The new ATD rules were codified as Title 8, Chapter 4, Subchapter 7, Article 109, Section 5199. The full text can be found at [http://www.dir.ca.gov/oshsb/atdproptext.pdf](http://www.dir.ca.gov/oshsb/atdproptext.pdf). The regulations require compliance by covered health care facilities and providers, which are summarized below.

Scope and Application

Scope. This section applies to work in the following facilities, service categories, or operations:

Each of the following health care facilities, services, operations:

- Hospitals
- Skilled nursing facilities
- Clinics, medical offices, and other outpatient medical facilities
- Facilities where high hazard procedures, as defined in subsection (b), are performed
- Home health care
- Long term health care facilities and hospices
- Medical outreach services
- Paramedic and emergency medical services including these services when provided by firefighters and other emergency responders
- Medical transport

Facilities, services, or operations that are designated to receive persons arriving from the scene of an uncontrolled release of hazardous substances involving biological agents, as defined in Section 5192, Hazardous Waste Operations and Emergency Response, of these orders.

Police services provided during transport or detention of persons reasonably anticipated to be cases or suspected cases of aerosol transmissible diseases; and police services provided in conjunction with health care or public health operations.

Public health services, such as communicable disease contact tracing or screening programs that are reasonably anticipated to be provided to cases or suspected cases of aerosol transmissible diseases, and public health services rendered in health care facilities or in connection with the provision of health care.

The following facilities, services or operations that are identified as being at increased risk for transmission of aerosol transmissible disease (ATD) infection:

- Correctional facilities and other facilities that house inmates or detainees
- Homeless shelters
- Drug treatment programs

Facilities, services or operations that perform aerosol-generating procedures on cadavers such as pathology laboratories, medical examiner’s facilities, coroner’s offices, and mortuaries.

Laboratories that perform procedures with materials that contain or are reasonably anticipated to contain aerosol transmissible pathogens – laboratory (ATP-L) or zoonotic aerosol transmissible pathogens as defined in Section 5199.1.
Any other facility, service or operation that has been determined in writing by the Chief of the Division of Occupational Safety and Health through the issuance of an Order to Take Special Action, in accordance with Section 332.3 of these orders, to require application of this standard as a measure to protect employees.

Maintenance, renovation, service, or repair operations involving air handling systems or equipment or building areas that may reasonably be anticipated to be contaminated with aerosol transmissible pathogens (ATPs) or ATPs-L, including:

- Areas in which Airborne Infectious Disease (AirID) cases and suspected cases are treated or housed.
- Air handling systems that serve airborne infection isolation rooms or areas (AIIRs).
- Equipment such as laboratory hoods, biosafety cabinets, and ventilation systems that are used to contain infectious aerosols.

In cases where an employee faces an increased risk of occupational exposure to ATDs, the regulations require that the employer provide special respirator protection at its own cost. A surgical mask is insufficient; the respirator must be at least as effective as the N95 filtering facepiece respirator. Employees covered by these enhanced protections include those who work in contaminated areas or in areas designated for the isolation or quarantine of ATD cases or those whose jobs include the handling of infected cadavers or transport of exposed materials or persons. Where applicable, these employees must be fitted annually for a respirator (the details of which are outlined in the regulations) and must use the respirator rather than a simple surgical mask.

I. EXPOSURE CONTROL PLAN POLICY

A. Riverside County Department of Public Health (DOPH) is committed to providing a safe and healthful work environment for our employees. The following exposure control plan is provided to eliminate or minimize occupational exposure to aerosol transmissible diseases. All health care workers* (HCW) employed at the Department of Public Health will adhere to the requirements outlined in the Exposure Control Plan (ECP) that follows:

B. Compliance with the ATD Standard requires the following activities:

1. Establishing and implementing a written ATD Exposure Control Plan
2. Providing engineering and work practice controls.
3. Providing personal protective equipment and respiratory protection.
4. Developing isolation plans for identified or suspected cases of ATDs.
5. Providing initial and annual training.
6. Ensuring accurate recordkeeping
7. Providing medical services to exposed workers.
C. Administrative Controls

1. Procedures have been developed to reduce employees’ exposure to persons with infectious TB or other aerosol transmissible diseases. Each Branch of the Department of Public Health is responsible for ensuring that healthcare workers follow established protective measures. The responsibility of the Branch Chief (or designee) for monitoring compliance, reporting non-compliance, and the action taken in response to non-compliance is clearly defined and communicated to the healthcare workers.

2. Each Branch is responsible for documenting that appropriate training has been given and that necessary personal protective equipment has been provided.

3. When monitoring reveals repeated failure to follow recommended practices after additional supplies, education and/or retraining, and counseling have been provided, disciplinary action may be taken according to usual progressive disciplinary procedure.

4. The Department of Public Health is responsible for the provisions of a work place free from recognized hazards. This includes healthcare workers on-site employed by another agency, volunteers, and students from all programs.

5. The Chief of Medical Services is responsible for obtaining physician compliance in following protective measures and safe work practices. This includes salaried, contract, resident, and student physicians.

6. Policies have been developed to insure the rapid detection, isolation, evaluation, and treatment of individuals likely to have TB, or other aerosol transmissible diseases.

7. Any room or area where an infectious TB, or other aerosol transmissible diseases case is placed, will be posted in such a way that employees will be apprised of the exposure hazard before entering the room or area.

II. GOALS OF THE ATD EXPOSURE CONTROL PLAN

A. The goal of the ATD Exposure Control Plan (ATDECP) is early identification, isolation, and treatment of persons who have active TB, or other ATDs, to reduce the risk of exposure for healthcare workers (HCWs).

B. The primary objectives of the plan are:

1. The use of administrative measures to reduce the risk of exposure to persons who have infectious TB, or other aerosol transmissible diseases.

2. The use of engineering controls to prevent the spread and reduce the concentration of infectious droplet nuclei.

3. The use of personal respiratory protective equipment in areas where there is still a risk for exposure to TB, or other aerosol transmissible diseases.

