California Aerosol Transmissible Disease (ATD)
To: California Employers and Healthcare Workers

California OSHA’s Aerosol Transmissible Diseases (ATDs) Standard took effect in the latter half of 2009 and represents a significant leap for healthcare workers towards achieving the reality of safe and healthful workplaces in which to deliver patient care. It represents the culmination of years of effort by committed safety and health professionals at California OSHA and other organizations.

The Standard is comprehensive and addresses many different aspects of protection needed to effectively block the transmission of ATDs in the workplace. It deals with such issues as source patient control, airborne infection isolation, engineering controls, infection control, reporting, training, medical surveillance, tuberculosis, immunizations, and recordkeeping, in short, all things necessary to achieve the goal of preventing the transmission of airborne or droplet transmitted diseases to healthcare workers.

Stericycle is committed to providing you with the tools necessary to fully comply with the Standard’s requirements. Due to the Standard’s broad application, an Overview Questionnaire and Facility Classification Flow Chart is provided on the following pages that will enable you to quickly:

- Determine whether the Standard applies to your workplace
- Determine which classification your workplace falls into if the Standard does apply, and
- Determine a broad overview of the things you must do to be in compliance

This Questionnaire and Flow Chart and the other supporting materials of the SteriSafeSM OSHA Compliance Program are contained in this section and provide everything needed to enable you to create either a full ATD Exposure Control Plan or the required written ATD protocols that may be necessary for your own particular workplace.

Sincerely,

Richard L. Best
Corporate Director, OSHA Compliance
Stericycle, Inc.
CALIFORNIA AEROSOL TRANSMISSIBLE DISEASES (ATD)

Table of Contents

Facility Classification Flow Chart ........................................ Part A-F
  See additional Table of Contents on following page

ATD Exposure Control Plan/Written Protocols ........................... 3.3-3.64

  *Elements 1-8 are applicable in both Treating and Referring Facilities*
  
  **Element 1:** ATD Administration. ........................................ 3.3
  **Element 2:** ATD Infection Control. ....................................... 3.9
  **Element 3:** ATD Cleaning and Disinfection/Decontamination. .... 3.15
  **Element 4:** ATD Screening and Referral ............................... 3.26
  **Element 5:** ATD Source Control ........................................ 3.31
  **Element 6:** ATD Medical Services ...................................... 3.40
  **Element 7:** ATD Training ................................................ 3.46
  **Element 8:** ATD Recordkeeping ........................................ 3.49

  *Elements 9-13 are applicable in Treating Facilities, and, depending on the circumstances, may also have application in some Referring Facilities*

  **Element 9:** ATD Engineering Controls ................................. 3.52
  **Element 10:** ATD Work Practice Controls ............................. 3.54
  **Element 11:** ATD Personal Protective Equipment ................... 3.55
  **Element 12:** ATD Respiratory Protection .............................. 3.57
  **Element 13:** ATD Surge Procedures .................................. 3.64

Resources

  *See additional Table of Contents for Resources section ................ 3.65*
Overview/Facility Classification Flow Chart

Flow Chart Table of Contents

Facility Classification Flow Chart ........................................ Part A-F
  Standards 5199 and 5199-1 ............................................ Part A
  Exceptions, Exemptions ............................................... Part B
  Typical Workplaces Covered ........................................... Part C
  Medical Laboratory ATD Standard BSP Requirements ............. Part C
  Conditionally Exempt Outpatient Dental or Medical Facilities .... Part C
  Conditionally Exempt Facilities and Emergency Patients ........... Part C
  Small Animal Veterinary Hospitals and Clinics Written IIPP Requirements .... Part D
  Zoonotic ATD Written Procedures ................................... Part D
  ATDs Requiring Airborne Infection Isolation ......................... Part E
  ATDs Requiring Droplet Precautions ................................ Part E
  Aerosol Transmissible Pathogens-Laboratory ........................ Part F

Use the Questionnaire/Facility Classification Flow Chart on the following pages to quickly and easily determine which classification your workplace falls into (Conditionally Exempt, Treating, or Referring) concerning compliance with the ATD Standard.

Important Disclaimer

Although Stericycle has taken every precaution to present information accurately, the information contained herein represents Stericycle’s understanding of Cal/OSHA requirements and CDC Guidelines. The information in this Cal/OSHA Aerosol Transmissible Diseases resource guide has been carefully checked and is believed to be accurate. However, the laws, regulations, protocols, and practices described on this product are subject to change at any time. Stericycle may release updates or new versions of this product from time to time with improved content to reflect changes in applicable laws, regulations, protocols, and practices without notice or obligations to the user of this resource guide.

The information and artwork contained in this resource guide are protected by copyright and all rights are reserved. No part of this resource guide may be reproduced or transmitted by any means or in any forms, without prior consent in writing from Stericycle. Stericycle makes no claim to any original government works referenced herein.
Facility Classification Flow Chart—Standards 5199 and 5199-1

Does your California workplace have occupational exposure to persons, animals, specimens, etc. with:

- Aerosol Transmissible Diseases (ATDs)
- Aerosol Transmissible Pathogens-Laboratory (ATPs-L)
- Zoonotic Aerosol Transmissible Diseases (Z-ATDs)

Please see full list of typically affected workplaces on Part C of this flow chart.
Please see full lists of typical ATDs and ATPs-L on Part E & F of this flow chart.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your workplace treat (or otherwise work with) patients, cases, specimens, animals, etc., that are suspected or known to be infected?</td>
<td>The ATD Standard does not apply to your workplace</td>
</tr>
</tbody>
</table>

Yes, we treat or otherwise work with such cases at our workplace.

Your workplace is a Treating Facility and is required to have a full, written ATD Exposure Control Plan and to implement the following methods of compliance:
1. Administrative
2. Infection Control
3. Cleaning and Disinfection/Decontamination
4. Screening and Referral
5. Source Control
6. Medical Services
7. Training
8. Recordkeeping
9. Engineering Controls
10. Work Practice Controls
11. Personal Protective Equipment
12. Respiratory Protection Program
13. Surge procedures, if applicable

Please refer to Steri-Safe™ materials to create required written protocols.

Aren’t there some exceptions, exemptions, or special requirements for certain facilities?
Yes, please continue to Part B & C to see requirements and circumstances that permit some exceptions or variations.

Does your workplace treat (or otherwise work with) patients, cases, specimens, animals, etc., that are suspected or known to be infected?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ATD Standard does not apply to your workplace</td>
<td>No, we refer all such cases to other facilities for treatment or handling.</td>
</tr>
</tbody>
</table>

Your workplace is a Referring Facility and is required to implement certain written protocols and to implement the following methods of compliance:
1. Administrative
2. Infection Control
3. Cleaning and Disinfection/Decontamination
4. Screening and Referral
5. Source Control
6. Medical Services
7. Training
8. Recordkeeping

Depending on circumstances, Referring Facilities may also need Personal Protective Equipment or Respiratory Protection Programs, etc. Please refer to Steri-Safe™ materials to create required written protocols.

Veterinary Hospitals that Do Not Work with Zoonotic ATDs Written IIPP Requirements

- Sanitation
- Investigation of occupational injuries and illnesses
- Training, including all exposure control procedures
- Biosecurity, where applicable

All veterinary employers with work operations involving handling, culling, transporting, killing, eradicating, or disposing of animals infected with Zoonotic ATDs, or the cleaning and disinfection of areas used, or previously used, to contain such animals or their wastes, are required to establish, implement, and maintain full, written zoonotic disease control procedures to control the risk of transmission of disease from the animals to employees. An abbreviated listing of the requirements for written zoonotic procedures appears below, but any employers in this category should refer to the ATD Zoonotic Standard itself for detailed further guidance beyond the scope of this Overview.

Animal Related Workplaces that Work with Zoonotic ATDs are Required to have the Following Protocols

- A detailed work plan including Risk Assessment to employees, and including biological, chemical, physical, and safety hazards
- Site control measures
- A list of all jobs, tasks, or procedures in which employees may have occupational exposure
- Engineering Controls, Work Practice Controls, and exposure monitoring
- Procedures for the safe handling of hazardous substances, including hazardous substances used for disinfection and decontamination
- Procedures for the application of toxic or asphyxiant gases, if such gases are to be used in the operation
- Respiratory Protection
- Personal Protective Equipment and protective clothing
- Decontamination procedures
- Disposal of animal waste and contaminated PPE
- Training
- Recordkeeping
- Procedures to provide employees ready or frequent access to drinking water and sanitation facilities, including appropriate decontamination methods for employees who need to access those facilities
- Procedures to protect employees from the risk of heat illness

© 2010 Stericycle, Inc. Rev.(1/10)
Facility Classification Flow Chart–Exceptions, Exemptions

### Part B

**Is your workplace an outpatient dental practice or medical specialty office?**

- **No**
  - **Do you treat patients (including emergency patients) with known or suspect ATDs?**
    - **No**
      - Your workplace is Conditionally Exempt, but there are still some requirements. Please see requirements for Conditionally Exempt Outpatient Dental or Medical Facilities on Part C.
    - **Yes**
      - **If you treat patients with ATDs, even just on an emergency basis, then your workplace is NOT Conditionally Exempt.**
        - Please see requirements for Treating Facility or Referring Facility on Part A of this flow chart.

- **Yes**
  - **Do you work with specimens capable of aerosolizing ATPs-L or have direct contact with suspected ATD cases or ATPs-L?**
    - **No**
      - The ATD Standard does not apply to your workplace.
    - **Yes**
      - **Please see requirements for Medical Laboratory ATD Standard BSP Requirements on Part C of the flow chart.**

**Is your workplace a medical laboratory, research facility, etc.?**

- **No**
  - **Is your workplace a small animal veterinary facility?**
    - **Yes**
      - **Do you work with animals or specimens capable of aerosolizing Z-ATDs?** See Standard 5199-1 for detailed information.
    - **No**
      - Please see requirements for Veterinary Hospitals That Do Not Work with Z-ATDs on Part D.
        - **Please see requirements for animal-related workplaces that work with Zoonotic ATDs on Part D of this flow chart, and also the Zoonotic ATD Standard 5199-1 for further guidance.**

**OTHER WORKPLACES**

- If your workplace does not match the conditions described on this page or on Part A of this flow chart, then please refer to the Standard for further specific guidance.

### Part C

**Typical Workplaces Covered by ATD Standard**

- Hospital
- Skilled nursing facility
- Clinic, medical office
- Other outpatient medical facility
- Facility where high hazard procedures are performed
- Home healthcare
- Long-term care facility
- Hospice
- Medical outreach service
- Paramedic
- Emergency responder
- Medical transport
- Facility or service to receive persons from release of biological agents
- Police service transporting or detaining persons with ATDs
- Public health service
- Correctional facility, jail, prison, etc.
- Homeless shelter
- Drug treatment center
- Pathology laboratory
- Medical examiner’s facility
- Coroner’s office
- Mortuary
- Laboratory that performs procedures with ATPs-L or zoonotic ATPs
- Maintenance, renovation, service, or repair of ATD contaminated ventilation, BSCs, etc.
- Hazardous waste and emergency response
- Workplace with other occupational exposure to ATPs

**Medical Laboratory ATD Standard BSP Requirements**

Establish a written Biosafety Plan to minimize employee exposures to ATPs-L that may be transmitted by laboratory aerosols.

- Appoint a qualified Biological Safety Officer (BSO)
- List job classifications with potential for exposure
- List ATPs-L present and biosafety measures required
- Treat incoming ATPs-L as virulent, wild-type until proven otherwise
- Identify necessary engineering controls and containment equipment
- Establish safe handling procedures and prohibited practices
- Establish disinfection and decontamination procedures
- Identify and describe use of required PPE

**Conditionally Exempt Outpatient Dental or Medical Facilities**

1. Establish written Screening and Referral procedures to refer all known or suspect ATD patients.
2. Incorporate Screening and Referral procedures into your facility’s Injury and Illness Prevention Program. Use Screening Questionnaire in Resources section.
3. Train employees on the Screening/Referral procedures. Use Screening Training Sign-In Form.
4. Be sure Screening/Referral procedures are actually implemented and followed. If emergency patients with ATDs are seen, then the facility is not Conditionally Exempt.

**Conditionally Exempt Facilities and Emergency Patients**

1. Conditionally Exempt status as described at left and on Part B of this flow chart is conditional and NOT automatic.
2. Conditionally Exempt Facilities such as outpatient dental or medical specialty practices should keep in mind that if emergency patients are seen even if those patients present with suspect or known ATDs, then the facility should ensure that it has complied with the requirements for Treating or Referring Facilities. This includes the preparation of written protocols, etc., just as any other Treating or Referring Facility would do.

Continue to next page...
Facility Classification Flow Chart—Standards 5199 and 5199-1

Does your California workplace have occupational exposure to persons, animals, specimens, etc. with:

- Aerosol Transmissible Diseases? (ATDs)
- Aerosol Transmissible Pathogens-Laboratory? (ATPs-L)
- Zoonotic Aerosol Transmissible Diseases? (Z-ATDs)

Please see full list of typically affected workplaces on Part C of this flow chart. Please see full lists of typical ATDs and ATPs-L on Part E & F of this flow chart.

Yes

Does your workplace treat (or otherwise work with) patients, cases, specimens, animals, etc., that are suspected or known to be infected?

Yes, we treat or otherwise work with such cases at our workplace.

Your workplace is a Referring Facility and is required to implement certain written protocols and to implement the following methods of compliance:

1. Administrative
2. Infection Control
3. Cleaning and Disinfection/Decontamination
4. Screening and Referral
5. Source Control
6. Medical Services
7. Training
8. Recordkeeping
9. Engineering Controls
10. Work Practice Controls
11. Personal Protective Equipment
12. Respiratory Protection Program
13. Surveillance procedures, if applicable

Depending on circumstances, Referring Facilities may also need Personal Protective Equipment or Respiratory Protection Programs, etc. Please refer to Steri-Safe™ materials to create required written protocols.

No, we refer all such cases to other facilities for treatment or handling.

Your workplace is a Treating Facility and is required to have a full, written ATD Exposure Control Plan and to implement the following methods of compliance:

1. Administrative
2. Infection Control
3. Cleaning and Disinfection/Decontamination
4. Screening and Referral
5. Source Control
6. Medical Services
7. Training
8. Recordkeeping

Part A

Part D

Veterinary Facilities

Veterinary Facilities are not exempt from ATD requirements, since they are fully covered by 5199-1, the Cal/OSHA Zoonotic ATD Standard, an offshoot of the 5199 ATD Standard. The Zoonotic ATD Standard may be downloaded at: http://www.dir.ca.gov/Title8/5199-1.html.

Even though veterinary facilities are not exempt, however, most small animal veterinary clinics and hospitals, not involved in work operations or exposure to Z-ATDs, are required only to establish, implement, and maintain effective procedures for preventing employee exposure to Z-ATDs in accordance with Cal/OSHA’s already existing Section 3203 Injury and Illness Prevention Program (IIPP) requirements. The following items must be covered in the IIPP written procedures.

- Sanitation
- Investigation of occupational injuries and illnesses
- Training, including all exposure control procedures
- Biosecurity, where applicable

Veterinary Hospitals that Do Not Work with Zoonotic ATDs

Written IIPP Requirements

All veterinary employers with work operations involving handling, culling, transporting, killing, eradicating, or disposing of animals infected with Zoonotic ATDs, or the cleaning and disinfection of areas used, or previously used, to contain such animals or their wastes, are required to establish, implement, and maintain full, written zoonotic disease control procedures to control the risk of transmission of disease from the animals to employees. An abbreviated listing of the requirements for written zoonotic procedures appears below, but any employers in this category should refer to the ATD Zoonotic Standard itself for detailed further guidance beyond the scope of this Overview.

Animal Related Workplaces that Work with Zoonotic ATDs are Required to have the Following Protocols

- A detailed work plan including Risk Assessment to employees, and including biological, chemical, physical, and safety hazards
- Site control measures
- A list of all jobs, tasks, or procedures in which employees may have occupational exposure
- Engineering Controls, Work Practice Controls, and exposure monitoring
- Procedures for the safe handling of hazardous substances, including hazardous substances used for disinfection and decontamination
- Procedures for the application of toxic or asphyxiant gases, if such gases are to be used in the operation

- Respiratory Protection
- Personal Protective Equipment and protective clothing
- Decontamination procedures
- Disposal of animal waste and contaminated PPE
- Training
- Recordkeeping
- Procedures to provide employees ready or frequent access to drinking water and sanitation facilities, including appropriate decontamination methods for employees who need to access those facilities
- Procedures to protect employees from the risk of heat illness

Aren’t there some exceptions, exemptions, or special requirements for certain facilities?

Yes, please continue to Part B & C to see requirements and circumstances that permit some exceptions or variations.
**ATDs Requiring Airborne Infection Isolation**

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
- Measles (rubeola)/Measles virus
- Monkeypox/monkeypox virus
- Novel or unknown pathogens
- Severe acute respiratory syndrome (SARS)
- Smallpox (variola)/Variola virus
- Tuberculosis (TB)/Mycobacterium tuberculosis - Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
- Any other disease for which public health guidelines recommend airborne infection isolation

**ATDs Requiring Droplet Precautions**

- Diphtheria pharyngeal
- Epiglottitis, due to *Haemophilus influenzae* type b
- *Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b - Infants and children
- Influenza, human (typical seasonal variations)/influenza viruses
- Meningitis *Haemophilus influenzae*, type b known or suspected *Neisseria meningitides* (meningococcal) known or suspected
- Meningococcal disease sepsis, pneumonia (see also meningitis)
- Mumps (infectious parotitis)/Mumps virus
- Mycoplasmal pneumonia
- Parvovirus B19 infection (erythema infectiosum)
- Pertussis (whooping cough)
- Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
- Pneumonia
- Adenovirus
- *Haemophilus influenzae* Serotype b, in infants and children
- Meningococcal
- Mycoplasma, primary atypical
- Streptococcus Group A
- Pneumonic plague/*Yersinia pestis*
- Rubella virus infection (German measles)/Rubella virus
- Severe acute respiratory syndrome (SARS)
- Streptococcal disease (group A streptococcus)
- Skin, wound or burn, Major
- Pharyngitis in infants and young children
- Pneumonia
- Scarlet fever in infants and young children
- Serious invasive disease
- Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)
- Any other disease for which public health guidelines recommend droplet precautions
Aerosol Transmissible Pathogens-Laboratory

In order to provide users of this flow chart a ready reference to what ATPs-L are covered for medical laboratories, the below list has been condensed and abbreviated. All qualifiers and descriptive terms have been removed in order to shrink the list to a size that can be shown on a single page. The goal is merely to provide a quick approximation of the types of things that are covered. If your workplace is a medical or research laboratory, please refer to Appendix D of the ATD Standard for a more complete listing.

