speak or sing during their interaction. The airborne pathogens are infected particles that travel on normal air currents throughout a room or building. The exposure incident occurs when the employee inhales the particles via mouth or nasal passages during the employee – offender interaction. The terms “exposure and exposure incident” are used interchangeably for both bloodborne and airborne pathogens in the Exposure Control Policy and Plan.

PPD Test: A simple skin test referred to as the Mantoux test, used to detect prior exposure to tuberculosis. PPD, a purified protein derivative of tuberculin, is injected under the skin of the forearm. After 48 to 72 hours, the injection site will exhibit a red, hard bump if a person has been infected with tuberculosis.

Sharps Injury: a parenteral injury caused by needles, needlesticks or any sharp object.

Titer Test: A test to measure the presence and amount of antibodies in blood against a particular type of tissue, cell or substance.

Tuberculosis (TB) Skin Testing Program – CSOSA will offer all employees in the “at risk” group for possible exposure to tuberculosis. Testing will be done using the Mantoux test, administration of PPD, to establish a baseline. The test will also be offered on an annual basis for monitoring purposes. If the rate of TB exposures appears to increase, testing may be recommended on a more frequent basis.

APPENDIX B

CONTENTS LIST

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Communicable Disease Health History

Name: _____

Confidential Information

Disease

Date of Illness

Measles (Rubeola) _____

Measles (Rubella) _____

Mumps _____

Chickenpox _____

Hepatitis _____ Type _____

Tuberculosis _____ Type _____

Meningitis _____ Type _____

Malaria _____ Type _____

HIV infection _____

Allergies:

Medications _____

Latex _____



Immunization Record

Name: _____

Confidential Information

Immunization/Vaccine

Date of Administration

Hepatitis B Vaccine

Antibody Titer

Result _____

Measles, Mumps, Rubella

TB Skin Test

Result _____

Tetanus/Diphtheria

Chickenpox Vaccine

Flu Vaccine



Tuberculosis (Mantoux) Screening Test Consent Form

I have attended an educational session or received pertinent information about exposure to Tuberculosis (TB). This included information regarding the Mantoux skin test, which is used to determine if the bacteria that causes tuberculosis is residing in my body.

I understand that I may be exposed to Tuberculosis and that I may be at risk for acquiring Tuberculosis. I understand that the Centers for Disease Control and Prevention (CDC) and the Occupational Safety & Health Administration (OSHA) recommend that I be tested for exposure to TB.

I have been given the opportunity to be tested using the Mantoux skin test through FOH, at no charge to myself. I understand I have the right to be tested at the medical facility of my choice at my cost and risk. If I chose a facility other than FOH I understand I must provide the results of testing to FOH. I have had the opportunity to ask questions regarding TB and the skin- testing program. Based on this information, I elect to be tested for exposure to TB.

Name: _____

Signature: _____

Position Title: _____

Date: _____

Administered By:

Name: _____
(Print name and title)

Signature: _____

Date of Test: _____ Date Read On: _____

Result: _____



Tuberculosis (Mantoux) Screening Test

INFORMED DENIAL

I have attended an educational session or received pertinent information about exposure to Tuberculosis (TB) as it relates to my position at CSOSA. This included information regarding the Mantoux skin test, which is used to determine whether the bacteria causing TB is residing in my body.

I understand that I may be occupationally exposed to TB and that I may be at risk for acquiring TB. I understand that the Centers for Disease Control and Prevention and the Occupational Safety and Health Administration recommend that I be tested to determine whether I have contracted TB.

I have been given the opportunity to be tested using the Mantoux skin test, at FOH, at no cost to myself, or at a medical facility of my own choice. However, I decline TB screening at this time. I understand that, by declining this screening, I am at risk of having TB exposure without my knowledge. I understand that I will be able to obtain testing for TB exposure in the future if I change my mind.

