Infectious Diseases
Quick Reference Guide

for
Designated Officers
Durham Region
2016
DURHAM REGION HEALTH DEPARTMENT

During Regular Health Department Office Hours
(8:30 a.m. - 4:30 p.m. Monday to Friday)
contact:

905 668-4113 ext. 2996
Or
1-800-841-2729 ext. 2996

After Hours and Weekends/Holidays contact:
905 576-9991

Ask the answering service to page the Durham Region Nurse on Standby

Calls will be returned within one hour and follow-up will proceed as appropriate.

For non-urgent questions/information please email
Designated.Officer@durham.ca
or visit durham.ca/designatedofficers
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Introduction

The Notification of Emergency Service Workers Protocol was established in 1994 by the Ontario Ministry of Health and Long Term Care. The purpose of the protocol was to ensure emergency service workers are able to obtain appropriate advice following a possible exposure to specified infectious diseases. The Exposure of Emergency Service Workers to Infectious Diseases Protocol, 2008 replaces the previous version of this document.

The Exposure of Emergency Service Workers to Infectious Diseases Protocol, 2008 requires boards of health to communicate with emergency services (i.e. police, firefighters, ambulance) in their jurisdiction and request the identification of designated officers (DO). DOs facilitate the exposure notification process. The purpose of this protocol is to ensure:
- Emergency service workers (ESWs) are notified by public health in the event that s/he may have been exposed to an infectious disease of public health importance, so that appropriate action can be taken.
- DOs are able to obtain advice from public health regarding possible exposure(s) of ESWs to infectious diseases of public health importance.


Ontario Public Health Standards 2008:

According to the Ontario Public Health Standards 2008, the board of health ensures that the medical officer of health or designate (usually public health staff) is available on a 24/7 basis to receive reports of and respond to infectious diseases of public health importance in accordance with the Health Protection and Promotion Act; the Mandatory Blood Testing Act; the Exposure of Emergency Service Workers to Infectious Diseases Protocol, 2008 (or as current); the Infectious Diseases Protocol, 2008 (or as current); the Institutional/Facility Outbreak Prevention and Control Protocol, 2008 (or as current); and the Public Health Emergency Preparedness Protocol, 2008 (or as current).

Confidentiality

Durham Region Health Department (DRHD) adheres to privacy and information security legislative requirements and best practices.

When follow up of a potential exposure is required all Designated Officers and DRHD staff have/will:

- A duty to maintain confidentiality
- Limit the use and disclosure of confidential information
- Share only as much information as required to complete the follow up investigation

Any disclosed confidential information related to an investigation or the provision of services provided by the Health Department should be treated in a confidential manner at all times.
## REPORTABLE DISEASE LIST

The following diseases are reportable to the local Medical Officer of Health (Ontario Reg 559/91 under the Health Protection and Promotion Act) **Bolded** diseases must be reported **immediately**. All other diseases may be reported on the next work day.

<table>
<thead>
<tr>
<th>Reportable Disease</th>
<th>Reportable Disease</th>
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<tbody>
<tr>
<td><strong>Report diseases listed below to:</strong></td>
<td><strong>Report diseases listed below to:</strong></td>
</tr>
<tr>
<td>PHNN Division Regional Head Office</td>
<td>Environmental Health Division</td>
</tr>
<tr>
<td>605 Rossland Road East, 2nd Floor</td>
<td>101 Consumers Drive, 2nd Floor,</td>
</tr>
<tr>
<td>P.O. Box 730, Whitby, ON L1N 0B2</td>
<td>Whitby, ON L1N 1C4</td>
</tr>
<tr>
<td>Phone: 905-668-7711 ext. 2996 or 1-800-841-2729</td>
<td>Phone: 905-723-3818 or 1-888-777-9613</td>
</tr>
<tr>
<td>Fax: 905-666-6215</td>
<td>Fax: 905-666-1833</td>
</tr>
<tr>
<td>After Hours: 905-576-9991 or 1-800-372-1104</td>
<td>After Hours: 905-576-9991 or 1-800-372-1104</td>
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<tr>
<td>Acquired Immunodeficiency Syndrome (AIDS)</td>
<td>Amebiasis</td>
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<tr>
<td>Acute Flaccid Paralysis (AFP)</td>
<td>Anthrax</td>
</tr>
<tr>
<td>Chancroid</td>
<td>Botulism</td>
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<tr>
<td>Chickenpox (Varicella)</td>
<td>Brucellosis</td>
</tr>
<tr>
<td>Chlamydia trachomatis infections</td>
<td>Campylobacter enteritis</td>
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<tr>
<td><strong>Diphtheria</strong></td>
<td>Choler</td>
</tr>
<tr>
<td><strong>Encephalitis, including:</strong></td>
<td>Clostridium difficile associated disease (CDAD)</td>
</tr>
<tr>
<td>1. Primary, viral</td>
<td>outbreaks in public hospitals</td>
</tr>
<tr>
<td>2. Post-infectious</td>
<td>Cryptosporidiosis</td>
</tr>
<tr>
<td>3. Vaccine-related</td>
<td>Cyclosporiasis</td>
</tr>
<tr>
<td>4. Subacute sclerosing panencephalitis</td>
<td>Food poisoning, all causes</td>
</tr>
<tr>
<td>5. Unspecified</td>
<td>Gastroenteritis, institutional outbreaks</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Giardiasis, except asymptomatic cases</td>
</tr>
<tr>
<td><strong>Group A Streptococcal disease, invasive</strong></td>
<td>Hantavirus pulmonary syndrome</td>
</tr>
<tr>
<td><strong>Group B Streptococcal disease, neonatal</strong></td>
<td>Hemorrhagic fevers, including:</td>
</tr>
<tr>
<td>Haemophilus influenzae b disease, invasive</td>
<td>1. Ebola virus disease</td>
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<tr>
<td>Hepatitis, viral</td>
<td>2. Marburg virus disease</td>
</tr>
<tr>
<td>1. Hepatitis B</td>
<td>3. Other viral causes</td>
</tr>
<tr>
<td>2. Hepatitis C</td>
<td><strong>Hepatitis A</strong></td>
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<tr>
<td><strong>Measles</strong></td>
<td>Influenza</td>
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<tr>
<td><strong>Meningitis, acute</strong></td>
<td>Lassa Fever</td>
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<tr>
<td>1. bacterial</td>
<td>Legionellosis</td>
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<tr>
<td>2. viral</td>
<td>Leprosy</td>
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<tr>
<td>3. other</td>
<td>Listeriosis</td>
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<tr>
<td><strong>Meningococcal disease, invasive</strong></td>
<td>Lyme Disease</td>
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<tr>
<td>Mumps</td>
<td>Malaria</td>
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<tr>
<td>Ophthalmia neonatorum</td>
<td>Paratyphoid Fever</td>
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<tr>
<td>Pertussis (Whooping Cough)</td>
<td>Paralytic Shellfish Poisoning (PSP)</td>
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<tr>
<td>Pneumococcal disease, invasive</td>
<td>Plague</td>
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<tr>
<td><strong>Poliomyelitis, acute</strong></td>
<td>Psittacosis/Omnithosis</td>
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<tr>
<td>Rubella</td>
<td>Q Fever</td>
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<td>Rubella, congenital syndrome</td>
<td>Rabies</td>
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<td><strong>Severe Acute Respiratory Syndrome (SARS)</strong></td>
<td>Respiratory infection outbreaks in institutions</td>
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<tr>
<td>Smallpox</td>
<td>Salmonellosis</td>
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<tr>
<td>Syphilis</td>
<td>Shigellosis</td>
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<tr>
<td>Tetanus</td>
<td>Transmissible Spongiform Encephalopathy</td>
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<tr>
<td>Tuberculosis</td>
<td>including:</td>
</tr>
<tr>
<td><strong>Yellow Fever</strong></td>
<td>1. Creutzfeldt-Jakob Disease, all types</td>
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<tr>
<td></td>
<td>Trichinosis</td>
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<td></td>
<td><strong>Tularemia</strong></td>
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<td></td>
<td>Typhoid Fever</td>
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<tr>
<td></td>
<td><strong>Verotoxin-producing E. coli infection indicator conditions, including Haemolytic Uraemic Syndrome (HUS)</strong></td>
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<tr>
<td></td>
<td>West Nile Virus Illness</td>
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<td></td>
<td>Yersiniosis</td>
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Notification

