POLICY AND PROCEDURE	
SUBJECT/TITLE:	Exposure Control Plan
APPLICABILITY:	All Staff
CONTACT TITLE & DIVISION:	Director of Nursing
ORIGINAL DATE ADOPTED:	11/15/2022
LATEST EFFECTIVE DATE:	8/12/2026
REVIEW FREQUENCY:	Annually and as needed
BOARD APPROVAL DATE:	N/A
REFERENCE NUMBER:	200-025-P

A. PURPOSE

The purpose of this Exposure Control Plan (ECP) is to create a culture of safety by eliminating or minimizing occupational exposure to bloodborne pathogens (BBP) and other potentially infectious materials (OPIM) in accordance with *OSHA Bloodborne Pathogens Standard 29 CFR 1910.1030*.

B. POLICY

Safety against bloodborne pathogens and OPIM is a shared responsibility at all levels of Canton City Public Health (CCPH). All employees, contractors, students (i.e., student nurses, medical residents, and other similar persons), and volunteers are expected to actively participate in maintaining a safe work environment. Principles of policy apply in all settings including but not limited to clinical, laboratory, office, and community settings.

The Exposure Control Plan has been developed in accordance with applicable federal and state regulations, including the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (hereafter referred to as the Standard), to eliminate or minimize occupational exposure and to protect employees from health hazards associated with bloodborne pathogens and OPIM.

This ECP outlines policies and procedures for identifying exposure risks, implementing engineering and work practice controls, ensuring the appropriate use of personal protective equipment (PPE), providing employee training, and managing post-exposure evaluation and follow-up.

This ECP is a living document, meaning it must be reviewed and updated annually and as needed to reflect changes in workplace conditions, procedures, job roles, regulations, and/or technology that could affect exposure risks. This policy applies to all CCPH staff in both clinical and community (field) settings.

Employees with occupational exposure to blood or OPIM must comply with the procedures and work practices outlined in this ECP.

This policy is primarily focused on clinical practices in the Nursing Division. Additional program or job/role specific exposure control practices not addressed in this ECP are to be determined by division leaders and may be found in division specific policies. For guidance on situations not addressed in this policy or for clarification, staff should reach out to their division leaders. If further clarification and guidance is needed, division leaders should consult the Director of Nursing (DON) (or designee).

Additional CCPH safety plans have been established and are maintained by the CCPH Laboratory. Refer to the 400-003-P Laboratory Safety Plan for more details. Included in this plan are 400-003-01-1A Laboratory Safety Chemical Hygiene Plan (CHP), 400-003-002-A Hazard Communication Plan, and 400-003-03-A Infectious Waste Spill Containment & Clean-Up Plan.

C. BACKGROUND

CCPH provides a broad range of public health services. The nature and location of the work of CCPH staff can be highly variable. Staff are often exposed to vulnerable and high-risk populations, which can increase the risk of exposure.

Certain job duties may involve occupational exposure to blood, body fluids, and OPIM. These exposures may occur in the clinical, office, or community setting. Job duties that may put individuals *at risk* for exposure include but are not limited to drawing blood, administering injectable medications, touching mucous membranes, administering vaccines, assisting patients with breastfeeding, cleaning up OPIM, handling lab specimens, disposing of dead animals, cleaning up trash/garbage of unknown origin, and other similar activities.

Unsafe practices can result in employee injury or illness. CCPH recognizes that injuries and exposures are preventable through systematic hazard identification, employee engagement, leadership accountability, and adherence to evidence-based infection prevention practices.

The Chain of Infection is a six-step sequence that describes how a pathogen travels from its source to a new host. It includes the Microorganism, Reservoir/Source, Portal of Exit, Modes of Transport, Portal of Entry, and Susceptible Host. Infection prevention focuses on breaking this chain at any of these critical points. If any one of these links is broken or interrupted, the transmission of the disease is stopped, preventing infection.

Based on the type of exposure, the employee may be *at risk* of infection. Exposure to blood and bodily fluids/OPIM may put the employee *at risk for* Hepatitis B (HBV), Hepatitis C (HCV), or Human Immunodeficiency Virus (HIV).

See the Respiratory Protection Program Policy for details related to protecting against respiratory infection transmission.

D. GLOSSARY OF TERMS

***At risk*:** For the purposes of this policy, *at risk* is defined as an employee who has reasonably anticipated exposure to bloodborne pathogens or OPIM while performing their job duties. The list of *at-risk* employees and job roles have been identified in this policy.

Blood: Human or animal blood, blood components, and products made from blood.

Bloodborne pathogens (BBP): Infectious microorganisms present in blood that can cause disease in humans. These pathogens include but are not limited to: Hepatitis B virus (HBV), Hepatitis C virus (HCV), and human immunodeficiency virus (HIV), the virus that causes AIDS.

Cleaning: The removal of visible soil from objects and surfaces, normally accomplished manually or mechanically using water with detergents (soap) or enzymatic products. (CDC)

Clinical Laboratory: Workplace where diagnostic or other screening procedures are performed on blood or OPIM.

Contaminated: Presence, or a reasonably anticipated presence, of blood or OPIM on an item or surface.

Disinfection: Process that eliminates many or all pathogenic microorganisms, except bacterial spores,

on inanimate objects. (CDC)

Engineering Controls: Devices that isolate or remove the bloodborne pathogens hazard from the workplace before it comes in contact with an individual. These are often a built-in feature to a device Examples: self-sheathing needles, safety devices, equipment guards/shields/lids, sharps containers, and fume/ventilation hoods.

Exposure Control Plan (ECP): A required written document outlining how an organization will identify, mitigate, and respond to occupational exposure to bloodborne pathogens and OPIM. Its primary goal is to eliminate or minimize employee risks of contracting diseases like HIV, Hepatitis B, and Hepatitis C.

Exposure Incident: Specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM that results from the performance of an employee's job duties.

Learning Management System: A web-based platform used to facilitate, administer, and track trainings and educational courses.

Occupational Safety and Health Administration: Federal agency within the United States Department of Labor. Established by the OSH Act of 1970, its mission is to ensure safe and healthful working conditions for workers by setting and enforcing standards and providing training, outreach, and education.