- Adenovirus
- Arboviruses
- Arenaviruses
- Bacillus anthracis
- Blastomyces dermatitis
- Bordetella pertussis
- Brucella abortus
- Burkholderia mallei
- Cercopithecine herpesvirus
- Chlamydia pneumoniae
- Chlamydia psittaci
- Chlamydia trachomatis
- Clostridium botulinum
- Coccidioides immitis
- Corynebacterium diphtheriae
- Coxiella burnetti
- Crimean-Congo haemorrhagic fever virus
- Cytomegalovirus, human
- EEEV
- Ebola virus
- Epstein-Barr virus
- Escherichia coli
- Francisella tularensis
- Guaranito virus
- Haemophilus influenzae, type b
- Hantaviruses
- Helicobacter pylori
- Hemorrhagic fever
- Hendra virus
- Hepatitis B, C, and D viruses
- Herpes simplex virus 1 and 2
- Herpesvirus simiae
- Histoplasma capsulatum
- Human herpesviruses 6A, 6B, 7, and 8
- Influenza virus, H5N1 - human, avian
- Junin virus
- Kyasanur forest disease virus
- Lassa fever virus
- Legionella pneumophila
- LCMV
- Machupo virus
- Marburg virus
- Measles virus
- Monkeypox virus
- Mumps virus
- M. tuberculosis complex
- Mycoplasma pneumoniae
- Neisseria gonorrhoeae
- Neisseria meningitidis
- Nipah virus
- Omsk hemorrhagic fever virus
- Parvovirus B19
- Prions
- Rabies virus
- Retroviruses
- Rickettsia
- RVFV
- Rubella virus
- Salmonella spp.
- Salmonella typhi
- SARS coronavirus
- Shigella spp
- Streptococcus spp., group A
- Tick-borne encephalitis viruses
- Vaccinia virus
- Varicella zoster virus
- Variola major virus (Smallpox virus)
- Variola minor virus (Alastrim)
- VEEV
- WNV
- WEEV
- Yersinia pestis

Based on our determination after working through the Facility Classification Flow Chart in the preceding pages, we have classified our workplace as a:

- Treating Facility (including Laboratories with exposure to ATP-Ls)
- Referring Facility
- Conditionally Exempt Facility
Exposure Control Plan/Written Protocols –
Element 1: ATD Administration

A copy of the California OSHA Aerosol Transmissible Diseases (ATD) Standard may be accessed at http://www.dir.ca.gov/Title8/5199.html.

Our Facility Classification
Based on our determination after working through the Facility Classification Flow Chart in the preceding Overview section, we have classified our workplace as a:

- Treating Facility (including Laboratories with exposure to ATP-Ls)
- Referring Facility
- Conditionally Exempt Facility

Treating and Referring Facilities
If your facility is not a Conditionally Exempt Facility and is either a Treating Facility or a Referring Facility, then please continue on the following pages to create your required ATD Exposure Control Plan/Written Protocols.

Exempt Facilities
Conditionally Exempt outpatient dental and medical specialty practices are required to include written procedures for screening patients for ATDs in the facility’s Injury and Illness Prevention Program (IIPP), and employees must also be trained in those screening procedures. Exempt dental facilities do not perform dental procedures on patients identified to them as ATD cases or suspected ATD cases, and both exempt dental and medical offices do not perform aerosol generating procedures on cases or suspected cases of ATDs. Keep in mind that Conditionally Exempt status is conditional upon the fact that you do not treat ATD patients. If you are an otherwise Conditionally Exempt Facility, for example, but you would treat emergency patients, even though such a patient might be suffering from either a suspect or known ATD at the time, then please be sure to classify your facility accordingly as either a Treating or Referring Facility, and proceed with creating the required written protocols for either a Treating or Referring Facility as the case may be.

If this facility is a Conditionally Exempt Facility and you have added your written Screening and Referral criteria to your IIPP, are properly screening your patients, do not treat ATD cases, and have complied with the other above criteria, then you are in compliance with the ATD Standard. Be sure to use the Patient Questionnaire in the Forms Section (or your own equivalent document) for properly screening and classifying your patients. Use the ATD Screening Protocol Training Sign-In Form for documenting that your staff has completed the required training. Conditionally Exempt Facilities do not have to complete an Aerosol Transmissible Diseases Exposure Control Plan or Written Protocols beyond the requirements discussed in this paragraph. If your workplace falls into this classification, therefore, and you have complied with these requirements, then you do not have to proceed further.
Administrative Responsibilities

This document contains this facility’s ATD Exposure Control Plan/Written Protocols as required by California OSHA’s Aerosol Transmissible Diseases Standard 5199 for Treating and Referring Facilities.

These ATD Exposure Control Plan/Written Protocols are site-specific to this facility located at:

- Name of Facility ________________________________
- Street Address ________________________________
- City, State, Zip ________________________________
- Telephone Number ________________________________

ATD Administrator and Alternate

ATD Administrator Contact Information

is responsible for the implementation of all administrative, engineering, and work practice controls implemented by this facility for the prevention of the transmission of ATDs or ATPs-L. This person will review, maintain, and update these control protocols no less than once a year or whenever new or modified tasks or procedures are introduced.

Alternate ATD Administrator Contact Information

is this facility’s Alternate ATD Administrator responsible for the implementation of ATD prevention protocols whenever the ATD Administrator is not on-site.

In each element of the following ECP/Written Protocols, the Administrator may draw a line through and place initials beside any portion that does not apply to this particular workplace.
Implementation and Annual Review and Update

This is to document and certify that on the below date I have either implemented for the first time or reviewed and updated this facility’s already existing ATD ECP/Written Protocols, including Infection Control and all other protocols, and that I have duly solicited and obtained input and active involvement from our employees as indicated below.

<table>
<thead>
<tr>
<th>ATD Administrator or Alternate</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employees Actively Involved in Implementation or Annual Review and Update

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Work Area</th>
<th>Signature Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Conclusions Found in Review and Update (insert additional pages as necessary)

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Retain this certification for a period of three years from the date of implementation or annual review and update.

Additional copies of this form are included in the Resources section.
**Exposure Determination**

The following is a list of this facility’s job classifications in which employees have potential occupational exposure to aerosol transmissible pathogens.

<table>
<thead>
<tr>
<th>Job Title/Category/Classification</th>
<th>Department/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**High Hazard Procedures**

High hazard procedures are defined by the Standard as:

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.

The facility’s ATD Administrator should indicate by initialing and checking the appropriate line below whether or not these procedures apply in this facility and by initialing and dating the indication.

Are high hazard procedures as defined by the ATD Standard performed in your facility?

- [ ] Yes; see list below
- [ ] No
- [ ] ATD Administrator’s Initials
- [ ] Date

<table>
<thead>
<tr>
<th>List of High Hazard Procedures, if Any, Performed in This Facility</th>
<th>Job Title/Category/Classifications with Potential Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Personal Protective Equipment and Respiratory Protection**

Is PPE or Respiratory Protection used in this facility?

- [ ] Yes; see list below of task/assignments
- [ ] No
- [ ] ATD Administrator’s initials
- [ ] Date

List of All Assignments or Tasks Requiring either PPE or Respiratory Protection

When Respiratory Protection is required, then full compliance with the Respiratory Protection Standard 5144 is also triggered.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
ATD Infection Control

is the person charged with ATD Infection Control responsibilities for this facility.

1. References and Guidelines

Infection Control guidelines current at the time of this publication are:


C. Other applicable CDC Guidelines or OSHA Enforcement Directives may be issued during outbreaks, epidemics, or pandemics, and such documents are followed in this facility.

D. Infection Control procedures necessarily overlap with those of Source Control, Screening and Referral, PPE, Work Practice Controls, etc. Be sure, therefore, to see each of those relevant protocols for further information.

2. Infection Control

A broad application ATD Infection Control protocol appears on the following pages. Alternatively you may replace that protocol and insert (or append) your facility’s own ATD Infection Control protocol.

This facility has adopted and follows the ATD Infection Control protocol that appears on the following pages in all applicable areas unless otherwise indicated. The annual review required for Infection Control is indicated on our Implementation and Annual Review and Update form found in the Administrative Protocol Element 1 of these ECP/Written Protocols.

Instructions for Administrator:

The below signature is to acknowledge that I have reviewed each line of the following protocol, and drawn a line through and initialed any portions that are not applicable for this facility.

<table>
<thead>
<tr>
<th>Name of person responsible for Infection Control at this facility</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Part A - for Referring and Treating Facilities

1. Reference


2. Screening

We utilize this facility’s Screening and Referral Protocol to screen patients for signs and symptoms of febrile respiratory illness at any point of entry into the facility. Provisions are made to allow for prompt isolation and assessment of symptomatic patients. Please refer to the separate Screening and Referral Protocol for further information.

3. Standard Precautions

The practice of Standard Precautions combines the major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and is based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions are followed in this facility.

Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene, use of gloves, gowns, masks, eye protection, or face shields, depending on the anticipated exposure, and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield, or mask and goggles is necessary.

Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate appropriate decision-making and promote adherence when HCWs are faced with new circumstances. Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.
4. **Hand Hygiene**

**Reference**


Prepared by John M. Boyce, M.D.
Hospital of Saint Raphael
New Haven, Connecticut

Didier Pittet, M.D.
University of Geneva
Geneva, Switzerland

Available at http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf.

Hand Hygiene is an integral element of Standard Precautions. During the delivery of healthcare, we avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces.

When hands are visibly dirty, contaminated with proteinaceous material, or visibly soiled with blood or body fluids, we wash hands with either a nonantimicrobial soap and water or an antimicrobial soap and water.

If hands are not visibly soiled, or after removing visible material with nonantimicrobial soap and water, we decontaminate hands. The preferred method of hand decontamination is with an alcohol-based hand rub. Alternatively, hands may be washed with an antimicrobial soap and water. Frequent use of alcohol-based hand rub immediately following handwashing with non-antimicrobial soap may increase the frequency of dermatitis.
We perform hand hygiene:

- Before having direct contact with patients.
- After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.
- After contact with a patient’s intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).
- If hands will be moving from a contaminated-body site to a clean-body site during patient care.
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
- After removing gloves.

We wash hands with non-antimicrobial soap and water or with antimicrobial soap and water if contact with spores (e.g., *C. difficile* or *Bacillus anthracis*) is likely to have occurred. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores.

We do not wear artificial fingernails or extenders if duties include direct contact with patients at high risk for infection and associated adverse outcomes (e.g., those in ICUs or operating rooms).

The wearing of non-natural nails by healthcare personnel who have direct contact with patients outside of the groups specified above, if applicable, is presented in our facility’s separate Bloodborne Pathogens Exposure Control Plan. Please see that ECP for further information.

5. **Standard Precautions - Barriers and other PPE**

The use of gloves, masks, and other PPE is an important element of Standard Precautions. If applicable in this facility, the subject of PPE is handled in our facility’s separate PPE protocol. Please see that protocol for further information.

6. **Standard Precautions - Safe Injection Practices**

The remaining primary element of Standard Precautions, Safe Injection Practices, is dealt with in our facility’s separate Bloodborne Pathogens Exposure Control Plan if applicable. Please see that protocol for further information.
**Part B - for Treating Facilities**

1. **Reference**
   

2. **Transmission-Based Precautions**
   
   In addition to Standard Precautions, we use Transmission-Based Precautions as discussed below for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically-important pathogens for which additional precautions are needed to prevent transmission.

3. **Contact Precautions**
   
   Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient’s environment as described. Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of transmission.

   Healthcare personnel caring for patients on Contact Precautions should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient’s environment. Donning PPE before room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., VRE, *C. difficile*, noroviruses, and other intestinal tract pathogens; RSV).

4. **Droplet Precautions**
   
   In addition to Standard Precautions, we advise healthcare personnel to observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact, but see also under Respiratory Protection below for situations when N95 or higher level respirators are required), when examining a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions are maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

5. **Airborne Precautions**
   
   Use Airborne Precautions consisting of Respiratory Protection (N95 or higher) and airborne infection isolation for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (e.g., *M. tuberculosis*, measles, chickenpox, disseminated herpes zoster).

   Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], *Mycobacterium tuberculosis*, and possibly SARS-CoV).

   Healthcare personnel caring for patients on Airborne Precautions wear a mask or respirator, depending on the disease-specific recommendations, that is donned prior to room entry. Whenever possible, non-immune HCWs should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox).
6. **Isolation Precautions**

All healthcare personnel who enter a patient’s room must take Standard and, depending on the CDC guidelines in place at the time and the particular situation, possibly also Contact Precautions, Droplet Precautions, or Airborne Precautions, plus eye protection as applicable, for all patient care activities for patients being evaluated or in isolation for ATDs. We maintain adherence to hand hygiene by washing with soap and water or using alcohol-based hand sanitizer immediately after removing gloves and other equipment and after any contact with respiratory secretions. Nonsterile gloves and gowns, as appropriate, along with eye protection, as applicable, are donned when entering a patient’s room.

7. **Respiratory Protection**

All healthcare personnel who enter the rooms of patients in isolation with confirmed, suspected, or probable ATDs for which CDC is recommending Respiratory Protection should wear a fit-tested, disposable N95 respirator or better. Respiratory protection should be donned when entering the patient’s room. Since these guidelines are subject to change, this facility follows CDC guidelines current at the time.

Respirator use should also be in the context of a complete Respiratory Protection Program in accordance with California OSHA’s Respiratory Protection Standard 5144 regulations. Staff are medically cleared, fit-tested, and trained for respirator use, including: proper fit-testing and use of respirators, safe removal and disposal, and medical contraindications to respirator use. See this facility’s separate ATD Respiratory Protection element of these ATD ECP/Written Protocols for further information.

A Respiratory Protection Program that includes education about use of respirators, fit-testing, and user seal checks is required in any facility with airborne infection isolation Rooms (AIIRs). In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIIR or returned to the home environment, as deemed medically appropriate.

8. **Aerosol Generating Procedures**

For procedures that are likely to generate aerosols (e.g., bronchoscopy, elective intubation, suctioning, administering nebulized medications, etc.), of ATDs, an airborne infection isolation room (AIIR) with negative pressure air handling, with at least 6 to 12 air changes per hour can be used. Air can be exhausted directly outside or recirculated after filtration by a high efficiency particulate air (HEPA) filter. Facilities should monitor and document the proper negative-pressure function of AIIRs, including those in operating rooms, intensive care units, emergency departments, and procedure rooms. See separate ATD Respiratory Protection and ATD Engineering Controls portions of this facility’s ATD ECP/Written Protocols for further information.
Exposure Control Plan/Written Protocols –
Element 3: ATD Cleaning and Disinfection/Decontamination

**ATD Cleaning and Disinfection/Decontamination Administrator**

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>is the person charged with ATD Cleaning and Disinfection/Decontamination responsibilities for this facility.</td>
</tr>
</tbody>
</table>

1. **References and Guidelines**
   The Cleaning and Disinfection/Decontamination guidelines current at the time of this publication are:
   D. Other applicable CDC Guidelines or OSHA Enforcement Directives may be issued during outbreaks, epidemics, or pandemics, and such documents are followed in this facility.

2. **Cleaning and Disinfection/Decontamination**
   A broad application ATD Cleaning and Disinfection/Decontamination protocol appears on the following pages. You may replace that protocol and insert (or append) your facility’s own ATD Cleaning and Disinfection/Decontamination protocol.

   ________ This facility has adopted and follows the ATD Cleaning and Disinfection/Decontamination protocol that appears on the following pages in all applicable areas, unless otherwise indicated.

**Instructions for Administrator:**
The below signature is to acknowledge that I have reviewed each line of the following protocol, and drawn a line through and initialed any portions that are not applicable for this facility.

<table>
<thead>
<tr>
<th>Name of person responsible for Cleaning, Disinfection, and Decontamination at this facility</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
ATD Cleaning, Disinfection, Decontamination, And Sterilization Protocol

References:


1. Occupational Health and Exposure
   A. We inform each worker of the possible health effects of his or her exposure to infectious agents and/or chemicals. The information should be consistent with Occupational Safety and Health Administration (OSHA) requirements and identify the areas and tasks in which potential exists for exposure.
   B. We educate healthcare workers in the selection and proper use of Personal Protective Equipment (PPE).
   C. We ensure that workers wear appropriate PPE to preclude exposure to infectious agents or chemicals through the respiratory system, skin, or mucous membranes of the eyes, nose, or mouth. PPE can include gloves, gowns, masks, and eye protection. The exact type of PPE depends on the infectious or chemical agent and the anticipated duration of exposure. The employer is responsible for making such equipment and training available.
   D. We establish, as necessary, a program for monitoring occupational exposure to regulated chemicals (e.g., formaldehyde, ethylene oxide (EtO), etc.) that adheres to state and federal regulations.
   E. We exclude healthcare workers with weeping dermatitis of hands from direct contact with patient-care equipment.

2. Cleaning of Patient-Care Devices
   A. We perform most cleaning, disinfection, and sterilization of patient-care devices in a central processing area (or department) in order to more easily control quality.
   B. We meticulously clean patient-care items with water and detergent, or with water and enzymatic cleaners before high-level disinfection or sterilization procedures.

We remove visible organic residue (e.g., residue of blood and tissue) and inorganic salts with cleaning. We use cleaning agents that are capable of removing visible organic and inorganic residues.

We clean medical devices as soon as practical after use because soiled materials become dried onto the instruments. Dried or baked materials on the instruments make the removal process more difficult and the disinfection or sterilization process less effective or ineffective.
C. We perform either manual cleaning (i.e., using friction) or mechanical cleaning (e.g., with ultrasonic cleaners, washer-disinfector, or washer-sterilizers).

D. If using an automatic washer/disinfector, we ensure that the unit is used in accordance with the manufacturer’s recommendations.

E. We ensure that the detergents or enzymatic cleaners selected are compatible with the metals and other materials used in medical instruments. We ensure that the rinse step is adequate for removing cleaning residues to levels that will not interfere with subsequent disinfection/sterilization processes.

F. We inspect equipment surfaces for breaks in integrity that would impair either cleaning or disinfection/sterilization. We discard or repair equipment that no longer functions as intended or cannot be properly cleaned, and disinfected, or sterilized.

3. Indications for Sterilization, High-Level Disinfection, and Low-Level Disinfection

A. Before use on each patient, we sterilize critical medical and surgical devices and instruments that enter normally sterile tissue or the vascular system or through which a sterile body fluid flows (e.g., blood).

B. We provide, at a minimum, high-level disinfection for semicritical patient-care equipment (e.g., gastrointestinal endoscopes, endotracheal tubes, anesthesia breathing circuits, and respiratory therapy equipment, etc.) that touches either mucous membranes or nonintact skin.

C. We perform low-level disinfection for noncritical patient-care surfaces (e.g., bedrails, over-the-bed table) and equipment (e.g., blood pressure cuffs) that touch intact skin (see Recommendation 5G).

4. Selection and Use of Low-Level Disinfectants for Noncritical Patient-Care Devices

A. We disinfect noncritical medical devices (e.g., blood pressure cuffs) with an EPA-registered disinfectant using the label’s safety precautions and use directions. Most EPA-registered disinfectants have a label contact time of 10 minutes. However, multiple scientific studies have demonstrated the efficacy of hospital disinfectants against pathogens with a contact time of at least 1 minute. By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered product label, the user assumes liability from any injuries resulting from off-label use and is potentially subject to enforcement action under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA).

B. We ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly).

C. If dedicated, disposable devices are not available, we disinfect noncritical patient-care equipment after using on a patient who is on Contact Precautions before using this equipment on another patient.
5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities and Vehicles

A. We clean housekeeping surfaces (e.g., floors, tabletops) on a regular basis, when spills occur, and when these surfaces are visibly soiled.

B. We disinfect (or clean) environmental surfaces on a regular basis (e.g., daily, three times per week, etc.) and when surfaces are visibly soiled.

C. We follow manufacturers’ instructions for proper use of disinfecting (or detergent) products --- such as recommended use-dilution, material compatibility, storage, shelf-life, and safe use and disposal.

D. We clean walls, blinds, and window curtains in patient-care areas when these surfaces are visibly contaminated or soiled.

E. We prepare disinfecting (or detergent) solutions as needed and replace these with fresh solution frequently (e.g., replace floor mopping solution every three patient rooms, change no less often than at 60-minute intervals), according to the facility’s policy.

F. We decontaminate mop heads and cleaning cloths regularly to prevent contamination.

G. We use a one-step process and an EPA-registered disinfectant designed for housekeeping purposes in patient care areas where
   i. uncertainty exists about the nature of the soil on the surfaces (e.g., blood or body fluid contamination versus routine dust or dirt); or
   ii. uncertainty exists about the presence of multidrug resistant organisms on such surfaces.

See 5N for recommendations requiring cleaning and disinfecting blood-contaminated surfaces.

