

CHAPTER II Operations
SUBJECT 4 Emergency Medical Operations
TOPIC 5 Infection Control Standard Operating Procedures

A. SOP #1: INFECTIOUS DISEASE EXPOSURE GUIDELINES

SCOPE: When a Cincinnati Fire Department member receives a significant exposure to the body fluids of a patient, or shares the intimate air space of an infectious TB patient without proper respiratory protection, the exposed member shall follow these guidelines.

B. A SIGNIFICANT EXPOSURE MEANS

1. More than just casual contact with the following body fluids: blood, sputum, saliva, semen, vaginal secretions or amniotic fluid, spinal fluid, synovial fluid (joint, bone, tendon), pleural fluid (lung), peritoneal fluid (abdomen), pericardial fluid (heart). These are body fluids to which universal precautions apply. The exposure to body fluids must occur via one of three routes:
 - a. Mucus membranes (body fluids splashed into eyes, nose, or mouth).
 - b. Exposed unhealed open sores, wounds, or rashes.
 - c. Percutaneous route (needle stick or break in the skin).
2. Exposure to a known contagious disease.

C. STEPS TO TAKE AFTER SUSTAINING A SIGNIFICANT EXPOSURE

1. Special arrangements have been made between University Hospital and the Cincinnati Fire Department, therefore all exposed CFD member should go to UC hospital immediately, even if this means taking the company out of service. If an injury or significant exposure occurred, the member should sign-in as a patient at the UC Emergency Room to be treated at the hospital. As with all injuries, the reports in the Workers Compensation folder should be completed, including the F-91 S/F, the BWC First Report of Injury, and the State of Ohio Sharps Injury Form, where applicable. The F-91 S/F must be completed for tracking the claim and identifying the source patients testing process. They are carried by all Medic Units and ALS 34/32.
2. Time is of the essence. Notify ALS 34/32 as soon as possible after a suspected significant exposure. An exposure must be reported to the hospital while the

patient is still under their care. Locating and obtaining permission to test patients that have been discharged is extremely difficult.

3. The paramedic, ALS 34/32, or hospital personnel should attempt to obtain a blood sample in a “tiger top” tube while the patient is still in our care in order to have the patient’s blood tested at U.C. The tube must be properly labeled. The label must contain the Source Patients Last Name, the word “LINK”, and then the Firefighters Last Name. (Example: Smith, LINK, Davis)
4. The Hospital Exposure Form officially notifies the hospital that you are requesting information about a patient, and allows them to give the EHS a follow-up report with results of the patient's blood tests. All of the necessary forms and informational sheets are contained in the Red Folder labeled “Infectious Disease Exposure Packet”. The Red Folders are carried on all Medic Units, and ALS 34/32.
5. In the event that the Emergency Physician and the exposed member disagree on whether there was an actual significant exposure, the member will be guided by ALS 34/32 and the CFD medical director’s instructions. The Paperwork should still be completed and submitted.
6. There may be some occasions in which a patient is suspected of having, or known to have, a contagious infectious disease and is not transported to the hospital, (e.g.: refuses aid, taken by police to jail, taken to the morgue, etc.). In this event, a Run Report completed at the scene should include, not only, all appropriate information about the patient (including physician's name), but also, the names and badge numbers of any police officers on the scene. Notify ALS 34/32 immediately upon your return to quarters and be guided by their instructions.

D. GENERAL INFORMATION ON INJURIES OR EXPOSURES

1. State laws (Statute 3701.242) permit area hospitals to test patients for contagious or infectious diseases when a health-care worker has sustained a significant exposure. In most cases, mouth-to-mouth contact with a patient is not considered a significant exposure unless blood is visualized in the body fluids. CFD members shall avoid mouth to mouth contact. Mouth to mouth ventilation is NOT an approved procedure for Fire Department personnel. All Fire Department Personnel must use devices provided for ventilation of patients.

