TOLEDO FIRE & RESCUE DEPARTMENT

# G Manual - Infectious Disease

Date Revised: ?

Last Modified: 04/30/2025 08:43

Export G Manual to PDF

## INFECTIOUS DISEASE POLICY STATEMENT

The Toledo Department of Fire and Rescue Operations recognizes that communicable disease exposure is an occupational health hazard. Potential communicable disease transmission is possible at any time including emergency response, non-emergency situations and in-house activities.

The Toledo Department of Fire and Rescue Operations is committed to a program that will provide the best available protection from occupationally acquired communicable disease.

The policy of the Toledo Department of Fire and Rescue Operations is:

To provide fire, rescue and EMS services to the public without regard to known or suspected diagnosis of communicable disease in any patient.

To regard all patient contact as potentially infectious; Body/Substance Isolation (Universal precautions) will be observed at all times by Toledo Fire and Rescue members.

To provide training, immunizations and all personal protective equipment (PPE) needed to be effectively protected from possible exposures.

To recognize the need for work restrictions of personnel due to concerns involving infection control.

To hold all medical information confidential. (No information will be released without the written consent of the person involved).

To educate the department on Critical Incident Stress Debriefing (C.I.S.D.) and encourage members to participate.

# EXPOSURE CONTROL PLAN

**Purpose:** To identify tasks and corresponding job classifications for which it can be expected or anticipated to be exposed to infectious and contagious materials (blood, body fluids, etc.); to develop, establish and maintain an Infection Control Plan. To identify the procedure for the evaluation of circumstances surrounding exposure incidents.

## I. Exposure determination

1. The following tasks can be expected to involve exposure to blood, body fluids, or other potentially infectious materials.

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

2. The following job classifications are reasonably anticipated to involve exposure to blood, body fluids or other potentially infectious substances in the performance of their duties.
    - Firefighter
    - Company Officer
    - Paramedic and EMS Supervisor (#122)
    - Hazardous materials response team members
    - Water Rescue team response members
    - Any other specialized rescue
    - Chief Officers
    - Safety Officers (#136)
    - EMS and Training Bureau members
    - Other emergency response personnel not otherwise classified

## II. Implementation

1. The Infection Control Program is applicable to all members of the Toledo Fire and Rescue Department providing fire, rescue, or emergency medical services. It is effective immediately.

2. The Infection Control Program consists of a policy statement, identification of roles and responsibilities, Standard Operating Procedures (SOPs), training and recordkeeping. SOPs identify specific procedural guidelines for all aspects of response and station environments where disease

transmission can be reasonably anticipated, as well as training, administrative aspects of the program, and post exposure evaluation/investigation. Specific program components are identified as follows:

- Infection Control Policy Statement
- Exposure Control Plan
- Infection control roles and responsibilities

SOP #IC 1: Health Maintenance
SOP #IC 2: Infection Control Training
SOP #IC 3: Station Environment
SOP #IC 4: Personal Protective Equipment
SOP #IC 5: Scene Operations
SOP #IC 6: Post-Response
SOP #IC 7: Post-Exposure Protocols
SOP #IC 8: Compliance and Quality Monitoring/Program Evaluation

### III. Evaluation of Exposure Incidents

The procedure for the evaluation/investigation of circumstances surrounding incidents of exposure to blood, other body fluids, or other potentially infectious materials is detailed in SOP #IC 7: Post Exposure Protocols. Medical follow-up, documentation, recordkeeping, and confidentiality requirements are also defined in SOP #IC 7.

---

## INFECTION CONTROL ROLES AND RESPONSIBILITIES

### I. Chief of the Department

The ultimate responsibility for the health & welfare of all members remains that of the Chief of the Department. The tasks of managing the department’s Occupational Health & Safety and Infection Control Programs are delegated to appropriate staff officers and committees as noted below.