OSHA Bloodborne Pathogens Standard (the Standard): Federal regulation **(29 CFR 1910.1030)** designed to protect workers from occupational exposure to infectious microorganisms like HIV, Hepatitis B (HBV), and Hepatitis C (HCV)

Other Potentially Infectious Materials (OPIM): Biological substances that can transmit bloodborne pathogens. Includes the following human or animal body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood (including saliva, urine, feces, emesis, tears, nasal secretions, and wound secretions) and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. Also includes unfixed tissue or organ (other than intact skin) from a human or animal (living or dead) and/or cell, organ, or tissue cultures containing HIV, HBV, or HCV.

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

Regulated Waste: Includes any materials potentially contaminated with blood or OPIM that pose infection risks.

Standard Precautions: Minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any and all settings where health care is delivered. Includes hand hygiene, use of personal protective equipment, respiratory hygiene, cough etiquette, sharps safety (engineering and work practice controls), safe injection practices, sterile instrument and devices, and cleaning and disinfecting environmental surfaces. Combines principles of Universal Precautions and Body Substance Isolation (BSI). This precaution is based on the principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes, may contain transmissible infectious agents.

Sterilization: Use of physical or chemical procedures to destroy all microbial life including highly resistant bacterial endospores. (CDC)

Universal Precautions: Approach to infection control with the main concept that all human blood and certain human body fluids are treated as if known to be infectious for HIV, HCV HBV, and other bloodborne pathogens.

Work Practice Controls: Practices that reduce the possibility of exposure by changing the way a task is performed (i.e., practices with handling sharps, laundry, specimens, and cleaning surfaces).

E. PROCEDURES & STANDARD OPERATING GUIDELINES

This ECP is a key document to assist our organization in implementing and ensuring compliance with the Standard, thereby making every effort to protect our employees.

1. **COMPONENTS OF THIS EXPOSURE CONTROL PLAN**
    - A. Program Administration
    - B. Determination of employee exposure risk by job role and tasks
    - C. Implementation of various methods of exposure control, including:
        1. Standard precautions
        2. Risk Based Exposure Assessment
        3. Hand Hygiene
        4. Respiratory Etiquette
        5. Sharps Safety
        6. Work exclusion
    - D. Engineering and Work Practice Controls
        1. Personal protective equipment (PPE)
        2. Sharps Safety
        3. Handling Specimens
        4. Housekeeping
        5. Laundry
        6. Labeling
        7. Employee Input
        8. Staff Adherence Evaluations
    - E. Hepatitis B vaccination
    - F. Exposure Incident Response
        1. Immediate Response Steps
        2. Initial post-exposure evaluation and follow-up
        3. Incident Report
        4. Employee Post exposure incident evaluation and follow-up
        5. Post exposure incident review and EPC evaluation and update
    - G. Employee training details
    - H. Employee medical and training recordkeeping

Implementation methods for the elements of the Standard are discussed in the subsequent pages of this ECP.

A. PROGRAM ADMINISTRATION

The Director of Nursing (DON), with the support of the Medical Director, is responsible for the overall implementation of the ECP. The DON's contact phone number is (330) 489-3322.

1. **The DON (or designees) will:**
   a. Maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures that affect occupational exposure and to reflect new or revised employee positions identified as at risk.
   b. Provide and maintain all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers) as required by the Standard for the Nursing Division.
   c. Coordinate with the CCPH Laboratory to obtain red biohazard bags and ensure proper labeling of biohazard containers.
   d. Ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.
   e. Be responsible for ensuring that all medical actions required by the Standard and this ECP are performed, and that appropriate employee health and OSHA records are maintained.
   f. Be responsible for finding adequate training related to BBP and OPIM that can be made available to all staff.
   g. Review all training certifications for BBP training obtained outside of CCPH to determine if they meet the requirement.
   h. Respond to reported hazards and exposure incidents.
   i. Track and maintain training documentation for the Nursing Division and all other CCPH staff in positions listed below.
   j. Make the written ECP available to employees, OSHA, and NIOSH representatives.

2. **Division Leaders (or designees) will:**
   a. Review this ECP annually and notify the DON of any recommended updates to this ECP, including new positions and specific job duties that put their division staff *at risk* for BBP exposure.
   b. Provide written supplemental policies for their division related to program or job specific exposure control practices that are not addressed in this ECP.
      i. Maintain, review, and update annually and as needed.
      ii. Must make readily available to staff, preferably included as an attachment to this ECP.
   c. Upon hire or change of job duties that now put the staff member *at risk*, schedule a time for employees who are *at risk* for occupational exposure to meet with the DON (or designee) to evaluate the employees Hepatitis B Vaccine status and allow employee time to obtain vaccination as needed.
   d. Provide a list of staff who need annual BBP training to the DON (or designee) annually and prior to staff members being assigned duties that put them at occupational risk.
   e. Ensure adequate supply of PPE, engineering controls, and first aid materials (i.e., eye wash solution) for staff in their division.
   f. Track training documentation for their division staff.
   g. Reinforcing safe work practices and ensuring staff compliance with this ECP.
   h. Participating in incident review and corrective actions as needed.

3. **Employees are responsible for:**
   a. Review this ECP annually and comply with the policies and procedures listed in this ECP and

additional supplemental instructions provided by their division leader and/or supervisor.

b. Reporting hazards, exposures, and near-misses in a timely manner.
c. Participate in training as assigned.
d. If working in an at-risk job, meet with the DON (or designee) to complete the Employee Hepatitis B Vaccination Acceptance/Declination Form upon hire, change in exposure risk, or decision to vaccinate after declination.
e. Be aware of where first aid supplies are located and be familiar with how to use them.
f. Perform risk-based exposure assessments to determine need for PPE and wear PPE based on exposure risk.

B. EMPLOYEE EXPOSURE DETERMINATION

An exposure incident (also referred to as an exposure) is when any blood or OPIM comes in contact with an individual's eye, mouth, mucous membranes, non-intact skin, or other parenteral contact. All blood and OPIM are considered to be contaminated and all known or suspected contact with these substances as listed above should be classified as an exposure. This includes being stuck with a needle/sharp when contamination cannot be ruled out.

All employees should make every effort to avoid exposures for themselves and those around them, including staff and guests of CCPH. All employees should perform a risk-based exposure assessment (see below) when conducting work activities, whether they are listed on this ECP or not. Standard precautions shall be observed to prevent contact with blood or OPIM. Furthermore, if a known or suspected exposure occurs, when possible, the employee should gather details regarding the nature of the exposure, the amount of exposure (duration and quantity), and known diseases present from the source of the exposure.