C. This ECP includes information on the following:

1. Determination of employee exposure
2. Implementation of various methods of exposure control, including:
   a. Engineering and work practice controls
   b. Personal Protective Equipment (PPE)
   c. Respiratory Protection Program
3. Post-exposure evaluation and follow-up
4. Communication of hazards to employees
5. Recordkeeping
6. Procedures for evaluating circumstances surrounding an exposure incident
7. Training requirements
8. Requirements for laboratories

III. DEFINITIONS

A. The standard contains definitions of key terms used in the document (see ATD Standard, page 3 - 8).

B. An abbreviated list is provided.

1. **Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP)**
   A disease or pathogen for which droplet or airborne precautions are required, as listed in Appendix A of the ATD standard.

2. **Aerosol transmissible pathogen -- laboratory (ATP-L)**
   A pathogen that meets one of the following criteria: (1) the pathogen appears on the list in Appendix D, (2) the Biosafety in Microbiological and Biomedical Laboratories (BMBL) recommends biosafety level 3 or above for the pathogen, (3) the biological safety officer recommends biosafety level 3 or above for the pathogen, or (4) the pathogen is a novel or unknown pathogen.

3. **Airborne Infection Isolation (AII)**
   Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens, and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

4. **Droplet Precautions**
   Infection control procedures as described in Guideline for Isolation Precautions designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.
5. **Exposure Incident**
   An event in which all of the following have occurred: (1) An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or to equipment that is reasonably expected to contain ATPs associated with a reportable ATD; and (2) The exposure occurred without the benefit of applicable exposure controls required by this section, and (3) It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

6. **Exposure Incident (laboratory)**
   A significant exposure to an aerosol containing an ATP-L, without the benefit of applicable exposure control measures required by this section.

7. **High Hazard Procedures**
   Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

8. **Novel or Unknown ATP**
   A pathogen capable of causing serious human disease meeting the following criteria:
   a. There is credible evidence that the pathogen is transmissible to humans by aerosols; and
   b. The disease agent is:
      i. A newly recognized pathogen, or
      ii. A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or
      iii. A recognized pathogen that has been recently introduced into the human population, or
      iv. A not yet identified pathogen.

*Note:* Variants of the human influenza virus that typically occur from season to season are not considered novel or unknown ATPs if they do not differ significantly in virulence or transmissibility from existing seasonal variants. Pandemic influenza strains that have not been fully characterized are novel pathogens.
9. **Occupational Exposure**
Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs or ATPs-L if protective measures are not in place. In this context, “elevated” means higher than what is considered ordinary for employees having direct contact with the general public outside of the facilities, service categories and operations listed in subsection (a)(1) of the ATD Standard.

10. **Referring employer**
Any employer that operates a facility, service, or operation in which there is occupational exposure and which refers AirID cases and suspected cases to other facilities. Referring facilities, services and operations do not provide diagnosis, treatment, transport, housing, isolation or management to persons requiring AirID. General acute care hospitals are not referring employers. Law enforcement, corrections, public health, and other operations that provide only non-medical transport for referred cases are considered referring employers if they do not provide diagnosis, treatment, housing, isolation or management of referred cases.

11. **Source control measures**
The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an ATD, such as persistent coughing.

12. **Suspected case**
Either of the following:
(1) A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence, to probably have a particular disease or condition listed in Appendix A of the ATD standard.
(2) A person who is considered a probable case, or an epidemiologically-linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Appendix A of the ATD standard.

13. **TB conversion**
A change from negative to positive as indicated by TB test results, based upon current CDC or CDPH guidelines for interpretation of the TB test.

### IV. AEROSOL TRANSMISSIBLE DISEASE EXPOSURE CONTROL PLAN

#### A. Employer Requirement

The Riverside County Department of Public Health shall establish, implement, and maintain an effective, written ATD Exposure Control Plan which is specific to the work place or operation(s), and which contains all of the elements in subsection (d)(2) of the ATD standard.

#### B. Administration of Plan

1. **Plan Administrator**

The Director for Disease Control is responsible for the annual review and update of the plan.
2. Schedule and Method of Implementation of All Provisions of the Plan  
   a. As of July 2010, all new healthcare workers will be educated on the components of the ATD Standard Plan and how to access a copy on the first day of employment, with additional training coordinated by the appropriate Disease Control staff and the designated trainer during the orientation period. 
   b. All existing healthcare workers will be educated on the components of the ATD Plan on their date of annual recertification.

3. Annual Review  
   a. The Plan will be reviewed and revised as appropriate on an annual basis.  
   b. The approved Plan, as well as verification of the annual review, will be maintained with the Public Health Officer (PHO) or designee.

4. Accessibility  
   a. The Exposure Control Plan is located in each Family Care Center, each Branch, and in health administration of the Department of Public Health. All healthcare workers are notified when they begin employment and during their annual recertification, of the location of the Plan and may review the Plan whenever desired.

C. List of Job Classification in Which Employees Have Occupational Exposure  

1. All healthcare workers (HCWs) have been placed in 1 of 3 categories for the potential of occupational exposure based on degree of direct patient contact, and/or exposure to air potentially contaminated with tubercle bacilli or other aerosol transmissible diseases.

2. The classification into exposure categories was determined without consideration of use of Personal Protective Equipment (PPE).
# AEROSOL TRANSMISSIBLE DISEASE STANDARD (ATD) EXPOSURE CONTROL PLAN FOR
## CATEGORY I
### HIGH EXPOSURE POSSIBILITY
(Direct contact w/TB or other ATD patients, laboratory specimens or contaminated air systems/equipment)
- Assistant Nurse Manager+ #
- Certified Medical Assistants+ #
- Clinic Laboratory Technologist II+ ▶
- Communicable Disease Branch Chief ☠
- Environmental Services Worker (custodian) ***
- Health Care Social Worker (TB) + #
- Health Care Social Worker #
- Health Services Assistant (TB) + #
- Health Services Assistant + #
- Industrial Hygienist I, II, III + #
- Licensed Vocational Nurse I & II+ #
- Laboratory Assistant + #
- Laboratory Director ☠
- Laboratory Manager ☠
- Laboratory OA II ☠
- Laboratory Secretary ☠
- Medical Consultant (TB) + ☠
- Medical Social Worker + #
- Nurse Managers + #
- Nurse Practitioner + #
- Physician + #
- Physician Assistant + #
- Preventive Medicine Residents †#
- Principal Public Health Physician + #
- Public Health Microbiologist + ☠
- Radiology Technologist+ ☠
- Registered Nurse (includes PHNs and Sr. PHNs) (TB) + #
- Registered Nurse (includes PHNs and Sr. PHNs) + #
- Senior Industrial Hygienist #
- Senior Laboratory Assistant + #
- Student Nurse #
- Supervising Clinic Site Nurse + #
- Supervising Public Health Microbiologist + #