### II. Infection Control Officer

The Department Infection Control Officer will be appointed by the Chief of the Department and will:

- Serve as the liaison between the department and the treating facility in an actual or suspected exposure, as required by the Ryan White Comprehensive AIDS Resources Act of 1990 (PL 101-381);
- Develop criteria for the use of personal protective equipment and determine adequate stocking levels for each station and response vehicle.
- Evaluate possible member exposures to communicable disease and coordinate communications between the department, area hospitals and the City Board of Health.
- Monitor compliance and quality assurance with regards to the department’s Infection Control Program.
- Conduct spot inspections of on-scene and station operations to ensure compliance with department infection control policy.
- Coordinate the immunization program and maintain immunization records.
- Maintain a confidential database of exposures and treatment given in conjunction with the Department Physician.
- Provide technical expertise to the Bureau of Training in development of the infection control curriculum.
- Keep abreast of developments in the field of infection control and make appropriate recommendations.

## III. The Department Physician

We currently use St. Vincent Mercy Medical Center, Occupational Health for technical assistance and guidance in the implementation of the Infection Control Program. Any members exposed to disease or any post exposure follow-up care is directed to SVMMC for treatment. After-hours exposures are treated in the emergency center.

## IV. Department Officers and Supervisors

Chief Officers and Company Officers will:

- Support and enforce compliance with the Infection Control Program
- Correct any unsafe acts, and refer members to remedial infection control training, if necessary
- Mandate safe operating practices on-scene and in-station
- Refer for medical evaluation any member possibly unfit for infection control or other reasons.

- Company Officers will not allow new members to assume emergency response duties until initial medical evaluation, immunizations, and infection control training has been completed. (These measures should be taken prior to the new members release from Fire Recruit Training).

## V. Toledo Fire Division Members

All Members will:

- Assume responsibility for their personal health and safety.
- Follow infection control protocols at the emergency scene.
- Report and document any suspected occupational exposure to communicable disease per chain of command; comply with recommended follow-up treatment.

## VI. Safety Officer (#136)

- The Safety Officer on duty will assume the duties of the Infectious Control Officer when the latter is unavailable.

---

# INFECTION CONTROL

### STANDARD OPERATING PROCEDURE

The Toledo Fire and Rescue Department will work towards compliance with the following SOP's as soon as funds become available. These procedures involving building changes will be adhered to in any remodeling of existing station and any new construction of fire stations. This will be done in consultation with the Infection Control Officer.

## I. SOP #IC 1 HEALTH MAINTENANCE

- No member will be assigned to emergency response duties until an entrance physical assessment has been performed by the Department Physician or his/her designee, and the member has been certified as fit for duty.
- Work restrictions for reasons of infection control may be initiated by SVMC, Occupational Health. These may be temporary or permanent.

- All members will be offered immunizations against Hepatitis B. Influenza vaccine will be offered annually when available. Members should also stay current on measles, mumps, rubella, poliomyelitis (polio), tetanus, and diphtheria vaccines. The risks and benefits of immunization will be explained to all members and informed consent obtained prior to immunization.
- Members may refuse immunizations, or may submit proof of previous immunizations. Members who refuse immunization will be counseled on the occupational risks of communicable disease, and required to sign a refusal of immunization release of liability, upon request.
- Any member that is returning to work following debilitating injury or illness or communicable disease (occupational or non-occupational) will be cleared by the City Physician or designee prior to resuming emergency response duties.
- The Department Infection Control Officer will maintain records in accordance with OSHA's CFR 29, part 1910.1030. Member participation in the Infection Control Program will be documented including:
    - Name and Social Security Number
    - Immunization Records
    - Circumstances of exposure to communicable disease
    - Post exposure medical evaluation, treatment and follow-up.
- Medical records are strictly confidential. Medical records concerning exposure testing will be maintained in the office of the Infection Control Officer and will not be kept with personnel records. Medical records will not be released without the signed written consent of the member.
- Members may examine their own medical records, and may request that copies be sent to their personal physician. Release of medical records to another physician will be made only with the signed written consent of the member.
- Abstracts of medical records without personal identifiers may be made for quality assurance, compliance monitoring, or program evaluation purposes, as long as the identity of individual members cannot be determined from the abstract.
- Communications between medical and personnel sections will focus on fitness to work or recommended restrictions, rather than upon specified diagnoses.