The medical officer of health or designate (public health staff) is available on a 24/7 basis to receive and respond to reports of infectious diseases of public health importance to ensure:

- Reports of a possible exposure of an ESW are received, assessed, and responded to as soon as possible but no later than 48 hours (depending on situation and disease, response may be required sooner) after receiving notification.
- Reports of all infectious diseases of public health importance are received and assessed with particular consideration given to potential exposures of ESW’s.
- If the ESW is confirmed as a contact, DRHD staff will obtain demographic information and will contact the ESW directly providing health education and recommended actions including chemoprophylaxis (preventative treatment) if applicable.

Notification Initiated by the Durham Region Health Department (DRHD) staff

In the course of routine case management for infectious diseases, DRHD staff may receive a report of an infectious disease where there is a concern that ESWs may have been exposed during his/her work. The notification of possible exposure may be received from several different sources, e.g. physicians, laboratories, infection control practitioners or other health units.

DRHD will notify the DO of the appropriate Emergency Service Agency(s) of the possible exposure. DRHD staff will provide the DO with enough information to assist in identifying the ESWs that attended to the patient such as time, date of exposure and address. The type of infectious disease exposure will be disclosed.

Any disclosed confidential information related to an investigation or the provision of services provided by the Health Department should be treated in a confidential manner at all times.
• Documentation of the exposure is the responsibility of the DO, and should be done on agency specific forms
• The DO will assess the exposure based on the information provided by the ESW
• The DO will refer to the Infectious Diseases Quick Reference Guide For Designated Officers for information on assessment of exposure
• The DO will determine whether the ESW could have been exposed to a specified infectious disease
• DO to notify DRHD of ESWs who are identified as confirmed contacts
• Additionally DRHD may include assessing the possible risk of occupational exposure and setting standards of practice, discussing appropriate use of personal protective equipment and providing education to prevent possible future exposures
Notification Initiated by a Designated Officer

When a designated officer reports an incident of a possible exposure to an infectious disease of public health importance the DRHD staff will:

- Review and assess the information provided
- Contact health care facilities and other persons (e.g., infection control practitioners and /or attending physicians) to obtain additional information on the specific case
- Inform the DO as soon as possible and no later than 48 hours after receiving notification (depending on the disease) of recommended actions
- The DO will assess the exposure based on the information provided by the ESW
- The DO will refer to the Infectious Diseases Quick Reference Guide For Designated Officers for information on assessment of exposure
- The DO will determine whether the ESW could have been exposed to a specified infectious disease
- DO to notify DRHD of ESWs who are identified as confirmed contacts

Notification Initiated By Emergency Service Worker

If an ESW is concerned about a possible or known exposure to an infectious disease of public health importance during his/her work:

- The ESW should notify a DO immediately and complete the appropriate forms (agency specific forms)
- The DO will assess the exposure based on the information provided by the ESW
- The DO will refer to the Infectious Diseases Quick Reference Guide For Designated Officers for information on assessment of exposure
- The DO will determine whether the ESW could have been exposed to a specified infectious disease
- DO to notify DRHD of ESWs who are identified as confirmed contacts
Notification Initiated by Emergency Service Worker (ESW) (eg. Bloodborne exposure)

YES

NO

DO assesses if ESW could have been exposed to infectious disease

DO directs ESW to hospital ER for assessment by on call Infectious Disease specialist Consult with ID Nurse if required

If physician determines exposure occurred ESW should:
- Complete baseline testing for Hep B, Hep C, HIV
- Be assessed for post exposure prophylaxis (PEP) and/or immunization
- Discuss Mandatory Blood Testing Act as applicable
- Continue to be followed by Infectious Disease Specialist (Positive Care Clinic)
- Consult with ID nurse if required

FESW seeks medical attention as required Notifies DO and completes agency specific forms

No further follow up
Roles and Responsibilities

**Emergency Service Agency will:**
- Appoint Designated Officer(s)
- Assess the risks of occupational exposure
- Set standard of practice, provide training, and appropriate personal protective equipment (PPE)
- Document exposure and complete Workplace Safety and Insurance Board forms as required
- Advise DRHD staff of any new appointments of DO(s)

**Emergency Service Worker(s) will:**
- Be aware of the risks of exposure to the specified infectious diseases and understand how to prevent or minimize the risk of exposure
- Prevent exposures by using routine practice and appropriate procedures and/or personal protective equipment
- Comply with workplace health and safety policies
- Report any possible exposure immediately to the DO

**Designated Officers(s) will:**
- Receive and document reports of exposure from ESW
- Assess the situation and determine if an exposure could have occurred
- Contact DRHD if assistance is required
- If ESWs are confirmed contacts, provide details of the incident including the ESWs demographic information to DRHD

**Durham Region Health Department will:**
- Be available to the DOs in Durham Region for consultation
- Review information on any reported incidents provided by a DO
- Assist the DO in assessing whether exposure may have occurred
- Provide education and counselling to the DO/ESW including testing and chemoprophylaxis if required
- Monitor reportable infectious diseases and notify contacts including notifying DOs and contacting ESWs if they are confirmed contacts
The transmission of microorganisms and subsequent infection may be likened to a “chain”, with each link in the chain representing a factor related to the spread.