*TB testing every 6 months
#TB testing every 12 months
◊Pertains to ISS Personnel in CHA Facilities, CHA Procurement and CHA Shipping and Receiving Departments
+Requires respiratory protection for situations described in section IV, D.
**Stocking/cleaning Family Care Centers

## CATEGORY II
### LOW EXPOSURE POSSIBILITY
(Contact with patients/clients who do not routinely exhibit signs and symptoms of ATDs in FCCs or other clinic settings)
- Admissions and Collections Clerk
- CHA Program Coordinator
- Communicable Disease Specialist
- Dental Assistant
- Dentist
- Disaster Preparedness Coordinator
- EMS Director+, EMS Specialist+ - patient contact when needed as secondary and tertiary responders
- Medical Therapy Unit Aide (MTU)
- Non-Medical Volunteers – clinic-based
- Nutrition Intern
- Occupational Therapist (OT)
- Occupational Therapy Assistant
- Office Assistant II & III (clinic based & MTU)
- Physical Therapist (PT)
- Physical Therapy Assistant
- Physician (office based)
- Physician Assistant+

Registered Nurse – Office based – patient contact when needed as surge responders, for ATD outbreaks, or other public health emergency (includes, PH Program Chief, Director of Public Health Nursing, NM, ANM, PHNs, Sr. PHNs)

- Senior Communicable Disease Specialist
- Senior Occupational Therapist
- Senior Physical Therapist
- Supervising Nutritionist
- Supervising Occupational Therapist
- Supervising Office Assistant
- Supervising Physical Therapist
- Support Services Technician**
- Volunteer
- Volunteer Services Manager

## CATEGORY III
### MINIMAL EXPOSURE POSSIBILITY
(No direct contact with patients)
- Accounting Clerk
- Accounting Technician
- Administrative Director
- Administrative Services Analyst
- Administrative Services Assistant
- Administrative Services Officer I & II
- Agency Support Services Classifications ◩
- Assistant Human Resources Officer
- Assistant Public Health Administrator II
- California Children’s Services Technician
- California Children’s Services Technician Coordinator
- Community Dental Hygienist
- Community Development Representative
- Data Entry Operator II
- Data Processing Coordinator
- Deputy Director I & II
- Director of Health Education
- Director of Public Health Dietetic Technician
- Epidemiologist
- Epidemiologist Analyst
- Environmental Services Worker (custodian, non-clinic based)
- Environmental Tech
- Executive Assistant
- Executive Secretary II
- Facilities and Internal Support Services Chief
- Facilities and Material Management Assistant
- Fiscal Officer
- Graphic Arts Illustrator
- Health Education Assistant II
- Health Educator
- Health Information and Community Outreach Manager
- Health Services Assistant (non-medical)
- HIV/AIDS Program Chief
- Human Resources Officer
- Human Resources Clerk
- Internal Audit Manager
- IT Officer II
- Medical Records Specialist II
- Medical Transcriptionist II
- Non-Medical Volunteers – not in patient care areas
- Nutrition Intern
- Nutrition Services HSA
- Nutritionist
- Office Assistant II & III (non-clinic based & MTU)
- Principal Accountant
- Professional Student Intern
- Public Health Program Chief I & II (non-licensed)
- Safety Coordinator
- Secretary I & II
- Senior Accountant
- Senior Accounting Clerk
- Senior Accounting Technician
- Senior Computer Systems Technician
- Staff Development Officer
- Senior Health Educator
- Student Nurse, non-clinic based
- Statistician
- Supervising Accountant
- Supervising Data Entry Operator
- Supervising Office Assistant I & II - non-clinic based
- Support Services Technician
- Support Services Supervisor
- Systems Administrator

Note: TB testing every 24 months

Note: TB testing every 12 months

Rev. 06/10
D. List of High Hazard Procedures

1. Sputum induction; or aerosolized medication administration

2. A procedure performed on a suspect or confirmed infectious TB case, which can aerosolize body fluids likely to be contaminated with TB bacteria, but not limited to:
   a. Operative procedures, such as thoracotomy, or lung biopsy;
   b. Respiratory care procedures, such as tracheostomy or endotracheal tube care;
   c. Diagnostic procedures, such as bronchoscopy, pulmonary function testing; gastric aspirates;
   d. Resuscitative procedures performed by emergency personnel.

3. Autopsy, laboratory, research, or production procedures performed on tissues known or suspected to be infected with TB, which can aerosolize TB-contaminated fluids.

4. Transporting a smear positive patient.

5. Repairing, replacing or maintaining air systems or equipment that may be anticipated to contain aerosolized M. tuberculosis, or other aerosol transmissible diseases.