H. Detergent and water are adequate for cleaning surfaces in nonpatient-care areas (e.g., administrative offices).

I. We do not use high-level disinfectants/liquid chemical sterilants for disinfection of non-critical surfaces.

J. We wet-dust horizontal surfaces regularly (e.g., daily, three times per week) using clean cloths moistened with an EPA-registered disinfectant (or detergent). We prepare the disinfectant (or detergent) as recommended by the manufacturer.

K. We disinfect noncritical surfaces with an EPA-registered disinfectant according to the label’s safety precautions and use directions.
L. We do not use disinfectants to clean infant bassinets and incubators while these items are occupied. If disinfectants (e.g., phenolics) are used for the terminal cleaning of infant bassinets and incubators, we thoroughly rinse the surfaces of these items with water and dry them before these items are reused.

M. We promptly clean and decontaminate spills of blood and other potentially infectious materials. We discard blood-contaminated items in compliance with federal regulations.

N. For site decontamination of spills of blood or other potentially infectious materials (OPIM), we implement the following procedures. We use protective gloves and other PPE (e.g., when sharps are involved we use forceps to pick up sharps, and we discard these items in a puncture-resistant container) appropriate for this task. We disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, a registered germicide on the EPA Lists D and E (i.e., products with specific label claims for HIV or HBV), or freshly diluted hypochlorite solution.

O. If the spill contains large amounts of blood or body fluids, we clean the visible matter with disposable absorbent material, and we discard the contaminated materials in appropriate, labeled containment.

P. We use protective gloves and other PPE appropriate for this task.

Q. We do not perform disinfectant fogging for routine purposes in patient-care areas.

6. Management of Equipment and Surfaces in Dentistry

A. Dental instruments that penetrate soft tissue or bone (e.g., extraction forceps, scalpel blades, bone chisels, periodontal scalers, and surgical burs) are classified as critical and are sterilized after each use or discarded. In addition, after each use, we sterilize dental instruments that are not intended to penetrate oral soft tissue or bone (e.g., amalgam condensers, air-water syringes) but that might contact oral tissues and are heat-tolerant, although classified as semicritical. We clean and, at a minimum, high-level disinfect heat-sensitive semicritical items.

B. Noncritical clinical contact surfaces, such as uncovered operatory surfaces (e.g., countertops, switches, light handles), are barrier-protected or disinfected between patients with an intermediate-disinfectant (i.e., EPA-registered hospital disinfectant with a tuberculocidal claim) or low-level disinfectant (i.e., EPA-registered hospital disinfectant with HIV and HBV claim).

C. Barrier protective coverings are used for noncritical clinical contact surfaces that are touched frequently with gloved hands during the delivery of patient care, that are likely to become contaminated with blood or body substances, or that are difficult to clean. We change these coverings when they are visibly soiled, when they become damaged, and on a routine basis (e.g., between patients). We disinfect protected surfaces at the end of the day or if visibly soiled.
7. Microbial Contamination of Disinfectants
   A. We institute the following control measures to reduce the occurrence of contaminated disinfectants:
      i. We prepare the disinfectant correctly to achieve the manufacturer’s recommended use-dilution.
      ii. We prevent common sources of extrinsic contamination of germicides (e.g., container contamination or surface contamination of the healthcare environment where the germicides are prepared and/or used).

8. Methods of Sterilization
   A. Steam is the preferred method for sterilizing critical medical and surgical instruments that are not damaged by heat, steam, pressure, or moisture.
   B. We cool either steam or heat-sterilized items before they are handled or used in the operative setting.
   C. We follow the sterilization times, temperatures, and other operating parameters (e.g., gas concentration, humidity) recommended by the manufacturers of the instruments, the sterilizer, and the container or wrap used, and that are consistent with guidelines published by government agencies and professional organizations.
   D. We use low-temperature sterilization technologies (e.g., EtO, hydrogen peroxide gas plasma) for reprocessing critical patient-care equipment that is heat or moisture sensitive.
   E. Dry-heat sterilization (e.g., 340°F for 60 minutes) can be used to sterilize items (e.g., powders, oils) that can sustain high temperatures.
   F. We comply with the sterilizer manufacturer’s instructions regarding the sterilizer cycle parameters (e.g., time, temperature, concentration).

9. Packaging
   A. We ensure that packaging materials are compatible with the sterilization process and have received FDA 510k clearance.
   B. We ensure that packaging is sufficiently strong to resist punctures and tears to provide a barrier to microorganisms and moisture.
10. Performance indicators for Monitoring of Sterilizers

We monitor adherence to high-level disinfection and/or sterilization guidelines on a regular basis. We review any adverse health events potentially resulting from exposure to disinfectants and sterilants, and we implement engineering controls, work practice controls, and PPE to prevent future exposures.

A. We use mechanical, chemical, and biologic monitors to ensure the effectiveness of the sterilization process.

B. We monitor each load with mechanical (e.g., time, temperature, pressure) and chemical (internal and external) indicators. If the internal chemical indicator is visible, an external indicator is not needed.

C. We do not use processed items if the mechanical (e.g., time, temperature, pressure) or chemical (internal and/or external) indicators suggest inadequate processing.

D. We use biologic indicators to monitor the effectiveness of sterilizers at least weekly with an FDA-cleared commercial preparation of spores (e.g., *Geobacillus stearothermophilus* for steam) intended specifically for the type and cycle parameters of the sterilizer.

E. After a single positive biologic indicator used with a method other than steam sterilization, we treat as nonsterile all items that have been processed in that sterilizer, dating from the sterilization cycle having the last negative biologic indicator to the next cycle showing satisfactory biologic indicator results. These nonsterile items should be retrieved, if possible, and reprocessed.

F. After a positive biologic indicator with steam sterilization, objects other than implantable objects do not need to be recalled because of a single positive spore test unless the sterilizer or the sterilization procedure is defective as determined by maintenance personnel or inappropriate cycle settings. If additional spore tests remain positive, we consider the items nonsterile and recall and reprocess the items from the implicated load(s).

G. We use biologic indicators for every load containing implantable items and quarantine items, whenever possible, until the biologic indicator is negative.

11. Load Configuration

A. We place items correctly and loosely into the basket, shelf, or cart of the sterilizer so as not to impede the penetration of the sterilant.
12. **Storage of Sterile Items**

A. We ensure the sterile storage area is a well-ventilated area that provides protection against dust, moisture, insects, and temperature and humidity extremes.

B. We store sterile items so the packaging is not compromised (e.g., punctured, bent). We label sterilized items with a load number that indicates the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.

C. The shelf life of a packaged sterile item depends on the quality of the wrapper, the storage conditions, the conditions during transport, the amount of handling, and other events (moisture) that compromise the integrity of the package. If event-related storage of sterile items is used, then packaged sterile items can be used indefinitely unless the packaging is compromised.

D. We evaluate packages before use for loss of integrity (e.g., torn, wet, punctured). The pack can be used unless the integrity of the packaging is compromised.

E. If the integrity of the packaging is compromised (e.g., torn, wet, or punctured), we repack and reprocess the pack before use.

F. If time-related storage of sterile items is used, we label the pack at the time of sterilization with an expiration date. Once this date expires, we reprocess the pack.

**Environmental Disinfection/Decontamination**

Reference:


13. **Carpeting and Cloth Furnishings**

A. We vacuum carpeting in public areas of healthcare facilities and in general patient-care areas regularly with well-maintained equipment designed to minimize dust dispersion.

B. We periodically perform a thorough, deep cleaning of carpeting as determined by facility policy by using a method that minimizes the production of aerosols and leaves little or no residue.

C. We avoid use of carpeting in high-traffic zones in patient-care areas or where spills are likely (e.g., burn therapy units, operating rooms, laboratories, and intensive care units).

D. We follow proper procedures for managing spills on carpeting.
   
   i. We spot-clean blood or body substance spills promptly.

   ii. If a spill occurs on carpet tiles, we replace any tiles contaminated by blood and body fluids or body substances.
E. We thoroughly dry wet carpeting to prevent the growth of fungi; we replace carpeting that remains wet after 72 hours.

F. No recommendation is offered regarding the routine use of fungicidal or bactericidal treatments for carpeting in public areas of a healthcare facility or in general patient-care areas.

G. We do not use carpeting in hallways and patient rooms in areas housing immunosuppressed patients.

H. We avoid the use of upholstered furniture and furnishings in high-risk patient-care areas and in areas with increased potential for body substance contamination (e.g., pediatric units).
   i. No recommendation is offered regarding whether upholstered furniture and furnishings should be avoided in general patient-care areas.
      • We maintain upholstered furniture in good repair.
   ii. We maintain the surface integrity of the upholstery by repairing tears and holes.
   iii. If upholstered furniture in a patient’s room requires cleaning to remove visible soil or body substance contamination, we move that item to a maintenance area where it can be adequately cleaned with a process appropriate for the type of upholstery and the nature of the soil.

14. Flowers and Plants in Patient-Care Areas
   A. Flowers and potted plants need not be restricted from areas for immunocompetent patients.
   B. We designate care and maintenance of flowers and potted plants to staff not directly involved with patient care.
   C. If plant or flower care by patient-care staff is unavoidable, we instruct the staff to wear gloves when handling the plants and flowers and to perform hand hygiene after glove removal.
   D. We do not allow fresh or dried flowers, or potted plants in patient-care areas for immunosuppressed patients.
15. Pest Control

A. We develop pest-control strategies, with emphasis on kitchens, cafeterias, laundries, central sterile supply areas, operating rooms, loading docks, construction activities, and other areas prone to infestations.

B. We install screens on all windows that open to the outside; we keep screens in good repair.

C. We contract for routine pest control service by a credentialed pest-specialist who will tailor the application to the needs of a healthcare facility.

D. We place laboratory specimens (e.g., fixed sputum smears) in covered containers for overnight storage.

16. Recommendations—Laundry and Bedding

A. Employer Responsibilities
   i. Employers must launder workers’ wearable and reusable Personal Protective Equipment that is contaminated with blood or other potentially infectious materials.

B. Laundry Facilities and Equipment
   i. We maintain the receiving area for contaminated textiles at negative pressure compared with the clean areas of the laundry in accordance with American Institute of Architects (AIA) Construction Standards in effect during the time of facility construction.
      • We ensure that laundry areas have handwashing facilities and products and appropriate PPE available for workers.
      • We use and maintain laundry equipment according to manufacturers’ instructions.
      • We do not leave damp textiles or fabrics in machines overnight.
      • Disinfection of washing and drying machines in residential care is not needed as long as gross soil is removed before washing and proper washing and drying procedures are used.

C. Routine Handling of Contaminated Laundry
   i. We handle contaminated textiles and fabrics with minimum agitation to avoid contamination of air, surfaces, and persons.

D. We bag or otherwise contain contaminated textiles and fabrics at the point of use.
   i. We do not sort or prerinse contaminated textiles or fabrics in patient-care areas.
   ii. We use leak-resistant containment for textiles and fabrics contaminated with blood or body substances.
   iii. We identify bags or containers for contaminated textiles with labels, color coding, or other alternative means of communication as appropriate.

E. Covers are not needed on contaminated textile hampers in patient-care areas.
F. If laundry chutes are used, we ensure that they are properly designed, maintained, and used in a manner to minimize dispersion of aerosols from contaminated laundry.
   i. We ensure that laundry bags are closed before tossing the filled bag into the chute.
   ii. We do not place loose items in the chute.

G. We establish a facility policy to determine when textiles or fabrics should be sorted in the laundry facility (i.e., before or after washing).

H. Laundry Process
   i. If hot-water laundry cycles are used, we wash with detergent in water >160°F (>71°C) for >25 minutes.
   ii. No recommendation is offered regarding a hot-water temperature setting and cycle duration for items laundered in residence-style healthcare facilities.
   iii. We follow fabric-care instructions and special laundering requirements for items used in the facility.
      We choose chemicals suitable for low-temperature washing at proper use concentration if low temperature (<160°F [<71°C]) laundry cycles are used.
   vi. We package, transport, and store clean textiles and fabrics by methods that will ensure their cleanliness and protect them from dust and soil during interfacility loading, transport, and unloading.

17. Regulated Medical Waste
   i. Generators of medical waste in California are required to implement a written Medical Waste Management Plan (MWMP). Further details of our facility’s handling of Regulated Medical Waste are presented in our MWMP.
   ii. Our ATD Administrator designates a person or persons to be responsible for establishing, monitoring, reviewing, and administering the MWMP.

A. Handling Regulated Medical Wastes
   i. We inform personnel involved in the handling and disposal of potentially infectious waste of the possible health and safety hazards; we ensure that they are trained in appropriate handling and disposal methods.
   ii. We use proper sharps disposal strategies.
   iii. We place disposable syringes with needles, including sterile sharps that are being discarded, scalpel blades, and other sharp items into puncture-resistant sharps containers located as close as practical to the point of use.
   vi. We do not bend, recap, or break used syringe needles before discarding them into a container.
ATD Screening and Referral

is the person charged with ATD Screening and Referral responsibilities for this facility.

ATD Screening and Referral Procedures

Note: Screening and Referral Procedures for Conditionally Exempt Facilities are not treated in this element but are instead already included in the Injury and Illness Prevention Program materials. The Screening and Referral Procedures presented below are for Referring Facilities and Treating Facilities.

1. Screening and Referral Procedures

The ATD Standard recognizes that not all healthcare facilities are engaged in treating patients with Aerosol Transmissible Diseases. Facilities that screen their patients for Aerosol Transmissible Diseases before undertaking treatment may choose, as medically appropriate, to either defer treatment until the condition has resolved, or to refer such patients to facilities that are equipped to treat patients with such diseases. One of the requirements of the Standard for such Referring Facilities, however, is that they have in place a written procedure for screening patients for ATDs.

Treating Facilities, as well, may not choose to treat every case that presents, and Treating Facilities too may have occasion, therefore, to also refer ATD patients for treatment elsewhere.

The following Screening Protocol is hereby adopted by this facility.

2. Screening Criteria

This facility utilizes a Screening Questionnaire (see copy inserted on the following page) to identify patients who present with signs or symptoms of ATDs. It is the policy of this facility that referrals (or, depending upon the medical situation, deferrals until signs and symptoms resolve) are (in the case of Referring Facilities) or may be (in the case of Treating Facilities) provided to persons who exhibit any of the following:

a. Have a cough for more than three weeks that is not explained by non-infectious conditions.

b. Exhibit signs and symptoms of a flu-like illness during March through October, the months outside of the typical period for seasonal influenza in the United States, or exhibit the signs and symptoms for longer than two weeks at any time during the year. These signs and symptoms generally include combinations of the following: coughing and other respiratory symptoms, fever, sweating, chills, muscle aches, weakness, and malaise.

c. State that they have a transmissible respiratory disease, excluding the common cold and seasonal influenza.

d. State that they have been exposed to any infectious ATD case, other than seasonal influenza.
Patient Questionnaire — Our Commitment to You

To ensure that our patients are treated in an environment that promotes health and well being, and in accordance with OSHA requirements for providing a safe and healthful workplace, patients suffering from aerosol transmissible illnesses such as mumps, chickenpox, measles, new types of flu, TB, or other illnesses that may be spread by droplets or by airborne transmission should make our office aware of their condition.

Respiratory Hygiene and Cough Etiquette

During your time in our facility, please be sure to observe the following practices recommended by the Centers for Disease Control and Prevention:

- Cover your nose and/or mouth when coughing or sneezing;
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
- Wash your hands with soap and water or with alcohol hand-gel after you have had contact with contaminated tissues or respiratory secretions, etc.

Patient Questionnaire

Please fill out and return the below questionnaire.

Today’s Date ____________________________________
Patient’s Name ________________________________
Patient’s Telephone Number ________________________________ (or other means of contact)

Are you suffering from any of the following signs or symptoms of aerosol transmissible illnesses?

Please check (Yes) or (No) for each question:

1. Do you have a transmissible respiratory illness other than the common cold or seasonal influenza?  Yes No

2. Have you had a cough for more than three weeks that is not explained by non-infectious conditions?  Yes No

3. Have you had coughing fits that interfere with eating, drinking, or breathing?  Yes No

4. In addition to cough, have you experienced:
   - unexplained weight loss (more than 5 pounds)
   - night sweats
   - fever
   - chronic fatigue or malaise
   - coughing up blood

   1. ______ ______
   2. ______ ______
   3. ______ ______
   4. ______ ______
Please check (Yes) or (No) for each question:

5. Have you had fever, headache, muscle aches, tiredness, poor appetite, followed by painful, swollen salivary glands on one or both sides of the face under the jaw?  5. _______  _______

6. Have you had fever, headache, stiff neck, chills, cough, runny nose, or watery eyes associated with the onset of an unexplained rash (diffuse rash or blister-type skin rash), or possibly mental status changes?  6. _______  _______

7. Do you show signs and symptoms of a flu-like illness during March through October, (the months outside of the typical period for seasonal influenza in the United States), or do you show the signs and symptoms of flu for longer than two weeks at any time during the year? These signs and symptoms generally include combinations of the following: coughing and other respiratory symptoms, fever, sweating, chills, muscle aches, weakness and malaise.  7. _______  _______

8. Have you been exposed to anyone with an infectious aerosol transmissible illness (see below for list of such illnesses) other than seasonal influenza?  8. _______  _______

**Illnesses That Should Be Reported on Page 1**

- Avian flu, novel flu, swine flu, or any other type of flu other than seasonal flu
- Chickenpox
- Shingles
- Measles
- Monkeypox
- SARS
- Smallpox
- Tuberculosis (TB)
- Diphtheria
- *Haemophilus influenzae* type b or Hib
- Meningitis
- Mumps
- Pneumonia
- Parvovirus
- Pertussis (whooping cough)
- Pharyngitis
- Epstein-Barr virus
- Strep
- Scarlet fever

Any new type of infectious illness
3. Additional screening criteria

A. For screening a coughing client with potential TB - privately ask the person
   i. if he or she has had a cough for more than three weeks
   ii. if, in addition to cough, he or she has had one or more of the following clinical symptoms of TB disease:
       - unexplained weight loss (more than 5 pounds)
       - night sweats
       - fever
       - chronic fatigue or malaise
       - coughing up blood

A person who has had a cough for more than three weeks and has one of the other symptoms in section A above, is considered for referral to a healthcare provider for further evaluation, unless that person is already under treatment. A person with any of the above symptoms, if there is no alternative explanation, is also considered for referral.

B. In addition to TB, other vaccine preventable Aerosol Transmissible Diseases, including pertussis, measles, mumps, rubella (“German measles”) and chickenpox should be considered when non-medical personnel screen individuals in non-healthcare facilities. The following is a brief list of some findings that also prompt consideration for referral to a healthcare provider for further evaluation when identified through a screening process:

- Severe coughing spasms, especially if persistent; coughing fits may interfere with eating, drinking, and breathing
- Fever, headache, muscle aches, tiredness, poor appetite followed by painful, swollen salivary glands, one side or both sides of face under jaw
- Fever, chills, cough, runny nose, watery eyes associated with onset of an unexplained rash (diffuse rash or blister-type skin rash)
- Fever, headache, stiff neck, possibly mental status changes
- Any client or patient who exhibits any of the above described findings and reports contact with individuals known to have any obvious transmissible illnesses in the past two to four weeks will be considered for referral for prompt evaluation by a healthcare provider.
- Health officials may issue alerts for community outbreaks of other diseases. They will provide screening criteria, and people will be referred to medical providers as recommended by the applicable health officer.

This facility's employees receive training in the above screening procedures upon hire and prior to being placed into positions of patient contact. A sign-in form (see Resources section) is used to record the delivery of this training, and a copy of this form is maintained for three years.
4. **Methods Employed to Document Non-Referral**

Any patients meeting the above criteria for referral but for whom a healthcare professional decides not to refer for medical reasons must have the reasons for the healthcare provider’s decision documented in writing.