1. **Patient Protection**

- The second area for consideration is exposure of patients to ill (Infectious) Toledo Fire and Rescue personnel. Many times dedicated member’s work when they should have remained at home. This poses additional risk to patients as well as co-workers. Listed are guidelines for patients and co-worker protection when a Toledo Fire and Rescue member is ill.

| **Disease or Condition** | **Work Status** |
|---|---|
| Positive PPD skin test | May work with follow-up |
| Conjunctivitis | Off work, no patient contact until drainage is absent. |
| Draining Wound | OFF until cleared up |
| Herpes Simplex (cold sores) | May work but no patient contact until lesions crusted. |
| Herpes Zoster (shingles) | May work but no patient contact until lesions are crusted. |

| Disease or Condition | Work Status |
|---|---|
| Hepatitis A | No patient contact until 7 days after jaundice disappears. |
| Hepatitis B | No patient contact until proven serologically non-effective. |
| Mononucleosis | OFF until directed by physician |
| Lice or Scabies | OFF until treated |
| Streptococcal Infection | OFF until directed by physician |
| Measles, Chickenpox, Mumps | OFF until directed by physician |
| Influenza | OFF until directed by physician |
| Impetigo | May work but no patient contact until lesions healed |

## II. SOP #IC 2: INFECTION CONTROL TRAINING

All members providing emergency services will be required to complete:

**1.** Initial infection control training at the time of assignment to tasks where occupational exposure may occur.

**2.** Refresher infectious control training periodically.

**3.** All infection control-training materials will be appropriate in content and Voluntary to the education level, literacy and language of members being trained.

**4.** Training will be in compliance with NFPA Standard 1581 and shall include;

- A general explanation of the epidemiology and symptoms of bloodborne disease;
- An explanation of the modes of transmission and routes of exposure of bloodborne pathogens;
- An explanation of the department exposure control plan and how an employee can obtain a copy;
- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
- Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
- An explanation of the basis for selection of personal protective equipment;
- A review of the requirement to wear Infection Control pouches (fanny Packs) and the items inside them. This would include a N95mask, gown, safety glasses, antimicrobial wipes or a waterless hand cleaner.
- A review of the patient hot zone (procedure C35.1)
- Information on the Hepatitis B vaccine, including information on its efficacy, safety, and the benefits of being vaccinated and notification that the vaccine and vaccination will be provided at no charge.

- Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
- Information on the post-exposure evaluation and follow-up that the department is required to provide following an exposure incident.
- An explanation of the signs and labels and/or color-coding required for biohazard materials; information on the proper disposal of biohazard materials.
- Opportunity for interactive questions and answers.

**5.** Infection control trainers shall be knowledgeable in all of the program elements listed above, particularly as they relate to emergency services provided by this department.

**6.** Written records of all training sessions will be maintained after the date on which the training occurs. Training records will include:

- The dates of the training session;
- The contents or a summary of the training sessions;
- The names and qualifications of the persons conducting the training, and
- The names and job titles of all persons attending the training sessions

## III. SOP #IC 3: STATION ENVIRONMENT

All stations will designate areas for:

- Equipment decontamination and disinfection. The station Captain shall designate a decontamination sink for infection control issues.
- Storage of clean patient care equipment and infection control personal protective equipment.
- Storage of biohazard waste (Medical Waste tubs)

> **Under no circumstances will kitchens, bathrooms, or living areas be used for decontamination or storage of patent care equipment or infectious waste.**

- Decontamination areas will be marked with biohazard signs.
- Have proper lighting and adequate ventilation.
- Adequate rack space to allow air-drying of equipment.
- Appropriate containers for disposal of biohazard waste.