E. List of Assignments or Tasks Requiring Personal Protective Equipment

<table>
<thead>
<tr>
<th>High Hazard Procedures/Conditions</th>
<th>Job Classifications</th>
<th>Personal Protective Equipment/Respiratory Protection</th>
<th>Engineering Controls/Work Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum Induction</td>
<td>HSA, CMA, LVN, RN/PHN</td>
<td>N95 respirator and gloves</td>
<td>Respirate Criminal Flow Hood</td>
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<td></td>
<td></td>
<td></td>
<td>UV Light</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Effective hand hygiene</td>
</tr>
<tr>
<td>Transporting Infectious Patients</td>
<td>HSA, CMA, LVN, RN/PHN, HCSW</td>
<td>N95 respirator</td>
<td>Patient in surgical mask</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Separate patient in vehicle, windows down</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Effective hand hygiene</td>
</tr>
<tr>
<td>Making home visit to an infected patient</td>
<td>RN/PHN, HSA, HCSW</td>
<td>N95 respirator</td>
<td>Interview outdoors if appropriate</td>
</tr>
<tr>
<td>Providing medical care to patients suspected or confirmed to have an ATD (e.g. establishing airway)</td>
<td>MD, 3A, NP, RN/PHN, Radiology Technician, CMA and HSA</td>
<td>N95 respirator, lab coat, or protective covering</td>
<td>Place patient in negative pressure isolation room, if available</td>
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<td></td>
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<td>Return if no negative pressure room</td>
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<td></td>
<td>Conform at least 12 air exchanges per hour</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Post clearance time for each isolation room</td>
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<td></td>
<td></td>
<td></td>
<td>Effective hand hygiene</td>
</tr>
<tr>
<td>Changing filters in the HGPA filter machine (repairing or replacing)</td>
<td>CMA, HSA, Environmental Services Worker, Clinic Based, RN/PHN</td>
<td>N95 respirator, gloves and gown</td>
<td>Effective hand hygiene after removing gloves</td>
</tr>
<tr>
<td>Maintaining/maintaining air systems or equipment that may be anticipated to contain aerosolized M. tuberculosis or other ATDs</td>
<td>Industrial Hygienist Building Services Maintenance Worker Building Services Maintenance Mechanic Building Services Air Conditioning Mechanic Building Services Engineer</td>
<td>N95 respirator</td>
<td>Effective hand hygiene after removing gloves</td>
</tr>
<tr>
<td>Handling materials containing TB and other Aerosol Transmissible Pathogens Laboratory (ATP-L)</td>
<td>Supervising PI Microbiologist, Public Health Microbiologist, Laboratory Manager, Senior Laboratory Assistant and Laboratory Assistant</td>
<td>Refer to DHSEO Laboratory Biosafety Plan</td>
<td>Refer to DHSEO Laboratory Biosafety Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effective hand hygiene</td>
</tr>
</tbody>
</table>
F. **Specific Control Measures**

1. **Containment**
   a. Identification of a symptomatic person
      All staff must be proactive in noticing a person who is coughing severely and notify the Triage Nurse.*
   b. Triage
      i. Triage of persons with pulmonary symptoms must be done by a designated licensed staff member.
      ii. A coughing patient is to immediately be masked and placed in an Isolation Room, or escorted outside to wait for a medical evaluation.
      iii. If there is no functional Isolation Room, the symptomatic and/or infectious patient is to be interviewed outside and referred to the nearest Family Care Center/Health Clinic with an Isolation Room.
      iv. Prompt medical evaluation of persons with symptoms suggestive of TB, or other ATDs, must be done by qualified, licensed health care professionals.
         *(Reference: DOPH Triage Protocol)*

2. **Engineering controls**
   a. Effective Ventilation requires:
      i. Air exchanges of minimum twelve/hour in exam room
      ii. Air should be exhausted to the outside and not recirculated within the facility;
      iii. Negative pressure in areas used for high-risk procedures, exam and respiratory isolation; validation of negative pressure will be done daily according to established procedures.
   b. All respiratory precaution areas must be identified and posted when in use
      i. The sign will be readily observable and shall be consistent with Cal OSHA’s requirements (See Attachment 2).
      ii. Specific wording shall be: “No Admittance Without Wearing a Type N-95 or More Protective Respirator”.
      iii. Specific “wash-out” time will be included for each isolation room (e.g., Aerosol Room Use Log – See Sample log: Attachment 3).
      iv. Airborne Infection Isolation (negative pressure) rooms will be tested daily per clinic procedure to confirm the rooms are functioning appropriately.

3. **Air decontamination**
   a. Ultra Violet (UV) light is to be maintained in all sputum induction rooms or in air ducts with appropriate precautions against employee eye injury. Appropriate hazard communication signs will be visibly posted.
   b. All UV lights are to undergo cleaning and bulb replacement, according to established procedure.
   c. Reverse Laminar Hoods are to be used in all sputum induction rooms, with regular maintenance according to established procedures.
   d. Equipment will be inspected for proper operation and safety on an annual basis, or more frequently if problems are identified.
4. Personal Protective Equipment
   a. Appropriate Protective Equipment will be provided to employees at no cost.
   b. HEPA Respiratory Protection Program
      i. Staff must be fit tested, and receive instructions on use and care.
      ii. Staff must adhere to the Department’s respiratory protection program.
      iii. A written Respiratory Protection program containing instructions on the use of respirators is included in this Plan.

G. Source Control Measures

1. Respiratory Precautions to be used by patient
   a. Cover the nose/mouth when coughing or sneezing.
   b. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
   c. Hand washing with soap, and water or alcohol-based hand rub after having contact with respiratory secretions and contaminated objects or materials.
   d. The patient must wear a surgical/procedure mask at all times if transport to another department is necessary (i.e. x-ray, CT).

2. Designated staff are responsible for educating patients about appropriate respiratory precautions.

H. Patient Identification/Transfer

1. Patient transfer
   a. Designated Department of Public Health staff will be responsible for communicating with other healthcare providers when a patient with a confirmed or suspect ATD requires a referral for care. Staff include: Disease Control, Family Care Centers, HIV/AIDS and Public Health Nursing.
   b. The receiving facility must be informed of all suspected or confirmed ATD infections prior to receiving facility acceptance and transfer.
   c. All transporting personnel (staff, ambulance and air transport personnel) must be informed of all suspected or confirmed aerosol transmissible infections prior to transfer.
   d. The patient must wear a procedure mask at all times.

2. While awaiting transfer, patients with a confirmed or suspected ATD will be placed in a negative pressure isolation room in the Family Care Center or ask to wait outside.

I. Medical Services

1. Requirements For Medical Surveillance
   a. Medical surveillance for Tuberculosis and other aerosol transmissible diseases must be provided for employees with occupational exposure.
      i. Surveillance for infection with aerosol transmissible pathogen (ATP) and aerosol transmissible pathogen – laboratory (ATP – L) will be provided based on the type of work setting.
ii. Following an exposure incident, employees may elect not to be evaluated or vaccinated by Riverside County Occupational Health as the “evaluating health care professional”, but can be seen by their health care provider.

iii. Medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, shall be:
   a. Performed by or under the supervision of a PLHCP;
   b. Provided according to applicable public health guidelines; and
   c. Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.