**Transmission occurs** when the **agent** in the reservoir, exits the **reservoir** through a **portal of exit**, travels via a **mode of transmission** and gains entry through a **portal of entry** to a susceptible host. Transmission does not take place unless all six of the elements in the chain of transmission are present. By eliminating any of the six links, or “breaking the chain”, transmission does not occur.
Transmission may be interrupted when:

- the **agent** is eliminated or inactivated or cannot exit the **reservoir**;
- **portals of exit** are eliminated through safe practices;
- **transmission** between objects or people does not occur due to barriers and/or safe practices;
- **portals of entry** are protected; and/or
- **hosts** are not susceptible.
Routine Practices

Routine Practices are based on the premise that all clients/patients/residents (C/P/R) are potentially infectious, even when asymptomatic, and that the same safe standards of practice should be used routinely with all C/P/R to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms.

The risk of transmission of microorganisms involves factors related to the microbe, the source C/P/R, the health care environment and the new host.

Emergency Service Workers must assess the risk of exposure to blood, body fluids, secretions/excretions and non-intact skin and identify the strategies that will decrease exposure risk and prevent the transmission of microorganisms. This risk assessment followed by the implementation of Routine Practices to reduce or remove risk should be incorporated into the daily practice of each ESW.

<table>
<thead>
<tr>
<th>ELEMENTS OF ROUTINE PRACTICES</th>
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<tbody>
<tr>
<td><strong>Risk Assessment</strong></td>
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<tr>
<td>Hand Hygiene + Barrier Equipment + Environmental Controls + Administrative Controls</td>
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</table>

**Risk Assessment**
Is the first step of Routine Practices conducted before each C/P/R interaction, and determines which interventions are required to prevent transmission of an infectious agent.

Assess the **risk of exposure** to blood, body fluids, secretions/excretions, non-intact skin, mucous membranes, body tissues, and contaminated equipment/environment.

If there is a risk of exposure, **identify the appropriate strategies:**
- **Hand Hygiene**
- **Barrier Equipment (PPE)**
- **Environmental Controls** (Cleaning and Disinfection, Linen, Waste & Sharps management)
- **Administrative Controls** (Divisional Policies and Procedures)
Hand Hygiene

Hand hygiene is considered the most important and effective infection prevention and control measure to prevent the spread of health care-associated infections.

Hand hygiene is performed using alcohol-based hand rub or soap and water:
- Before and after each C/P/R contact
- Before performing invasive procedures
- Before preparing, handling, serving or eating food
- After care involving body fluids and before moving to another activity
- Before putting on and after taking off gloves and PPE
- After personal body functions (e.g., blowing one’s nose)
- Whenever hands come into contact with secretions, excretions, blood and body fluids
- After contact with items in the C/P/R’s environment

When hands are visibly dirty and there is no access to a handwashing sink:
- Use a wet wipe to remove visible dirt
- Allow hands to dry
- Use an alcohol-based hand rub

Barrier Equipment or Personal Protective Equipment (PPE)

PPE is used based on risk assessment:

Mask and Eye Protection or Face Shield [based on risk assessment]
- Protect eyes, nose and mouth during procedures and care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions
- Wear within two metres of a coughing C/P/R

Gown [based on risk assessment]
- Wear a long-sleeved gown if contamination of skin or clothing is anticipated

Gloves [based on risk assessment]
- Wear gloves when there is a risk of hand contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or contaminated surfaces or objects
- Wearing gloves is NOT a substitute for hand hygiene
- Remove immediately after use and perform hand hygiene after removing gloves
Routine Practices Risk Assessment Algorithm for Client Interactions

START

Assess the anticipated interaction with the client and/or their environment

Will I be exposing myself to a splash or spray of blood, excretions or secretions?

Will I have contact with the client’s environment?

Will my hands be exposed to blood, excretions, secretions or contaminated items?

Will my face be exposed to a splash, spray, cough or sneeze?

Will my clothing or skin be exposed to splashes/sprays or items contaminated with blood, excretions, secretions?

Follow specific additional precautions as required

Does the client have a known infection or symptoms of an infection?

No further action required

Wear gloves

Perform hand hygiene

YES

YES

NO

NO

NO

YES

YES
Recommended Steps for Putting On and Taking Off Personal Protective Equipment (PPE)

**Putting On PPE**

1. Perform hand hygiene

2. **Put on gown**
   - Tie neck and waist ties securely

3. **Put on Mask/N95 Respirator**
   - Place mask over nose and under chin
   - Secure ties, loops or straps
   - Mould metal piece to your nose bridge
   - For respirators, perform a seal-check

4. **Put on Protective Eyewear**
   - Put on eye protection and adjust to fit
   - Face shield should fit over brow

5. **Put on gloves**
   - Put on gloves, taking care not to tear or puncture glove
   - If a gown is worn, the glove fits over the gown’s cuff

**Taking Off PPE**

1. **Remove gloves**
   - Remove gloves using a glove-to-glove/skin-to-skin technique
   - Grasp outside edge near the wrist and peel away, rolling the glove inside-out
   - Reach under the second glove and peel away
   - Discard immediately into waste receptacle

2. **Remove Gown**
   - Remove gown in a manner that prevents contamination of clothing or skin
   - Starting at the neck ties, the outer “contaminated”, side of the gown is pulled forward and turned inward, rolled off the arms into a bundle, then discarded immediately in a manner that minimizes air disturbance

3. **Perform Hand Hygiene**
4. Remove Eye Protection

- Arms of goggles and headband of face shields are considered to be “clean” and may be touched with the hands
- The front of goggles/face shield is considered to be contaminated
- Remove eye protection by handling ear loops, sides or back only
- Discard into waste receptacle or into appropriate container to be sent for reprocessing
- Personally-owned eyewear may be cleaned by the individual after use

5. Remove Mask/N95 Respirator

- Ties/ear loops/straps are considered “clean” and may be touched with hands
- The front of the mask/respirator is considered to be contaminated
- Untie bottom tie then top tie, or grasp straps or ear loops
- Pull forward off the head, bending forward to allow mask/respirator to fall away from the face
- Discard immediately into waste receptacle

6. Perform Hand Hygiene

**Environmental Controls**

Environmental controls should be put in place to prevent exposure and transmission to others and includes:

- Cleaning of equipment that is being used by more than one C/P/R
- Cleaning of the health care environment, including safe handling of linen and waste
- Sharps containers and hand hygiene products available for use at point of care

Refer to Best Practices Routine Practices and Additional Precautions in all healthcare settings (PIDAC, 2012)
Cleaning and Disinfection

Refer to Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, PIDAC (May 2013)  

It is important that policies and procedures are in place to clean and disinfect equipment. Manufacture’s instructions for product use, concentration of product and exposure time must be followed.