Name: _____
(Please print your name)

Signature: _____

Division/Branch: _____

Position Title: _____

Date: _____



Tuberculosis (TB) Surveillance

Annual TB Screen for Positive Reactions

Name: _____

Job Classification: _____

Since records indicate that you have previously tested positive on PPD skin testing, the following questions must be answered each year as part of our annual TB surveillance program.

Please complete this form and return to: _____

During the past year, have you experienced or are you now experiencing any of the following signs/symptoms?

	<u>YES</u>	<u>NO</u>
Weight loss (unrelated to dieting)	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough (2 – 3 weeks duration)	<input type="checkbox"/>	<input type="checkbox"/>
Fever/Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>

Print Name

Signature

Date: _____



POST – EXPOSURE

FOH DECLINATION FORM

I understand that due to my occupational exposure I may be at risk for acquiring _____ disease.

(Please check box.)

I have been given the opportunity to be treated prophylactically by FOH for this exposure, at no charge to myself. However, I decline follow up medical treatment from FOH at this time. I understand if I do not seek treatment, I continue to be at risk for acquiring the disease to which I have been exposed. I understand that if I acquire this disease I will be placed under the Agency's work restriction guidelines.

Name _____ Date _____

Signature _____



**Court Services and Offender Supervision Agency
for the District of Columbia**

EXPOSURE REPORT FORM

Patient Information:

Name: _____ Sex _____ Age _____ Patient # _____

Exposure Information: Bloodborne Airborne

Exposed to: Blood Hands Nose
 Bloody Fluid Face Mouth
 Other _____ Eyes Other _____

Personal Protective Equipment Used: Yes No Type: _____

Task Being Performed: _____

Needle Safe Device Used: Yes No

Employee Information:

Name: _____ Exposure Date: _____

Phone # (H) _____ (W) _____

Exposure Time: _____

Exposure Location: Facility _____ Unit: _____

Reported To: _____

First Aid Performed: Yes No

Source Patient Blood Drawn: (HIV rapid test, HBV, HCV) Yes No

Reporting Process:

Supervisor Notified: Yes No

Post-Exposure Follow Up:

Employee Given Source Patient Test Results: Yes No

Date: _____ Time: _____

Employee Medical Follow Up Referral to: _____



Physician Counseling Documentation Form

This form is to serve as documentation that _____, an employee of CSOSA has been advised of the result of laboratory testing that was performed on _____. This laboratory work was performed for the purpose of:

____ Post exposure medical follow up

____ Post hiring physical examination

Appropriate counseling was provided to this employee and all test results will remain confidential. A copy of the results will be held in the employee's confidential medical record.

Physician Signature

Employee Signature

Date: _____



Court Services and Offender Supervision Agency for the District of Columbia

OSHA Regulations (Standards - 29 CFR)

Sample authorization letter for the release of employee medical record information to a designated representative (Non-mandatory) - 1910.1020AppA

- Standard Number:** 1910.1020AppA
 - Standard Title:** Sample authorization letter for the release of employee medical record information to a designated representative (Non-mandatory)
 - Subpart Number:** Z
 - Subpart Title:** Toxic and Hazardous Substances
-

I, _____, (full name of worker/patient) hereby authorize
_____ (individual or organization holding the medical records) to release
to _____ (individual or organization authorized to receive the medical
information), the following medical information from my personal medical records:

(Describe generally the information desired to be released).

I give my permission for this medical information to be used for the following purpose:

But I do not give permission for any other use or re-disclosure of this information. (Note: Several extra lines are provided below so that you can place additional restrictions on this authorization letter if you want to. You may, however, leave these lines blank. On the other hand, you may want to (1) specify a particular expiration date for this letter (if less than one year); (2) describe medical information to be created in the future that you intend to be covered by this authorization letter; or (3) describe portions of the medical information in your records which you do not intend to be released as a result of this letter.)