The final notice for the Ryan White Act issued March 21, 1994 and effective April 20, 1994 states:

- If the hospital determines the patient has TB it must notify the ERE's (Emergency Response Employee) designated officer as soon as practicable but not later than 48 hours after the determination has been made.
- For exposures to a blood borne or other infectious diseases listed, the ERE may submit a request to determine whether a significant exposure occurred to the designated officer for the Fire Department who investigates the exposure.
- The hospital then determines:
 - Was the exposure significant?
 - Can a patient be identified?
 - Do the patient's records show a disease listed or does the patient show symptoms of the listed diseases?
- If the answers above are yes, the hospital then notifies the designated officer as soon as possible but not later than 48 hours after receipt of the request.
- The Ryan White Act does not authorize hospitals to require testing of victims for disease nor does it allow the patient's confidential medical information be disclosed. The hospital notifies: that the ERE may have been exposed to an infectious disease, the name of the disease involved, actions the ERE should take, and, the date of the emergency.

The Ohio Senate Bill 2, the omnibus AIDS bill became effective November 1, 1989 contains the following provisions for HIV test results:

HIV test results may be released to a health care provider, emergency medical services worker or peace officer that has sustained significant exposure to the body fluids of the tested individual. However the identity of the individual tested is not to be revealed.

Exceptions to Informed Consent for HIV testing:

When the test is performed in a medical emergency by a nurse or physician and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual (counseling is to be given to the individual tested as soon as possible after the emergency is over);

When the test is performed by or on the order of a physician who, in the exercise of his or her professional judgment, determines the test is necessary for providing diagnosis and treatment to the individual to be tested, if the individual or the individual's parent or guardian has given consent to the physician for medical treatment;

When an infection control committee of a health care facility or other body performing a similar function of a health care facility determines that a health care provider, emergency medical services worker or peace officer, while rendering health or emergency care to an individual, has sustained a significant exposure to the body fluids of that individual and that individual has refused to be tested.

2. No overtime will be paid for time spent seeking medical assistance or while hospitalized (e.g.: a member injured at 0630 hours and taken to the hospital will not be paid past 0700 hours).
3. A member working past shift change who becomes injured while in an overtime status will be paid one hour of overtime per Union Contract.
4. No CFD member is required to report to EHS while in an off-duty status. However, per CFD Procedures Manual 903.03, if a member wishes to be carried in an IWP status, he or she must contact the EHS Physician the next business day. As has been our past policy, no overtime will be paid for these visits.

E. SOP #2: POST-EXPOSURE PROTOCOLS

1. Any member exposed to potentially infectious material will immediately wash the exposed area with water or saline eye wash if the eyes are involved.
2. Any member exposed to a communicable disease will immediately report the incident to a supervisor and ALS 34/32. Needle stick injuries will be reported to the infection control officer immediately. Refer and be guided by procedures in SOP #1: INFECTIOUS DISEASE EXPOSURE GUIDELINES.
3. The supervisor will complete the F-91 F/S unofficial worksheet and forward it the District Chief to be entered into the injury report program on the computer.
4. Disciplinary action may be required to ensure all members are wearing PPE for infection control. Retraining will be required and/or stress management counseling will be given if indicated. Spousal stress management / family counseling will also be made available.

5. The source patient will be traced to the receiving medical facility by the Infection Control Officer/ALS 34/32. The Infection Control Officer will notify the receiving facility that a communicable disease exposure took place, and request an infectious disease determination, as provided under the Ryan White Act of 1990. Notify ALS 34/32 IMMEDIATELY to respond when any exposure takes place. Time is of the essence. See sections A through D of SOP #1 Infectious Disease Exposure Guidelines.
6. The Employee Health Physician or UC Hospital will provide appropriate diagnostic work-up and treatment of members with communicable disease exposures. All long-term follow up and member counseling will be through EHS and the Department.

F. SOP #3: SCENE OPERATIONS

1. The blood, body fluids, and tissues of all patients are considered potentially infectious, and Universal Precautions/Body Substance Isolation procedures will be used for all patient contact.
2. The choice of personal protective equipment is specified in 204.05 (H) SOP #5: Personal Protective Equipment. Members will be encouraged to use maximal rather than minimal PPE for each situation.
3. While complete control of the emergency scene is not possible, scene operations, as much as possible, will attempt to limit splashing, spraying, or aerosolizing of body fluids.
4. The minimum number of members required to complete the task safely will be used for all on-scene operations. Members not immediately needed will remain a safe distance from operations where communicable disease exposure is possible or anticipated.
5. Hand washing is the most important infection control procedure. Members will wash hands:
 - After removing PPE.
 - After each patient contact.
 - After handling potentially infectious materials.
 - After cleaning or decontaminating equipment.
 - After using the bathroom.