- Facilities for the safe storage, use and disposal of cleansing and disinfecting solutions.
- Appropriate PPE for the use of disinfecting solutions.
- Material Safety Data Sheets (MSDS) for cleansing and disinfecting solutions. All personnel using these solutions will be familiar with the MSDS and will use the recommended PPE.
- Infectious waste storage areas will be marked with biohazard signs and will be maintained in accordance with all EPA and local regulations.
- Contaminated sharps will be stored in closed puncture-resistant containers (sharps containers) with appropriate biohazard markings and color-coding.
- Other contaminated materials will be stored in leak-proof bags with appropriate biohazard markings and color coding.
- If outside contamination of a disposal bag is a possibility, a second bag with identical markings will be placed over the first.
- All stations have extractor washing machines. The extractors can be used for the decontamination of turnout gear and station clothing.
- Members checking the EMS equipment at the 0700 equipment check or any other time should have on latex or nitrile gloves. The gloves should be disposed of properly prior to touching anything else. This includes the steering wheel in the rig.

> **All disposal of biohazard waste will be in accordance with EPA and local regulations and will be performed by an approved licensed contractor. Currently the contractor being used is B.F.I.**

## IV. SOP #IC 4: Personal Protective Equipment

Specification, purchase, storage and issue of personal protective equipment (PPE)

- Standards for personal protective equipment will be developed by the EMS Captain and the Infection Control Officer and updated or modified as needed.
- The department is responsible for the supply, repair, replacement, and safe disposal of infection control PPE.
- The EMS Captain and the Infection Control Officer will determine proper stock supply levels for both stations and for response vehicles.
- The Captain at each station will ensure that the station stock of PPE is adequate and that supplies nearing expiration dates are used first.
- The amount, type, location of PPE will be standardized on all response vehicles.
- Disposable gloves will be constructed of latex rather than plastic. While both types provide equal protection, latex is more durable during on-scene operations.

- Sharps containers will be closable, puncture resistant, and leak-proof. Sharps containers will be color coded, labeled as biohazard, and immediately accessible.

**Selection and use of personal protective equipment (PPE)**

- Emergency response often is unpredictable and uncontrollable. While blood is the single most important source of HIV and HBV infection in the workplace, in the field it is safest to assume that all body fluids are infectious. For this reason, PPE will be chosen to provide barrier protection against all body fluids.
- In general, members should select PPE appropriate to the potential for spill, splash, or exposure to body fluids. No standard operating procedure or PPE ensemble can cover all situations. Common sense must be used. When in doubt, select the maximal rather than the minimal PPE.
- Disposable latex or nitrile gloves will be worn during any patient contact when potential exists for contact with blood, body fluids, non-intact skin, or other infectious material. All members will carry extra pairs of disposable gloves in turnout coats and/or EMS jumpsuits and/or EMS fanny packs.
- Gloves will be replaced as soon as possible when soiled, torn, or punctured. Wash hands after glove removal.
- Disposable latex gloves will not be reused or washed and disinfected for reuse.
- Where possible, gloves should be changed between patients in multiple casualty incidents.
- Structural firefighting gloves will be worn in situations where sharp or rough edges are likely to be encountered. *Latex or Nitrile gloves should be worn under the firefighting gloves to protect against any body fluids.*
- Heavy-duty utility gloves may be used for the handling, cleaning, decontamination or disinfection of potentially contaminated patient care equipment.
- Facial protection will be used in any situation where splash contact with the face is possible. Facial protection may be afforded by using both a face mask (N95) and eye protection, or by using a full-face shield. When treating a patient with a suspected or known airborne transmissible disease, face masks (N95) will be used. The first choice is mask the patient; if this is not feasible, mask the member(s)
- *A 5’ hot zone shall be observed around every patient. Any member inside the 5’ zone shall have on a minimum of safety glasses and latex/nitrile gloves. Any patient with symptoms of respiratory illness of unknown origin, a productive cough or bronchitis, TB, pneumonia, MRSA, SARS, etc… should be masked with a N95 mask along with anyone else in the 5’ hot zone. Considerations should be given by the Incident Commander to expand the patient hot zone.*
- Face shields on structural firefighting helmets will not be used for infection control purposes.
- Fluid resistant gowns are designed to protect clothing from splashes. Structural firefighting gear also protects clothing from splashes and is preferable in fire, rescue, or vehicle extrication activities. Gowns may interfere with, or present hazard to, the member in these circumstances. The decision to use barrier protection to protect clothing and the type of barrier protection used will be left up to the member. Structural firefighting gear will always be worn for fire suppression and extrication activities.