5. **Procedure for Communication of Disease Status**

The Standard requires that a written procedure be developed, implemented, and maintained in place for communicating with employees, other employers, and the local health officer regarding the suspected or diagnosed infectious disease status of referred patients. These shall include procedures to receive information from the facility to which patients were referred and to provide necessary infection control information to employees who were exposed to the referred person.

In compliance with these communications requirements, this office requires all receiving facilities to inform a designated person at this office concerning the infectious disease status of all referrals.

The dedicated person at our facility to receive communications from facilities to which we have referred patients is _______________________________.

Enter name of designated person

Any such communications having relevance to the safety of employees in this facility will be communicated by the above designated person to affected employees, other employers, and the local health officer, as applicable by the circumstances.

6. **Procedures to Reduce Risk of Transmission**

During the time that a patient being referred remains in this facility the Source Control procedures listed separately in the ATD Source Control portion of these overall ATD Exposure Control Plan/Written Protocols will be in effect.

Patients being referred as the result of known or suspected ATD disease status, and who must remain in this facility for a period of time, must be placed in a separate room or area. All transfers must occur within 5 hours of the identification of the case or suspected case, and employees must be protected during the time the patient is still within this facility. A separate ventilation or filtration in the room must be provided if feasible.

If the patient is not compliant with ATD Source Control measures, then Respiratory Protection in compliance with the Respiratory Protection Standard is required of all employees entering the room or area in which the person requiring referral is located. When Respiratory Protection is required, then full compliance with the Respiratory Protection Standard is also required. See the ATD Respiratory Protection protocol portion of these ATD Exposure Control Plan/Written Protocols for further information.
Exposure Control Plan/Written Protocols –
Element 5: ATD Source Control

ATD Source Control Measures and Procedures

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>is the person charged with ATD Source Control Measure and Procedures for this facility.</td>
</tr>
</tbody>
</table>

Source Control procedures necessarily overlap with those of Infection Control, Screening and Referral, PPE, Work Practice Controls, etc. Be sure, therefore, to see each of those relevant protocols for further information.


This Source Control Protocol follows the CDC Prevention Strategies for Seasonal Influenza in Healthcare Settings as its basic guide for the prevention of transmission of Aerosol Transmissible Diseases. Depending upon the specific diagnosis for any particular patient, however, the current CDC guidelines and OSHA requirements applicable at the time for prevention of transmission of the particular illness being treated take precedence and are followed.

Other applicable CDC Guidelines or OSHA Enforcement Directives may be issued during outbreaks, epidemics, or pandemics, and such documents are followed in this facility.

Part A – for Referring and Treating Facilities

1. Vaccinations, Including Seasonal Influenza Vaccine

   Annual vaccination is the most important measure to prevent seasonal influenza infection. Achieving high influenza vaccination rates of healthcare personnel (HCP) and patients is a critical step in preventing healthcare transmission of influenza from HCP to patients and from patients to HCP. According to current national guidelines, unless contraindicated, all affected HCP in this facility are provided with the opportunity for vaccination for ATDs in accordance with CDC and CDPH guidelines and OSHA requirements. See this facility's Medical Services protocol for further information.

2. Steps to Minimize Potential Exposures

   A range of administrative policies and practices are used to minimize influenza and other ATD exposures before patient arrival, upon arrival, and throughout the duration of the patient visit to this healthcare setting. Measures include screening and triage of symptomatic patients and implementation of Respiratory Hygiene/Cough Etiquette. Respiratory Hygiene/Cough Etiquette are measures designed to minimize potential exposures of all respiratory pathogens, including influenza virus, in healthcare settings and should be adhered to by everyone--patients, visitors, and HCP--upon entry and continued for the entire duration of stay in this healthcare setting [http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm].
Before Arrival to a Healthcare Setting

When scheduling appointments, instruct patients and persons who accompany them to inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry, follow triage procedure).

During Periods of Increased Influenza Activity

Take steps to minimize elective visits by patients with suspected or confirmed influenza or other ATDs. For example, consider establishing procedures to minimize visits by patients seeking care for mild influenza-like illness who are not at increased risk for complications from influenza or other ATDs (e.g., provide telephone consultation to patients with mild respiratory illness to determine if there is a medical need to visit the facility).

Upon Entry and During Visit to a Healthcare Setting - Procedure for identifying, Masking, and Referral (for Referring Facilities) or Separation/Isolation (for Treating Facilities) of Persons with Respiratory Symptoms or Other Symptoms of Aerosol Transmissible Diseases

Patients are screened for signs and symptoms of febrile respiratory illness or other ATDs at any point of entry to this facility. A Screening Questionnaire is used (see sample in Appendix).

Patients are instructed to don masks and practice Respiratory Hygiene/Cough Etiquette, as necessary. Provisions are made as medically appropriate to allow for prompt assessment, referral, (for Referring Facilities) and isolation/proper patient placement (for Treating Facilities) of symptomatic patients.

Steps are taken to ensure all persons with symptoms of a respiratory infection adhere to Respiratory Hygiene/Cough Etiquette, hand hygiene, and triage procedures throughout the duration of the patient visit. These steps include:

A. Visual Alerts

Visual alerts (in appropriate languages) are posted at the entrance to this facility instructing patients and persons who accompany them (e.g., family, friends), to inform healthcare personnel of symptoms of a respiratory infection when they first register for care and to practice Respiratory Hygiene/Cough Etiquette. The following visual alerts, or other appropriate alerts, are utilized:

- Notice to Patients to Report Flu Symptoms
  Emphasizes covering coughs and sneezes and the cleaning of hands

- Cover Your Cough
  Tips to prevent the spread of germs from coughing

- Information about Personal Protective Equipment
  Demonstrates the sequences for donning and removing Personal Protective Equipment.

Samples of these posters are included in the Appendix.
B. Implementation of Respiratory Hygiene/Cough Etiquette

The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection:

- Cover the nose/mouth when coughing or sneezing
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use
- Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.

This facility ensures the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.

- Tissues and no-touch receptacles for used tissue disposal are provided.
- Conveniently located dispensers of alcohol-based hand rub are provided; where sinks are available, supplies for hand washing (i.e., soap, disposable towels) are consistently made available.
- When possible, space is provided and persons with symptoms of respiratory infections are encouraged to sit as far away from others as possible (at least three feet but preferably six feet away from others, if feasible). These patients are placed in a separate area if available while waiting for care or referral.
- During periods of increased community influenza activity, triage stations that facilitate rapid screening of patients for symptoms of influenza or other ATDs and separation from other patients may be implemented.

3. Monitor and Manage Ill Healthcare Personnel

HCP who develop fever and respiratory symptoms are:

- Instructed not to report to work, or if at work, to stop patient-care activities, don a facemask, and promptly notify their supervisor and, if applicable, infection control personnel/occupational health before leaving work.
- Excluded from work until at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines such as acetaminophen.
- HCP with influenza or other ATDs may have fever alone as an initial symptom or sign. Thus, it can be very difficult to distinguish influenza from many other causes, especially early in a person’s illness. HCP with fever alone should follow workplace policy for HCP with fever until a more specific cause of fever is identified or until fever resolves.
• HCP who develop acute respiratory symptoms without fever may still have influenza infection but should be allowed to continue or return to work unless assigned to care for patients requiring a Protective Environment. See instructions below for Protective Environments such as HSCT (Hematopoietic Stem Cell Transplantation) [http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf]; these HCP should be considered for temporary reassignment or excluded from work for 7 days from symptom onset or until the resolution of all non-cough symptoms, whichever is longer. HCP recovering from a respiratory illness may return to work with patients in PE sooner if absence of influenza viral RNA or other ATD in respiratory secretions is documented by rRT-PCR. (See below for further information regarding HCP working in Protective Environments).

• Reminded that adherence to Respiratory Hygiene/Cough Etiquette after returning to work remains important because viral shedding may occur for several days following an acute respiratory illness. If symptoms such as cough and sneezing are still present, HCP should wear a facemask during patient care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact) should be reinforced.

• This facility follows sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance to allow and encourage HCP with suspected or confirmed influenza or other ATDs to stay home.

• Exclusion of HCPs who develop a fever and respiratory symptoms from work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines is encouraged.

• This facility ensures that all HCP, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.

• Based upon job tasks, personnel known to be at higher risk for exposure to those with suspected or confirmed influenza or other ATDs are given priority for vaccination; employees have access via telephone to medical consultation and, if necessary, early treatment; individuals with possible influenza or other ATDs are promptly identified. HCP should self-assess for symptoms of febrile respiratory illness. Decisions about work restrictions and assignments for personnel with respiratory illness will be guided by clinical signs and symptoms rather than by laboratory testing for influenza because laboratory testing may result in delays in diagnosis, false negative test results, or both.
HCP working in Protective Environments

- HCP in PEs, if applicable for this facility, are considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, if returning to care for patients in a Protective Environment (PE) such as hematopoietic stem cell transplant patients (HSCT) [http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf].

- HCP recovering from a respiratory illness may return to work with PE patients sooner if absence of influenza viral RNA or other ATDs in respiratory secretions is documented by real-time reverse transcriptase polymerase chain reaction (rRT-PCR).

- Patients in these environments are severely immunocompromised, and infection with influenza virus or other ATDs can lead to severe disease. Furthermore, once infected, these patients can have prolonged viral shedding despite antiviral treatment and expose other patients to influenza virus or other ATD infection. Prolonged shedding also increases the chance of developing and spreading antiviral-resistant influenza strains or other ATDs; clusters of influenza antiviral resistance cases have been found among severely immunocompromised persons exposed to a common source or healthcare setting.

- HCP are reminded that adherence to Respiratory Hygiene/Cough Etiquette after returning to work remains important because viral shedding may occur for several days after resolution of fever. If symptoms such as cough and sneezing are still present, HCP wear a facemask during patient-care activities. The importance of performing frequent hand hygiene (especially before and after each patient contact and contact with respiratory secretions) is reinforced.

- HCP assigned to care for patients requiring a Protective Environment such as HSCT [http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf] should be considered for temporary reassignment or excluded from work for 7 days from symptom onset or until the resolution of all non-cough symptoms, whichever is longer. HCP recovering from a respiratory illness may return to work with patients in PE sooner if absence of influenza viral RNA or other ATD in respiratory secretions is documented by rRT-PCR. (See below for further information regarding HCP working in Protective Environments).

4. Standard Precautions

During the care of any patient, all HCP in our facility will adhere to Standard Precautions, which are the foundation for preventing transmission of infectious agents in all healthcare settings. Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. Elements of Standard Precautions that apply to patients with respiratory infections, including those caused by the influenza virus, are summarized below. Additional details about these recommendations can be found in the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) guideline titled Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings and Guidelines for Preventing Healthcare-Associated Pneumonia [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#4; http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm]
Hand Hygiene
HCP are required to perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of Personal Protective Equipment, including gloves. Washing with soap and water or using alcohol-based hand rubs can be used. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs. This facility ensures that supplies for performing hand hygiene are available.

Gloves
Wear gloves for any contact with potentially infectious material. Remove gloves after contact, followed by hand hygiene. Do not wear the same pair of gloves for care of more than one patient. Do not wash gloves for the purpose of reuse.

Gowns
Wear gowns for any patient-care activity when contact with blood, body fluids, secretions (including respiratory), or excretions is anticipated.

Part B – for Treating Facilities
1. Droplet Precautions
Droplet Precautions are implemented for patients with suspected or confirmed influenza or other ATD for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in our facility. In some cases, this facility may choose to apply Droplet Precautions for longer periods based on clinical judgment, such as in the case of young children or severely immunocompromised patients, who may shed influenza virus for longer periods of time [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#5.

Place patients with suspected or confirmed influenza or other ATD in a private room or area. When a single patient room is not available, consultation with infection control personnel is recommended to assess the risks associated with other patient placement options (e.g., cohorting [i.e., grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients], keeping the patient with an existing roommate). For more information about making decisions on patient placement for droplet precautions, see CDC HICPAC Guidelines for Isolation Precautions [section V.C.2: http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#5].

HCP don a facemask when entering the room of a patient with suspected or confirmed influenza or other ATD. Remove the facemask when leaving the patient’s room, dispose of the facemask in a waste container, and perform hand hygiene.

Based on local needs, and in compliance with CDC and CDPH guidelines and Cal/OSHA requirements, this facility may opt to provide employees with alternative Personal Protective Equipment as long as it offers the same protection of the nose and mouth from splashes and sprays provided by facemasks (e.g., face shields and N95 respirators or powered air purifying respirators which would also protect against inhaling airborne particles). See the Respiratory Protection Protocol for further information.
Movement or Transport Outside of Room for a Patient under Droplet Precautions

Have the patient wear a facemask, if possible, and follow Respiratory Hygiene/Cough Etiquette and hand hygiene.

Communicate information about patients with suspected, probable, or confirmed influenza or other ATDs to appropriate personnel before transferring them to other departments in this facility (e.g., radiology, laboratory) or to other facilities.

2. Aerosol-Generating Procedures and airborne infection isolation Rooms

Some procedures performed on patients with suspected or confirmed influenza or other ATD infection may be more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These procedures potentially put HCP at an increased risk for influenza exposure. Although there are limited data available on influenza transmission related to such aerosols, many authorities [refs: WHO, http://www.who.int/csr/resources/publications/aidememorereviewepidemiopandemic/en/index.html] recommend that additional precautions be used for the following procedures: bronchoscopy; sputum induction; endotracheal intubation and extubation; open suctioning of airways; cardiopulmonary resuscitation; autopsies. A combination of measures should be used to reduce exposures from these aerosol-generating procedures performed on patients with suspected or confirmed influenza, including: confirmed influenza or other ATDs including:

- Only performing these procedures on patients with suspected or confirmed influenza or other ATDs if they are medically necessary and cannot be postponed.

- Limiting the number of HCP present during the procedure to only those essential for patient care and support. All HCP that are required to perform or be present during these procedures are offered influenza or other ATD vaccination. See the Medical Services protocol for further information.

- Conducting the procedures in an airborne infection isolation room (AIIR) when feasible. Such rooms are designed to reduce the concentration of infectious aerosols and prevent their escape into adjacent areas using controlled air exchanges and directional airflow. They are single patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour for new construction or renovation). Air from these rooms should be exhausted directly to the outside or be filtered through a high-efficiency particulate air (HEPA) filter before recirculation. Room doors are kept closed except when entering or leaving the room, and entry and exit is minimized during and shortly after the procedure. This facility monitors and documents the proper negative-pressure function of these rooms. [http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm]
• Use of portable HEPA filtration units to further reduce the concentration of contaminants in the air is considered where feasible. Some of these units can connect to local exhaust ventilation systems (e.g., hoods, booths, tents) or have inlet designs that allow close placement to the patient to assist with Source Control; however, these units do not eliminate the need for Respiratory Protection for individuals entering the room because they may not entrain all of the room air. Information on air flow/air entrainment performance should be evaluated for such devices.

• HCP are required to adhere to Standard Precautions [http://www.cdc.gov/hicpac/2007IP/2007ip_part4.html#4], including wearing gloves, a gown, and either a face shield that fully covers the front and sides of the face or goggles.

• Signs or other effective means are utilized to communicate that Isolation Precautions are to be followed in the room.

• HCP are required to wear respiratory protection equivalent to a fitted N95 filtering facepiece respirator (i.e., N95 respirator) or higher level of protection (e.g., powered air purifying respirator) during aerosol-generating procedures in accordance with CDC and CDPH guidelines and Cal/OSHA requirements. When Respiratory Protection is required in an occupational setting, respirators must be used in the context of a comprehensive Respiratory Protection Program that includes fit-testing and training as required under California OSHA’s Respiratory Protection Standard (5144) at http://www.dir.ca.gov/title8/5144.html. See Respiratory Protection protocol.

• Unprotected HCP are not allowed in a room where an aerosol-generating procedure has been conducted until sufficient time has elapsed to remove potentially infectious particles. More information on clearance rates under differing ventilation conditions is available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm#tab1.

3. Manage Visitor Access and Movement within the Facility

Visitors are limited for patients in isolation for influenza or other ATDs to persons who are necessary for the patient’s emotional well-being and care. Visitors who have been in contact with the patient before and during hospitalization are a possible source of influenza or other ATDs for other patients, visitors, and staff.

For persons with acute respiratory symptoms, this facility implements visitor restriction policies that consider location of patient being visited (e.g., oncology units) and circumstances, such as end-of-life situations, where exemptions to the restriction may be considered at the discretion of the facility. Regardless of restriction policy, all visitors should follow precautions listed in the Respiratory Hygiene/Cough Etiquette section. Visits to patients in isolation for influenza should be scheduled and controlled to allow for:

• Screening visitors for symptoms of acute respiratory illness before entering the hospital.

• Instruction is provided before visitors enter patients’ rooms on hand hygiene, limiting surfaces touched, and use of Personal Protective Equipment (PPE) according to current facility policy while in the patient’s room.
• Visitors should not be present during aerosol-generating procedures.
• Visitors should be instructed to limit their movement within the facility.
• If consistent with this facility’s policy, visitors can be advised to contact their healthcare provider for information about influenza or other ATD vaccination.

4. Monitor Influenza Activity
HCP are promptly alerted about increased influenza or other ATD activity in the community or this facility.

5. Implement Environmental Infection Control
See the Infection Control protocol.

6. Implement Engineering Controls
Engineering controls to reduce or eliminate exposures by shielding HCP and other patients from infected individuals are utilized in this facility. See Engineering Controls protocol.

7. Training Healthcare Personnel
Our ATD Administrator ensures that all HCP receive job-or task-specific education and training on preventing transmission of infectious agents, including influenza, associated with healthcare during orientation to this healthcare setting. This information is updated periodically during ongoing education and training programs on ATDs associated with healthcare during orientation to this healthcare facility. See Training protocol.

8. Considerations for Healthcare Personnel at Higher Risk for Complications of Influenza
HCP are made aware that, if they have conditions that place them at higher risk of complications, they should inform their healthcare provider immediately if they become ill with an influenza-like or other ATD illness so they can receive early treatment if indicated. HCP at higher risk for complications from influenza infection include pregnant women and women up to 2 weeks postpartum, persons 65 years old and older, and persons with chronic diseases such as asthma, heart disease, diabetes, diseases that suppress the immune system, certain other chronic medical conditions, and possibly morbid obesity [www.cdc.gov/h1n1flu/highrisk.htm].

Vaccination and early treatment with antiviral medications are very important for HCP at higher risk for influenza complications because they can decrease the risk of hospitalizations and deaths. HCP at higher risk for complications should check with their healthcare provider if they become ill so that they can receive early treatment. For HCP who identify themselves as being at higher risk of complications, this facility offers work accommodations to avoid potentially high-risk exposure scenarios, such as performing or assisting with aerosol-generating procedures on patients with suspected or confirmed influenza or other ATDs.
ATD Medical Services

Name | Contact Information
--- | ---
is the person charged with ATD Medical Services responsibilities for this facility and ensures compliance with all elements of the below Medical Services Procedures.

ATD Medical Services Procedures

1. Abbreviations

The following abbreviations appear in these procedures:

- **ATD**: Aerosol Transmissible Disease
- **ATP**: Aerosol Transmissible Pathogen
- **ATP-L**: Aerosol Transmissible Pathogen-Laboratory
- **CDC**: Centers for Disease Control and Prevention
- **CDPH**: California Department of Public Health
- **DOSH**: Department of Occupational Safety and Health
- **LTBI**: Latent Tuberculosis Infection
- **OSHA**: Occupational Safety and Health Administration
- **PLHCP**: Physician or Licensed Healthcare Provider
- **TB**: Tuberculosis
- **RATD**: Reportable Aerosol Transmissible Disease

2. Medical Surveillance

This facility provides any employee with occupational exposure with medical surveillance for tuberculosis and other ATDs, ATPs, and ATPs-L, as recommended by the CDC and/or the CDPH for the type of work setting.