6. Hand washing with soap and water will be performed for ten to fifteen seconds. If soap and water is not available at the scene, a waterless handwash may be used, provided that a soap and water wash is performed immediately upon return to quarters or hospital.
7. Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited at the scene of operations and while in an ambulance or rescue unit, and decontaminating equipment.
8. The paramedic or firefighter who is starting the IV, administering medications or checking blood sugar with a needle will be responsible for immediately securing the needle in an approved sharps container. This means that the needle should not be dropped onto the floor or sat on the seat next to the technician performing the procedure. Once the needle is removed from the plastic catheter or the needle is removed from the patient after giving medications, it should be immediately placed in a sharps container. This may require that a sharps container be placed next to the paramedic performing the procedure prior to starting the IV. All drug boxes have been issued and should contain single use sharps containers. Everyone will be held responsible for the proper disposal of contaminated needles. Needles will not be recapped, re-sheathed, bent, broken, or separated from disposable syringes.
9. Sharps containers will be easily accessible on-scene. If sharps are used remote from response vehicles, transport the individual sharps containers to the vehicle and place contaminated sharps in the vehicle sharps container. The goal is to place the contaminated sharps in the proper containers ASAP to prevent needle sticks from occurring.
10. Disposable resuscitation equipment will be used whenever possible. For CPR, the order of preference is:
 - Disposable bag-valve mask.
 - Demand valve resuscitator with disposable mask.
 - Disposable pocket mask with one-way valve.
11. Mouth-to-mouth resuscitation is not an approved procedure for CFD members. All members will use pocket masks with one-way valves to eliminate the need for mouth-to-mouth resuscitation. Disposable resuscitation equipment will be kept readily available during on-scene operations.

12. Patients with suspected airborne communicable diseases will be transported wearing a face mask or particulate respirator whenever possible. Medic Unit windows will be open and ventilation systems turned on fully whenever possible.

G. SOP #4: POST RESPONSE

1. Any contaminated regular work clothing, fatigues or firefighting PPE, shall be removed IMMEDIATELY at the scene. Take care to prevent further contamination to any building or apparatus. Use hospital sheets to contain blood products/infectious material and provide contaminated member with a visual barrier from bystanders. The goal is to place PPE suits on prior to having any possibility of contamination. However, it may rarely occur that the patient's need for rescue, as in a structure fire, requires immediate action. Should this happen, immediately remove contaminated work clothing. Bag the contaminated clothing in a plastic contamination bag. Contaminated member will then dress in provided infection PPE suits. Any contaminated hospital sheets shall be sent to the hospital for cleaning per procedures. Upon returning to quarters, contaminated work clothing will be sent to central stores for laundering. Personal protective suits worn at the scene will be removed after leaving the work area, or as soon as possible if contaminated. After use, all PPE suits will be placed in red leak proof Biohazard bags and transported back to the station for proper disposal in contaminated waste receptacles.
2. At conclusion of scene operations, all potentially contaminated patient care equipment will be removed for appropriate disposal or decontamination and reuse. Contaminated equipment will be stored only in the decontamination area and removed only after decontaminated or sent out to be decontaminated. The Fire Department has a contract to supply and pick up medical waste containers at each station.

The containers are red in color and constructed of a plastic material with a locking style lid. Each container will have a plastic red color polyethylene liner. The container and the liner shall have the biohazard symbol imprinted on them. Only medical waste shall be disposed of in this container. Latex gloves, bandages, tyvek biohazard suits, etc., are a few examples. Sharps containers can also be deposited in the biohazard container. Do not dispose of other regular trash in these containers.

The container shall be stored in a safe manner on the apparatus floor. The biohazard container will be picked up by the vendor on a monthly basis for proper

disposal. A replacement container will be delivered. If the container becomes full before the monthly scheduled pick up, the company officer shall request an earlier pick up by calling Central Stores.