Group A: The following is a list of all job classifications at CCPH in which ALL employees have risk of occupational exposure on a routine basis based on their job duties. This determination is made without regard to personal protective equipment (PPE) use. Included is a list of tasks and procedures, in which occupational exposure may occur for these individuals.

Job Title	Division	Exposure Risk
Nurse Practitioner	Nursing	Handling sharps, blood, and OPIM
Director of Nursing (DON)	Nursing	Handling sharps, blood, and OPIM
Nursing Supervisor	Nursing	Handling sharps, blood, and OPIM
Staff Nurse II/Public Health Nurse	Nursing	Handling sharps, blood, and OPIM
Health Services Coordinator	Nursing	Handling sharps, blood, and OPIM
Linkage to Care Specialist	Nursing	Handling sharps, blood, and OPIM
Early Intervention Navigator	Nursing	Handling sharps, blood and OPIM
HIV/STI Prevention Health Educator	Nursing	Handling sharps, blood and OPIM
Harm Reduction Program Manager	Nursing	Handling sharps, blood and OPIM
Harm Reduction Outreach Specialist	Nursing	Handling sharps, blood and OPIM
Harm Reduction Administrative Specialist	Nursing	Handling sharps, blood and OPIM
Harm Reduction Peer Support Specialist	Nursing	Handling sharps, blood and OPIM
DIS Supervisor	Nursing	Handling sharps, blood and OPIM
Disease Intervention Specialist (DIS)	Nursing	Handling sharps, blood and OPIM
Dental Program Manager	Nursing	Handling sharps, blood and OPIM
Dental Hygienist (contract)	Nursing	Handling sharps, blood and OPIM

WIC Director	WIC	Handling sharps, blood and OPIM
WIC Dietitian	WIC	Handling sharps, blood and OPIM
WIC Assistant	WIC	Handling sharps, blood and OPIM
Lactation Consultant	WIC	Handling blood and OPIM
WIC Peer Helper	WIC	Handling blood and OPIM
Laboratory Manager	Lab	Handling sharps, blood, and OPIM
Laboratory Technician	Lab	Handling sharps, blood, and OPIM

Group B: The following is a list of job classifications at CCPH in which some employees are determined to have occasional occupational exposure risk. This determination is made without regard to personal protective equipment (PPE) use. Included is a list of tasks and procedures, or groups of closely related tasks and procedures, in which occupational exposure may occur for these individuals:

Job Title	Division	Exposure Risk
Director of Environmental Health	EH	Nuisance Activities Including: Handling sharps, blood and OPIM
Environmental Health Specialist	EH	Nuisance Activities Including: Handling sharps, blood and OPIM
Environmental Health Specialist in Training (EHSIT)	EH	Nuisance Activities Including: Handling sharps, blood and OPIM
Epidemiologist	HPP	Blood and OPIM
Clinical Receptionist/Office Assistant	Nursing	Handling sharps, blood, and OPIM
Medical Director	Nursing	Handling sharps, blood, and OPIM

NOTE: Temporary, contract, and per diem employees are covered by the Standard and this ECP. The expectation is that these individuals provide written verification of bloodborne pathogens training and are familiar with this ECP as well as any division specific polices related to potential exposures.

All employees/roles NOT listed above are determined to be at low risk for routine exposure. If employees encounter blood or other OPIM they should follow standard precautions and follow the guidelines listed in this policy.

All employees should follow general safety precautions even if they are not identified as being *at risk* for routine exposure. Examples of employee tasks where exposure is not reasonably anticipated exposure include general administrative/clerical work, customer service, information technology, food service, and educational/instructional duties. There is a remote possibility that an employee may experience a minor cut or abrasion during office hours, this is generally not covered by this ECP, and the employee can treat themselves. If employees contaminate a work surface with blood or OPIM, they are to consult the DON or a BBP trained staff member for disinfection of the contaminated area. Consult the CCPH Laboratory staff for products to disinfect the contaminated surface.

C. IMPLEMENTATION OF EXPOSURE CONTROL METHODS

1. STANDARD PRECAUTIONS

a. All CCPH employees are to follow standard precaution principles at all times. They are to treat all human or animal blood and body fluid and OPIM as if known to be infectious. Standard Precautions include the principles of hand hygiene, use of personal protective equipment,

respiratory etiquette, and sharps safety. Standard Precautions are based on risk-based decision-making and personal protective equipment (PPE) use that protect employees from infection and prevent the spread of infectious materials from person to person.

2. RISK BASED EXPOSURE ASSESSMENT

a. Determine the level of risk of exposure based on anticipated contact with mucous membranes, blood, or saliva contaminated with blood and implement infection prevention practices in accordance with th*at risk* level.
   I. Wear personal protective equipment (PPE) based on exposure risk. See work practice controls below for more information about PPE need determination and use.

3. HAND HYGIENE

a. All CCPH personnel must practice proper hand hygiene using soap/water or ≥60% alcohol-based rub according to CDC guidelines, including:
   I. Wash hands with soap and water at the start and end of the day
   II. Before and after patient/client contact
   III. Before glove placement and after glove removal
   IV. After touching potentially contaminated surfaces/substances
   V. After removing torn or punctured gloves
   VI. When hands are visibly soiled (soap/water)
   VII. After coughing/sneezing or blowing their nose.

4. RESPIRATORY ETIQUETTE

a. Cover mouth and nose with a tissue when coughing or sneezing.
b. Throw used tissues in the trash.
c. If a tissue is not available, cough or sneeze into an elbow, not into hands.
d. Perform hand hygiene immediately after blowing their nose or touching respiratory secretions.
e. Symptomatic staff will follow exclusion guidelines listed below.

5. SHARPS SAFETY

a. Do not bend, recap, shear, or break contaminated needles.
b. Use mechanical devices (i.e., hemostats) or a one-handed technique when recapping sterile needles. See engineering and work practice controls for more information.
c. Use needleless alternatives whenever possible.
d. Immediately dispose of contaminated sharps in appropriate puncture resistant sharps containers.