Cleaning

Physical action of cleaning is more important than the cleaning product used. Cleaning must always be performed from the clean area to the dirty area. Cleaning must always be done before disinfection.

The key to cleaning is the use of friction to remove microorganisms and debris.

- Cleaning removes foreign material (e.g., dust, soil, organic material such as blood, secretions, excretions and microorganisms) from a surface or object.
- Cleaning physically removes rather than kills microorganisms, reducing the organism load on a surface. It is accomplished with water, detergents and mechanical action.
- Thorough cleaning is required for any equipment/device to be disinfected, as organic material may inactivate a disinfectant. This may be accomplished through a two-step process involving a cleaner followed by a disinfectant, but is more commonly accomplished in the health care setting through a one-step process using a combined cleaner/disinfectant product.
Disinfection

Level of disinfection required for reusable equipment is determined by the degree of contact it will have with a patient and where this contact is likely to occur. Follow manufacturer’s recommendations when using disinfection products to ensure best results.

- Disinfection is a process used on inanimate objects and surfaces to kill microorganisms. Disinfection will kill most disease-causing microorganisms but may not kill all bacterial spores. Only sterilization will kill all forms of microbial life.

Refer to Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, (PIDAC, May 2012)

Contact time is required for proper disinfection to occur (refer to manufacturer instructions).

Low level disinfection: kill most vegetative bacteria, and some fungi, as well as enveloped (lipid) viruses (e.g. hep B, C, HIV, Hantavirus); does not kill mycobacterium or bacterial spores

High level disinfection: destroy vegetative bacteria, mycobacterium (TB), fungi and enveloped (lipid) virus such as HIV, herpes, HCV, HBV and non-enveloped (non-lipid) viruses such as enterovirus, but not necessarily bacterial spores

Administrative Controls

Administrative controls should include:
- Policies and procedures in place to assist with the management of transmission risks to infectious disease
- Staff education on infectious diseases transmission and prevention of transmission
- Healthy workplace policies
- Respiratory etiquette, cough or sneeze into your sleeve or tissue
- Accessible PPE
**Cleaning a Blood or Body Fluid Spill**

**Preventing the spread of infections**

1. **Restrict area and assemble supplies**

   Gather supplies needed. Your spill kit should include: adequate supplies of disposable gloves, paper towels, cleaning and disinfecting products, 70-90% alcohol-based hand sanitizer, garbage bags, and other personal protective equipment (PPE) such as a mask, eye goggles, gown, etc.

2. **Put on gloves and other personal protective equipment (PPE)**

   Use hand sanitizer and put on disposable gloves and other PPE if there is a possibility of splashing.

3. **Clean the surfaces**

   Wipe up the spill using disposable towels to remove all visible soil, checking the surrounding area for splatters or splashes. Thoroughly scrub soiled surfaces with cleaning solution and warm water. Rinse surfaces with clean water to remove cleaning solution. Discard all waste in a plastic-lined receptacle.

4. **Disinfect the surfaces**

   Use a Health Canada approved disinfectant which has a drug identification number (DIN) and manufacturer’s instructions on the labelling. Follow these instructions to disinfect the entire soiled area and allow it to stand for the required contact time. Most disinfectant solutions must remain wet on the surface for at least a 10 minute contact time to be effective.

5. **Remove PPE**

   Remove and discard gloves, then use hand sanitizer. Remove and discard all other PPE, then use hand sanitizer again.

6. **Remove waste and perform hand hygiene**

   Double-bag, seal and remove waste from the area and perform hand hygiene. Hands must be washed with soap and running water if visibly soiled or 70-90% alcohol-based hand sanitizer may be used only if hands are not visibly soiled.

---

Environmental Help Line
905-723-3818 or 1-888-777-9613
durham.ca

If you require this information in an accessible format, contact 1-888-777-9613.
Diseases Spread by Bloodborne Route

For DRHD FACTS About... specific diseases go to durham.ca/factsabout

**Hepatitis B**
Hepatitis B is spread through blood, blood products, saliva, semen and vaginal secretions, or any other fluid containing blood. Hepatitis B vaccination is the most effective measure to prevent hepatitis B virus infection.

Refer to FACTS About... Hepatitis B

**Hepatitis C**
Hepatitis C virus is transmitted through exposure to infected blood. Hepatitis C is a virus which is carried in the blood and attacks the liver. Hepatitis C is known as a “silent killer” as most people infected have no symptoms until the damage has already been done to their liver.

Refer to FACTS About... Hepatitis C

**Human Immunodeficiency Virus (HIV)**
HIV is usually spread by sexual contact with an infected partner. The virus can enter the bloodstream through open lesions on the vagina, vulva, penis, rectum, or mouth. HIV is also spread by sharing contaminated needles and syringes and through the use of non-sterile instruments that enter the body (e.g., tattooing or skin piercing equipment). A woman infected with HIV can pass the virus on to her baby during pregnancy, during birth, and through breast-feeding. Certain behaviours can carry an increased risk of becoming infected.

Refer to FACTS About... HIV/AIDS

**An exposure to Hepatitis B, Hepatitis C and HIV viruses can occur as a result of:**
- A needle stick injury, with a used needle
- An injury with a sharp object that has been in contact with body fluids
- When damaged skin (rash, or open wound) comes in contact with body fluid
- Splashing of blood or body fluids into the mouth or eye
- Splashing of mouth, eye, or open wound with another body fluid (i.e. vomit) that has blood in it
- A bite that breaks the skin
An exposure to these viruses does NOT occur as a result of:

- A needle stick, where the needle has not been used
- Blood or body fluids coming in contact with hands covered by intact gloves
- Blood or body fluids coming in contact with protective clothing, where no fluid comes in contact with the non-intact skin, or if it does soak through the skin beneath is intact
- Splashing of blood or body fluids into the face where a mask and goggles are worn

Assessing the exposure:

- Did the blood or body fluid enter the ESW’s body through a break in the skin, needle stick, cut from a sharp object, or bite that breaks the skin or through mucosal lining (i.e. eyes, nose, mouth) or non-intact skin (i.e. chapped or scraped)?
- Has the ESW been immunized for Hepatitis B? (Antibody levels can be measured to ensure immunity)

Actions:

1. Provide immediate care to the exposure site
   - Allow injury to bleed freely, then cover lightly, do not promote bleeding
   - Remove clothing that is contaminated with body fluids
   - Thoroughly flush exposed area with water or saline
   - Clean area with soap and water and dry

2. ESW notifies the Designated Officer (DO) to provide information on the exposure.

3. If there has been an exposure to blood or body fluids, the ESW should go immediately to one of the hospital emergency departments for medical assessment by a physician.