3. Disinfecting will be performed with a department-approved disinfectant or with a 1:10 solution of bleach in water. All disinfectants will be tuberculocidal and EPA approved and registered.
4. Any damaged equipment will be cleaned and disinfected before being sent out for repair.
5. The manufacturer's guidelines will be used for the cleaning and decontamination of all equipment. Unless otherwise specified:
 - Durable equipment (backboard, splints, MAST pants) will be washed with hot soapy water, rinsed with clean water, and disinfected with an approved disinfectant or 1:10 bleach solution. Equipment will be allowed to air dry.
 - Delicate equipment (radios, cardiac monitors, etc.) will be wiped clean of any debris using hot soapy water, wiped with clean water, then wiped with disinfectant or 1:10 bleach solution. Equipment will be allowed to air dry.
6. Work surfaces will be decontaminated with an appropriate disinfectant after completion of procedures, and after spillage or contamination with blood or potentially infectious materials. Seats on response vehicles contaminated with body fluids from soiled PPE also will be disinfected ASAP and prior to placing apparatus in service and/or sitting on same with regular work clothes.
7. Contaminated structural fire fighting gear will be cleaned by special extractor machines at Central Stores. Washing firefighting gear by our previous methods has been found to deteriorate the materials in the firefighting PPE. Under no circumstances should contaminated work clothes be laundered at home by any member. Contaminated firefighting PPE will be removed at the scene immediately and bagged appropriately as detailed in #1 of this section: SOP #4: Post Response.
8. Contaminated boots will be brushed and scrubbed with a hot solution of soapy water, rinsed with clean water, and allowed to air dry.
9. Contaminated fatigue work clothes will be sent to Central Stores for cleaning. All members will maintain extra clean work uniforms in the station to change into if necessary. If body fluids were in contact with skin under work clothes, member will wash/disinfect area on scene and shower immediately upon arrival back at quarters prior to being placed in an in-service status.

H. SOP #5: PERSONAL PROTECTIVE EQUIPMENT

1. Standards for Personal Protective Equipment (PPE) will be developed by the Fire Department Infection Control Committee and will be updated or modified as needed.
2. The Cincinnati Fire Department will supply personal protective equipment.
3. The Company Commander at each station will ensure that station stock of PPE is adequate and that supplies nearing expiration dates are used first.
4. The amount, type, and location of PPE will be standardized on all response vehicles as much as possible.
5. Available PPE (in addition to PPE for structural firefighting) will include disposable gloves, face masks, eye protectors, the Fluidshield Procedure Mask with Wraparound Splashguard Visors, Tyvek polyethylene coated suits (first choice for blood borne pathogens and body fluid protection), Tyvek/Saranex 23-P; Splash Protection Suits (offer chemical protection in addition to blood borne pathogens and body fluid protection), CPR Microshield Clear Mouth Barrier carried in personal turnout gear, sharps containers, leakproof disposal bags marked with the infection control symbol and red in color..
6. Disposable gloves will be constructed of latex and non-latex rather than plastic. While both types provide equal protection, latex is more durable for on-scene operations. In the event that a member is allergic to latex, N-DEX nitrile disposable gloves will be provided to the identified member, available from central stores.
7. Sharps containers will be closable, puncture resistant, and leakproof. Sharps containers will be red in color, labeled as a biohazard, and be immediately accessible.
8. All members are issued a pocket mask with one-way valve the CPR Microshield Clear Mouth Barrier. The Microshield shall always be carried in the member's personal turn out gear. Replacement pocket masks will be carried on every response vehicle and stocked in each station. Fire Companies will keep additional shields available for use while members are out of quarters in uniform performing assigned duties.
9. Selection and use of personal protective equipment:

- Emergency response often is unpredictable and uncontrollable. While blood is the single most important source of HIV and HBV (Hepatitis B Virus) infection in the workplace, in the field it is safest to assume that all body fluids are infectious. For this reason, PPE will be chosen to provide barrier protection against all body fluids.
- In general, members should select PPE appropriate to the potential for spill, splash, or exposure to body fluids. No standard operating procedure or PPE ensemble can cover all situations. Common sense must be used. When in doubt, select maximum rather than minimal PPE.
- Disposable latex gloves will be worn during any patient contact when the potential exists for contact with blood, body fluids, non-intact skin, or other infectious material.
- Gloves will be replaced as soon as possible when soiled, torn, or punctured, and will not be reused. Wash hands after removing gloves.
- Gloves should be changed between patients in multiple casualty situations where possible.
- Structural fire fighting gloves will be worn in situations where sharp or rough edges are likely to be encountered.
- Heavy duty utility gloves may be used for the handling, cleaning, decontamination, or disinfecting of potentially contaminated patient care equipment.
- Facial protection will be used for the handling, cleaning, decontamination, or disinfecting of potentially contaminated patient care equipment.
- Facial protection will be used in any situation where splash contact with the face is possible. Facial protection may be afforded by using the Fluidshield Procedure Mask with Wraparound Splashguard Visors to provide both face mask and eye protection. When treating a patient with a suspected or known airborne transmissible disease, face masks or approved particulate respirators will be used. Additional protection is afforded by placing a mask on the patient. However, if the patient is contagious, masking the provider is required in addition to masking the patient.
- Face shields on structural fire fighting helmets will not be used for infection control purposes.
- The Tyvek polyethylene coated suits and the Tyvek/Saranex 23-P; Splash Protection Suits are designed to protect clothing from splashes. Structural firefighting gear also protects clothing from splashes and is preferable in fire, rescue, or vehicle extrication activities. Splash protection suits may interfere with, or present a hazard to the member in these circumstances. The decision

to use barrier protection to protect clothing, and the type of barrier protection used will be left to the member. Structural fire fighting gear will always be worn for fire suppression and extrication activities.

10. SUMMARY:

- If it's wet, it's infectious - use gloves.
- If it could splash onto your face, use the procedures for wearing the Fluidshield Mask with Wraparound Splashguard Visor.
- If it's airborne, mask yourself and the patient.
- If it could splash on your clothes, head, or feet, use the infectious PPE suits: Tyvek polyethylene coated suit or the Tyvek/Saranex 23-P; Splash Protection Suit

I. SOP #6: STATION ENVIRONMENT

1. All fire stations will designate the following separate storage, decontamination, and disposal areas:
 - Equipment decontamination and disinfecting.
 - Storage of clean patient care equipment and infection control personal protective equipment.
 - Storage of biohazard waste.
2. The Department has installed decontamination sinks in all fire stations. In addition, it will be a goal to have decontamination areas marked with biohazard signs and equipped with:
 - Two sinks, constructed of non-porous materials, equipped with spray attachments and foot controls.
 - Proper lighting and adequate ventilation.
 - Adequate counter areas constructed of non-porous materials.
 - Adequate rack space to allow air drying of equipment.
 - Appropriate containers for disposal of biohazard waste.
 - Facilities for safe storage, use, and disposal of cleansing and disinfecting solutions.
 - Appropriate PPE for the use of disinfecting solutions.
 - Material safety data sheets (MSDS) for cleansing and disinfecting solutions. All personnel using these solutions will be familiar with the MSDS and will use the recommended PPE.

3. Infectious waste storage areas will be marked with biohazard signs and will be maintained in accordance with all EPA and local regulations.
4. Contaminated sharps will be stored in closed puncture resistant containers (sharps boxes) with appropriate markings and red in color.
 - If outside contamination of a disposal bag is a possibility, a second bag with identical markings will be placed over the first.
 - Reusable bins and containers used to store biohazard waste will be inspected, cleaned and disinfected weekly, and immediately if outside contamination is present.
5. All disposal of biohazard waste will be in accordance with EPA and local regulations and will be performed by an approved licensed contractor designated by the department.
6. LAUNDRY: All fire stations shall be equipped with a clean laundry area with washer, dryer, and wash sink.
 - All linen used for patient transport is considered potentially contaminated. Contaminated linen will be exchanged by the medical facility receiving the patient. Contaminated linen will not be washed in station laundry facilities. Disposable gloves shall be worn when handling potentially contaminated linen.
7. KITCHEN:
 - Under no circumstances will any kitchen facility be used for the purpose of cleaning, sterilizing, disinfecting, storing, or disposal of any infectious material or waste. This also applies to bathrooms and other living areas.
 - Food will be properly prepared and cooked. Hands will be washed before eating and preparing food.