3. Provision of PLHCP

A. When this employer is also acting as the evaluating healthcare professional, we advise the employee following an exposure incident that the employee may refuse to consent to vaccination, post-exposure evaluation, and follow-up from the employer-healthcare professional. When consent is refused, we immediately make available a confidential vaccination, medical evaluation, or follow-up from a PLHCP other than the exposed employee’s employer.

B. Medical surveillance provisions, including vaccinations, examinations, evaluations, determinations, procedures, and medical management and follow-up, are:

   i. Performed by or under the supervision of a PLHCP;
   
   ii. Provided according to any CDC and CDPH recommendations that are current at the time these evaluations and procedures take place; and
   
   iii. Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions are provided without providing the name of the source individual.
4. **Tuberculosis Surveillance**

A. This employer makes surveillance for latent tuberculosis infection (LTBI) available to all employees with occupational exposure. Surveillance procedures are in accordance with the most recent recommendations of the CDC and CDPH.

B. EXCEPTION: Research and production laboratories in which *M. tuberculosis* containing materials are not reasonably anticipated to be present, need not provide surveillance for LTBI infection.

C. TB tests and other forms of surveillance are provided in accordance with the current CDC guidelines, and more frequently, if the CDC, CDPH, or local health officer recommends more frequent testing. Employees with a baseline positive TB test shall have an annual symptom screen.

D. This employer refers employees who experience a TB conversion to a PLHCP knowledgeable about TB for evaluation.

E. This employer provides the PLHCP with a copy of California OSHA’s Aerosol Transmissible Diseases Standard 5199 and the employee’s TB test records. If this employer has determined the source of the infection, then any available diagnostic test results including drug susceptibility patterns relating to the source patient shall be provided to the PLHCP.

F. This employer shall request that the PLHCP, with the employee’s consent, perform any necessary diagnostic tests and inform the employee about appropriate treatment options.

G. This employer shall request that the PLHCP determine if the employee is a TB case or suspected case, and do all of the following, if the employee is a case or suspected case:
   i. Inform the employee and the local health officer
   ii. Consult with the local health officer and inform the employer of any infection control recommendations related to the employee’s activity in the workplace
   iii. Make a recommendation to the employer regarding precautionary removal due to suspect active disease, and provide the employer with a written opinion in accordance with California OSHA’s Aerosol Transmissible Diseases Standard.

H. TB conversions shall be recorded in accordance with California Code of Regulations, Title 8, Section 14300 et seq.

I. Unless it is determined that the TB test conversion is not occupational, this employer shall investigate the circumstances of the conversion, and correct any deficiencies found during the investigation. The investigation shall be documented.

5. **Laboratory Tests**

Laboratory tests shall be conducted by an accredited laboratory.
6. **Vaccinations**

A. This employer makes available to all susceptible healthcare workers with occupational exposure all vaccine doses listed in Appendix E of the Aerosol Transmissible Diseases Standard.

B. This employer makes available seasonal influenza vaccine to all employees with occupational exposure. We ensure that each employee who declines to accept the seasonal influenza vaccine signs a declination statement.

C. EXCEPTION: Seasonal influenza vaccine shall be provided during the period designated by the CDC for administration and need not be provided outside of those periods.

D. Employees in laboratory operations outside of healthcare settings, and within the scope of the ATD Standard, shall be provided with vaccines in accordance with CDC and CDPH recommendations for the specific laboratory operations.

E. Recommended vaccinations are made available to all employees who have occupational exposure after the employee has received the training required 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 current CDC and CDPH guidelines; or
   
   iii. The vaccine(s) is contraindicated for medical reasons.

F. This employer shall make additional vaccination(s) available to employees within 120 days of the issuance of new CDC or CDPH recommendations.

G. This employer shall not make participation in a prescreening program a prerequisite for receiving a vaccine, unless CDC or CDPH guidelines recommend prescreening prior to administration of the vaccine.

H. If the employee initially declines a vaccination but at a later date, while still covered under the Standard, decides to accept the vaccination, this employer shall make the vaccination available within 10 working days of that request.

I. This employer shall ensure that employees who decline to accept a recommended and offered vaccination sign the declination statement in Appendix C of the ATD Standard for each declined vaccine.

J. EXCEPTION: Where these procedures cannot be implemented because of the lack of availability of vaccine, this employer shall document efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability. The employer shall check on the availability of the vaccine at least every 10 working days and inform employees when the vaccine becomes available.
7. Exposure Incidents

A. If this employer determines that a person is a Reportable ATD (RATD) case or suspected case we shall:

i. Report the case to the local health officer, in accordance with Title 17.

ii. Determine, to the extent that the information is available in the employer’s records, whether the employee(s) of any other employer(s) may have had contact with the case or suspected case. This employer shall notify the other employer(s) within 24 hours of diagnosis of the date, time, and nature of the potential exposure, and provide any other information that is necessary for the other employer(s) to evaluate the potential exposure of his or her employees.

iii. NOTE: These employees may include, but are not limited to, paramedics, emergency medical technicians, emergency responders, home healthcare personnel, personnel at homeless shelters, at referring healthcare facilities or agencies, and corrections personnel.

B. This employer, upon becoming aware that his or her employees may have been exposed to a RATD case or suspected case, or to an exposure incident involving an ATP-L, shall do all of the following:

i. Within 24 hours of becoming aware of the potential exposure, conduct an analysis of the exposure scenario to determine which employees had significant exposures. This analysis shall be conducted by an individual knowledgeable in the mechanisms of exposure to ATPs or ATPs-L, and shall record the names and identification numbers of persons who were included in the analysis. The analysis shall also record the basis for any determination that an employee need not be included in post-exposure follow-up because the employee did not have a significant exposure or because a PLHCP determined that the employee is immune to the infection in accordance with current CDC or CDPH guidelines. The name of the person making the determination, and the identity of any PLHCP or local health officer consulted in making the determination shall be recorded.

ii. Within 48 hours of becoming aware of the potential exposure, notify employees who had significant exposures of the date, time, and nature of the exposure.

iii. As soon as feasible, provide post-exposure evaluation to all employees who had a significant exposure. The evaluation shall be conducted by a PLHCP knowledgeable about the specific disease, including appropriate vaccination, prophylaxis and treatment. For *M. tuberculosis*, and for other pathogens where recommended by the CDC or CDPH, this shall include testing of the isolate from the source individual or material for drug susceptibility, unless the PLHCP determines that it is not feasible.

iv. Obtain from the PLHCP a written opinion and a recommendation regarding precautionary removal in accordance with California OSHA’s Aerosol Transmissible Diseases Standard 5199.

v. Determine, to the extent that the information is available in the employer’s records, whether employees of any other employers may have been exposed to the case or material. This employer shall notify these other employers within 24 hours of becoming aware of the exposure incident of the nature, date, and time of the exposure, and shall provide the contact information for the diagnosing PLHCP. The notifying employer shall not provide the identity of the source patient to other employers.
8. Information Provided to the Physician or Other Licensed Healthcare Provider

A. This employer shall ensure that all PLHCPs responsible for making determinations and performing procedures as part of the medical surveillance program are provided a copy of this Standard and applicable CDC and CDPH guidelines. For respirator medical evaluations, this employer shall provide information regarding the type of respiratory protection used, a description of the work effort required, any special environmental conditions that exist (e.g., heat, confined space entry), additional requirements for protective clothing and equipment, and the duration and frequency of respirator use.

B. This employer shall ensure that the PLHCP who evaluates an employee after an exposure incident is provided the following information:
   i. A description of the exposed employee’s duties as they relate to the exposure incident
   ii. The circumstances under which the exposure incident occurred
   iii. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee
   iv. All of the employer’s medical records for the employee that are relevant to the management of the employee, including tuberculin skin test results and other relevant tests for ATP infections, vaccination status, and determinations of immunity

9. Precautionary Removal Recommendation from the Physician or Other Licensed Healthcare Provider

A. When providing a post-exposure evaluation, or an evaluation of an employee’s TB conversion, this employer shall request from the PLHCP an opinion regarding whether precautionary removal from the employee’s regular assignment is necessary to prevent spread of the disease agent by the employee and what type of alternate work assignment may be provided. This employer shall request that the PLHCP convey to the employer any recommendation for precautionary removal immediately via phone or fax and that the PLHCP document the recommendation in the written opinion.

B. Where the PLHCP recommends precautionary removal, this employer shall maintain until the employee is determined to be noninfectious, the employee’s earnings, seniority, and all other employee rights and benefits, including the employee’s right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited.

C. EXCEPTION: Precautionary removal provisions do not extend to any period of time during which the employee is unable to work for reasons other than precautionary removal.
10. Written Opinion from the Physician or Other Licensed Healthcare Provider

A. This employer shall obtain, and provide the employee with a copy of, the written opinion of the PLHCP within 15 working days of the completion of all medical evaluations required by this section.

B. For respirator use, the physician’s opinion shall have the content required by California OSHA’s Respiratory Protection Standard, Section 5144(e)(6).

C. For TB conversions and all RATD and ATP-L exposure incidents, the written opinion shall be limited to the following information:
   i. The employee’s TB test status or applicable RATD test status for the exposure of concern
   ii. The employee’s infectivity status
   iii. A statement that the employee has been informed of the results of the medical evaluation and has been offered any applicable vaccinations, prophylaxis, or treatment
   iv. A statement that the employee has been told about any medical conditions resulting from exposure to TB, other RATD, or ATPs-L that require further evaluation or treatment, and that the employee has been informed of treatment options
   v. Any recommendations for precautionary removal from the employee’s regular assignment
   vi. All other findings or diagnoses shall remain confidential and shall not be included in the written report
Exposure Control Plan/Written Protocols –
Element 7: ATD Training

Training

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
</table>

is the person charged with training responsibilities for this facility and will ensure that all training as required by California OSHA’s Aerosol Transmissible Diseases Standard 5199 is provided and that records are maintained for a period of three years.

This employer ensures that all employees with occupational exposure participate in a training program.

ATD Training Procedures

1. Provision of Training

ATD Training is provided by this employer as follows:

A. At the time of initial assignment to tasks where occupational exposure may take place;

B. At least annually thereafter, not to exceed 12 months from the previous training;

C. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures, or institution of new tasks or procedures, affect the employee’s occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures

2. Training Elements for Treating Facilities – the training program shall contain at a minimum the following 13 elements:

A. An accessible copy of the regulatory text of this Standard and an explanation of its contents.

B. A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.

C. An explanation of the modes of transmission of ATPs or ATPs-L and applicable source control procedures.

D. An explanation of the employer’s ATD Exposure Control Plan (and/or Biosafety Plan if applicable), and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.

E. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATPs or ATPs-L.

F. An explanation of the use and limitations of methods that will prevent or reduce exposure to ATPs or ATPs-L including appropriate engineering and work practice controls, decontamination and disinfection procedures, and Personal and Respiratory Protective Equipment.
G. An explanation of the basis for selection of Personal Protective Equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination, and disposal of the items of PPE employees will use.

H. A description of the employer’s TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for LTBI.

EXCEPTION: Research and production laboratories do not need to include training on surveillance for LTBI if *M. tuberculosis* containing materials are not reasonably anticipated to be present in the laboratory.

I. Training meeting the requirements of California OSHA’s Respiratory Protection Standard 5144 for employees whose assignment includes the use of a respirator.

J. Information on the vaccines made available by the employer, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

K. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.

L. Information on the employer’s surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including PPE and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

M. An opportunity for interactive questions and answers with the person conducting the training session.

3. **Training Elements for Referring Facilities – the training program shall contain at a minimum the following 10 elements:**

   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 employer’s source control measures and how these measures will be communicated to persons the employees contact

   D. The employer’s procedures for making referrals

   E. The employer’s procedures for temporary risk reduction measures prior to transfer
F. Respiratory Protection training when Respiratory Protection is used

G. The employer’s ATD medical services procedures, methods of reporting exposure incidents, and the employer’s procedures for providing employees with post-exposure evaluation

H. Information on vaccines the employer 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 employer’s written procedures and how employees can participate in reviewing the effectiveness of the employer’s procedures

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

4. Trainer Qualifications

The person conducting the training shall be knowledgeable in the subject matter covered by the training program as it relates to the workplace that the training will address.

5. Training Material

Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
Exposure Control Plan/Written Protocols –
Element 8: ATD Recordkeeping

ATD Recordkeeping

Name  Contact Information

is the person charged with ATD Recordkeeping for this facility.

1. Medical Records

A. This facility shall establish and maintain an accurate medical record for each employee with occupational exposure, in accordance with California OSHA’s Section 3204, Access to Employee Exposure and Medical Records.

NOTE: This record may be combined with the medical record required by Section 5193, Bloodborne Pathogens, but may not be combined with non-medical personnel records.

B. This record shall include:

1. The employee’s name and any other employee identifier used in the workplace
2. The employee’s vaccination status for all vaccines required by this Standard, including the information provided by the PLHCP in accordance with the Standard, any vaccine record provided by the employee, and any signed declination forms; Exception: As to seasonal influenza vaccine, the medical record need only contain a declination form for the most recent seasonal influenza vaccine
3. A copy of all written opinions provided by a PLHCP in accordance with the Standard, and the results of TB assessments; and
4. A copy of the information regarding an exposure incident that was provided to the PLHCP as required by the Standard

C. Confidentiality.

This facility shall ensure that all employee medical records required by this section are:

1. Kept confidential; and
2. Not disclosed or reported without the employee’s express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law

NOTE: These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.

D. This facility shall maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with California OSHA’s Section 3204, Access to Employee Exposure and Medical Records.
2. Training Records

A. Training records shall include the following information:

1. The date(s) of the training session(s);
2. The contents or a summary of the training session(s);
3. The names and qualifications of persons conducting the training; and
4. The names and job titles of all persons attending the training sessions.

B. Training records shall be maintained for 3 years from the date on which the training occurred.

3. ATD ECP/Written Protocols

Records of implementation of the ATD ECP Plan/Written Protocols (and/or Biosafety Plan, if applicable).

A. Records of annual review of the ATD ECP/Written Protocols (and Biosafety Plan if applicable) shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusions. The record shall be retained for three years.

B. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.

C. Records of the unavailability of airborne infection isolation rooms (AIIR) or areas shall include the name of the person who determined that an AIIR or area was not available, the names and affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer providing assistance, and the times and dates of these contacts. This record shall be retained for three years.

D. Records of decisions not to transfer a patient to another facility for airborne infection isolation for medical reasons shall be documented in the patient’s chart, and a summary shall be provided to the Plan Administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review. This record shall be retained for three years.

E. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems shall be maintained for a minimum of five years and shall include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken.
F. Records of the Respiratory Protection Program shall be established and maintained in accordance with Section 5144, Respiratory Protection.

4. Availability

A. The employer shall ensure that all records, other than the employee medical records more specifically dealt with in the ATD Standard, required to be maintained shall be made available upon request to the Chief of California OSHA and NIOSH for examination and copying.

B. Employee training records required by this subsection shall be provided upon request to employees, employee representatives, the Chief of California OSHA and NIOSH for examination and copying.

C. Employee medical records required by this subsection shall be provided upon request to the subject employee, anyone having the written consent of the subject employee, the Chief of California OSHA and NIOSH in accordance with California OSHA's Section 3204, Access to Employee Exposure and Medical Records, for examination and copying.

5. Transfer of Records

A. This facility shall comply with the requirements involving the transfer of employee medical and exposure records that are set forth in California OSHA's Section 3204, Access to Employee Exposure and Medical Records.

B. If this employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify DOSH and NIOSH, at least three months prior to the disposal of the records and shall transmit them to NIOSH, if required by NIOSH to do so, within that three-month period.


Exposure Control Plan/Written Protocols –
Element 9: ATD Engineering Controls

**ATD Engineering Controls**

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

is the person charged with ensuring, with professional assistance from maintenance personnel, HVAC vendors, etc., that the design, installation, and maintenance of this facility’s ventilation and other engineering controls are in compliance with the requirements of California OSHA’s Airborne Transmissible Diseases Standard 5199.

1. **Reference**
   

2. **Engineering Controls Employed**
   
   Based on the CDC guidelines cited above, this facility employs the following environmental engineering controls for the prevention of transmission of Aerosol Transmissible Diseases:

   Check all that apply:
   
   _____Airborne infection isolation room(s)
   _____Local exhaust ventilation
   _____General ventilation
   _____HEPA (High Efficiency Particulate Air) filtration
   _____UVGI (Ultraviolet Germicidal Irradiation)

3. **Airborne Infection Isolation**
   
   Negative pressure shall be maintained in airborne infection isolation rooms (AIIR) or areas. The ventilation rate shall be 12 or more air changes per hour (ACH). The required ventilation rate may be achieved, in part, by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than 6 ACH.


   Negative pressure shall be visually demonstrated by smoke trails or equally effective means daily while a room or area is in use for airborne infection isolation.
4. **Annual Inspection**

   Engineering controls shall be maintained, inspected, and performance monitored for filter loading and leakage at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness. Records will be maintained as part of the ATD Standard’s recordkeeping procedures.

5. **UVGI**

   Where UVGI is used, it shall be used, maintained, inspected and controlled in accordance with Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Healthcare Settings available as previously referenced. Problems found shall be corrected in a reasonable period of time. If the problem(s) prevent the room from providing effective airborne infection isolation, then the room shall not be used for that purpose until the condition is corrected.

6. **Ventilation**

   Ventilation systems for airborne infection isolation rooms or areas shall be constructed, installed, inspected, operated, tested, and maintained in accordance with California OSHA’s Section 5143, General Requirements of Mechanical Ventilation Systems. Inspections, testing, and maintenance shall be documented in writing, in accordance with recordkeeping requirements of the California OSHA ATD Standard.

7. **Exhaust**

   Air from airborne infection isolation rooms or areas, and areas that are connected via plenums or other shared air spaces, shall be exhausted directly outside, away from intake vents, employees, and the general public. Air that cannot be exhausted in such a manner or that must be recirculated must pass through HEPA filters before discharge or recirculation.

   Ducts carrying air that may reasonably be anticipated to contain aerosolized *M. tuberculosis* or other airborne infectious pathogen shall be maintained under negative pressure for their entire length before in-duct HEPA filtration or until the ducts exit the building for discharge.

8. **Doors and Windows**

   Doors and windows of airborne infection isolation rooms or areas shall be kept closed while in use for airborne infection isolation, except when doors are opened for entering or exiting and when windows are part of the ventilation system being used to achieve negative pressure.

9. **Cleaning**

   When an ATD case or suspected ATD case vacates an airborne infection isolation room or area, the room or area shall be ventilated according to the Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Healthcare Settings previously referenced for a removal efficiency of 99.9% before permitting employees to enter without respiratory protection.
## ATD Work Practice Controls

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>is the person charged with ATD Work Practice Control responsibilities for this facility.</td>
</tr>
</tbody>
</table>

### 1. Safe Work Practices
We avoid touching the eyes, nose, mouth, or exposed skin with contaminated hands (gloved or un gloved); avoid touching surfaces with gloves and other PPE that are not directly related to patient care (e.g. door knobs, keys, light switches).

### 2. Patient Resuscitation
We avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.

### 3. Soiled Patient Care Equipment
We handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; we wear gloves if visibly contaminated.

### 4. Soiled Linen and Laundry
We handle in a manner that prevents transfer of microorganisms to ourselves, to others, and to environmental surfaces; we wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and we perform hand hygiene afterwards.

### 5. Needles and Other Sharps
We use devices with safety features when available; we do not recap, bend, break or hand-manipulate used needles; if recapping is medically necessary, we use a one-handed scoop technique or an engineering control; we place used sharps in a puncture-resistant container.

### 6. Environmental Cleaning and Disinfection
Our facility uses either an EPA-registered or an FDA-cleared detergent-disinfectant; we follow standard facility procedures for cleaning and disinfection of environmental surfaces; we emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).