4. For assistance or more information contact the DRHD staff.
5. If the emergency room physician examines the ESW and determines that an exposure has occurred, the ESW should ensure they have baseline testing for Hepatitis B, Hepatitis C and HIV. If blood tests are negative, they should be repeated at 3 months and 6 months after the exposure.

6. The physician who assesses the ESW will determine the need for post exposure prophylaxis (PEP) treatment or vaccination to prevent infection from occurring. It is recommended that the ESW be referred to an infectious disease physician for further follow up and counselling.

7. The ESW will be counselled to take the following precautions to protect others until he/she is certain that they have not been infected (this may take several months).

- **Practice safe sex by using a condom** with lubricant at all times during intercourse or abstain from sexual intercourse
- **Do not donate** blood, plasma, organs, tissue or sperm
- **Do not share** toothbrushes, razors, needles or other implements which may be contaminated with blood or body fluids
- **Avoid pregnancy.** If the ESW is pregnant a referral to an infectious disease specialist is recommended.
- If breastfeeding, it is recommended the ESW be referred to an infectious disease specialist. Breast milk can be pumped and discarded until blood results become available.

**Post exposure prophylaxis may be offered, after assessment by a physician, at hospital emergency departments.**
Diseases Spread by Airborne Route

For DRHD Facts About ... specific diseases go to durham.ca/factsabout

Small bacteria and viruses (for example: tuberculosis, measles and chickenpox) can be spread through the air. These micro-organisms are so small that they can float in the air and can be spread through coughing, sneezing, laughing, talking and singing.

Active Tuberculosis (TB)
TB is spread when people, who have TB disease (active pulmonary TB) in their lungs or throat, cough, sneeze or speak, and send the bacteria into the air. Close and prolonged contact with someone who has TB disease can cause others to become infected with the bacteria.

Refer to FACTS About...Tuberculosis, Tuberculosis – Latent Tuberculosis Infection

An exposure to TB could occur when:
- ESW is confined in an enclosed area (e.g. ambulance, car) over a long period of time with an individual who is coughing vigorously, and neither is wearing a mask that covers mouth and nose
- Giving mouth-to-mouth resuscitation without barrier protection

An exposure to TB is unlikely to occur when:
- ESW is confined in an enclosed area with a coughing individual, when either or both are wearing a mask that covers mouth and nose (for near 100% protection)
- Mouth-to-mouth resuscitation is performed using a barrier protection or bag valve mask

Assessing exposure:
- Was the DO notified of ESW contact with an active pulmonary tuberculosis case by DRHD?
- Was the ESW exposed to a client with active pulmonary tuberculosis?
- How often, and for how long was the ESW in contact with the individual?
- How close was the ESW to the individual?
- Did the ESW perform any procedures that put him/her in face-to-face contact with the individual?
- Was the ESW in a confined space with the patient and for how long?
- Did the ESW wear appropriate PPE?
**Actions:**
1. DRHD staff will contact DO if ESW has been identified in the care of an active pulmonary TB patient which may have placed the ESW at risk of exposure.

2. DO to conduct initial assessment confirming exposure.

3. If ESW is assessed as a confirmed contact, the DO will notify DRHD staff providing demographic information.

4. DRHD staff will contact the ESW and provide education and recommendations for health care provider assessment, testing and skin testing if required.

5. If required and recommended by the DRHD nurse, testing for TB may include 2 skin tests: one after exposure and repeated at least 8 weeks after exposure. The test must be read 48–72 hours later by a doctor or nurse. If the skin test is positive, a chest x-ray is performed to assess for active TB disease. If the ESW has a positive skin test, antibiotics may be recommended.

6. If the ESW has had a previous positive skin test, a TB skin test will not be repeated. A chest x-ray and referral to a health care provider is recommended.

Refer to FACTS About...Tuberculosis, FACTS About...Latent Tuberculosis Infection, FACTS About...Positive Skin Test at durham.ca

**Measles**
Transmission of measles is spread by airborne droplet nuclei, close personal contact or direct contact with the respiratory secretions of a case. Articles of clothing or bedding freshly soiled with infectious discharge occasionally transmit the disease. Measles virus can remain active and contagious in the air or on infected surfaces for up to two hours.

Refer to FACTS About...Measles

**An exposure to Measles could occur if:**
- The ESW shared the same airspace with a confirmed case of measles
An exposure to Measles is unlikely to occur when:

- ESW shared the same airspace with an individual with confirmed measles and appropriate PPE was worn
- ESW’s immunization is up to date
- Resuscitation is performed using a barrier protection or bag valve mask

Assessing exposure:

- Was the DO notified of ESW contact with measles by Durham Region Health Department?
- Was the ESW exposed to a client with measles?
- How often, and for how long was the ESW in contact with the individual?
- How close was the ESW to the individual?
- Did the ESW wear appropriate PPE?
- Is the ESW immunized against measles?

Actions:

1. DRHD staff will contact DO if ESW have been identified in the care of a patient diagnosed with measles (a laboratory confirmed report is required) which may have placed the ESW at risk of exposure.

2. DO to conduct initial assessment confirming exposure.

3. If ESW is assessed as a confirmed contact, the DO will notify DRHD staff providing demographic information.

4. DRHD staff will contact the ESW and will provide education and recommendations for immunization if required.
Diseases Spread Through Direct Contact or Droplets

For DRHD Facts About ... specific diseases go to durham.ca/factsabout

**Meningococcal Disease (meningitis/meningococcemia)**

Transmission is from direct contact with the nose and throat secretions of an infected person, and often with an asymptomatic carrier or by respiratory droplets. Close and prolonged contact, such as kissing, sneezing, and sharing eating and drinking utensils facilitates the spread of disease.

Refer to FACTS About...Meningitis

**Invasive Group A Streptococcus (GAS)**

Transmission is generally person to person most commonly by:
- Droplet spread when an infected individual coughs or sneezes
- Direct or indirect contact of the oral or nasal mucous membranes with infectious respiratory secretions or with exudates from wound or skin lesions
- Direct or indirect contact of non-intact skin with infectious respiratory secretions or skin wound exudates
- Sharing of contaminated needles

Refer to FACTS About...Group A Streptococcal Infection

**An exposure to these infections could occur when:**
- Giving mouth-to-mouth resuscitation without barrier protection or bag valve
- Someone with one of these infections, coughs, sneezes, spits or vomits directly into the face of an ESW
- Unprotected suctioning or intubation where nasal or oral secretions come in contact with mucous membranes

**An exposure to these infections does NOT occur when:**
- Barrier protection or bag valve is used for mouth-to-mouth resuscitation
- Uncovered intact skin comes in contact with the saliva or nasal secretions of someone with these infections
- Routine Practices are used
- Appropriate PPE is used
Assessing exposure:

- Did the ESW perform any procedures that put him/her in direct contact with oral/nasal secretions?
- Did the ESW wear appropriate personal protective equipment (PPE)?
- Did the ESW have any broken areas on their skin?