**SUMMARY:**

- If it's wet, it's infectious-use gloves
- If it could splash onto your face, use eye shields and mask or full-face shield.
- If it's airborne, mask the patient and/or yourself.
- If it could splash on your clothes, use a gown or structural firefighting gear.
- If it could splash on your head or feet, use appropriate barrier protection.

## V. SOP #IC 5: Scene Operations

- The blood, body fluids, and tissues of all patients are considered potentially infectious, and Universal Precautions/ Body Substance Isolation procedures will be used for all patient contact.
- The choice of personal protective equipment is specified in SOP#IC 4. Members will be encouraged to use maximal rather than minimal PPE for each situation.
- While complete control of the emergency scene is not possible, every attempt must be made to limit splashing, spraying or aerosolization of body fluids.
- The minimum number of members required to complete the task safely will be used for all on-scene operations. Where communicable disease exposure is possible or anticipated, members not immediately needed will remain a safe distance from operations.

**Hand washing is the most important infection control procedure. Members will wash hands:**

- As soon as possible after removing PPE
- As soon as possible after each patient contact
- After handling potentially infectious materials
- After cleaning or decontaminating equipment
- After using the bathroom
- Before eating
- Before and after handling or preparing food
- Hand washing with soap and water will be performed for ten to fifteen seconds. If soap and water are not available at the scene, a waterless handwash may be used, provided that a soap and water wash is performed immediately upon return to quarters or hospital.
- Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited at the scene of operations.
- Used needles and other sharps shall be disposed of in approved sharps containers. Needles will not be recapped, re-sheathed, bent, broken, or separated from disposable syringes. The most common occupational blood exposure occurs when needles are recapped.

- Sharps containers will be easily accessible on-scene. All crews carry Sharps Containers and Sharps shuttles. Needles should immediately be put into the Sharps Container after use. The container should be placed next to the paramedic (opened) for easy disposal in one movement.
- Disposable resuscitation equipment will be used whenever possible. For CPR, the order of preference is:
    - **1.** Disposable bag-valve mask
    - **2.** Demand valve resuscitator with disposable mask.
    - **3.** Disposable pocket mask with one-way valve.
- Mouth to mouth resuscitation will be performed only as a last resort if no other equipment is available. Disposable resuscitation equipment will be kept readily available during on-scene operations.
- Patients with suspected airborne communicable diseases will be transported wearing a face mask or particulate respirator whenever possible. Transport Unit windows will be open and ventilation systems turned on full whenever possible.
- Personal protective equipment will be removed after leaving the work area, and as soon as possible if contaminated. After use, all contaminated PPE will be placed in leakproof bags, color-coded and marked as biohazard, and transported back to the station for proper disposal. All non-contaminated gloves, etc., can be thrown in station trash.
- On-scene public relations will be handled by the Incident Commander or the Department Public Information Officer, if available. The public should be reassured that infection control PPE is used as a matter of routine for the protection of all members and the victims that they treat. The use of PPE does not imply that a given victim may have a communicable disease.
- No medical information will be released on-scene. Media queries will be referred to the Incident Commander or the Department Public Information Officer. Patient confidentiality will be maintained at all times.
- At the conclusion of on-scene operations, all potentially contaminated patient care equipment will be removed for appropriate disposal or decontamination and reuse.