2. Risk Assessment for Tuberculosis

The DOPH laboratory, TB clinic and homes of infectious TB patients are classified as high risk areas, due to the lab handling and processing of large volumes of TB cultures; and potential exposure of staff in the clinic or patients home.

The data listed below was used to complete the risk assessment for exposure possibility.

   a. Patients with active and suspect active tuberculosis are routinely seen in the Department of Public Health clinics and in their homes by HCWs.
   b. A review of surveillance data indicates that 60, 74, 80, 79 and 69 active cases were reported County-wide for the years 2005, 2006, 2007, 2008, and 2009 respectively.
   c. TB conversion data indicates the following number of converters: 2005:1; 2006:1; 2007:5; 2008:4 and 2009:3.
   d. The number of MDR TB Cases for the last five years is as follows:

   
   2005 = 1
   2006 = 6
   2007 = 1
   2008 = 0
   2009 = 1

3. Employee TB Surveillance/Follow-up

   a. Initial Exam
      i. Baseline TB skin test (TST) unless documented previous positive TST, using a two step method, unless documented negative TST in past 12 months.
      ii. Chest x-ray, if TST positive; or documented history of past positive TST.
      iii. Exclusion of employees with suspect pulmonary TB until cleared; OR
      iv. Referral for treatment of latent TB infection for all employees who meet TB Control guidelines.
   b. Repeat Exam
i. Determine frequency of TST testing by assessment

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>FREQUENCY OF TESTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL (III)</td>
<td>Every 24 months – TB testing and control evaluation</td>
</tr>
<tr>
<td>LOW (II)</td>
<td>Every 12 months - TB skin testing and control evaluation (includes category I HCWs with direct contact with non-TB patients in FCCs and other clinic settings).</td>
</tr>
<tr>
<td>HIGH (I)</td>
<td>Every 6 months - TST skin testing and control evaluation (HCWs with direct contact with TB patients or laboratory specimens).</td>
</tr>
<tr>
<td>CLUSTER*</td>
<td>Two or more TST conversions in one area or a single occupational group working in multiple areas over a 3-month period. If there is a cluster of TST conversions, then HIGH RISK employees in the area will be tested every 3 months with TB skin testing, until conversion rate is reduced to baseline for 2 consecutive 3-month periods.</td>
</tr>
</tbody>
</table>

*PHO/DPHO to be notified

ii. Annual symptom review for all documented reactors.

iii. Chest x-ray if symptom screen indicates signs and symptoms suggestive to TB.

c. All required TB skin tests, medical evaluations, and treatment of Latent TB Infection (LTBI) will be:
   i. Made available to the employee at a reasonable time and place;
   ii. Performed by a licensed, trained healthcare professional; AND
   iii. Made available at no cost to the employee

d. Employee skin test conversion
   i. Employees who convert their TB skin test from negative to positive on routine screening will have a symptom screen and be referred for a chest x-ray immediately.
   ii. Symptomatic employees, and those who are unable to obtain a chest x-ray with a “STAT” reading, will be excluded from work until medically cleared.
   iii. The Occupational Health Nurse (OHN) will interview the employee to determine the possible source of infection.
   iv. The Public Health Officer (PHO), Deputy Public Health Officer (DPHO) and Director for Disease Control will be notified of employees whose chest x-ray is suggestive of active tuberculosis.

e. Documentation, Data Collection and Evaluations
   i. Mantoux skin test results, medical evaluations, and treatment are to be included in the employee medical records. They must be kept for at least the duration of employment plus 30 years.
   ii. All TB skin tests for HCWs must be documented and include: the name of the person tested, the date of the test, the results of the test in millimeters of induration, and the interpretation of the result. If known, state if patient is immunocompromised. The HCW’s HIV status is kept confidential.
   iii. All TST converters and diagnosed cases of TB must be entered on the Cal-OSHA 300 Log, (only after consultation with the PHO or DPHO), unless it can be demonstrated that conversion or TB case is not work related.
iv. TST conversion rate by work area and/or occupational group will be evaluated annually by the Director for Disease Control and the Occupational Health Nurse.

4. Vaccination for Susceptible Health Care Workers (HCWs)
   a. All HCWs with occupational exposures to ATD will be offered all vaccine doses listed in appendix E of the ATD standard.
   b. Recommended vaccinations shall be made available to all employees who have occupational exposure after the employee has received the training required in subsection (c) or (i) and within 10 working days of initial assignment unless:
      i. The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose; or
      ii. A PLHCP has determined that the employee is immune in accordance with applicable public health guidelines; or
      iii. The vaccine(s) is contraindicated for medical reasons.
   c. Employees shall be offered additional vaccinations within 120 days of the issuance of new CDC or CDPH recommendations.
   d. Employees cannot be required to participate in a pre-screening program as a prerequisite for receiving a vaccine unless CDC or CDPH guidelines recommend pre-screening prior to administration of the vaccine.
   e. If employee initially declines a vaccination but at a later date, while still covered under the standard, decides to accept the vaccination, the employer shall make the vaccination available in accordance with subsection (h)(5)(A) within 10 working days of receiving a written request from the employee.
   f. Employees who decline to accept a recommended and offered vaccination must sign the declination statement (see Appendix C of DOPH Policy P-102).
   g. Human Resources and Occupational Health will be notified in writing by Disease Control if a recommended vaccination is not available to be offered to HCWs.

J. Post Exposure Follow-Up

1. In the event a HCW is exposed to TB or other ATD in the workplace, the Public Health Officer (PHO), Deputy Public Health Officer (DPHO), Director for Disease Control (D, DC), and Occupational Health Nurse (OHN) will be notified.

2. The OHN will coordinate the workplace contact investigation (CI) according to DOPH procedure (Refer to Attachment 1).

3. Specific follow-up will be determined based on the ATD to which the HCW is exposed, refer to attachments:
   a. Management of Ill Exposed Health Care Workers.
   b. Novel Influenza Viruses.
   c. Severe Acute Respiratory Syndrome (SARS).
   d. Guidelines for the Control of Pertussis Outbreaks

4. HCWs and supervisors will follow Policy CHA A-11 (Employee Accident/Incident Reporting and Injury Management).

5. HCWs who decline a medical evaluation must sign a Human Resources Department, Worker’s Compensation Declination Statement.
6. HCWs may elect to be evaluated by their own health care provider rather than Occupational Health per the Worker’s Compensation Policy (see Facts for Injured Workers).