Full name of Employee or Legal Representative

Date

Signature of Employee or Legal Representative

Date

[6R 31427, June 20, 1996]



Sharps Injury Log

Date: _____

Employee Name	Device Used	Task Performed	Location of the Incident



**Court Services and Offender Supervision Agency
for the District of Columbia**

INTERVENTION / INCIDENT REPORT

INTERVENTION

INCIDENT

Employee Name: _____

Branch/Office: _____

Date: _____

Incident: _____

Intervention: _____

Decision: _____

Completed by: _____

Designated Health Official

Date



SAMPLE Compliance Monitor Chart

Date: _____

Area: _____

Criteria	Compliance		Observation/Notes	% Compliance
	Yes	No		
Urine specimens are processed according to proper procedures	<input type="checkbox"/>	<input type="checkbox"/>		
Handwashing solutions are available	<input type="checkbox"/>	<input type="checkbox"/>		
Handwashing solution containers are filled	<input type="checkbox"/>	<input type="checkbox"/>		
Waterless hand wash solutions are available	<input type="checkbox"/>	<input type="checkbox"/>		
Personal Protective attire is readily available	<input type="checkbox"/>	<input type="checkbox"/>		
Stocked medical supplies are in a clean area	<input type="checkbox"/>	<input type="checkbox"/>		
Laundry facilities are provided <input type="checkbox"/> Contracted Service	<input type="checkbox"/>	<input type="checkbox"/>		
Specified area for cleaning equipment	<input type="checkbox"/>	<input type="checkbox"/>		
Exposure incidents and follow up are in the employee health record	<input type="checkbox"/>	<input type="checkbox"/>		
Immunization records are in each employee health file	<input type="checkbox"/>	<input type="checkbox"/>		
Education and training records are in each employee health file	<input type="checkbox"/>	<input type="checkbox"/>		
Employee job descriptions contain information on OSHA Category assignment	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		



SAMPLE Compliance Monitor Chart -2

Date: _____

Area: _____

Criteria	Compliance		Observation/Notes	% Compliance
	Yes	No		
Solutions for high level disinfection are in date, covered and in an appropriate container	<input type="checkbox"/>	<input type="checkbox"/>		
There is documentation of all routine cleaning of equipment in drug testing area	<input type="checkbox"/>	<input type="checkbox"/>		
Needle-disposal containers are located at the site of use	<input type="checkbox"/>	<input type="checkbox"/>		
Staff is aware of the policy for reporting exposure situations	<input type="checkbox"/>	<input type="checkbox"/>		
Bio-hazards signs are properly posted	<input type="checkbox"/>	<input type="checkbox"/>		
Infectious waste containers are readily available	<input type="checkbox"/>	<input type="checkbox"/>		
There is a designated area for storage of infectious waste	<input type="checkbox"/>	<input type="checkbox"/>		
Records area maintained for infectious waste removal and disposal	<input type="checkbox"/>	<input type="checkbox"/>		
Exposure incidents have been reviewed and discussed	<input type="checkbox"/>	<input type="checkbox"/>		
Exposure follow up is documented for each incident	<input type="checkbox"/>	<input type="checkbox"/>		

Action/Follow Up _____

Date for Next Review: _____

Employee Interview: _____

DC ST § 8-901

Formerly cited as DC ST 1981 § 6-2911

DISTRICT OF COLUMBIA OFFICIAL CODE 2001 EDITION
DIVISION I. GOVERNMENT OF DISTRICT.
TITLE 8. ENVIRONMENTAL AND ANIMAL CONTROL AND PROTECTION
SUBTITLE B. WASTE DISPOSAL AND MANAGEMENT.
CHAPTER 9. ILLEGAL DUMPING ENFORCEMENT.
§ 8-901. Definitions.

For the purposes of this chapter, the term:

(1) "Commercial purpose" means for the purpose of a person's economic gain.

(1A) "Dispose" means to discharge, deposit, dump, or place any solid waste in the District of Columbia.

(2) "District" means the District of Columbia.