6. WORK EXCLUSION (Per Ohio Law and IDCM)

a. Healthcare workers in the CCPH must be excluded from work under the following conditions:
   I. Fever, cough, respiratory symptoms, or COVID-19 infection – follow CDC isolation and return-to-work criteria.
b. Hepatitis A, Norovirus, Salmonella, Shigella, or E. coli O157:H7 infection – excluded until clearance per the Ohio Department of Health (ODH) Infectious Disease Control Manual (IDCM), local public health authority, and CCPH policies.
c. Open or draining skin lesions on hands or forearms – excluded until resolved or securely covered.
d. Active Tuberculosis (TB) – excluded until cleared with documentation of non-infectious status.
e. Other reportable diseases or condition deemed transmissible in a healthcare setting as specified in the Ohio IDCM, a physician, individuals local health district, or the CCPH DON (or designee).
f. Return to work requires clearance from CCPH DON (or designee). Clearance should align with

IDCM clearance criteria and CCPH return to work policies.

D. ENGINEERING CONTROLS AND WORK PRACTICE CONTROLS

Engineering controls and work practice controls will be used to prevent or minimize exposure to bloodborne pathogens. These work hand in hand to prevent exposures in the workplace. For example, engineering controls do not help provide protection if they are not incorporated into work practice.

Engineering Controls are primary methods to help reduce or remove the hazard from the area before exposure can occur (i.e., ventilation hoods, safety shields, retractable needles, and other similar devices).

Work practice controls are practices and procedures used to reduce risk of exposure (hand hygiene, wearing PPE, reducing cross contamination, and other similar activities). See examples below.

Examples of Engineering and Work Practice Controls	
Engineering Controls	**Work Practice Control**
Using hemostats to recap a sterile needle	Using a one-handed technique when recapping a sterile needle. NEVER recap a contaminated needle.
Non-glass capillary tubes and vacutainers	Use non-glass supplies, when available
Benchtop splash shield	Use splash shields when there is potential for splash.
Safety syringes (i.e., VanishPoints®)	Use retractable syringes whenever possible. NEVER recap a contaminated needle.
Sterile equipment	Use a new sterile needle, syringe, or lancet for each patient and procedure. Discard used equipment immediately after use in a properly labeled sharps container.
Bag Valve Mask (BVM) and Ambu bag	Use an Ambu bag with a Bag Valve Mask (BVM) for resuscitation.
Disposable exam gloves	Wear gloves when there is reasonable expectation of exposure to blood or OPIM. Dispose of gloves between patients and when soiled.
Puncture proof red sharps containers labeled with a biohazard symbol	Immediately after use, place sharps in a properly labeled puncture proof red sharps container. Store sharps containers in the upright position and securely closed during transport. Keep out of reach of children.
Red biohazard waste containers marked with a biohazard symbol in each clinic room.	Discard regulated waste in properly labeled red biohazard containers immediately after use. Tie up biohazard waste bags and dispose of routinely and/or when full.
Ventilation hood for laboratory area	Utilize ventilation hood when working with specimens with respiratory exposure risk. See Respiratory Protection Program Policy for more information.
	NEVER eat, drink, apply cosmetics or lip balm, or handle contact lenses in clinical/patient care areas (i.e., examination rooms and med room) or in laboratory work/specimen testing areas. No food and drink will be

	stored in vaccine or specimen refrigerators or freezers.

1. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**
   a. All staff should make every effort to avoid coming in contact with blood or OPIM. Contact with blood or OPIM is not always avoidable. Staff should evaluate their risk and use the appropriate level of precaution in the form of PPE, based on the potential risk of exposure.
   b. PPE is provided to employees at no cost to them.
   c. Training in the use of the appropriate PPE for specific tasks or procedures is provided by division supervisors.
   d. Staff should follow the current CDC guidance for donning and doffing PPE.
   e. The types of PPE available to employees are as follows:
      I. Gloves (non-latex is preferred)
         i. Non-latex, single-use, discarded after each patient or when soiled
         ii. Utility gloves for cleaning and sterilization tasks
      II. Safety glasses/goggles and/or face shields
      III. Chin-length shield or side-shield eyewear.
         i. Disinfect between uses.
      IV. Lab coats
      V. Simple Surgical Masks
         i. Level 1–3 surgical masks, replaced when damp.
      VI. N-95
         i. N95 respirators during aerosol-generating procedures (AGPs) in areas of substantial/high transmission. See Respiratory Protection Program Policy for more information.
      VII. Resuscitation equipment
         i. Bag Valve Mask (BVM) and Ambu bag
      VIII. Gowns
         i. Restricted to clinical care area; discarded prior to leaving and when soiled.

   f. PPE for the Nursing Division is located in the Nursing Division clinical rooms and/or storage room and may be obtained through Nursing Division staff. The DON (or designee) is responsible for ensuring that PPE is available for the Nursing Division and provide assistance to other CCPH Divisions to obtain PPE as needed.
      I. Division Leaders are responsible for maintaining adequate PPE stock for their divisions for commonly used PPE.

   g. All employees using PPE must observe the following precautions:
      I. Don and doff PPE per CDC guidelines.
      II. Wash hands immediately or as soon as feasible after removing gloves or other PPE.
      III. Remove PPE after it becomes contaminated and before leaving the work area.
      IV. Used PPE may be disposed of in the appropriate areas – trash containers, biohazard container, and laundry bag depending on contamination level and if item is to be reused (i.e., lab coat).
      V. Wear appropriate gloves when it is reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces.

VI. Replace gloves if torn, punctured, or contaminated, or if their ability to function as a barrier is compromised.
VII. Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
VIII. Never wash or decontaminate disposable gloves for reuse.
IX. Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
X. Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.