J. SOP #7: INFECTION CONTROL TRAINING

1. All members providing emergency services will be required to complete initial infection control training at time of assignment to tasks where occupational exposure may occur. This training will be given by the EMS Education with assistance from the Fire Training Center Personnel, EMS 1, EMS 2, ALS 34/32 Personnel, and the Safety Officer / Risk Manager. Ongoing infection control training will be part of the regular and continuing medical training program.

2. All infection control-training materials will be appropriate in content and vocabulary to the educational level, literacy, and language of members being trained.
3. Training will be in compliance with NFPA Standard 1581 and OSHA Regulation 29 CFR Part 1910.1030 and shall include:
 - An accessible copy of 29 CFR Part 1910.1030 and an explanation of its contents.
 - A general explanation of the epidemiology and symptoms of blood borne diseases.
 - An explanation of the modes of transmission of blood borne pathogens.
 - An explanation of the Cincinnati Fire Department's exposure control plan and how the employee can obtain a copy.
 - An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
 - Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.
 - An explanation of the bases for selection of personal protective equipment.
 - Information on the hepatitis B vaccine, including information on its efficacy, safety, and the benefits of being vaccinated.
 - Notification that the hepatitis B vaccine and vaccination will be provided at no charge.
 - Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
 - An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
 - Information on the post-exposure evaluation and follow-up that the department is required to provide following an exposure incident.
 - An explanation of the signs and labels and/or color-coding required for biohazard materials.
 - Information on the proper storage and disposal of biohazard materials.
 - Opportunity for interactive questions and answers.
4. Infection control trainers, directed and trained by the EMS Education, shall be knowledgeable in all of the program elements listed above, particularly as they relate to emergency services provided by this department.

5. Training records shall be maintained in sufficient detail to document the program taught and the members who attended. Records shall be updated whenever additional or refresher training is provided.

K. SOP #8: HEALTH MAINTENANCE

1. No member will be assigned to emergency response duties until an entrance physical assessment has been performed by the Employee Health Physician or his/her designee, and the member has been certified as fit for duty.
2. Work restrictions for reasons of infection control may be initiated by the Employee Health Physician.
3. The Cincinnati Fire Department will offer all members immunization against hepatitis B. The risks and the benefits of immunization will be explained to all members, and consent obtained prior to immunization.
4. A member may request serologic testing prior to hepatitis B immunization to determine if previous immunity exists. Members may refuse immunizations, or may submit proof of previous immunization. Members who refuse immunization will be counseled on the occupational risks of communicable disease, and required to sign a refusal of immunization form. Members who initially refuse immunization may later receive immunization upon request.
5. Any member returning to work following debilitating injury or illness or communicable disease (occupational or non-occupational) will be cleared by the Employee Health Physician or designee prior to resuming emergency response duties.
6. The Employee Health Physician will maintain records in accordance with OSHA's CFR 29, Part 1910.1030. Member participation in the Infection Control Program will be documented, including:
 - Name and SSN of member.
 - Immunization records.
 - Circumstances of exposure to communicable diseases.
 - Post-exposure medical evaluation, treatment, and follow-up.
7. Infection control records will become a part of the member's personal medical file and will be maintained for the duration of employment plus thirty years.
8. Medical records will be maintained by the Employee Health Physician, and will not be kept with personnel records.

9. Members may examine their own medical records, and may request that copies be sent to their personal physician. Release of medical records to another physician will be made only with the signed written consent of the member.
10. Abstracts of medical records without personal identifiers may be made for quality assurance, compliance monitoring, or program evaluation purposes, as long as the identity of members cannot be determined from the abstract. The first consideration will be the confidentiality of all members.

L. SOP #9: COMPLIANCE AND QUALITY MONITORING/PROGRAM EVALUATION

1. Compliance and quality monitoring: The infection Control Officer will collect compliance and quality monitoring data including:
 - Inspections of station facilities.
 - Observation of on-scene activities.
 - Analysis of reported exposures to communicable diseases.
2. A quarterly quality and compliance report will be made by the Infection Control Officer to the Safety/Infection Control Committee.
3. Program evaluation:
 - The Infection Control Program will be reevaluated at least annually by the Infection Control Committee to ensure that the program is both appropriate and effective.
 - In addition, the Infection Control Program will be reevaluated as needed to reflect any significant changes in assigned tasks or procedures, in medical knowledge related to infection control, or in regulatory matters.