### 7. Disposal of Solid Waste
We contain and dispose of solid waste (medical and nonmedical) in accordance with facility procedures and/or local or state regulations; wear gloves when handling waste; wear gloves when handling waste containers; we perform hand hygiene afterwards.

### 8. Other
We follow Standard Precautions and facility procedures for handling linen, laundry, dishes, or eating utensils, and for cleaning/disinfection of environmental surfaces, and used patient care equipment.
ATD Personal Protective Equipment (PPE)

is the person charged with ATD Personal Protective Equipment responsibilities for this facility.

1. **PPE and Point of Care Risk Assessment (PCRA)**

   Level of PPE Required by this Facility for Interaction with ATD Patients
   
   A. Hand hygiene and Respiratory Hygiene/Cough Etiquette are recommended for all levels.
   
   B. No patient interaction, non-clinical settings – offices, pharmacy, etc.
      - No PPE required
   
   C. No direct patient interaction and no indirect contacts – hallways, cafeterias, public areas
      - No PPE generally required; N95 Respirator if known or suspect TB or measles
   
   D. Indirect contact areas – Healthcare worker contact only with patient environment or contaminated inanimate objects; room cleaning, equipment cleaning
      - Gloves, Gowns, Masks, Eye Protection, as per usual
      - N95 or higher Respirator, if known or suspect TB or measles
   
   E. Direct patient contact – Patient care, home care, diagnostic imaging, etc.
      - N95 or higher Respirator, Eye Protection
      - Gowns, Gloves, as per usual
   
   F. Direct patient contact with potential for aerosol generation – Endotracheal suctioning, bronchoscopy, intubation, tracheostomy, nebulized therapy, cardiopulmonary resuscitation
      - Powered Air Purifying Respirator (PAPR) or other appropriate respirator (See Respiratory Protection Protocol), Eye Protection
      - Gown, Gloves, as per usual

2. **PPE**

   The primary items of PPE appropriate for protection against ATDs consist of:
   
   - Gloves
   - Gowns
   - Face/eye protection (e.g., surgical or procedure mask, and goggles or face shield)
PPE will be worn for touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin.
PPE will be worn during procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
PPE will be worn during procedures and patient-care activities likely to generate splash or spray of blood, body fluids, secretions, excretions.
The subject of PPE is addressed more fully in this facility's BBP ECP and its Hazard Communication Program. See those protocols for further information.
Respirators are also addressed separately in the ATD Respiratory Protection Program of this facility’s ATD ECP/Written Protocols. Whenever respirators are required in the workplace, then compliance with all elements of the Respiratory Protection Standard is triggered and followed by this facility.

3. Procedures to Ensure Adequate Supply of PPE
Our PPE Administrator is charged with the responsibility of ensuring that there is an adequate supply of PPE and other equipment necessary to minimize employee exposure to ATPs in normal operations and in foreseeable emergencies. The PPE Coordinator will regularly monitor supplies of these materials and procure them as needed to ensure availability without interruption.

4. Use of PPE
Wear a fit-tested NIOSH-approved N95 or higher level respirator for respiratory protection when entering the room or home of a patient when the following diseases are suspected or confirmed:

- Infectious pulmonary or laryngeal tuberculosis or when infectious tuberculosis skin lesions are present and procedures that would aerosolize viable organisms (e.g., irrigation, incision and drainage, whirlpool treatments) are performed.
- Smallpox (vaccinated and unvaccinated). Respiratory protection is recommended for all healthcare personnel, including those with a documented “take” after smallpox vaccination, due to the risk of a genetically engineered virus against which the vaccine may not provide protection, or of exposure to a very large viral load (e.g., from high-risk aerosol-generating procedures, immunocompromised patients, hemorrhagic or flat smallpox.)

See also this facility’s separate ATD Respiratory Protection protocol for further information.

No recommendation is made regarding the use of PPE by healthcare personnel who are presumed to be immune to measles (rubeola) or varicella-zoster based on history of disease, vaccine, or serologic testing when caring for an individual with known or suspected measles, chickenpox or disseminated zoster, due to difficulties in establishing definite immunity.

No recommendation is made regarding the type of Personal Protective Equipment (i.e., surgical mask or Respiratory Protection with an N95 or higher respirator) to be worn by susceptible healthcare personnel who must have contact with patients with known or suspected measles, chickenpox, or disseminated herpes zoster.
ATD Respiratory Protection Program

Name: 
Contact Information: 
is the ATD Respiratory Protection Program Administrator for this facility.

Be sure to see the Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases) Issue Date: 02-16-10. A copy is provided in the Resources section. Be sure to check the Cal/OSHA website for further updates at http://www.dir.ca.gov/dosh/

1. ATD Respiratory Protection Program
   The Respiratory Protection Program utilized by this facility for protection against Aerosol Transmissible Diseases is composed of the following seven components:
   • Respirator selection
   • Medical evaluations
   • Fit testing
   • Use of respirators
   • Maintenance and care of respirators
   • Training and information
   • Program evaluation
   This Respiratory Protection Program is specific to this facility only and is limited to the specific hazards of Aerosol Transmissible Diseases.

2. Respirator Selection
   A. Where respirator use is required for protection against potentially infectious aerosols and is not required to meet the requirements of high hazard procedures as described in the next paragraph, this facility shall provide a respirator that is at least as effective as an N95 filtering facepiece respirator, unless the CDC or CDPH specifies a more protective level, in which case the more protective respirator shall be provided.

   B. Effective September 1, 2010, this facility shall provide a powered air purifying respirator (PAPR) with a High Efficiency Particulate Air (HEPA) filter(s) to employees who perform high hazard procedures on airborne infectious disease (AirID) cases or suspected cases and on cadavers potentially infected with ATPs, 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 Exposure Control Plan and shall be reviewed by the employer and employees at least annually in accordance with the Standard.
C. Where respirators are necessary to protect the user from other hazards, including the uncontrolled release of microbiological spores, or exposure to chemical or radiologic agents, respirator selection shall also be made in accordance with Sections 5144, Respiratory Protection, and 5192, Hazardous Waste and Emergency Response Operations, of California OSHA special orders, as applicable.

D. Respirators provided for compliance with this section shall be approved by NIOSH for the purpose for which they are used.

3. Medical Evaluation

This facility shall provide a medical evaluation, in accordance with California OSHA’s Respiratory Protection Standard 5144(e), to determine the employee’s ability to use a respirator before the employee is fit tested or required to use the respirator. For employees who use respirators solely for compliance with 2A and 2B above, the Medical Evaluation Questionnaire on the following pages may be used.
Respirator Medical Evaluation Questionnaire
(taken from Appendix B of the Standard with slight modification)

To the Physician or Licensed Healthcare Provider (PLHCP): Answers to questions in Section 1, and
to question 6 in Section 2 do not require a medical examination. Employees must be provided with
a confidential means of contacting the healthcare professional who will review this questionnaire.

To the employee: Can you read and understand this questionnaire? (circle one): Yes / No

Your employer must allow you to answer this questionnaire during normal working hours or at a
time and place that is convenient to you.

To maintain your confidentiality, your employer or supervisor must not look at or review your
answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare
professional who will review it.

Section 1. The following information must be provided by every employee
who has been selected to use any type of respirator (please print).

Today's date: ____________________________

Name: ________________________________  Job Title: ______________________________

Your age (to nearest year): ____________

Sex (circle one): Male / Female

Height: _________ ft. _________ in.  Weight: _________ lbs.

Phone number where you can be reached (include the Area Code): ______________________

The best time to phone you at this number: _______________________

Has your employer told you how to contact the healthcare professional who will review this
questionnaire? (circle one)  Yes / No

Check the type of respirator you will use (you can check more than one category):

☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
☐ Other type (half- or full-facepiece type, PAPR, supplied-air, SCBA).
☐ (fill-in type here) ___________________________________________________________

Have you worn a respirator? (circle one)  Yes / No

If “yes,” what type(s)? _______________________________________________________

__________________________________________________________
Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle “yes” or “no”).

1. Have you ever had any of the following conditions?
   - Allergic reactions that interfere with your breathing? Yes / No
   - Claustrophobia (fear of closed-in places)? Yes / No
   - What did you react to? ______________________________

2. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - Shortness of breath when walking fast on level ground or walking up a slight hill or incline? Yes / No
   - Have to stop for breath when walking at your own pace on level ground? Yes / No
   - Shortness of breath that interferes with your job? Yes / No
   - Coughing that produces phlegm (thick sputum)? Yes / No
   - Coughing up blood in the last month? Yes / No
   - Wheezing that interferes with your job? Yes / No
   - Chest pain when you breathe deeply? Yes / No
   - Any other symptoms that you think may be related to lung problems? Yes / No

3. Do you currently have any of the following cardiovascular or heart symptoms?
   - Frequent pain or tightness in your chest? Yes / No
   - Pain or tightness in your chest during physical activity? Yes / No
   - Pain or tightness in your chest that interferes with your job? Yes / No
   - Any other symptoms that you think may be related to heart or circulation problems? Yes / No

4. Do you currently take medication for any of the following problems?
   - Breathing or lung problems? Yes / No
   - Heart trouble? Yes / No
   - Nose, throat, or sinuses Yes / No
   - Are your problems under control with these medications? Yes / No

5. If you’ve used a respirator, have you ever had any of the following problems while respirator is being used?
   (If you’ve never used a respirator, check the following space and go to question 6:)
   - Skin allergies or rashes? Yes / No
   - Anxiety? Yes / No
   - General weakness or fatigue? Yes / No
   - Any other problem that interferes with your use of a respirator? Yes / No

6. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes / No

Employee Signature  Date

PLHCP Signature  Date

For an additional copy - see the ATD Resource Section
4. Fit Testing
   A. This facility shall perform either quantitative or qualitative fit tests in accordance with the procedures outlined in Appendix A of California OSHA’s Respiratory Protection Standard 5144. The fit test shall be performed on the same size, make, model, and style of respirator as the employee will use. When fit testing single use respirators, a new respirator shall be used for each employee.

   B. The employer shall ensure that each employee who is assigned to use a filtering facepiece or other tight-fitting respirator passes a fit test:
       i. At the time of initial fitting;
       ii. When a different size, make, model, or style of respirator is used; and
       iii. At least annually thereafter.

   EXCEPTION: Until January 1, 2014, employers may increase the interval for repeat fit testing to no more than two years for employees who do not perform high hazard procedures. As of January 1, 2015, an employee who uses a respirator shall have been fit-tested within the previous 12 months.

   C. The employer shall conduct an additional fit test when the employee reports, or the employer, PLHCP, supervisor, or program administrator makes visual observations of changes in the employee’s physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.

   D. If, after passing a fit test, the employee subsequently notifies the employer, program administrator, supervisor, or PLHCP that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator face piece and to be retested.

5. Use of Respirators
   A. This facility shall provide, and ensure that employees use, a respirator when the employee:
       i. Enters an airborne infection isolation room or area in use for airborne infection isolation;
       ii. Is present during the performance of procedures or services for an airborne infectious disease (AirID) case or suspected case;
       iii. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens;
       iv. Is working in an area occupied by an AirID case or suspected case, and during decontamination procedures after the person has left the area;
       v. Is working in a residence where an AirID case or suspected case is known to be present;
       vi. Is present during the performance of aerosol generating procedures on cadavers that are suspected of, or confirmed as, being infected with airborne infectious pathogens;
       vii. Is performing a task for which the Biosafety Plan or Exposure Control Plan requires the use of respirators; or
       viii. Transports an AirID case or suspected case in an enclosed vehicle (e.g., van, car, ambulance or helicopter) or who transports an AirID case or suspected case within the facility when that individual is not masked.
6. Maintenance and Care of Reusable Respirators

A. Cleaning and Disinfecting. The employer shall provide each respirator user with a respirator that is clean, sanitary, and in good working order. The employer shall ensure that respirators are cleaned and disinfected using the procedures in Appendix B-2 of California OSHA’s Respiratory Protection Standard or procedures recommended by the respirator manufacturer, provided that such procedures are of equivalent effectiveness. The respirators shall be cleaned and disinfected at the following intervals:

- Respirators issued for the exclusive use of an employee shall be cleaned and disinfected as often as necessary to be maintained in a sanitary condition
- Respirators issued to more than one employee shall be cleaned and disinfected before being worn by different individuals
- Respirators maintained for emergency use shall be cleaned and disinfected after each use, and
- Respirators used in fit testing and training shall be cleaned and disinfected after each use

B. Storage. The employer shall ensure that respirators are stored as follows:

i. All respirators shall be stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals, and they shall be packed or stored to prevent deformation of the facepiece and exhalation valve.

ii. In addition to the above requirements, emergency respirators shall be:
   - Kept accessible in the work area
   - Stored in compartments or in covers that are clearly marked as containing emergency respirators, and
   - Stored in accordance with any applicable manufacturer instruction

C. Inspection. The employer shall ensure that respirators are inspected as follows:

i. All respirators used in routine situations shall be inspected before each use and during cleaning

ii. The employer shall ensure that respirator inspections include the following:
   - A check of respirator function, tightness of connections, and the condition of the various parts, including, but not limited to, the facepiece, head straps, valves, connecting tube, and cartridges, canisters, or filters, and
   - A check of elastomeric parts for pliability and signs of deterioration
D. Repairs. The employer shall ensure that respirators that fail an inspection or are otherwise found to be defective are removed from service, and are discarded, repaired, or adjusted in accordance with the following procedures:

i. Repairs or adjustments to respirators are to be made only by persons appropriately trained to perform such operations and shall use only the respirator manufacturer’s NIOSH-approved parts designed for the respirator;

ii. Repairs shall be made according to the manufacturer’s recommendations and specifications for the type and extent of repairs to be performed; and

iii. Reducing and admission valves, regulators, and alarms shall be adjusted or repaired only by the manufacturer or a technician trained by the manufacturer.

7. Training

This facility shall ensure that each respirator user is provided with initial and annual training in accordance with California OSHA’s Respiratory Protection Standard 5144.

8. Enforcement

Please see a copy of a document, located in the ATD Resources Section, from Cal/OSHA concerning the use of N95 respirators and enforcement. A copy of the form referenced in that document for use in documenting attempts to resupply N95s is also included in the Forms section of these materials. Be sure, however, to check the Cal/OSHA website yourself for possible updates that may have occurred since this protocol was prepared. You can access the Cal/OSHA website at http://www.dir.ca.gov/dosh/.
ATD Surge Procedures Administrator

is the ATD Surge Procedures Administrator for this facility.

1. ATD Surge Procedures

The ATD Surge Procedures Administrator will indicate by initialing below whether or not this facility has employees designated to provide service in surge conditions:

_____ This facility does not have any employees designated to provide service in surge conditions or to persons who have been contaminated as the result of a release of a biological agent. If you have selected this designation, then you do not need to complete this protocol any further.

_____ This facility does have employees designated to provide service in surge conditions or to persons who have been contaminated as the result of a release of a biological agent. As a result, this facility will establish and implement work practices and procedures for such events.

Creating a Surge Procedure Protocol is beyond the scope of this document, since each facility employing surge procedures must, of necessity, create its own program tailored to conditions at that facility.

A useful guide, however, to assist you in the creation of your own facility’s Surge Procedures Protocol is available at The New York State Department of Health Website. The guide provides helpful information for dealing with environmental control measures for airborne infection isolation surge capacity planning, and it may be accessed at http://www.health.state.ny.us/nysdoh/sars/preparedness_guidance/pdf/2i surge_capacity_planning.pdf.

Be sure you have incorporated the following into your facility’s surge procedures:

- Work practices and procedures
- Patient isolation
- Provision of decontamination facilities
- Personal Protective Equipment
- Respiratory Protection for such events
Resources

Table of Contents

Appendix

CDC “Important Notice” .................................................. 3.66
CDC “Cover Your Cough” ............................................... 3.67
CDC “PPE Chart” .......................................................... 3.68
Medical Laboratories ....................................................... 3.70
Veterinary and Animal Related Facilities ............................ 3.72
Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199, ...................... 3.74

Forms

• Implementation and Annual Review and Update
• ATD Training Sign-in Sheet
• ATD Screening Training Sign-in Sheet
• Patient Questionnaire
• Respirator Fit Test Screening Questions
• Respirator Medical Evaluation Questionnaire
• Vaccination Declination
• Respirator Supply Documentation
IMPORTANT NOTICE TO ALL PATIENTS

Please tell staff immediately if you have flu symptoms

Flu symptoms include fever, headache, tiredness, dry cough, sore throat, nasal congestion and body aches.

1. Cover Your Cough and Sneeze
   - Use a tissue to cover your mouth and nose when you cough or sneeze.
   - Drop your used tissue in a waste basket.
   - You may be asked to wear a mask if you are coughing or sneezing.

   and

2. Clean Your Hands
   - Wash your hands with soap and warm water or clean with gels or wipes with alcohol.
   - Cleaning your hands often keeps you from spreading germs.
Stop the spread of germs that make you and others sick!

**Cover Your Cough**

- Cover your mouth and nose with a tissue when you cough or sneeze or cough or sneeze into your upper sleeve, not your hands.
- Put your used tissue in the waste basket.
- You may be asked to put on a surgical mask to protect others.
- Clean your Hands after coughing or sneezing.
  - Wash hands with soap and warm water for 20 seconds or clean with alcohol-based hand cleaner.
**SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)**

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

1. **GOWN**
   - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
   - Fasten in back of neck and waist.

2. **MASK OR RESPIRATOR**
   - Secure ties or elastic bands at middle of head and neck.
   - Fit flexible band to nose bridge.
   - Fit snug to face and below chin.
   - Fit face respirator.

3. **GOGGLES OR FACE SHIELD**
   - Place over face and eyes and adjust to fit.

4. **GLOVES**
   - Extend to cover wrist of isolation gown.

---

**USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION**

- Keep hands away from face.
- Limit surfaces touched.
- Change gloves when torn or heavily contaminated.
- Perform hand hygiene.

---

**SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)**

El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo Estándar y de Contagio o de Aislamiento de infecciones transportadas por gotas o por aire.

1. **BATA**
   - Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y el abdomen.
   - Ánviles por detrás de la gola y la cintura.

2. **MÁSCARA O RESPIRADOR**
   - Asegúrese los cordones o la banda elástica en la mitad de la cabeza y en el cuello.
   - Ajuste la banda flexible en el puente de la nariz.
   - Acomó�ese en la cara y por debajo del mentón.
   - Verifique el ajuste del respirador.

3. **GAFAS PROTECTORAS O CAPETAS**
   - Calóquese sobre la cara y los ojos y ajústela.

4. **GUANTES**
   - Extienda los guantes para que cubran la parte del pulso en la bata de aislamiento.

---

**UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE USTED MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN**

- Mantenga las manos alejadas de la cara.
- Limit el contacto con superficies.
- Cambie los guantes si se rompen o están demasiado contaminados.
- Realice la higiene de las manos.
Centers for Disease Control
PPE Chart
California ATD Standard Medical Laboratories

ATD Standard Requirements for Laboratories

1. Employers with laboratory operations in which employees have direct contact with cases or suspected cases are required to comply with applicable portions of California OSHA ATD Standard subsections:
   A. Exposure Control Plan,
   B. Engineering controls,
   C. Respiratory protection,
   D. Medical services,
   E. Training, and
   F. Recordkeeping.

2. The Biological Safety Officer shall perform a risk assessment in accordance with the methodology included in Section II of the BMBL (available for download from the CDC at http://www.cdc.gov/od/OHS/biosfty/bmb15/bmb15toc.htm ) for each agent and procedure involving the handling of ATPs-L. The BSO shall record the safe practices required for each evaluated agent/procedure in the Biosafety Plan.

3. The employer shall implement feasible engineering and work practice controls, in accordance with the risk assessment performed to minimize employee exposures to ATPs-L. Where exposure still remains after the institution of engineering and work practice controls, the employer shall provide, and ensure that employees use, PPE, and, where necessary to control exposure, Respiratory Protection. Control measures shall be consistent with the recommendations in BMBL.