2. SHARPS SAFETY

a. Sharps should be handled cautiously to avoid unintended puncture of the skin. Sharps (including needles) should be disposed of in red puncture-resistant biohazard containers (a.k.a. sharps containers) immediately after use. Sharps containers are to be easily accessible to staff in point of care areas, closable, puncture-resistant, leak proof on sides and bottoms, and appropriately labeled with a biohazard symbol and color-coded red. Empty sharps disposal containers are available in the Nursing Division storage room.
b. Sharps containers should be stored in the upright position and are to be inspected and maintained or replaced by bloodborne pathogen trained CCPH staff, whenever necessary to prevent overfilling.
c. Transporting sharps container should be done with caution. Containers should remain upright, closed, and secure at all times during transport.
d. Needle grinders (a.k.a. Needle Sharks) use is no longer a routine practice used at CCPH.
e. NO ONE, including staff and other CCPH clients, guests, visitors, should EVER put their hand or any body part inside a sharp's container.
f. Sharps containers are to be disposed of as regulated biohazard waste per the CCPH lab policy and with Ohio Environmental Protection Agency (EPA) standards.
    i. CCPH main location (420 Market Ave N, Canton, OH 44702): Sharps should be taken to the CCPH laboratory for disposal by laboratory staff.
    ii. McKinley Location (832 McKinley Ave NW Suite B, Canton, OH 44703): Sharps are to be collected and disposed of in the designated biohazard bin.
g. CCPH is licensed by Ohio EPA as an infectious waste generator. The license is maintained by the laboratory division. See the CCPH laboratory infectious waste policy for more information.

3. HANDLING SPECIMENS

a. To help ensure a reduced risk of exposure in case of spills or drops, specimens being transported (i.e., from the clinical area to the CCPH laboratory) will be transported in a closed plastic container marked with a red biohazard symbol.
b. All specimens needing shipped, will be shipped in compliance with Division 6.2 packaging and shipping rules and regulations. The laboratory personnel will be trained to properly ship specimens before performing the task.

4. HOUSEKEEPING

a. Waste Disposal
    i. General Waste

1. Trash bins in clinic spaces will have disposable plastic liners and the bins will be constructed to contain all contents and prevent leakage. This is not considered regulated waste.
2. These plastic liners are to be changed daily by the contracted cleaning company or sooner by CCPH staff if needed.

ii. Regulated Waste

1. Sharps
   i. All used sharps are to be disposed of in a puncture proof red sharps container marked with the biohazard symbol, immediately after use and should NEVER be placed in a trash container.
   ii. See Sharps Safety section in this ECP for more information.
2. Biohazard Waste
   i. All biohazard waste, including blood or body fluid-soaked items are to be immediately placed into a red biohazard bag and stored in a red-biohazard waste container/bin that is labeled with a biohazard symbol. These bins are to have a lid and be covered at all times, except when in use.
      1. At this facility, speculums and any other objects that may come into contact with blood or body fluids are discarded into a biohazard container located in each clinic room.
      2. BBP trained Nursing Division staff assigned to the clinic room are responsible for disposing of the biohazard waste in that clinic room every two weeks (or sooner if full or if the bag has been compromised). The red biohazard bag shall be closed/tied prior to removal from the container to prevent spillage or protrusion of contents during handling and taken to the CCPH laboratory to be disposed of per CCPH laboratory policies. The staff member will place a new red biohazard bag in the bin upon removal of the old bag.
      3. Red biohazard cans/bins are cleaned and decontaminated as soon as feasible after visible contamination by a BBP trained CCPH staff member. These containers are visually examined by the staff member using them. Any damage should be immediately reported to the DON (or designee) for repair or replacement. Red biohazard bag liners are purchased by the Nursing Division.
      4. Broken glassware should not be picked up by hand, especially if it may be contaminated.
         a. Broken glass should be picked up by mechanical means (i.e., hemostats).
         b. All broken glass will be discarded into a sharp's container.

b. Nursing Division Examination Room Cleaning Schedule
   i. Nursing examination rooms will be cleaned and decontaminated according to the following schedule:
      1. Division staff members assigned to or working in that examination room that day are responsible for maintaining the area in a clean and safe manner and disinfecting surfaces at the end of the clinic day or sooner if indicated.
      2. All exam tables, venipuncture tables, and specimen preparation and collection areas are to be covered with a paper or water-resistant barrier (i.e. drape sheets or exam table paper) during use. Covers on exam tables are to be changed after each client use. Any other surface will be cleaned at the end of the clinic unless

contaminated with blood or body fluids during use.

3. Areas noted to be soiled with blood or OPIM will be cleaned and disinfected as soon as possible by a BBP trained staff member using the following procedure:
    a. Don PPE appropriate for the task (i.e., gloves);
    b. Blot up as much of the spill as possible with a disposable absorbent paper towel or drape sheet and discard in a red biohazard container lined with a red biohazard bag, taking extra care not to allow spill, splash, spread to other non-affected areas;
        i. Spill kits should be used for larger spills. If there is a major accident involving a large amount of blood and/or infectious body fluid, refer to 400-003-03-A Infectious Waste Spill Containment & Clean-Up Plan.
        ii. Heavily saturated items, materials, and disposable towels/drape sheets will be discarded in a red biohazard bin;
    c. Contaminated area will be washed with soap and water; and
    d. Contaminated area will be cleansed with approved disinfectant for that specific surface, and it will be allowed to air dry according to manufacturer product instructions, ensuring adequate contact time is achieved. Re-application of disinfectant may be needed to ensure adequate contact time.
    e. Discard lightly soiled gloves, other PPE, cleaning materials, and other soiled objects in a plastic-lined trash container.
    f. Discard heavily soiled materials into a red biohazard bag and dispose of per lab biohazard waste disposal policy.
    g. Wash hands and other skin areas that may have come into contact with the blood or OPIM thoroughly with soap and water.
4. Disinfecting at the end of the clinic day:
    a. BBP trained Nursing Division staff member assigned to/working in that space will disinfect the following work areas with a manufacturer approved cleaning product (that does not degrade the integrity of the surface being cleaned) using an appropriate amount of contact time and be allowed to air dry.
        i. Exam Tables: tabletop, lamp, basin, arm rests, stirrups, step, and any other possibly contaminated areas;
        ii. Entire sink area (faucets included);
        iii. Any worktable and desktop; and
        iv. Doorknobs.
    b. Gloves will be worn by all individuals during this disinfecting procedure. Gloves must be properly discarded in plastic-lined container after use, followed by good hand washing.
5. General office and clinic cleaning
    a. A contracted cleaning service is responsible for daily cleaning of this facility. In the clinic areas and waiting areas, hard-surface floors are to be mopped with disinfectant solution daily. Any flat surfaces are to be cleansed with disinfectant solution and allowed to air dry. Trash containers are to be tied shut and discarded as a unit. New plastic

liners are to be in place daily. Normal cleaning (dusting and sweeping) is sufficient for the rest of the working areas.

b. The contractor cleaning lists are to be reviewed at least annually. Areas that need addressed with the cleaning crew should be communicated on the communication log stored near Vital Statistics.