(2A) "Hazardous waste" means any waste or combination of wastes of a solid, liquid, contained gaseous, or semisolid form which, because of its quantity, concentration, or physical, chemical, or infectious characteristics, as established by the Mayor, may:

(A) Cause, or significantly contribute to an increase in mortality or an increase in serious irreversible, or incapacitating, reversible, illness; or

(B) Pose a substantial present or potential hazard to human health or the environment when improperly treated, stored, transported, or disposed of, or otherwise managed. Such wastes include, but are not limited to, those which are toxic, carcinogenic, flammable, irritants, strong sensitizers, or which generate pressure through decomposition, heat, or other means, as well as containers and receptacles previously used in the transportation, storage, use or application of the substances described as a hazardous waste.

(3) "Mayor" means the Mayor of the District of Columbia.

(3A) "Medical waste" means solid waste from medical research, medical procedures, or pathological, industrial, or medical laboratories. Medical waste includes, but is not limited to, the following types of solid waste:

(A) Cultures and stocks of infectious agents and associated biologicals, including cultures from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(B) Pathological waste, including tissues, organs, and body parts that are removed during surgery or autopsy;

(C) Human blood waste and products of blood, including serum, plasma, and other blood components;

(D) Sharps that have been used in patient care or medical research, or industrial laboratories, including hypodermic needles, syringes, pasteur pipettes, broken glass, and scalpel blades;

(E) Contaminated animal carcasses, body parts, and bedding of animals that were exposed to infectious agents during research, production of biologicals, or testing of pharmaceuticals;

(F) Waste from surgery or autopsy that was in contact with infectious agents, including soiled dressings, sponges, drapes, lavage tubes, drainage sets, underpads, and surgical gloves;

(G) Laboratory waste from medical, pathological, pharmaceutical, or other research, commercial, or industrial laboratories that was in contact with infectious agents, including slides, and cover slips, disposable gloves, laboratory coats, and aprons;

(H) Dialysis waste that was in contact with the blood of patients undergoing hemodialysis, including contaminated disposable equipment and supplies such as tubing, filters, disposable sheets, towels, gloves, aprons, and laboratory coats;

(I) Discarded medical equipment and parts that were in contact with infectious agents;

(J) Biological waste and discarded materials contaminated with blood, excretion, exudates and secretion from human beings or animals who are isolated to protect others from communicable diseases; and

(K) Such other waste material that results from the administration of medical care to a patient by a health care provider and is found by the Mayor to pose a threat to human health or the environment.

(4) "Motor vehicle" means any conveyance propelled by an internal combustion engine, electricity, or steam.

(5) "Person" means any individual, partnership, corporation (including a government corporation), trust, association, firm, joint stock company, organization, commission, the District or federal government, or any other entity.

(6) "Solid waste" means combustible or incombustible refuse. Solid waste includes dirt, sand, sawdust, gravel, clay, loam, stone, rocks, rubble, building rubbish, shavings, trade or household waste, refuse, ashes, manure, vegetable matter, paper, dead animals, garbage or debris of any kind, any other organic or inorganic material or thing, or any other offensive matter.

CREDIT(S)

(May 20, 1994, D.C. Law 10-117, § 2, 41 DCR 524; May 9, 1995, D.C. Law 11-12, § 3(a), 42 DCR 1265; Apr. 18, 1996, D.C. Law 11-110, § 15(a), 43 DCR 530; Apr. 29, 1998, D.C. Law 12-90, § 2(a), 45 DCR 1308.)

HISTORICAL AND STATUTORY NOTES

Prior Codifications

1981 Ed., § 6-2911.

Temporary Amendments of Section

Section 3(a) of D.C. Law 10-191 amended (1) to read as follows:

"For the purposes of this chapter, the term:

"(1) "Dispose" means to discharge, deposit, dump, or place any solid waste in the District of Columbia."

Section 4(b) of D.C. Law 10-191 provided that this act shall expire on the 225th day of its having taken effect or upon the effective date of the Recycling Fee and Illegal Dumping Amendment Act of 1994, whichever occurs first.

Temporary Addition of Section

D.C. Law 10-62 enacted §§ 8-901 through 8-904, comprising chapter 9 of title 8.