Actions:

1. DRHD staff will contact DO if ESW have been identified in the care of a patient diagnosed with meningococcal disease or iGAS (a laboratory confirmed report is required) which may have placed the ESW at risk of exposure.

2. DO to conduct initial assessment confirming exposure.

3. If ESW is assessed as a confirmed contact, the DO will notify DRHD staff providing demographic information.

4. DRHD staff will contact the ESW and will provide education and recommendations for chemoprophylaxis if required.

Prophylactic medication is not routinely indicated for ESWs
Rabies Exposure and Mandatory Animal Bite Reporting

Report all animal bites and scratches!

Rabies is spread through the bite or scratch of a warm blooded mammal, including dogs, cats, skunks, raccoons, foxes, and bats. The rabies virus is concentrated in the saliva of the infected mammal.

The vast majority of animal bite investigations undertaken by the Health Department involve vaccinated and non-vaccinated domestic animals such as cats and dogs. However, human contact with any warm blooded animal whether it is domestic or wild (fox, raccoon, bat, etc...) are required to be immediately reported to the Health Department as specified in the Health Protection and Promotion Act, Regulation 557 (Communicable Diseases General).

Please contact Durham Region Health Department Environmental Help Line
Monday to Friday 8:30-4:30
905-723-3813
or 1-888-777-9613

If After Hours contact: (905) 576-9991; ask for the Public Health Inspector On-Call

Reports can also be faxed to 905-666-1887. For a copy of the form to complete and fax, visit our website at durham.ca – Rabies Control. Include in the report the name, address and phone number of the animal owner and victim.

To report lost, injured, wild or stray animals, call the Municipal Animal Control Centres:
• Ajax 905-683-8275
• Brock 1-705-432-2355 or 1-866-223-7668
• Clarington 905-623-7651
• Oshawa 905-436-3311
• Pickering 905-427-0093
• Whitby 905-655-0283
• Uxbridge & Scugog 905-985-9547 or 1-800-871-4374
Mandatory Blood Testing Act (MBTA), 2006

This law makes sure that police officers, firefighters, paramedics, correctional services staff and others get faster access to information that can help them decide the best way to reduce the chances of getting sick should they be exposed to a serious disease.

Refer to:
https://www.mcscs.jus.gov.on.ca/english/MandatoryBloodTesting.html

Frequently Asked Questions

What is the purpose of the Mandatory Blood Testing Act, 2006?

The Mandatory Blood Testing Act, 2006, reduces the time for getting a mandatory blood test to less than three weeks. Before the act, the process could take more than two months.

What diseases are listed as communicable diseases under the act?

- Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)
- Hepatitis B
- Hepatitis C

Should I start treatment immediately following exposure, or wait for my application to be processed?

Anyone who believes he or she has been exposed to a communicable disease as a result of coming into contact with a bodily substance of another person should immediately contact a medical professional who can help assess the risk of infection and decide whether to start treatment or preventive measures.
**Who can submit an application under the Mandatory Blood Testing Act, 2006?**

Anyone may apply to a Medical Officer of Health to have a blood sample of another person analysed if he or she has come into contact with a bodily substance from that person in any of the following circumstances:

- As a result of being a victim of crime
- While providing emergency health care services or emergency first aid to the person or
- In the course of his or her duties, if the person belongs to an identified group of individuals, including:
  - Persons who are employed in a correctional institution, place of open custody or place of secure custody
  - Police officers, civilian employees of a police service, First Nations constables and auxiliary members of a police service
  - Firefighters (including volunteer firefighters)
  - Paramedics and emergency medical attendants
  - Members of the College of Nurses of Ontario
  - Paramedic students engaged in field training

**Where should applications be submitted?**

Applications must be submitted to the Medical Officer of Health in the health unit where the respondent lives.

At the bottom of the application form there is a phone number that applicants can call to obtain a list of health units and the geographical areas they cover.

**Who is responsible for screening the application?**

The Medical Officer of Health is responsible for screening the application to make sure it meets the requirements of the act and for seeking voluntary compliance from the respondent.
Is there a time restriction on making an application under the Mandatory Blood Testing Act, 2006?

The Medical Officer of Health in the health unit where the respondent lives must receive an application no more than seven days after the date of the occurrence. However, if the deadline falls on a Saturday, Sunday or other holiday, the deadline is extended by one day.

What happens when a Medical Officer of Health receives an application?

Once the application has been screened to make sure it meets the requirements of the act, the Medical Officer of Health or their designate will attempt to contact the respondent and request that the respondent voluntarily provide a blood sample for testing.

What happens with the respondent’s blood test results?

The results of the blood tests will be reported to DRHD. DRHD staff will contact the applicant’s health care provider with the results. DRHD staff will contact the applicant to notify them that their health care provider has the respondent’s blood test results.

What steps are taken if the respondent fails to provide a blood sample voluntarily?

If the respondent does not provide a blood sample within two days of the Medical Officer of Health receiving the application, or if the respondent cannot be located in time, the application will be referred to the Consent and Capacity Board. The board will hold a hearing to decide whether to issue a mandatory order.

When will the Consent and Capacity Board hold the hearing?

The Consent and Capacity Board must begin and complete a hearing within seven days of receiving an application from a Medical Officer of Health. The board must make its decision within one day after the hearing ends. However if this day falls on a Saturday, Sunday or any other holiday, the deadline will be extended by one day.
How will the Consent and Capacity Board inform me of their decision?

The board will provide the applicant and the respondent (or their representative), as well as the Medical Officer of Health, with a copy of the board’s decision and a copy of any order made by the board.

What can I do if I disagree with the Consent and Capacity Board’s decision?

A decision of the board is final. There is no right of appeal. However, both the applicant and the respondent have the right to apply for a judicial review of the decision by the Superior Court of Justice.

How long does the respondent have to comply with an order of the Consent and Capacity Board?

The respondent has seven days from the date the order is made to comply.

What are the penalties for failing to comply with an order made by the Consent and Capacity Board?

Every person who fails to obey an order made by the board is guilty of an offence and is liable on conviction to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues.

Where can I find the mandatory blood testing forms?