K. Evaluation of Exposure Incidents

1. The purpose of the evaluation of each exposure is to identify and correct problems with the goal of prevention of recurrence.

2. The supervisor/manager is responsible for ensuring the required paperwork is completed and reviewed to identify the nature of the exposure, whether it was a significant exposure and that the employee was referred for appropriate medical evaluation.

3. Evaluation of the exposure/incident will include a review of utilization of appropriate control measures, including source control measures and personal protective equipment.

4. HCWs failing to adhere to provisions of the ATD ECP or Departmental policies and procedures after additional training will be subject to progressive disciplinary measures.

L. Notification of Employees of Potential Exposure to ATD

1. The Director of Disease Control will notify the PHO, DPHO, Director of Public Health and Occupational Health Manager of an occupational exposure of HCWs to ATD.

2. Employees will be notified in writing by the DPHO or designee of an occupational exposure to ATD.

M. Notification of Other Employers of Potential Exposure to ATD

Disease Control is responsible for notifying other employers of potential employee exposure to ATD, if the patient is diagnosed after being seen at a clinic, M.D. office or discharged from a health care facility.

N. Maintaining Adequate Supply PPE

1. The Department of Public Health will ensure that an adequate supply of PPE is available for employees.

2. Appropriate PPE will be maintained by each Family Care Center, Disease Control, Public Health Nursing, and other branches, who provide staff for surge response for ATD outbreaks or other public health emergencies.

3. In the event there is a shortage of N-95 respirators, due to a pandemic, current CDC/CDPH guidance for re-use of single use respirators will be provided.

O. Initial and Annual Training

1. The Director of Disease Control is responsible for the coordination of training and will hold a Train the Trainer update for the staff involved in training DOPH employees on the ATD ECP. Only staff who complete the Train the Trainer update may provide updates for other DOPH staff.
2. Each Trainer is responsible for ensuring that documentation of training for each employee is submitted to the Community Health Agency (CHA) Human Resource Department.

3. Effective July, 2010, new healthcare workers will be educated on the components of the ATD Exposure Control Plan and on how to access a copy of the plan, at the time of initial assignment of tasks where occupational exposure may take place and at least annually thereafter.

4. All existing HCWs will be educated on the components of the ATD Plan, on their date of annual recertification and when new information is required on ATDs.

5. Training will include:

   a. A general explanation of ATDs including the signs and symptoms that require further medical evaluation;
   b. Screening methods and criteria for persons who require referral;
   c. The Riverside County Department of Public Health’s (RCDOPH’s) source control measures and how these measures will be communicated to persons with whom employees have contact;
   d. RCDOPH’s procedures for making referrals in accordance with subsection (c)(3);
   e. RCDOPH’s procedures for temporary risk reduction measures prior to transfer;
   f. Training in accordance with subsection (g) and Section 5144 of these orders, when respiratory protection is used;
   g. The RCDOPH’s medical services procedures in accordance with subsection (h), the methods of reporting exposure incidents, and the employer’s procedures for providing employees with post-exposure evaluation;
   h. Information on vaccines RCDOPH will make available, including the seasonal influenza vaccine. For each vaccine, this information shall include the efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
   i. How employees can access the RCDOPH’s written procedures and how employees can participate in reviewing the effectiveness of the RCDOPH’s procedures in accordance with subsection (c)(8); and
   j. An opportunity for interactive questions and answers with a person who is knowledgeable in the subject matter as it relates to the workplace that the training addresses and who is also knowledgeable in the employer’s infection control procedures.

P. Documentation of Training

   1. Documentation of training shall be maintained for at least three years.
   2. Documentation shall include:
      a. Employee’s name
      b. Employee identification
      c. Training dates
      d. Content of the training
      e. The name of the trainer (Attachment 4).
   3. The documentation of individual employee training will be kept in the employee’s Human Resource file.
Q. Active Involvement of Employees – Plan Review

1. Each supervisor/manager is responsible for reviewing the ATD ECP to identify changes that are required for in job classifications and/or required tasks.

2. Each supervisor/manager will solicit input from staff under their supervision.

3. Exposure incidents will be reviewed by the Quality Improvement committee which is comprised of managers, supervisors and staff. Recommendations will be made for corrective action.

R. Surge Procedures

1. All DOPH employees are designated as emergency disaster workers and are expected to respond in the event of a Public Health emergency. The Rapid Response Team comprised of key DOPH responders may be convened in the event of a disease outbreak or other Public Health emergency.

2. Employees receive training in SEMS/NIMS and core Public Health competencies at level I, II or III according to their job responsibilities. Training and exercises are coordinated by Public Health Emergency Preparedness and Response Branch (PHEPR).

3. HCWs are trained and fit-tested with N-95 respirators.

4. Surge fit-testing can be performed by trained Disease Control and Public Health Nursing staff, in addition to Occupational Health.

5. Response branches maintain an emergency notification system, with key staff notified via CAHAN.

6. Specific procedures for stockpiling and accessing respiratory and personal protective equipment are found in the DOPH Emergency Response Plan and the SNS Plan which are maintained by PHEPR Branch. Respiratory Personal Protective Equipment is also maintained by Disease Control; Public Health Nursing and the Family Care Centers.

7. The Public Health laboratory maintains PPE as delineated in their Biosafety Plan.

S. Specific Requirements for Laboratories

1. The ATD Standard requires lab employers to use feasible engineering and work practice controls to limit exposure and to provide PPE and respirators when that equipment is necessary to control exposures.

2. The Public Health Laboratory is required to develop, implement and annually review a written Biosafety Plan (BSP) that includes the following:
   a. Safe handling procedures and list of prohibited practices.
   b. Engineering controls, including containment facilities such as biosafety cabinets.
   c. Procedures requiring the use of PPE and/or respirators.
   d. Effective decontamination/disinfection procedures.
   e. A requirement that all incoming materials containing ATPs-L be treated as containing the virulent or wild-type pathogen, until proven otherwise.
f. Inspection procedures to be performed annually.
g. Emergency procedures for uncontrolled releases within the lab & untreated releases outside the lab, including reporting incidents to the local health officer.