4. Biosafety Plan (BSP). The employer shall establish, implement, and maintain an effective written Biosafety Plan to minimize employee exposures to ATPs-L that may be transmitted by laboratory aerosols. The BSP may be incorporated into an existing Bloodborne Pathogens Exposure Control Plan or an ATD Exposure Control Plan, and shall do all of the following:
   A. Identify a Biological Safety Officer(s) with the necessary knowledge, authority and responsibility for implementing the BSP.
   B. Include a list of all job classifications in which all or some employees have occupational exposure, and a list of all tasks and procedures in which employees have occupational exposure.
   C. Include a list of ATPs-L known or reasonably expected to be present in laboratory materials and the applicable biosafety measures.
   D. Include a requirement that all incoming materials containing ATPs-L are to be treated as containing the virulent or wild-type pathogen, until procedures have been conducted at the laboratory to verify that a pathogen has been deactivated or attenuated.
E. Identify and describe the use of engineering controls, including containment equipment and procedures, to be used to minimize exposure to infectious or potentially infectious laboratory aerosols.

F. Establish safe handling procedures and prohibit practices, such as sniffing in vitro cultures, that may increase employee exposure to infectious agents.

G. Establish effective decontamination and disinfection procedures for laboratory surfaces and equipment.

H. Identify and describe the use of the appropriate PPE to be used to minimize exposure to infectious or potentially infectious laboratory aerosols.

I. Identify any operations or conditions in which Respiratory Protection will be required. The use of Respiratory Protection shall be in accordance with the Respiratory Protection Standard.

J. Establish emergency procedures for uncontrolled releases within the laboratory facility and untreated releases outside the laboratory facility. These procedures shall include effective means of reporting such incidents to the local health officer.

K. Include a medical services program including the provision of all vaccinations as recommended by applicable public health guidelines for the specific laboratory operations, and the methods for providing investigation and medical follow up for exposure incidents (laboratory).

EXCEPTION: Research and production laboratories in which it is not reasonably anticipated that materials containing M. tuberculosis will be present need not provide surveillance for LTBI.

L. Include procedures for communication of hazards and employee training. This shall include training in the employer’s Biosafety Plan and emergency procedures.

M. Include an effective procedure for obtaining the active involvement of employees in reviewing and updating the Biosafety Plan with respect to the procedures performed by employees in their respective work areas or departments on an annual (or more frequent) basis.

N. Include procedures for the Biological Safety Officer(s) to review plans for facility design and construction that will affect the control measures for ATP5-L.

O. Include procedures for inspection of laboratory facilities, including an audit of biosafety procedures. These inspections shall be performed at least annually. Hazards found during the inspection, and actions taken to correct hazards, shall be recorded.

5. Recordkeeping shall be in accordance with the Standard.
As the ATD Standard 5199 was first being developed, zoonotic facilities were originally included, but eventually a Zoonotic Aerosol Transmissible Diseases Standard 5199-1 was implemented separately. Veterinary Facilities, therefore, are not exempt from ATD requirements, since they are fully covered by 5199-1, their own Zoonotic ATD Standard. The Zoonotic ATD Standard may be downloaded at: http://www.dir.ca.gov/Title8/5199-1.html.

**Small Animal Veterinary Clinics and Hospitals**

Even though veterinary facilities are not exempt from the Zoonotic ATD Standard, most small animal veterinary clinics and hospitals, are not involved in work operations or exposure to zoonotic ATDs (Z-ATDs), and are, therefore, required only to establish, implement, and maintain effective procedures for preventing employee exposure to Z-ATDs in accordance with Cal/OSHA’s already existing Section 3203 Injury and Illness Prevention Program (IIPP) requirements. The following items must be covered in such veterinary IIPP written procedures.

**Small Animal Veterinary Hospitals and Clinics Written IIPP Requirements**

Small animal veterinary hospitals and clinics with no ZATD exposure must still cover the below four topics in their required written Injury and Illness Prevention Program:

- Sanitation
- Investigation of occupational injuries and illnesses
- Training, including all exposure control procedures
- Biosecurity, where applicable

**Animal Related Operations with Exposure to Z-ATDs**

All veterinary or other animal related employers with work operations involving handling, culling, transporting, killing, eradicating, or disposing of animals infected with Zoonotic ATDs, or the cleaning and disinfection of areas used, or previously used, to contain such animals or their wastes, are required to establish, implement, and maintain full, written zoonotic disease control procedures to control the risk of transmission of disease from the animals to employees. These written procedures are analogous to the ATD Exposure Control Plan/Written Protocols required for Treating or Referring Facilities covered in the 5199 ATD Standard, applicable for facilities treating humans. An abbreviated listing of the requirements for written zoonotic procedures appears on the next page, but any employers in this category should refer to the ATD Zoonotic Standard itself for detailed guidance beyond the scope of this guide.
Zoonotic ATD Written Procedures

- A detailed work plan including Risk Assessment to employees, and including biological, chemical, physical, and safety hazards
- Site control measures
- A list of all jobs, tasks, or procedures in which employees may have occupational exposure
- Engineering Controls, Work Practice Controls, and exposure monitoring
- Procedures for the safe handling of hazardous substances, including hazardous substances used for disinfection and decontamination
- Procedures for the application of toxic or asphyxiating gases, if such gases are to be used in the operation
- Respiratory Protection
- Personal Protective Equipment and protective clothing
- Decontamination procedures
- Disposal of animal waste and contaminated PPE
- Training
- Recordkeeping
- Procedures to provide employees ready or frequent access to drinking water and sanitation facilities, including appropriate decontamination methods for employees who need to access these facilities
- Procedures to protect employees from the risk of heat illness
Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases) Issue Date: February 16, 2010

Background

Cases of pandemic 2009 H1N1 influenza A virus (previously called “swine flu” or “novel H1N1”) were first recognized in California in April 2009. The World Health Organization has declared a pandemic, with widespread human-to-human transmission in many countries.

On October 14, 2009 the Centers for Disease Control and Prevention (CDC) issued updated guidelines regarding infection control procedures for H1N1. This guidance continued the recommendation that employees who have direct exposure to H1N1 patients use respirators at least as protective as N95 filtering facepiece respirators. Respirators are to be used by employees who must enter rooms or areas where people with suspected or confirmed H1N1 influenza are located. Respirators are only one component of a hierarchy of controls that are recommended to protect employees from inhalation exposure to this disease. The California Department of Public Health (CDPH) has issued guidance that concurs with these recommendations.

The federal Occupational Safety and Health Administration (OSHA) has stated that it will enforce these recommendations for the protection of health care employees, including the use of respirators. California operates a “state plan” under the authority of the federal Occupational Safety and Health Act, and is required to be as effective as federal OSHA.

On September 8, 2009, Cal/OSHA issued interim guidance for healthcare facilities regarding protecting employees from H1N1. This guidance was issued in anticipation of respirator supply shortages that would force employers into a respirator prioritization mode, in which some employees with patient contact would not be provided with respirators. However, in order to protect healthcare workers from H1N1, the State of California has released stockpiled respirators through local health departments. Therefore the previous Cal/OSHA guidance regarding respirator prioritization was rescinded on October 22, 2009 and respirators were to be provided for contact with all potentially infectious patients, as discussed in detail below.

As the state stockpile began to be deployed some concerns regarding one of the respirators in the stockpile arose. It was determined that the 3M™ 8000 respirator, which constitutes over 60 percent of the state stockpile, did not reliably fit some healthcare workers. At this time, CDPH is distributing other models contained within the stockpile. Because there are concerns regarding maintaining a reliable respirator supply facilities should adopt respirator conserving measures, as described below, in order to ensure that respirators remain available. For more information on this respirator, please see the Cal/OSHA alert at: http://www.dir.ca.gov/DOSH/CalOSHA_3M.pdf

On November 20, 2009, federal OSHA issued “Instruction 02-02-075, “Enforcement Procedures for High to Very High Occupational Exposure Risk to 2009 H1N1 Influenza.” State programs, including Cal/OSHA are required to take equivalent action. Therefore, Cal/OSHA is issuing this updated guidance. The changes in this guidance include:

1. Clarification of policies regarding redonning/reuse and extended use of filtering facepiece respirators, and documentation of shortages, to be consistent with the OSHA Instruction
2. Information about use of respirators provided from state and federal stockpiles
3. Recordkeeping requirements for work-related H1N1 infections
4. Clarification of vaccination requirements for healthcare workers as they apply to influenza this year.

Applicability of the California Aerosol Transmissible Disease Standard to H1N1 Exposure Control

On August 5, 2009, California’s new Aerosol Transmissible Diseases (ATD) Standard (Title 8 CCR Section 5199) took effect. This standard establishes a comprehensive approach to control of diseases identified as either requiring “droplet precautions” or “airborne infection isolation.” Among the controls required by the Standard are written infection control procedures including source control measures such as providing surgical masks or other materials to symptomatic persons who enter the facility. The procedures should include how those patients can be placed in separate areas, to the extent feasible, to reduce exposure to employees. The standard can be found at: http://www.dir.ca.gov/Title8/5199.html.

The ATD Standard also establishes certain requirements for “novel and unknown aerosol transmissible pathogens (ATPs).” A novel or unknown ATP is defined in the standard as follows: A pathogen capable of causing serious human disease meeting the following criteria:

1. There is credible evidence that the pathogen is transmissible to humans by aerosols; and

2. The disease agent is:
   a. A newly recognized pathogen, or
   b. 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
   c. A recognized pathogen that has been recently introduced into the human population, or
   d. 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.

H1N1 influenza has been identified as a pandemic influenza strain. Neither the CDC nor CDPH has determined that this strain is “fully characterized,” at this time. In addition, as stated above the CDPH continues to recommend that healthcare workers be protected against airborne transmission of H1N1 through the use of appropriate patient placement, engineering controls, administrative controls, and the use of respirators. The ATD Standard therefore also currently requires these precautions for H1N1. The CDC and CDPH are continuing to evaluate this pandemic virus. Cal/OSHA will update this advice if CDPH recommendations change.
Vaccination Requirements

The ATD Standard requires that employers provide the seasonal influenza vaccine to all employees who are covered by this Standard. This requirement is in effect at the present time. A declination statement must be completed for each employee who declines the vaccine.

On November 12, 2009 CDPH recommended that H1N1 vaccine be provided to all healthcare personnel in licensed facilities.

"Health and Safety Code (HSC) section 1288.7(a) provides that each General Acute Care Hospital (GACH) licensed pursuant to HSC Section 1250 must annually offer onsite influenza vaccinations, upon availability, to all hospital employees at no cost to the employee. That HSC section mandates that each GACH must require its employees to be vaccinated, or, if the employee elects not to be vaccinated, to obtain a written declaration that the employee declined the vaccination. HSC section 1288.7(a) applies to the newly developed Novel H1N1 vaccine. The Novel H1N1 vaccination is mandated to be offered by all GACHs, in addition to the seasonal influenza vaccination.

Due to the anticipated extensive spread and the severity of the illness caused by this virus, and in an effort to maintain the workforce and reduce the likelihood of healthcare workers transmitting the virus to patients, the California Department of Public Health (CDPH) recommends all other facility types to offer the Novel H1N1 vaccine to all of their employees free of charge. CDPH also asks that facilities maintain written records of the employees who have received the vaccination, and requests that facilities obtain written declinations from any employee who chooses not to be vaccinated."

http://www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL09.aspx

As of September 1, 2010, additional Section 5199 requirements regarding vaccinations of healthcare workers and laboratory workers will become effective. For healthcare workers, these requirements will include “influenza” vaccine, including the monovalent H1N1 vaccine, if it is still available and recommended. Cal/OSHA joins with CDPH in encouraging healthcare employers to implement the H1N1 vaccine for all exposed employees as soon as it becomes available.

Although the H1N1 vaccine is anticipated to be as effective as seasonal influenza vaccine, the ATD Standard’s requirements for the use of other control measures, including respirators, remain in effect for vaccinated employees. No vaccine is 100 percent effective, and experience with seasonal influenza vaccine indicates that some individuals do not develop immunity after vaccination. The requirement that all employees with direct exposure to H1N1 patients use respiratory protection is consistent with CDC and CDPH recommendations, and the OSHA Instruction.
The Impact of Respirator Supply on Compliance with the ATD Standard

Some hospitals have reported low inventories of respirators and ongoing difficulty in getting orders filled. As a result, and until further notice, the CDPH has determined that it will be working with local health authorities to ensure that the combined local and state respirator stockpiles will be used to fill supply gaps and allow compliance with the ATD

Standard in Exposure Scenarios Requiring Respirator Use

The purpose of distributing these respirators is to ensure that every healthcare worker who is in direct contact with an H1N1 patient will be able to use to an appropriate respirator, as required. Hospitals and other healthcare facilities and operations that are unable to obtain an adequate supply of respirators should request respirators through their local health department.

Measures to Maximize and Conserve Respirator Supplies

Given the increased demand for respirators created by the H1N1 pandemic and supply issues, measures should be taken to maximize respirator supplies and to reduce the need for respirator use, to the extent reasonably possible. This will help ensure that a sufficient supply of respirators will remain on hand to treat patients with H1N1, tuberculosis, or any other disease requiring respiratory protection. These conservation measures are consistent with the ATD Standard, the CDC Interim Infection Control guidance dated October 14 that delineates a hierarchy of controls to prevent influenza transmission in healthcare settings, and the OSHA Instruction. These policies should include:

1. Reviewing patient flow and work organization to determine whether unnecessary employee contact with suspected or confirmed H1N1 cases can be reduced.

2. Taking full advantage of opportunities to obtain respirators through non-medical supply chains, such as safety equipment suppliers. These respirators are of comparable quality and efficacy to those provided by medical distributors.

3. Taking full advantage of opportunities to use the variety of NIOSH-certified respirators available and appropriate for use in work involving close contact with H1N1 patients. For example, if an institution’s policy has been to order only fluid-resistant or “surgical” N95 respirators, other N95 respirators not designated as “surgical” can be used in patient-care scenarios where contact with splashes or sprays of body fluids is not anticipated, as long as the respirators are NIOSH-certified. Surgical N95s are required when needed to protect against splashes or sprays of bodily fluids, and may also be required for infection control during surgery, but are not required in situations where fluid contact is not an issue.

For most patient-care activities, including support activities such as housekeeping in patient rooms, a non-surgical or standard N95 respirator can be used. Employers should also consider using non-disposable elastomeric facepiece respirators or powered air purifying respirators (PAPR) which can be reused and disinfected. All respirators must be approved by the National Institute for Occupational Safety and Health (NIOSH), must be used in compliance with the conditions of their approval, and must function at a level of protection equal to or greater than an N95 respirator.
Extended Use and Redonning to Reduce Respirator Demand

Although the release of stockpiled respirators is expected to mitigate immediate respirator shortages, there is still no assurance that an adequate supply of respirators will be available throughout the coming months. Cal/OSHA regulations require employers to develop policies for the use, cleaning, and decontamination and/or disposal of respirators as appropriate so that they remain effective in protecting employees and do not become a hazard. A respirator should always be removed and discarded if it becomes damaged or deformed, or it no longer forms an effective seal to the employee’s face. A reusable respirator may be shared between users, but only if cleaned and disinfected between users. In addition, in health care settings, respirator use may be affected by infection control policies.

Disposable respirators should never be shared between users. A disposable respirator should always be discarded if (1) it becomes contaminated with a hazardous substance, (2) it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients, (3) it has been used during an aerosol generating procedure or during surgery, (4) it becomes wet or visibly dirty, or (5) breathing through it becomes more difficult.

In the October 14 guidance, the CDC discontinued the recommendation for contact precautions for H1N1. Therefore, for routine patient care, healthcare workers are no longer required to wear gowns and other protective coverings and remove them upon exiting the patient room. Hand hygiene, and protection against bodily fluids is required by standard precautions, which are to be implemented for all patients.

Prior to the emergence of H1N1, healthcare institutions have had different policies regarding the disposal of N95 respirators used to protect against TB and other diseases. In some institutions, these respirators were removed, stored and put back on (redonned) by the same healthcare worker, when caring for the same, or for different patients. In some facilities, N95 respirators have been worn continuously by the same healthcare worker when caring for different patients (extended use), and then disposed of when the respirator is taken off. In other facilities, respirators have been discarded after each patient contact.

Although there is little data available regarding whether any of these policies reduce the protection provided by the respirator, studies have consistently found that materials that are captured in a respirator filter will not be released, even if the user coughs or sneezes. There may be some potential for contact transmission whenever the outside of a respirator (or any clothing item or exposed body area) is touched, in that materials that may be on the outside of the respirator can be transferred to the employee’s hands. Whether or not respirators are to be redonned or reused, employees should be instructed to perform hand hygiene whenever their hands touch the outside of the respirator or any other potentially contaminated surface, in accordance with standard precautions.
Another potential concern with redonning of filtering facepiece respirators is that the respirator may be structurally compromised with repeated donning and doffing. If employers implement redonning procedures, employees must be instructed to inspect the respirator prior to putting it back on, and to discard any respirators that are damaged, wet or dirty, or that fail to seal to the face. Employees should perform a user seal check every time a respirator is put on. If air is felt leaking around the respirator, the respirator should be adjusted or discarded. Because the user seal check involves touching the outside of the respirator, hand hygiene should be performed after the user seal check on a redonned respirator.

Because materials that are captured in respirator filters are not released, wearing a respirator between patients without removal (“extended use”) will not expose either the employee or the patient to any pathogens that are in particles captured by filter fibers. Respirators should not be worn between patients after high hazard procedures or surgery, or if the respirator has become contaminated with bodily fluids, due to the increased risk of contact transmission from materials on the outside surface of the respirator. The CDC has recommended that facilities facing supply shortages consider extended use in preference to reuse/redonning, because the respirator is handled less. The CDC’s recommendations regarding respirator use can be found at http://www.cdc.gov/h1n1flu/guidance/ill-hcp_qa.htm#reuse

If redonning of disposable filtering facepiece respirators is necessary, the employer must establish procedures for this type of use, provide appropriate facilities for storage, and train employees in how to remove, store, inspect, and redon the respirator. Employees must also be trained in how to recognize a respirator that must be discarded. Employer redonning policies cannot include an absolute limit on the number of respirators that will be furnished to an exposed employee during a given period of time.

Extended use and redonning should be adopted only when necessary to address respirator shortages. Therefore, facilities that adopt these policies, as well as facilities that access state or local stockpiles of respirators, should document their attempts to address respirator shortages through reviewing work organization, minimizing exposures, and attempting to maximize the respirator supply as described above. Appendix A can be used for this purpose.

Protecting the Outside Surfaces of the Respirator

It may be possible to prolong the useful life of the respirator and reduce surface contamination by protecting the outer surface from sprays with a face shield, but a face shield may be used only if it does not interfere with the function of the respirator. Cal/OSHA regulations require that respirators be used as approved by the National Institute for Occupational Safety and Health (NIOSH) and must not be altered. Therefore surgical masks should not be placed over the respirator, as they may unseat or deform the respirator and may also make it more difficult to breathe through.
Respirator Doffing, Storage and Redonning Procedures

When an employee removes a respirator in the context of redonning practices, the employee should lift the respirator straps from the back of the head. The respirator should be handled as little as possible, and the employee should avoid touching the inside surfaces of the respirator. If the respirator is visibly contaminated with blood or other bodily fluids, if it is wet, dirty, damaged or deformed, it should be discarded. If it is in good condition, the respirator should be placed in a clean container labeled with the employee’s name or other identifier.

The respirator container should be located in an area free from chemical contamination, and it should be sufficient to protect the respirator against contamination or crushing, but it need not be “airtight.” Prior to redonning, the employee should inspect the respirator, including straps, clips, sealing surfaces and general condition. If it is in good condition, the employee should don the respirator according to instructions provided for the specific respirator, and perform the user seal check. After handling the respirator, the employee should perform hand hygiene.