## VI. SOP #IC 6: POST – RESPONSE

- Upon return to quarters, contaminated equipment will be removed and replaced with clean equipment. Supplies of PPE on response vehicles will be replenished.
- Contaminated equipment will be stored only in the decontamination area.
- Cleaning and decontamination will be performed as soon as practical.
- Disposable equipment and other biohazard waste generated during on-scene operations will be stored in the biohazard disposal area in appropriate leakproof containers. Sharps containers will be closed and placed in the biohazard area.
- Gloves will be worn for all contact with contaminated equipment or materials. Other PPE will be

used depending on splash or spill potential. Heavy-duty utility gloves may be used for cleaning, disinfection, or decontamination of equipment.

- Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited during cleaning or decontamination procedures.
- Disinfection will be performed with a department-approved disinfectant or with a 1:10 solution of bleach in water. All disinfectants will be tuberculocidal and EPA approved and registered.
- Any damaged equipment will be cleaned and disinfected before being sent out for repair.
- The manufacturer's guidelines will be used for the cleaning and decontamination of all equipment. Unless otherwise specified:
    - Durable equipment (backboards, splints, MAST pants) will be washed with hot soapy water, rinsed with clean water, and disinfected with an approved disinfectant or 1:10 bleach solution. Equipment will be allowed to air dry.
    - Delicate equipment (radios, cardiac monitors, etc.) will be wiped clean of any debris using hot soapy water, wiped with clean water, then wiped with disinfectant of 1:10 bleach solution. Equipment will be allowed to air dry.
    - Work surfaces will be decontaminated with an appropriate disinfectant after completion of procedures, and after spillage or contamination with blood or potentially infectious materials. Seats on response vehicles contaminated with body fluids from soiled PPE also will be disinfected upon return to the station.
    - Contaminated structural firefighting gear (turnout coat, bunker pants) will be cleaned *in the station extractor* according to manufacturer's recommendations found on attached labels. Normally, this will consist of a wash with hot soapy water followed by a rinse with clean water. Turnout gear will be air-dried. Chlorine bleach may impair the fire retardant properties of structural firefighting gear and will not be used.
    - Contaminated work clothes (jump suits, t-shirts, uniform pants) will be removed and exchanged for clean clothes. The member will shower if body fluids were in contact with skin under work clothes.
    - Infectious wastes generated during cleaning and decontamination operations will be properly bagged and placed in the biohazard container.

## VII. SOP #IC 7: EXPOSURE PROTOCOLS

- Any member exposed to potentially infectious material will immediately wash the exposed area with soap and water or saline eye wash if the eyes are involved.
- Any member having an occupational communicable disease exposure will immediately report the exposure to his or her supervisor. The supervisor will then contact the on-duty Safety Officer.

Needle stick injuries will be reported immediately to the Infection Control Officer or the on-duty Safety Officer. The EMS bureau can also be contacted for assistance in these matters.