V. RESPIRATORY PROTECTION PROGRAM

A. Policy Statement

All HCWs involved in direct patient care will be required to be fit tested with the appropriate respiratory protective device annually or when the HCW’s physical condition warrants it. Personal Protective Equipment (PPE) will be issued to all designated Category I HCWs free of cost. This includes non-County employees assigned to DOPH clinics. NIOSH approved respirator is to be used by DOPH staff. Staff must wear the N-95 for which they were test fitted. Staff will routinely be re-fit-tested and re-trained each time a new product is implemented.

The Occupational Health Nurse will coordinate the Respiratory Protection Program.

B. Work Assignments

HCWs shall not be assigned to work areas or tasks that require respirator use unless they have been medically determined to be physically able to perform the task wearing the equipment.

C. Respiratory Protection is Requirements:

1. When entering an Airborne Infection Isolation (AII) or exam room that is occupied, or has been occupied within the posted clearance time, or the past hour if clearance time is not posted by a known or suspected infectious tuberculosis patient.

2. While certain high risk medical procedures are being performed [such as aerosol administration of medication (pentamidine), and diagnostic sputum induction] on patients who have or are suspected of having infectious TB, or other aerosol transmissible diseases.

3. Changing filters in the HEPA filter machine.

4. While transporting an infectious patient with TB or other aerosol transmissible diseases.

5. Making home visits or interacting with a new TB-5 or TB-3 Pulmonary or Laryngeal TB patient who is potentially infectious, in an enclosed area with inadequate ventilation.

6. Repairing, replacing or maintaining air systems or equipment that may be anticipated to contain aerosolized M. tuberculosis, or other aerosol transmissible diseases.

7. When providing care to patients suspected or confirmed to have TB, SARS, avian influenza or other aerosol transmissible diseases.
D. Evaluation of HCWs Medical Status

The HCW’s medical status will be evaluated yearly at the time of the annual health screen. This may be done by completion of a questionnaire unless there is a medical problem requiring a physical exam by a physician. Pulmonary function tests may be ordered to determine respiratory fitness. HCWs may be exempt from wearing respirator masks because of medical problems. HCWs with positive findings on their Respirator Medical Evaluation Form may be evaluated by their own physician or Occupational Health. These HCWs may not be assigned to tasks involving suspected or infectious tuberculosis patients, or other infectious patients, which require the use of respiratory protection (novel influenza viruses).

E. Employee Training

The training must be comprehensive, understandable, and recur annually and more often if necessary. This subsection also requires the employer to provide the basic information on respirators in Appendix D of the ATD standard to employees who wear respirators when not required by this section or by the employers to do so.

1. Employees must demonstrate knowledge of:
   a. Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effect of the respirator.
   b. What the limitations and capabilities of the respirator are.
   c. How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions.
   d. How to inspect, put on and remove, use, and check the seals of the respirator.
   e. What the procedures are for maintenance and storage of the respirator.
   f. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.
   g. The general requirements of this section.

2. The training shall be conducted in a manner that is understandable to the employee.

3. Training will be provided prior to requiring the employee to use a respirator in the workplace.

4. Retraining shall be administered annually, and when the following situations occur:
   a. Changes in the workplace or the type of respirator renders previous training obsolete.
   b. Inadequacies in the employee’s knowledge or use of the respirator indicate that the employee has not retained the requisite understanding or skill.
   c. Any other situation arises in which retraining appears necessary to ensure safe respirator use.

5. The basic advisory information on respirators, as presented in Appendix D of the ATD standard, shall be provided by the employer in any written or oral format, to employees who wear respirators when such use is not required by this section or by the employer.

F. Respiratory Protection Program Evaluation

1. Evaluations of the workplace will be conducted as necessary to ensure that the provisions of the current written program are being effectively implemented and that it continues to be effective.
2. Employees required to use respirators will be consulted to assess their views on program effectiveness and to identify any problems. Any problems that are identified during this assessment shall be corrected. Factors to be assessed include, but are not limited to:

   a. Respirator fit (including the ability to use the respirator without interfering with effective workplace performance)
   b. Appropriate respirator selection for the hazards to which the employee is exposed
   c. Proper respirator use under the workplace conditions the employee encounters
   d. Proper respirator maintenance

G. Recordkeeping

1. Medical Evaluation. Records of medical evaluations required by this section must be retained and made available in accordance with section 3204.

2. Fit testing
   a. A record will be maintained of the qualitative and quantitative fit tests administered to an employee including:
      i. The name or identification of the employee tested
      ii. Type of fit test performed
      iii. Specific make, model, style, and size of respirator tested
      iv. Date of test
      v. The pass/fail results for Qualitative Fit Test (QLFTs) or the fit factor and strip chart recording or other recording of the test results for Quantitative Fit Test (QNFTs).

   b. Fit test records and respirator evaluation forms will be maintained by the OHN and placed in the HCWs medical record.

3. A written copy of the current respirator program shall be retained.

4. Written materials required to be under this subsection shall be made available upon request to affected employees and to the Chief or designee for examination and copying.

VI. RESPIRATOR MASK PROCEDURES

A. Education and Training

   All HCWs performing duties described in section IV. D. will be trained in the proper use of NIOSH N95 respirators and their limitations at the time of hire, during their annual health screen, and when the HCWs physical condition warrants it (i.e., weight loss or gain of 10% of body mass, dentures, facial disfigurement).

B. Factors that will Affect Respirator Leakage are:

   1. Incorrect respirator size
   2. Beard growth on wearer
3. Failure to use both head straps
4. Incorrect positioning on the wearer’s face
5. Incorrect head strap tension
6. Improper respirator maintenance
7. Respirator damage
8. Significant weight loss or gain, over 10% body weight
9. Facial deformities or scars

C. Fit Testing

The HCW must do a fit check each time the respirator is worn. This may be done by cupping hands over the respirator and gently exhaling. Air escaping from the seal indicates an improper fit. The HCW will reposition the respirator until the fit is secure.