Use of Stockpiled Respirators

Many of the respirators that will be provided from the State stockpile are not the same respirators that have been in use in some healthcare facilities. OSHA and Cal/OSHA regulations require that a fit-test be provided for each model of respirator used. Fit tests are important in ensuring that the respirator will provide an employee with the required level of protection. Section 5144, Appendix A, describes the fit test methods that are required to be used.

It may take some time to provide fit tests to every respirator user when an employer is forced to switch to the stockpiled respirators. Employers can limit the number of employees needing fit testing by strategies such as assigning existing stock of respirator models that may be in short supply to certain units, while rolling out the new models to a limited number of employees.

Employers should not fail to provide a respirator because the employee who will use it has not yet been fit tested for the respirator, since even a respirator that has not been fit tested will offer better protection than a surgical mask, and almost all users will achieve some level of protection from any given respirator. Where all users cannot be immediately fit tested, employers should first target employees who perform aerosol generating procedures or are otherwise at higher risk of exposure. Employers may also seek help in performing fit testing from workers’ compensation carriers, respirator suppliers, occupational medicine service providers, trade associations, the local health departments, industrial hygiene consultants, and the Cal/OSHA Consultation Service.

Non-Hospital Healthcare Facilities, Services and Operations

Under the ATD Standard, healthcare employers are required to determine which services they can provide safely to patients with airborne infectious diseases. At this time, for the reasons stated above, airborne infectious diseases include H1N1.
This category of employer is generally required to refer patients who need continuing care to a facility that can provide airborne infection isolation, unless the transfer is not appropriate for medical reasons, or unless there are no airborne infection isolation rooms (AIIR) available in another facility. However, in the case of a novel pathogen, the ATD Standard does not require referral or transfer where such actions are not feasible. Employees who are exposed to the patient are required to be protected by respirators. These requirements are consistent with current CDC and CDPH guidance, which does not require AIIRs for routine patient care of H1N1 patients, but does recommend the use of respirators by employees who have direct contact with H1N1 patients.

Under subsection (c) of the ATD Standard, referring employers must have infection control procedures that include early identification of patients who may have an airborne infectious disease, including H1N1. These patients should be provided with source control materials such as surgical masks or tissues and hand hygiene materials, and to the extent feasible, these patients should be placed in a separate room or area with separate ventilation. The CDC and CDPH have recommended that employees providing care to these patients use a respirator at least as effective as an N95 respirator.

Under Cal/OSHA’s ATD Standard, employees who enter that room or area must use an approved respirator, such as an N95 filtering facepiece respirator, unless either the patient uses source control measures (i.e., the patient wears a surgical mask to cover their cough) or respirator use by the employee is not feasible. Although obtaining a nasopharyngeal swab or examination of the mouth or throat are not considered high hazard procedures under this standard, employees who perform these activities or similar activities should use a respirator, since the procedures cannot be performed with the patient’s mouth and nose covered and they may stimulate coughing, thereby exposing the employee to infectious aerosols. Title 8 of the California Code of Regulations Section 5199(c)(5) contains these and other requirements applicable to referring employers during periods when people requiring referral are in the facility.

**Long-term Healthcare Settings**

Most long-term health care facilities do not have AIIR and function as referring employers under the ATD Standard. Generally, referring employers must transfer patients who require airborne infection isolation to a hospital or other appropriate facility. However, the standard provides an exception for novel pathogens, such as H1N1, recognizing that AIIR may not be available. CDPH has recommended that decisions to transfer H1N1 suspected or confirmed cases be based on clinical considerations and not solely on the need for isolation. CDPH and CDC now recommend that these patients be managed in individual rooms, and need not be transferred to an airborne infection isolation room for routine patient care. AIIR are recommended for high hazard procedures.

To the extent feasible, H1N1 suspected and confirmed cases not in AIIR should be placed in a single room or cohorted, with the door closed, unless closing of the door would jeopardize patient safety or patient’s rights. Employees who enter rooms where HN1 suspected or confirmed cases are located or who otherwise are exposed to those patients must be protected with an N95 respirator (or higher level of respiratory protection). In addition, the employer should place signs or use other effective means to communicate that isolation precautions are to be followed in the room.
**Training for Respirator Users**

Cal/OSHA regulations require that employees who use respirators be trained initially and annually. The required training elements are: (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; and (G) The general requirements of Title 8, Section 5144. If redonning or extended use procedures are to be implemented, employees must receive training in how to recognize when a respirator must be discarded. For redonning, training must also include how to safely remove, store, inspect, and redon or discard the respirators as well as specific training on the employer’s redonning policies.

**Recording of Work-related H1N1 Infections**

The OSHA Instruction states that work-related H1N1 infections in workplaces at high or very high risk of H1N1 transmission (which includes most health care facilities) must be recorded on the Log 300 (Log of Work Related Injuries and Illnesses).

> "For purposes of OSHA injury and illness recordkeeping, illnesses due to the 2009 H1N1 influenza is not considered a common cold or seasonal flu. The work-relatedness exception for the common cold or flu at 29 CFR 1904.5(b)(2)(viii) does not apply to these cases. Employers are responsible for recording cases of 2009 H1N1 illness if all of the following requirements are met: (1) the case is a confirmed case of 2009 H1N1 illness as defined by CDC; (2) the case is work-related as defined by 1904.5; and (3) the case involves one or more of the recording criteria set forth in 1904.7 (e.g., medical treatment, days away from work)."

Physicians’ offices and some other healthcare employers are not required to maintain a Log 300. A complete list of those establishments, by Standard Industrial Classification code, can be found at: [http://www.dir.ca.gov/T8/14300_2.html](http://www.dir.ca.gov/T8/14300_2.html). However, all employers must report to the Division of Occupational Safety and Health any workplace incident that results in a serious injury or illness or death, as required by Title 8 Section 342. All employers must also complete other forms (such as workers compensation forms) to document individual cases of occupational injuries and illnesses. Hospitals and long-term care facilities are among the categories of employers that are required to maintain a Log 300.
Recordkeeping

The employer should ensure that the written respiratory protection program or ATD exposure control plan reflects current respirator use policies and procedures in the facility. Records of plan implementation should include documentation of control measures taken to reduce employee exposure. These records also include actions taken to obtain adequate supplies of respiratory protection, including attempts made to obtain respirators through alternate suppliers, and through public stockpiles. Appendix A, Respirator Supply Documentation, can be used for this purpose. Records of plan implementation must be maintained in accordance with subsection 5199(j)(3). These records must be made available, in accordance with subsection 5199(j)(4) to Cal/OSHA, NIOSH, the local health officer, employees and employee representatives.

1 The current CDPH case definition can be found at: http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf.

2 The CDC and CDPH have recommended that aerosol generating procedures be conducted in airborne infection isolation rooms if available.

3 “Filter contamination refers, in particular, to the collection of organisms on filters (in the case of aerosol exposures). Laboratory loading tests of inert bacterial particles have found that while filters will capture particles throughout the extent of the media, particles are held with considerable attractive force and are quite difficult to remove, even when the filter is subjected to high bursts of air similar to coughs and sneezes or when dropped onto a hard surface (Qian et al., 1997a; Qian et al., 1997b; Kennedy and Hinds, 2004). As a result, the filter material in respirators and medical masks does not present a hazard during use.” Reusability of Facemasks During an Influenza Pandemic: Facing the Flu. Institute of Medicine, 2006.

4 Additional information about donning and taking off (doffing) personal protective equipment, including respirators, is available from the CDC at http://www.cdc.gov/ncidod/dhqp/ppe.html.

5 If a respirator manufacturer provides documentation that a standard N95 is identical in construction, size, and shape to a surgical N95 respirator the employee has been using, an additional fit-test is not required.
Implementation and Annual Review and Update

This is to document and certify that on the below date I have either implemented for the first time or reviewed and updated this facility’s ATD ECP/Written Protocols, including Infection Control and all other protocols, and that I have duly solicited and obtained input and active involvement from our employees as indicated below.

ATD Administrator or Alternate                        Date

Employees Actively Involved in Implementation or Annual Review and Update

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Work Area</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Conclusions Found in Review and Update

(insert additional page as necessary)

Retain this certification for a period of three years from the date of implementation or annual review and update.
Aerosol Transmissible Diseases — Training Sign-in Sheet

Our ATD Training has been reviewed by:

<table>
<thead>
<tr>
<th>Reviewer’s Name (print)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Reviewer</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sign below to indicate that you have received training in Aerosol Transmissible Diseases and that you have been given the opportunity to ask interactive questions of the person presenting the training at the time of the training.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of Training for Treating Facilities
1. Copy of ATD Standard and explanation
2. ATDs, Signs/Symptoms
3. Modes of transmission; source control
4. ECP or BSP, how to get a copy, employee input
5. Recognizing tasks with exposure
6. Methods to prevent/reduce exposure
7. PPE
8. TB surveillance
9. Respiratory Protection if applicable
10. Vaccines

Summary of Training for Referring Facilities
11. Procedures if exposed; PEP
12. Surge procedures if applicable
13. Interactive Q&A
1. ATDs Signs/Symptoms
2. Screening methods; Referral criteria
3. Source control
4. Making referrals
5. Risk reduction
6. Respiratory Protection, if applicable
7. Medical services; exposure incidents; PEP
8. Vaccinations
9. Accessing written procedures; reviewing
10. Interactive questions and answers

Maintain a copy of this form for a period of three years.

<table>
<thead>
<tr>
<th>Name of person presenting training</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Qualifications: Specialized Training
# Training in Aerosol Transmissible Diseases Screening Protocol Sign-in Sheet

Our ATD Screening Protocol has been reviewed by:

<table>
<thead>
<tr>
<th>Reviewer’s Name (print)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Reviewer Date

Sign below to indicate that you have read and received training in your facility’s ATD Screening Protocol and that you have been given the opportunity to ask questions to management to ensure a complete understanding of the screening protocol:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Job</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maintain a copy of this form for a period of three years.
Patient Questionnaire — Our Commitment to You

To ensure that our patients are treated in an environment that promotes health and well being, and in accordance with OSHA requirements for providing a safe and healthful workplace, patients suffering from aerosol transmissible illnesses such as mumps, chickenpox, measles, new types of flu, TB, or other illnesses that may be spread by droplets or by airborne transmission should make our office aware of their condition.

Respiratory Hygiene and Cough Etiquette

During your time in our facility, please be sure to observe the following practices recommended by the Centers for Disease Control and Prevention:

- Cover your nose and/or mouth when coughing or sneezing;
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
- Wash your hands with soap and water or with alcohol hand-gel after you have had contact with contaminated tissues or respiratory secretions, etc.

Patient Questionnaire

Please fill out and return the below questionnaire.

Today’s Date  ____________________________________

Patient’s Name  ________________________________

Patient’s Telephone Number ________________________________
(or other means of contact)

Are you suffering from any of the following signs or symptoms of aerosol transmissible illnesses?

Please check (Yes) or (No) for each question:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have a transmissible respiratory illness other than the common cold or seasonal influenza?</td>
<td>______</td>
</tr>
<tr>
<td>2. Have you had a cough for more than three weeks that is not explained by non-infectious conditions?</td>
<td>______</td>
</tr>
<tr>
<td>3. Have you had coughing fits that interfere with eating, drinking, or breathing?</td>
<td>______</td>
</tr>
<tr>
<td>4. In addition to cough, have you experienced:</td>
<td></td>
</tr>
<tr>
<td>• unexplained weight loss (more than 5 pounds )</td>
<td></td>
</tr>
<tr>
<td>• night sweats</td>
<td></td>
</tr>
<tr>
<td>• fever</td>
<td></td>
</tr>
<tr>
<td>• chronic fatigue or malaise</td>
<td></td>
</tr>
<tr>
<td>• coughing up blood</td>
<td></td>
</tr>
</tbody>
</table>
Please check (Yes) or (No) for each question:

5. Have you had fever, headache, muscle aches, tiredness, poor appetite, followed by painful, swollen salivary glands on one or both sides of the face under the jaw?

6. Have you had fever, headache, stiff neck, chills, cough, runny nose, or watery eyes associated with the onset of an unexplained rash (diffuse rash or blister-type skin rash), or possibly mental status changes?

7. Do you show signs and symptoms of a flu-like illness during March through October, (the months outside of the typical period for seasonal influenza in the United States), or do you show the signs and symptoms of flu for longer than two weeks at any time during the year? These signs and symptoms generally include combinations of the following: coughing and other respiratory symptoms, fever, sweating, chills, muscle aches, weakness and malaise.

8. Have you been exposed to anyone with an infectious aerosol transmissible illness (see below for list of such illnesses) other than seasonal influenza?

**Illnesses That Should Be Reported on Page 1**

- Avian flu, novel flu, swine flu, or any other type of flu other than seasonal flu
- Chickenpox
- Shingles
- Measles
- Monkeypox
- SARS
- Smallpox
- Tuberculosis or TB
- Diphtheria
- *Haemophilus influenzae* type b or Hib
- Meningitis
- Mumps
- Pneumonia
- Parvovirus
- Pertussis or whooping cough
- Pharyngitis
- Epstein-Barr virus
- Strep
- Scarlet fever

Any new type of infectious illness
Respirator Fit-Test Screening Information and Form

The information below is taken directly from Appendix G of the ATD Standard with slight modification.

Respirators are an important means of reducing your exposure to infectious aerosols. Air purifying respirators provide a barrier to prevent health care workers from inhaling *Mycobacterium tuberculosis* and other pathogens. The level of protection a respirator provides is determined by the efficiency of the filter material and how well the facepiece fits or seals to your face.

Cal/OSHA regulations require that you be provided with a fit test at the time of initial fitting, whenever a different size, make, model, or style of respirator is used, and whenever you report a change in physical characteristics that may affect fit, such as major dental work, facial surgery or injury, or a change in weight.

Fit tests must also be repeated periodically, because people are not always aware of facial changes that may have affected the fit of the respirator. Generally, Cal/OSHA regulations require that fit tests be repeated annually. See Respiratory Protection protocol and the ATD Standard itself for exceptions to the annual requirement. The aerosol transmissible disease regulation permits employers to lengthen this interval to every two years for employees who are not exposed to high hazard procedures, such as bronchoscopies. However, if you believe that you need another fit test to ensure that the respirator is fitting you correctly, you may request an additional fit test, and your employer will provide it.

A respirator will not protect you if it does not fit, and if it is not worn properly. In addition to fit testing, it is important for you to be aware of the size, make, model, and style of respirator that fits you, and to understand and practice how to put the respirator on and take it off. It is particularly important to properly place the straps, and in some models, to adjust the straps and adjust the nose piece, so that it forms a snug seal on your face. During your initial and annual training, you will be shown how to use a respirator.

Fit-Test Screening Questions (Answer Yes/No)

Have you had recent major dental work, facial injury or facial surgery since your last fit test?

Have you had a significant weight gain or loss since your last fit test?

Do you want to be provided with an additional fit-test for your current respirator?

Name __________________________ Date __________________________

Employee ID number ______________ (if applicable)

Date of fit-test (if provided) __________________________
Respirator Medical Evaluation Questionnaire
(taken from Appendix B of the Standard with slight modification)

To the Physician or Licensed Healthcare Provider (PLHCP): Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Employees must be provided with a confidential means of contacting the healthcare professional who will review this questionnaire.

To the employee: Can you read and understand this questionnaire? (circle one): Yes / No

Your employer must allow you to answer this questionnaire during normal working hour, or at a time and place that is convenient to you.

To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

Section 1. The following information must be provided by every employee who has been selected to use any type of respirator (please print).

Today's date: ________________

Name: ________________________________  Job Title: ___________________

Your age (to nearest year): ___________

Sex (circle one): Male / Female

Height: __________ ft. __________ in.  Weight: ____________ lbs.

Phone number where you can be reached (include the Area Code): ___________________

The best time to phone you at this number: _______________________

Has your employer told you how to contact the healthcare professional who will review this questionnaire? (circle one)   Yes / No

Check the type of respirator you will use (you can check more than one category):

N, R, or P disposable respirator (filter-mask, non-cartridge type only).

Other type (half- or full-facepiece type, PAPR, supplied-air, SCBA).

(fill-in type here) ______________________________________________________

Have you worn a respirator? (circle one)   Yes / No

If “yes,” what type(s)?  ___________________________________________________
Section 2. Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator (please circle “yes” or “no”).

1. Have you ever had any of the following conditions?
   - Allergic reactions that interfere with your breathing? Yes / No
   - Claustrophobia (fear of closed-in places)? Yes / No
   - What did you react to? ________________________________

2. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - Shortness of breath when walking fast on level ground or walking up a slight hill or incline? Yes / No
   - Have to stop for breath when walking at your own pace on level ground? Yes / No
   - Shortness of breath that interferes with your job? Yes / No
   - Coughing that produces phlegm (thick sputum)? Yes / No
   - Coughing up blood in the last month? Yes / No
   - Wheezing that interferes with your job? Yes / No
   - Chest pain when you breathe deeply? Yes / No
   - Any other symptoms that you think may be related to lung problems? Yes / No

3. Do you currently have any of the following cardiovascular or heart symptoms?
   - Frequent pain or tightness in your chest? Yes / No
   - Pain or tightness in your chest during physical activity? Yes / No
   - Pain or tightness in your chest that interferes with your job? Yes / No
   - Any other symptoms that you think may be related to heart or circulation problems? Yes / No

4. Do you currently take medication for any of the following problems?
   - Breathing or lung problems? Yes / No
   - Heart trouble? Yes / No
   - Nose, throat, or sinuses Yes / No
   - Are your problems under control with these medications? Yes / No

5. If you’ve used a respirator, have you ever had any of the following problems while the respirator is being used?
   (If you’ve never used a respirator, check the following space and go to question 6:)
   - Skin allergies or rashes? Yes / No
   - Anxiety? Yes / No
   - General weakness or fatigue? Yes / No
   - Any other problem that interferes with your use of a respirator? Yes / No

6. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes / No

Employee Signature  Date
PLHCP Signature  Date
**Vaccination Declination Forms**
The two declination forms below are taken directly from Appendix C of the ATD Standard

**Vaccination Declination Statement (Mandatory)**

The employer shall ensure that employees who decline to accept a recommended vaccination offered by the employer sign and date the following statement as required by subsection (h)(5)(E):

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with ________________ (name of disease or pathogen). I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring ________________, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Seasonal Influenza Vaccination Declination Statement (Mandatory)**

The employer shall ensure that employees who decline to accept the seasonal influenza vaccination offered by the employer sign and date the following statement as required by subsection (h)(10):

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Appendix A: Respirator Supply Documentation

If you are having difficulty obtaining a sufficient supply of respirators, please complete the following documentation:

Date of survey: __________________________________________________

What actions have you taken to address any potential shortages?

A. Contacted other suppliers for same respirator model.

<table>
<thead>
<tr>
<th>Respirator model</th>
<th>Supplier contacted</th>
<th>Date of contact</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Attempted to switch to a different model of surgical N95.

<table>
<thead>
<tr>
<th>Respirator model</th>
<th>Supplier contacted</th>
<th>Date of contact</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. Attempted to switch to a non-surgical N95 (general purpose N95), or other type of respirator (e.g. elastomeric)

<table>
<thead>
<tr>
<th>Respirator model</th>
<th>Supplier contacted</th>
<th>Date of contact</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D. Adopted respirator conserving policies (please describe below):

<table>
<thead>
<tr>
<th>Type of policy</th>
<th>Brief description</th>
<th>In writing (y/n)</th>
<th>Employees trained (y/n)</th>
<th>Date to be reevaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Requested respirators from local emergency management organizations

Date of Contact_______________ Person/Agency Contacted _________________

Result? ____________________________________________________________