All relevant forms, (including the applicant report, respondent report and physician report) can be found on:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/MinistryResults?Openform&SRT=T&MAX=5&ENV=WWE&STR=1&TAB=PROFILE&MIN=008&BRN=10&PRG=11
Immunization Information

Immunization may help to protect you and your patients from some very serious and potentially life threatening illnesses. Not all recommended vaccines listed below are publicly funded. It is important to keep a copy of your immunization record (yellow card) to ensure you have all recommended immunizations.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</td>
<td>All HCW should be immune</td>
</tr>
<tr>
<td>Tetanus</td>
<td>Primary series if no previous immunization</td>
</tr>
<tr>
<td></td>
<td>Booster doses of Td vaccine every 10 years</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>If no evidence of immunity</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annually</td>
</tr>
<tr>
<td>Measles</td>
<td>If no evidence of immunity, regardless of age - 2 doses</td>
</tr>
<tr>
<td>Mumps</td>
<td>If no evidence of immunity, regardless of age - 2 doses</td>
</tr>
<tr>
<td>Pertussis</td>
<td>A single dose of Tdap vaccine if not previously received in adulthood</td>
</tr>
<tr>
<td>Polio</td>
<td>Primary series if no previous immunization - 3 doses</td>
</tr>
<tr>
<td>Rubella</td>
<td>If no evidence of immunity - 1 dose</td>
</tr>
<tr>
<td>Varicella</td>
<td>If no evidence of immunity - 2 doses</td>
</tr>
</tbody>
</table>

For more information please refer to the Canadian Immunization Guide - Vaccination of Emergency Service Workers ([http://www.phac-aspc.gc.ca/publicat/cig-qci/p03-work-travail-eng.php#a1](http://www.phac-aspc.gc.ca/publicat/cig-qci/p03-work-travail-eng.php#a1)) and/or your health care provider.
Hand Hygiene
Hand hygiene is performed using alcohol-based hand rub or soap and water:
• Before and after each client/patient/resident contact
• Before performing invasive procedures
• Before preparing, handling, serving or eating food
• After care involving body fluids and before moving to another activity
• Before putting on and after taking off gloves and PPE
• After personal body functions (e.g., blowing one’s nose)
• Whenever hands come into contact with secretions, excretions, blood and body fluids
• After contact with items in the client/patient/resident’s environment

Mask and Eye Protection or Face Shield [based on risk assessment]
• Protect eyes, nose and mouth during procedures and care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions
• Wear within two metres of a coughing client/patient/resident

Gown [based on risk assessment]
• Wear a long-sleeved gown if contamination of skin or clothing is anticipated
## Gloves [based on risk assessment]
- Wear gloves when there is a risk of hand contact with blood, body fluids, secretions, excretions, non-intact skin, mucous membranes or contaminated surfaces or objects
- Wearing gloves is not a substitute for hand hygiene
- Remove immediately after use and perform hand hygiene after removing gloves

## Environment and Equipment
- All equipment that is being used by more than one client/patient/resident must be cleaned between clients/patients/residents.
- All high-touch surfaces in the client/patient/resident’s room must be cleaned daily

## Linen and Waste
- Handle all soiled linen and waste carefully to prevent personal contamination and transfer to other clients/patients/residents

## Sharps Injury Prevention
- NEVER RECAP USED NEEDLES
- Place sharps in sharps containers
- Prevent injuries from needles, scalpels and other sharp devices
- Use safety-engineered medical devices

## Patient Placement/Accommodation
- Use a single room for a client/patient/resident who contaminates the environment
- Perform hand hygiene on leaving the room
<table>
<thead>
<tr>
<th>Classification</th>
<th>Definition</th>
<th>Level of Processing/Reprocessing</th>
<th>Level of Processing/Reprocessing</th>
</tr>
</thead>
</table>
| Critical Equipment/Device | Equipment/device that enters sterile tissues, including the vascular system | Cleaning followed by sterilization                                    | • Surgical instruments  
                                  |                                                                             | • Implants  
                                  | • Biopsy instruments  
                                  | • Foot care equipment  
                                  | • Eye and dental equipment                                           |
| Semicritical Equipment/Device | Equipment/device that comes in contact with non-intact skin or mucous membranes but do not penetrate them | Cleaning followed by High-Level Disinfection (as a minimum) Sterilization is preferred | • Respiratory therapy  
                                  |                                                                             | • equipment  
                                  | • Anaesthesia  
                                  | • equipment  
                                  | • Tonometer                                                             |
| Noncritical Equipment/Device | Equipment/device that touches only intact skin and not mucous membranes or does not directly touch the C/P/R | Cleaning followed by Low-Level Disinfection (in some cases, cleaning alone is acceptable) | • ECG machines  
                                  |                                                                             | • Oximeters  
                                  | • Bedpans, urina                                                        |
Hospitals in Durham Region with 24 hour Emergency Departments

Rouge Valley Health System – Ajax site
580 Harwood Avenue South
Ajax, ON L1S 2J4
(905)683-2320

Lakeridge Health-Bowmanville
47 Liberty Street South
Bowmanville, ON L1C 2N4
(905)623-3331

Lakeridge Health-Oshawa
1 Hospital Court
Oshawa, ON L1G 2B9
(905)576-8711

Lakeridge Health-Port Perry
451 Paxton Street
Port Perry, ON L9L 1L9
(905)985-7321

Markham Stouffville Hospital – Uxbridge site
4 Campbell Drive
Uxbridge, ON L9P 1S4
(905)852-9771
Available Resources

**Cover your Cough**

1. Cover your mouth and nose with a tissue when you cough or sneeze; cough or sneeze into your upper arm, not your hands.
2. Put your used tissue in the waste basket.
3. Wash your hands with soap and water after coughing or sneezing.

**Hand Sanitizers**

**Step 1:** Apply 1-2 pumps of sanitizer to palm of dry hand

**Step 2:** Spread hand sanitizer over all surfaces of hands
   - palms, backs of hands, between fingers, around thumbs and fingertips

**Step 3:** Continue to rub hands together until dry

**WARNING!** Needles Are A Danger

1. Always assume the needle is contaminated
2. Do not injure yourself or others
3. Never reuse needles or sharps
4. Do not remove needles from syringe
5. Dispose used needles and sharps safely
6. Wash your hands with soap and water after handling needles or sharps

**Handwashing**

1. Wet hands
2. Apply liquid soap
3. Scrub backs of hands, between fingers, elbows and around fingernails for at least 15 seconds
4. Rinse
5. Towel dry
6. Turn off taps with towel

REMEMBER, proper handwashing can remove germs that make you sick.

Environmental Help Line 1-888-777-9613 • durham.ca
You may also visit www.durham.ca for more information.
Glossary

**Additional Precautions:** (i.e., Contact Precautions, Droplet Precautions and Airborne Precautions). Precautions that are necessary in addition to Routine Practices for certain pathogens or clinical presentations. These precautions are based on the method of transmission (e.g., contact, droplet, airborne).

**Administrative Controls:** Measures put in place to reduce the risk of infection to staff or to patients (e.g., infection prevention and control policies/ procedures, education/ training).