5. LAUNDRY

a. Lab coats are provided by CCPH to cover uniforms during patient contact and are to be used as PPE.
b. Individual staff members are responsible for ensuring that they have a clean lab coat to utilize during patient care. Lab coats are to be changed immediately if they become soiled and replaced with a clean coat. Clean lab coats are to be worn for all clinics.
c. Contaminated lab coats will be laundered by a professional laundering company at CCPH's expense. Laundering will be performed by an approved cleaner on a regular basis.
d. The following laundering requirements must be met:
    i. Handle contaminated laundry as little as possible, with minimal agitation;
    ii. Place wet contaminated laundry in leak-proof, labeled containers before transport. Use either red bags or bags marked with the biohazard symbol for any laundry grossly contaminated with biohazard materials for this purpose.
    iii. Contaminated laundry is placed in biohazard bag and then in laundry bag;

6. LABELING

All regulated biohazard waste and sharps should be properly identified with labels and signs.

a. Laboratory personnel are responsible for ensuring that warning labels are affixed to biohazard waste bins. Employees are to notify laboratory personnel if they discover regulated waste containers, refrigerators containing blood or OPIM, or contaminated equipment are not labeled properly.
b. All CCPH staff handing blood or OPIM are to ensure that biohazard waste is stored and transported within a CCPH facility, off-site clinic (directly related to CCPH services), or vehicle is properly stored and transported in appropriately marked puncture proof containers.

7. EMPLOYEE INPUT

a. In accordance with 1910.1030 (c)(1)(v) of the Standard, the DON (or designee) will solicit and document input from non-managerial/frontline staff responsible for direct patient care who are potentially exposed to injuries from contaminated sharps. This survey will seek input regarding safety issues, work practice controls, and/or engineering controls utilized in at CCPH.
b. This solicitation will be completed annually by the DON (or designee), currently the Nursing Supervisor, and will be reviewed by the DON.
    i. Currently, the solicitation of employee is completed using an online survey tool which allows staff comments to be compiled for easy review. Staff will be provided a link to this survey through the LMS system. Only clinical staff are required to complete this survey. Non-clinical staff are also welcome to submit concerns.
    ii. All BBP exposure concerns will be reviewed and addressed by the employee's Division Leader or Supervisor. The Division Leader is responsible for initiating and documenting corrective actions. The DON (or designee) will provide consultation to ensure compliance with the Standard and will review identified concerns for appropriateness of response

and alignment with this ECP. If concerns are not resolved at the division level, or if they involve significant exposure risk, they will be escalated to the DON for further review.

8. EXPOSURE CONTROL PLAN REVIEW AND REVISION

a. As dictated in the Standard, the Program Manager (CCPH DON) is responsible for updating this EPC annually and as needed to reflect changes in tasks, procedures, and positions that affect occupational exposure, as well as technological changes that eliminate or reduce occupational exposure.
b. The DON will also annually document consideration for using appropriate, commercially available effective and safer medical devices designed to eliminate or minimize occupational exposure.
c. New procedures and new products are evaluated as needed by conducting literature reviews, reviewing supplier information, and requesting outside agency input if necessary.
d. Both front-line staff and management are involved in this evaluation process in the following manner: A review of the staff input is to be conducted by the Medical Director, DON, Nursing Supervisor, and other division leader whose staff have reported an issue. The topics shall be discussed amongst leadership with additional input from the frontline staff if needed. The DON is responsible for ensuring that the appropriate recommendations are implemented.

9. STAFF EXPOSURE CONTROL PLAN ADHERENCE EVALUATION

a. All CCPH staff are subject to review of adherence to the principles defined in this ECP during their probationary period and periodically throughout their tenure at CCPH. Division leaders (or designees) will determine which evaluation tools (i.e., infection prevention check lists) and at which intervals the staff will be evaluated on their performance in this area. Evaluations should be focused on education and correction of unwanted habits/behaviors in order to prevent against possible exposures.

E. EMPLOYEE HEPATITIS B VACCINATION

1. CCPH job roles and duties that could put staff at reasonable anticipated risk of occupational exposure to blood or OPMI listed in this ECP are eligible for Hepatitis B vaccination through the CCPH Immunization Clinic.
2. The DON (or designee) will provide education to *at risk* employees about Hepatitis B vaccinations including safety, benefits, efficacy, methods of administration, and availability.
3. The employee will be provided the *OSHA FactSheet: Hepatitis B Vaccination Protection* for review.
4. After initial employee education and vaccine history evaluation, all employees identified in the exposure determination section of this ECP will be offered a Hepatitis B vaccination series at no cost to the employee. This vaccine may be billed to the employee's medical insurance, but no additional fees will be charged to the employee. If the staff member does not have insurance or is underinsured, 317 vaccine may be utilized, if available.
5. The Hepatitis B vaccination will be offered after training and within 10 working days of initial assignment to the job where there will be occupational exposure. It is up to the employee's supervisor to report the need for Hepatitis B vaccine evaluation to the DON (or designee) and arrange the staff members work schedule around this 10-day window.
6. Under the direction of the DON (or designee), employees will be directed to schedule their immunization appointment with the Nursing Division Clinical Receptionist(s). Employees are responsible for communicating with their direct supervisors and/or division leaders of their need for vaccination and the time and date of their scheduled appointment.
7. Vaccination is encouraged unless:

a. Documentation exists that the employee has previously received a completed series.
b. Antibody testing reveals that the employee is immune; or
c. Medical evaluation shows that vaccination is contraindicated.

8. After speaking with the DON (or designee), all new or previously un-evaluated employees shall complete an Employee Hepatitis B Vaccine Acceptance/Declining Form.
   a. This form, including any documentation of vaccination, immunity, or refusal (declination) of the vaccination, will be kept in the employee's personnel file per the CCPH records retention policy. Employees who decline vaccination may request and obtain the vaccination at a later date at no cost.
      i. OSHA-required declination language should be included on this Employee Hepatitis B Vaccine Acceptance/Declining Form.
9. Employees may request a copy of their CCPH or Ohio ImpactSIIS immunization record by following the CCPH Immunization Records Release Policy. A copy of the employees immunization record may also be filed in the employee's personnel file upon their request.