- **1.** The Safety Officer along with the member will fill out a Infectious Disease Exposure Report (On TFRDWeb Forms) for any of the following exposures:
  - Needlestick injury
  - Break in skin caused by a potentially contaminated object
  - Splash of blood or other potentially infectious material onto eyes, mucous membranes, or non-intact skin.
  - Mouth to mouth resuscitation without pocket mask/one-way valve.
  - Other exposures that the member may feel significant.
- **2.** If determined to be a “significant Exposure”, the member will be directed to a medical facility for treatment and testing.
- **3.** A “
  Request for Notification form
  ” shall be filled out by the Infection Control Officer or the Safety Officer or member in charge. The report will include details of the task being performed, the means of transmission, the portal of entry, and the type of PPE in use at the time. It is important to get the form to the hospital of the source patient promptly to insure proper testing of the source patient. It also will insure that if Post Exposure Prophylaxis (PEP) is indicated for the member involved, the time frame for administering the medications will be met.
- **4.** If not present, the Communicable Disease Exposure Report should be forward to the Infection Control Officer.
- **5.** The Infection Control Officer will evaluate the report for exposure hazards. If a possible exposure occurred, medical evaluation by the Department Physician or designee will be arranged by the Infection Control Officer no later than 48 hours post-exposure. If no exposure took place, the Infection Control Officer will counsel the member on exposure hazards. The Infection Control Officer will complete the communicable disease exposure report, indicating disposition of medical management, and file the report.
- **6.** The Infection Control Officer will refer members for infection control retraining (any retraining needs to be done in cooperation with Training Bureau to provide documentation) or for stress management counseling if indicated. Spousal counseling will be available.
- **7.** The source patient will be traced to the receiving facility by the Infection Control Officer. The Infection Control Officer or his designee will notify the receiving facility that a communicable disease exposure took place, and request an infectious disease determination, as provided under the Ryan White Act of 1990. **Request for consent to test the source patient for HIV and HBV will be made.** The source patient has the right to refuse such testing under present regulations.
- **8.** St. Vincent Medical Center - Occupational Health or designee will provide appropriate diagnostic workup and treatment of members with communicable disease exposures.

Services will include long-term follow-up and member/spousal counseling.

- **9.** Under the Ryan White Act, medical treatment facilities will notify the department Infection Control Officer of any patient transported by members of the department with a diagnosis of an airborne transmissible disease. When so notified, the Infection Control Officer will contact members involved and schedule medical evaluation with the Department of Physician or designee.

## VIII. SOP#IC 8: Compliance and Quality Monitoring/Program Evaluation

**1.** Compliance and quality monitoring

1. The Infection Control Officer will collect compliance and quality monitoring date including:
    - Inspections of station facilities
    - Observations of on-scene activities
    - Analysis of reported exposures to communicable diseases
    - The Infection Control Officer will coordinate with St. Vincent Mercy Medical Center, Occupational Health or designated facility in assuring all members get the follow-up treatment required.

**2.** Program Evaluation

- The Infection Control Program will be reevaluated at least annually to ensure that the program is both appropriate and effective.
- In addition, the Infection Control Program will be re-evaluated as needed to reflect any significant changes in assigned tasks or procedures; in medical knowledge related to infection control; or regulatory matters.

---

# EMERGENCY CARE WORKER (ECW) EXPOSURE FOLLOW-UP PROCEDURE

According to Ohio Law (Ohio Revised Code, Section 3701.248) Emergency Care Workers have access to information regarding patients that may have a contagious or infectious disease. In the event that an Emergency Care Worker suffers a significant exposure through contact with a patient, they must submit a written request (attached) to be notified of the results of any tests performed to determine the

presence of a contagious or infectious disease.

**I. Emergency Care Worker (ECW)**

- 1. Report incident to your immediate supervisor or infection control coordinator.
- 2. Fill-out part 1 of attached form.

  Request for Notification form
- 3. Submit form to head nurse at hospital receiving patient.
- 4. Seek attention for exposure per your department's protocol.

**II. Nurse or Physician:**

- 1. Accept written request from Emergency Care Worker (ECW)
- 2. Determine if significant exposure occurred
- 3a. if significant:
  - **1. For Blood or Body Fluid Exposure**
    - a. Apprise patient and/or family of exposure, obtain written informed consent for source patient blood draw protocol, council patient on HIV and test results.
    - b. **Hand deliver** Emergency Care Worker (ECW) written request to the infection control department. If not available, slide request under the door.
  - **2. For All Other Exposures:** Council Emergency Care Worker (ECW) on what action he/she needs to take (e.g. seek immediate attention, etc.)
- 3b. If exposure is not significant, return form to Emergency Care Worker (ECW) and explain why there will be no follow-up.