**Airborne Precautions:** Used in addition to Routine Practices for clients/patients/residents known or suspected of having an illness transmitted by the airborne route (i.e., by small droplet nuclei that remain suspended in the air and may be inhaled by others).

**Alcohol-Based Hand Rub (ABHR):** A liquid, gel or foam formulation of alcohol (e.g., ethanol, isopropanol) which is used to reduce the number of microorganisms on hands in clinical situations when the hands are not visibly soiled. ABHRs contain emollients to reduce skin irritation and are less time-consuming to use than washing with soap and water. Hand sanitizing with a 70–90% alcohol-based hand rub is the preferred method (when hands are not visibly soiled)

**Applicant:** A person who applies to a medical officer of health under section 2 of the Mandatory Blood Testing Act

**Barrier:** Equipment or objects used to prevent exposure of skin, mucous membranes or clothing of staff to splashes or sprays of potentially infectious materials.

**Blood or body fluid (BBF) exposure:** An event where blood or potentially infectious body fluid comes into contact with skin, mucous membranes, or subcutaneous tissue (via percutaneous injury)

**Case:** An individual who is infected or colonized with an infectious agent.

**Chain of Transmission:** A model used to understand the infection process.

**Cleaning:** The physical removal of foreign material (e.g. dust, soil) and organic material (e.g. blood, secretions, excretions, microorganisms). Cleaning physically removes rather than kills microorganisms. It is accomplished with water, detergents and mechanical action.

**Contact Precautions:** Used in addition to Routine Practices to reduce the risk of transmitting infectious agents via contact with an infectious person.

**Contamination:** Presence of an infectious agent on hands or on a surface, such as clothing, gloves, bedding, patient care equipment, dressings, etc.
Designated Officer (DO): A person identified in an emergency service (i.e., police, firefighters, ambulance) who is responsible for receiving and assessing reports regarding the possible exposure of an emergency service worker to an infectious disease of public health importance and then contacting the medical officer of health or designate.

Direct Care: Providing hands-on care to a client/patient/resident.

Disinfection: The inactivation of disease-producing microorganisms. Disinfection does not destroy bacterial spores. Medical equipment/devices must be cleaned thoroughly before effective disinfection can take place.

Droplet Precautions: Used in addition to Routine Practices for clients/patients/residents known or suspected of having an infection that can be transmitted by large infectious droplets.

Eye Protection: A device that covers the eyes and is used by health care providers to protect the eyes when it is anticipated that a procedure or care activity is likely to generate splashes or sprays of blood, body fluids, secretions or excretions, or within two metres of a coughing client/patient/resident. Eye protection includes safety glasses, safety goggles, face shields and visors.

Facial Protection: Personal protective equipment that protect the mucous membranes of the eyes, nose and mouth from splashes or sprays or blood, body fluids, secretions or excretions. Facial protection may include a mask or respirator in conjunction with eye protection, or a face shield that covers eyes, nose and mouth.

Hand Hygiene: A general term referring to any action of hand cleaning. Hand hygiene relates to the removal of visible soil and removal or killing of transient microorganisms from the hands. Hand hygiene may be accomplished using soap and running water or an alcohol-based hand rub.

Health Care Provider: Any person delivering care to a client/patient/resident. This includes, but is not limited to, the following: emergency service workers, physicians, dentists, nurses, respiratory therapists and other health professionals, personal support workers, clinical instructors, students and home health care workers. In some non-acute settings, volunteers might provide care and would be included as health care providers.

Infection: The entry and multiplication of an infectious agent in the tissues of the host. Asymptomatic or subclinical infection is an infectious process running a course similar to that of clinical disease but below the threshold of clinical symptoms. Symptomatic or clinical infection is one resulting in clinical signs and symptoms (disease).

Infectious diseases of public health importance: Diseases include, but are not limited to, those specified reportable diseases as set out by O. Reg. 559/913 (as amended) under the HPPA1, and include zoonotic diseases.
Infection Prevention and Control (IPAC): Evidence-based practices and procedures that when applied consistently in health care settings, can prevent or reduce the risk of transmission of infectious agents to health care workers and other clients/patients/residents and visitors.

Infectious Agent: A microorganism, i.e., a bacterium, fungus, parasite, virus or prion, which is capable of invading body tissues and multiplying.

Mask: A device that covers the nose and mouth, is secured in the back and is used by health care providers to protect the mucous membranes of the nose and mouth.

Mode of Transmission: The method by which infectious agents spread from one person to another (e.g., contact, droplet, or airborne routes).

Percutaneous exposure: Blood or body fluid from one person is potentially introduced into the bloodstream of another person through the skin via needlestick, tattooing, body piercing, or other sharps injury.

Personal Protective Equipment (PPE): Clothing or equipment worn by health care providers for protection against hazards (e.g. gown, gloves, mask/95 respirator, face shield/eye goggles, etc.).

Pre-hospital Care: Acute emergency patient assessment and care delivered in an uncontrolled environment by a designated practitioner (e.g. Paramedics, fire, police), performing delegated medical acts at the beginning of the health care continuum.

PIDAC: Provincial Infectious Diseases Advisory Committee.

Respiratory Etiquette: Personal practices that help prevent the spread of bacteria and viruses that cause acute respiratory infection (e.g. covering the mouth when coughing, care when disposing of tissues).

Respondent: The person who the applicant identifies as a person with whose bodily substance the applicant came into contact (Mandatory Blood Testing Act).

Risk Assessment: An evaluation of the interaction of the health care provider, the client/patient/resident and the client/patient/resident environment to assess and analyze the potential for exposure to infectious disease.

Routine Practices: The system of infection prevention and control practices recommended by the Public Health Agency of Canada to be used with all health clients/patients/residents during all care to prevent and control transmission of microorganisms in all health care settings.

Sharps: Objects capable of causing punctures or cuts (e.g., needles, syringes, blades, clinical glass).
REFERENCES

Mandatory Blood Testing Act, 2006
Ministry of Community Safety and Correctional Services (Mandatory Blood Testing) retrieved from:
https://www.mcscs.jus.gov.on.ca/english/MandatoryBloodTesting.html

Public Health Ontario Best Practice Guidelines
Routine Practices and Additional Precautions in All Healthcare Settings, 3rd Edition retrieved from:

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, 3rd Edition retrieved from:

Best Practices for Environmental Cleaning for Prevention and Control of Infections – In All Health Care Settings, 2nd Edition retrieved from:

Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition retrieved from:

Ministry of Health and Long-Term Care, Ontario Public Health Standards 2008 Exposure of Emergency Service Workers to Infectious Diseases protocol

Ministry of Health and Long-Term Care, Ontario Public Health Standards 2008
If you require this information in an accessible format, contact 1-800-841-2729.