F. EXPOSURE INCIDENT RESPONSE

An exposure incident occurs when an individual's eye, mouth, other mucous membrane (including parenteral), and/or non-intact skin come in contact with blood or OPIM. The individual should take immediate action to prevent prolonged exposure and risk of infection and subsequent disease.

1. IMMEDIATE RESPONSE STEPS:

a. Wash needlesticks and cuts with soap and water immediately.
   I. Do not use caustic agents, bleach, or inject antiseptics into the wound.
b. Flush splashes to nose, mouth, or skin with water or sterile saline.
c. Rinse eyes with clean water, saline, or sterile irrigation solutions for at least 15 minutes.
   I. An eye wash station is located in the CCPH lab and eye wash bottles are located in the Nursing Clinic area.

2. INITIAL POST-EXPOSURE EVALUATION AND FOLLOW-UP

A post exposure evaluation and follow-up is available to any occupationally exposed staff member who experiences an exposure incident, at no cost to the staff member, and includes documenting the route(s) and the circumstances in which the exposure incident occurred. This evaluation should begin immediately (ideally within hours).

Should an exposure incident occur, after the immediate first aid is provided (see immediate response listed above), contact the DON (or designee) and/or the Medical Director at (330) 489-3322.

An immediately available confidential medical evaluation and follow-up will be conducted by the Medical Director. If the medical director is not available, the employee may be directed to a local provider for occupational health or a stat care. Currently CCPH is contracted with Aultworks (address: 4650 Hills and Dales Rd NW, Canton, OH 44708, (330) 491-9675).

The medical evaluation and follow-up will include the following (and documented using an exposure incident form or equivalent evaluation tool):

a. Document the routes of exposure and how the exposure occurred.
b. Identify and document the source individual (unless the employer can establish that

identification is infeasible or prohibited by state or local law).

c. Obtain consent and decide to have the source individual tested as soon as possible to determine HIV, HCV, and HBV infectivity; document that the source individual's test results were conveyed to the employee's health care provider.
d. If the source individual is already known to be HIV, HCV and/or HBV positive, new testing need not be performed.
e. The employee should be educated about post-exposure prophylaxis (PEP) and provided counseling. PEP should be provided at no cost to the employee.
f. Assure that the exposed employee is provided with the source individual's test results and with information about applicable disclosure laws and regulations concerning the identity and infectious status of the source individual (e.g., laws protecting confidentiality).
g. If the Medical Director completes the evaluation of the patient, s/he will provide a limited written opinion to the employer and all the diagnosis must remain confidential. Confidential medical records will be maintained per HIPAA and OSHA and per the CCPH record retention policy.
h. Results of the employee's evaluation will be placed in medical section of the employee's personnel file.
i. Refer the employee to Aultworks at (330) 491-9675 for initial testing and follow-up testing.

3. INCIDENT REPORT

a. An Employee Injury Report must be completed the same day by the employee detailing what occurred. Employees who witness the event shall also submit a statement of their accounts of the incident. Injury reports should be submitted to the DON (or designee) by the end of the business day, or by noon of the following business day if the incident occurred at the end of the previous day. The DON will review the report and has the right to discuss the incident in person with the individual and/or their supervisor. Employee Injury Report forms are located on the Employee Information page of the CCPH website.

4. EMPLOYEE POST-EXPOSURE EVALUATION AND FOLLOW-UP

a. The DON ensures that health care professional(s) responsible for employee's post-exposure evaluation and follow-up are given a copy of the Standard.
b. The DON ensures that the health care professional evaluating an employee after an exposure incident receives the following:
    i. A description of the employee's job duties relevant to the exposure incident
    ii. Route(s) of exposure
    iii. Circumstances of exposure
    iv. If possible, results of the source individual's blood test
    v. Relevant employee medical records, including vaccination status.
c. The DON provides the employee with a copy of the evaluating health care professional's written opinion within 15 days after completion of the evaluation.
d. Per OSHA Employee exposure records must be maintained for the duration of employment plus 30 years and per CCPH Records Retention Policy. These records are to be kept in the employee's medical file.

5. POST EXPOSURE INCIDENT REVIEW AND EPC EVALUATION AND UPDATE

a. The Medical Director and DON will review the circumstances of all exposure incidents to determine:
   I. Procedure being performed when the incident occurred.
   II. Adherence to engineering controls at time of incident.
   III. Adherence to work practice controls at the time of incident.
   IV. Which devices were used (including type and brand) that may have contributed to the exposure.
   V. Adherence to PPE recommendations at the time of the exposure incident (i.e., use of gloves and eye/face shields).
   VI. Location of the incident (clinic room, med room, waiting area, clinical lab, and/or community setting).
   VII. Employee's training history.
   VIII. What could or should have been done differently.
b. The DON (or designee) will record all percutaneous injuries from contaminated sharps in a Sharps Injury Log. Reference OSHA Needlestick/Sharps Injuries form (OSHA 300 Log).
c. The Medical Director and the DON will determine if changes need to be made to this ECP and update it accordingly.
   I. Changes may include an evaluation of safer devices and adding job roles to the exposure determination list.

G. EMPLOYEE TRAINING

1. Employees with job duties identified as *at risk* for per the Standard (29 CFR 1910.1030) in this ECP, are required to review this ECP and complete a CCPH Nursing Division approved OSHA BBP training during their initial orientation and/or change in job duties, and prior to anticipated potential exposure. The employee must complete annual refresher training as long as that employee continues to perform job duties that put them *at risk* (per list above). The specific BBP training made available to staff will be selected and approved by the DON (or designee). Employees can ask questions to the DON (or designee) who is arranging the BBP training. The training will be provided at an educational level and in a language that the staff member understands.
2. All employees can review this ECP digitally at any time during their work shifts by accessing the Policies and Procedures on the CCPH website. If the employees are unable to access it through the website, they may contact the DON (or designee). If requested, the DON (or designee) will provide an employee with a copy of the ECP free of charge and within 5 days of the request.
3. All employees who have occupational exposure to BBPs should receive training that covers all elements of the Standard including, but not limited to:
   a. Epidemiology, symptoms, and transmission of BBPs and diseases.
   b. Methods used to control occupational exposure.
   c. Hepatitis B vaccine
   d. Medical evaluation and post-exposure follow-up procedures.
   e. A copy and explanation of the Standard
   f. An explanation of this ECP and how to obtain a copy
4. BBP trainings may be web based or in person as long as they cover all elements required by the Standard. All BBP trainings that were not coordinated by the DON (or designee) that are completed by employees or contracted staff, must be reviewed by the DON to determine if they meet the requirements. Employees or contracted staff who complete outside training must still review this ECP prior to being assigned to work that puts them at known potential risk.
   a. At this time, CCPH is using a Learning Management platform to conduct this training.