D. HCWs who Cannot be Fit-Tested with a N-95 Respirator

HCWs who cannot be fit tested with the N95 respirator and are exposed to suspected active tuberculosis or other aerosol transmissible diseases while performing their job will be instructed on the use of the Powered Air-Purifying respirators (PAPR) and receive education and training pertaining to that respirator, with annual review. These HCWs may be individuals who:

1. Have facial hair that interferes with a correct fit,
2. Have facial scars or deformities,
3. Are not saccharin sensitive,
4. Are allergic to N95 respirator material,
5. Have temple pieces on glasses that interfere with the seal.

A hood will be given to each of these HCWs. These hoods are reusable until integrity is compromised. They must be cleaned at the end of each shift, and stored in a clean area. PAPRs and battery chargers will be assigned to each work area depending on how many HCWs are required to wear them.

E. PAPR Requirement

Effective September 1, 2010, employee will provided with a powered air purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s), or a respirator providing equivalent or greater protection, when performing high hazard procedures on AirID cases or suspected cases, unless the employer determines that this use would interfere with the successful performance of the required task or tasks. This determination shall be documented in accordance with the ATD Plan and shall be reviewed by the employer and employees at least annually in accordance with subsection (d)(3).
Exception 1 to subsection (g)(3)(B): Where a high hazard procedure is performed by placing the patient in a booth, hood or other ventilated enclosure that effectively contains and removes the aerosols resulting from the procedure, and the employee remains outside of the enclosure, the employee may use a respirator meeting the requirements of subsection (g)(3)(A), (N-95).

F. Respirator Requirement for Laboratories

Respirators used in laboratory operations to protect against infectious aerosols shall be selected in accordance with the risk assessment and biosafety plan, in accordance with subsection (f).

G. Multiple Use Respirators

1. The respirator may be worn until:
   a. The respirator’s integrity is compromised;
   b. It has been splashed or contaminated by fluid; or is soiled; AND/OR
   c. The HCW has difficulty breathing.

2. The multiple use respirator may be stored in a paper bag (if plastic is used, HCW must vent with holes) between uses.

3. HCWs will replace their re-use respirator by notifying their supervisor or designee and receiving a replacement respirator from the authorized person in their work area. A supply of respirators will be kept at each Family Care Center and the Disease Control office.

H. Single Use Respirators

1. Are to be used once and discarded.

2. Each employee is to be provided with an ample supply of single use respirators.

3. Reuse of single use respirator due to a pandemic or other public health emergency will be based on current CDPH/CDC guidance.

VII. RESPIRATOR FIT TESTING

An assessment of the need for respirator re-fit testing will be done at the time of the HCW’s annual health screen. If there are factors that may change the fit of the respirator, the employee will be retested. Fit testing may be done by the Occupational Health Nurse at the assigned Family Care Center or by an HCW trained to do fit testing.

Procedure

A. No food or drink, except water, for 30 minutes prior to fit test. No one with facial hair interfering with the respirator will be fit tested.

B. Show respirator fitting instruction video. DO NOT allow HCWs to open the packages until they have been assisted in picking the correct size.

C. Demonstrate proper procedure for fit checking and removal. Assist HCW with picking the correct size.
D. HCW must do a return demonstration of proper donning, fit checking, and removal.

E. Fit Test Procedure

1. Fill nebulizers below “O” ring; use threshold solution first to determine if the HCW can taste the saccharin. Start with five squirts to maximum of 20. If unable to taste the saccharin have the HCW rinse mouth with water. If still unable to taste the saccharin, the HCW may have to be retested with a bitter solution or wear PAPR.

2. Have HCW put respirator on, place hood over head, and have HCW close eyes. Using Qualitative solution squirt five times into hood.

   a. Head stationary - breathe normal 30 seconds - 1 minute
   b. Head stationary - deep breathe 30 seconds - 1 minute
   c. Head turning side-to-side 30 seconds - 1 minute
   d. Head moving up and down 30 seconds - 1 minute
   e. Have HCW speak and repeatedly open and close mouth.

3. After speaking and repeatedly opening and closing mouth, have the HCW indicate whether he/she can taste or smell saccharin.

4. If the HCW can taste saccharin at any time during the test, have the HCW remove the mask and drink water. Reposition the respirator and start the test over.

5. If the HCW passes the test, complete the Respiratory Fit Testing Report and the Assignment Form, and the Respiratory ID Card for the HCW. All “Fit Test Reports” are kept by the Occupational Health Nurse. HCWs retain the ID card to present when requesting replacement of their respirator.

6. A copy of the Training Log will be provided to the Clinic Site Manager (CSM, or the approved supervisor).

VIII. ZOONOTIC AEROSOL TRANSMISSIBLE DISEASE STANDARD

A. What is a Zoonotic ATD

1. Disease agents that are transmissible from animal to humans
2. Capable of causing human disease that may be transmitted by air or by droplet exposure
3. Examples: TB, SARS, H1N1 Influenza and Avian Influenza

B. Who are affected by the new standard

1. Services that capture, sample, transport or dispose of birds and other wildlife
2. Farms producing animals or animal products
3. Slaughterhouses
4. Veterinary animal inspection
5. Importers of live or untreated animals or animal products
6. Zoos
7. Animal parks
8. Pet stores
9. Laboratory operations

C. Requirements of the Zoonotic ATD standard
1. Establish procedures that minimize production of aerosols
2. Controls for cleaning and decontaminating
3. PPE and respiratory protection
4. Posting of signs in areas containing identified or suspected cases
5. Training
6. Recordkeeping
7. Provision of medical services to exposed workers
Attachment I

*Post Exposure Protocol for Occupational Tuberculosis Exposure*
Attachment II

Isolation Room notice & Sample “Stop” sign
Attachment III

Aerosol Room Use Log
Attachment IV

*Documentation of Individual Employee Training Form*
Attachment V

Management of Ill/Exposed Health Care Workers
Attachment VI

Novel Influenza Viruses
Attachment VII

Severe Acute Respiratory Syndrome (SARS)
Attachment VIII

Guidelines for the Control of Pertussis Outbreak