Expiration of Law 10-62: Section 8(b) of D.C. Law 10-62 provided that the act shall expire on the 225th day of its having taken effect or upon the effective date of the Illegal Dumping Enforcement Act of 1993 whichever occurs first.

Emergency Act Amendments

For temporary addition of chapter 29A, see §§ 2-6 of the Illegal Dumping Enforcement Emergency Act of 1993 (D.C. Act 10-89, August 4, 1993, 40 DCR 6074) and §§ 2-6 of the Illegal Dumping Enforcement Congressional Recess Emergency Act of 1993 (D.C. Act 10-138, November 1, 1993, 40 DCR 7741).

For temporary amendment of section, see § 3 (a) of the Recycling Fee and Illegal Dumping Emergency Amendment Act of 1994 (D.C. Act 10-269, July 7, 1994, 41 DCR 4669).

Legislative History of Laws

D.C. Law 10-62, the "Illegal Dumping Enforcement Temporary Act of 1993," was introduced in Council and assigned Bill No. 10-353. The Bill was adopted on first and second readings on July 13, 1993, and September 21, 1993, respectively. Signed by the Mayor on October 4, 1993, it was assigned Act No. 10-115 and transmitted to both Houses of Congress for its review. D.C. Law 10-62 became effective on November 20, 1993.

Law 10-117, the "Illegal Dumping Enforcement Act of 1994," was introduced in Council and assigned Bill No. 10-249, which was referred to the Committee on Public Works and the Environment. The Bill was adopted on first and second readings on December 7, 1993, and January 4, 1994, respectively. Signed by the Mayor on January 25, 1994, it was assigned Act No. 10-181 and transmitted to both Houses of Congress for its review. D.C. Law 10-117 became effective on May 20, 1994.

Law 10-191, the "Recycling Fee and Illegal Dumping Temporary Amendment Act of 1994," was introduced in Council and assigned Bill No. 10-701. The Bill was adopted on first and second readings on June 21, 1994, and July 19, 1994, respectively. Signed by the Mayor on August 4, 1994, it was assigned Act No. 10-317 and transmitted to both Houses of Congress for its review. D.C. Law 10- 191 became effective on October 1, 1994.

Law 11-12, the "Recycling Fee and Illegal Dumping Amendment Act of 1995," was introduced in Council and assigned Bill No. 11-15, which was retained by Council. The Bill was adopted on first and second readings on January 17, 1995, and February 7, 1995, respectively. Signed by the Mayor on March 6, 1995, it was assigned Act No. 11-23 and transmitted to both Houses of Congress for its review. D.C. Law 11-12 became effective on May 9, 1995.

Law 11-110, the "Technical Amendments of 1996," was introduced in Council and assigned Bill No. 11-485, which was referred to the Committee of the Whole. The Bill was adopted on first and second readings on December 5, 1995, and January 4, 1996, respectively. Signed by the Mayor on January 4, 1996, it was assigned Act No. 11-199 and transmitted to both Houses of Congress for its review. D.C. Law 11-110 became effective on April 18, 1996.

Law 12-90, the "Illegal Dumping Enforcement Amendment Act of 1998," was introduced in Council and assigned Bill No. 12-167, which was referred to the Committee on the Judiciary. The Bill was adopted on first and second readings on December 4, 1997, and January 6, 1998, respectively. Signed by the Mayor on January 26, 1998, it was assigned Act No. 12-263 and transmitted to both Houses of Congress for its review. D.C. Law 12-90 became effective on April 29, 1998.

Miscellaneous Notes

Mayor authorized to issue regulations: Section 6 of D.C. Law 10-62 provided that the Mayor is authorized to promulgate regulations necessary to implement and enforce this act in accordance with subchapter I of Chapter 15 of Title 1.

Mayor authorized to promulgate regulations: Section 7 of D.C. Law 10-117 provided that the Mayor is authorized to promulgate regulations necessary to implement and enforce this chapter in accordance with subchapter I of Chapter 5 of Title 2.

DC CODE § 8-901

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