b. Training is done on an annual basis, typically in June with a completion deadline to be determined annually by the DON, or sooner if determined by the staff members supervisor/division leader.
   I. Annually in April or May, the DON (or designee), currently the Nursing Supervisor, will request names of staff members needing the training from the Division leaders. If the Division leader is unsure if the employee needs BBP training, they should consult the list in this ECP and/or ask the DON
   c. Trainings will be purchased using division specific general funds based on the number of staff each division wants to complete the training.
d. After obtaining input from the Division leaders, the DON (or designee), currently the Nursing Supervisor, will submit a master list of those needing training to the Fiscal Manager so a purchase order can be created and purchased by the Fiscal Manager on the training administration website.
e. The master list will also be submitted to the Workforce Development Specialist, or whoever is currently managing the Learning Management System (LMS), so that the training course can be disseminated to the appropriate staff needing the training.
f. Details of the training will be built into a LMS course and will consist of the following components:
   i. Details for how to access the BBP training on the third-party website.
   ii. The most up-to-date ECP
   iii. ECP Comprehension questions
   iv. Link to a survey about obtaining staff input on safety concerns.
g. The DON (or designee), will track the number of trainings purchased, which staff have completed them, and survey results.
h. The Workforce Development Coordinator will monitor the completion of the training in the LMS and report employee attestation and knowledge comprehension assessment results to the DON (or designee).
i. All updates will be reported to the DON.
j. If Division leaders have questions about the BBP training (including staff training completion logs) or the need to add additional trainings, they should reach out to the DON (or designee), currently the Nursing Supervisor.

H. RECORD KEEPING

1. TRAINING RECORDS

a. Employee BBP training records are to be maintained by DON (or designee) and kept per the CCPH Records Retention Policy. Training records may consist of a log and/or a copy of the individual training certificates. If an employee or contracted staff completes a training different than the one coordinated by the DON (or designee), the employee or contracted staff must provide a copy of the training certificate to the DON (or designee) and records will be kept on file at CCPH for at least three years and per the CCPH record retention policy.
b. Employees are encouraged to keep a copy of their training certificate on file.
   i. Employee training records may be provided to the employee or the employee's authorized representative upon request. These requests should be directed to the DON and will be fulfilled within 15 days upon receipt of the request.
c. BBP training records will include:
   i. The dates BBP training was completed.
   ii. The names and job titles of all persons attending the training sessions.

iii. If the training is conducted by CCPH staff, a copy of the training itself and all training evaluations will be retained per CCPH records retention policy.
iv. Copies of training certificates are required to be provided to the DON by staff who complete outside trainings.

d. ECP review attestation records will include:
   i. The first and last name of the employee and the date they attested to reviewing the ECP.
   ii. CCPH is currently utilizing the LMS platform for policy review. A record of the employees' attestation for reviewing the ECP will be collected by the Workforce Development Specialist (or designee) and will be reported annually to the DON (or designee) every November.

e. ECP comprehension assessment records will include:
   i. Employee's may be subject to passing a comprehension assessment (i.e., quiz) to determine their understanding of this ECP. Comprehension assessment questions and passing score values will be determined by the DON (or designee). The record will include the first and last name of the staff member, the date completed, and score of the assessment.
   ii. CCPH is currently utilizing the LMS platform for policy comprehension assessments. A record of the employees' comprehension assessment will be collected by the Workforce Development Specialist (or designee) and will be reported annually to the DON (or designee) every November.

2. MEDICAL RECORDS

a. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.1020, "Access to Employee Exposure and Medical Records."
b. The Fiscal Manager (or designee) is responsible for maintenance of the required medical records in staff's employee file. These confidential records are kept in the Fiscal Office for at least the duration of employment plus 30 years. Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to the DON.

3. INCIDENT REPORTS

a. Exposure related Employee Injury Reports should be submitted to the DON for review and follow up. These reports will be filed per CCPH policy. The division leader or direct supervisor or the staff member involved in incident may request a copy of the report.

4. OSHA RECORD KEEPING

a. An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping Requirements (29 CFR 1904). This determination and the recording activities are done by the DON.
b. All waste documents (i.e., waste manifests) required under Ohio EPA rules and regulations are maintained by the laboratory.

5. SHARPS INJURY LOG

a. In addition to the 1904 Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in a Sharps Injury Log (Attachment A). All incidences must include at least:
   I. Date of the injury

II. Type and brand of the device involved (syringe, suture needle)
III. Division and work area where the incident occurred.
IV. Explanation of how the incident occurred.

b. This log is reviewed as part of the annual program evaluation for trends and is maintained for at least five years following the end of the calendar year covered. The log is maintained in the DON's office in a manner that protects employee confidentiality. If a copy is requested by anyone, it must have any personal identifiers removed from the report. Reference OSHA Needlestick/Sharps Injuries form (OSHA 300 Log).

F. CITATIONS & REFERENCES

Occupational Safety and Health Administration, Occupational Safety and Health Standards: Bloodborne pathogens.

OSHA Fact Sheet, OSHA's Bloodborne Pathogens Standard

The National Institute of Occupational Safety and Health (NIOSH)

Hierarchy of Controls

Healthy Habits: Coughing and Sneezing

G. CONTRIBUTORS

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H. APPENDICIES & ATTACHMENTS

200-025-01-A Sharps Injury Log

I. REFERENCE FORMS

200-025-01-F Employee Hepatitis B Vaccine Acknowledgment Form

J. REVISION & REVIEW HISTORY

Revision Date	Review Date	Author	Notes
11/15/2022	11/15/2022	Sarah Thomas	Multiple areas corrected. Track changes saved.
7/6/2026	7/6/2026	Sarah Thomas	Overhaul of policy
8/12/2026	8/12/2026	Sarah Thomas	WIC Assistant added back to exposure determination list.

K. APPROVAL

This document has been approved in accordance with the "800-001-P Policy Development" procedure as of the effective date listed above.