

IL 10-2012-012 Reply to: 10P3D

August 2, 2012

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

RESPIRATORY PROTECTION USED FOR INFECTIOUS DISEASE AND ANNUAL FIT-TESTING

1. <u>**Purpose.**</u> This Information Letter addresses management of respiratory protection programs in follow-up to an Office of the Inspector General (OIG) Combined Assessment Program Review (CAP), Evaluation of Infection Prevention Practices in Veterans Health Administration Facilities, Report No. 11-03361-274, dated September 13, 2011. The CAP review identified problems with annual fit-testing and covered populations.

2. Background

a. **Respiratory Protection in Health Care.** Use of respiratory protection strategies has been essential to protecting health care personnel and was widely acknowledged at least since 1994, when the Centers for Disease Control and Prevention (CDC) promulgated the Guidelines for Tuberculosis (TB) Control in Healthcare Facilities. These guidelines have been expanded to address protection against other diseases transmitted through airborne route. In the past several years, these principles have guided protection strategies against hazards from several novel infections. Studies have documented that transmission of the Severe Acute Respiratory Syndrome (SARS) occurred through aerosols both indoors and outdoors. Some forms of pandemic influenza, including the Avian Flu outbreak in 2006, generated the need for similar protection strategies.

(1) The respiratory protection program represents a major element of all programs directed at controlling respiratory diseases in hospitals. Additional important elements include: maintenance of negative pressure, airborne infection isolation rooms, and early detection of patients with potentially airborne-transmissible infectious diseases. Commonly encountered diseases, such as TB, require different control strategies than pandemic diseases. Facility staff need to be careful to define and distinguish the populations covered and the strategies directed at pandemics and more routine diseases.

- (2) Essential components in a respirator program include:
- (a) Identification of a respirator program manager.
- (b) Development of a written respirator program with:
 - <u>1</u>. Selection of the appropriate respirators for the specific hazard and the degree of hazard;

2. Identification of individuals enrolled in the program;

<u>3</u>. Initial medical clearance of individuals to wear a respirator; and additional medical clearance according to Title 29 Code of Federal Regulations 1910.134(e)(7); and

4. Initial and annual fit-testing of respirators that require a face-to-facepiece seal.

- (c) Initial and annual training.
- (d) Medical surveillance.

(3) Facility staff need to adhere to all the provisions of the Occupational Safety and Health Administration (OSHA) Respiratory Protection standard (Title 29 Code of Federal Regulations (CFR) 1910.134), including annual fit-testing for respirators that require a face-to-facepiece seal. Powered Air Purifying Respirators (PAPRs) with loose-fitting hoods or helmets are exempt from the fit-testing requirements. PAPRs may be shared by staff if they are maintained and disinfected in accordance with OSHA regulatory requirements and manufacturer's instructions, where available. Consideration needs to be given to their initial costs and maintenance needs. Additional strategies are described in Standard Operating Procedure 7.2.3, Infection Control, in the Emergency Management Program Guidebook found at: http://vaww.ceosh.med.va.gov/01HP/02HP_Guidebooks/03_Collections/04HP_EmergencyManagement/Nethelp/2011EMP.htm NOTE: This is an internal Web site and is not available to the public.

b. Decision-based Approach for VHA facilities. The following approach is suggested:

(1) Identifying and designating a minimum number of individuals required to support current infectious disease programs based on local needs and a clear strategy. Individuals identified to be fit-tested need to undergo initial and annual fit-testing, as defined in OSHA standard 1910.134, found at 29 CFR 1910.134.

(2) Clarification to address TB, measles, varicella, and other common diseases transmitted by the respiratory route through appropriate programs and staffing.

(3) The number of staff included in the program may depend on the protection strategy, but always needs to address staff on all three shifts in the Emergency Room and Urgent Care Clinics; there needs to be enough staff available to ensure proper functioning of the negative pressure rooms on all three shifts. This includes sufficient staff in clinical units to:

(a) Provide the required care as dictated by the needs of the patient, such as specific facilitydesignated unit, possibly with an Airborne Infection Isolation Room (AIIR), which serves as the primary admission point; and

(b) Ensure that fit-tested staff are present on all three shifts on that unit.

(4) Expansion of the designated staff to respond to emergencies represents an alternative to including all facility staff in a program. The facility preparedness plan may address how to conduct medical evaluation, fit-testing, and training of additional needed staff on the next working day or on that same shift, either through the use of an industrial hygienist or a trained staff member, functioning as a collateral-duty respiratory fit-test technician. When such emergencies do arise, including additional staff in the designated populations expands the individuals enrolled in the program. Once pandemics have been declared resolved, these additional staff need to be removed from the covered population.

NOTE: Medical evaluation needs to precede fit-testing and the first use of respirator for protection. Next-day or same-shift medical evaluation and fit-testing after exposure does not meet the requirements of OSHA standard 1910.134.

(5) Collateral-duty respiratory fit-test technicians to assist in just-in time fit-testing programs could be identified.

(6) The following questions need to be added to the mandatory respiratory protection Medical Evaluation Questionnaire (a questionnaire containing the pertinent questions as defined in OSHA standard 1910.134 *to assist in prioritizing fit-testing*). The questions, included in the Occupational Health Record-Keeping System module on respiratory protection and clearance, are:

(a) Have you gained or lost 10 pounds or more in the last year?

(b) Have you had dental procedures with tooth removal or prostheses in the last year?

(c) Have you had jaw surgery in the last year?

(d) Have you used a respirator with a tight-fitting face piece, such as a disposable N95 or an elastomeric respirator, in the last 6 months at work?

(e) When were you last fit-tested for the respirator you're currently using?

3. <u>References</u>

a. Centers for Disease Control. Guidelines for Preventing the Transmission of MTb in Health-care Facilities. <u>Morbidity and Mortality Weekly Report</u> (<u>MMWR</u>) 2005; 54 (RR17): 1-141

b. Department of Labor, OSHA, 29 CFR 1910.134, Respiratory Protection.

c. OSHA Standard Interpretations 12/22/2004 - Tuberculosis and Respiratory Protection: prohibition of enforcing annual fit-testing requirements during 2005 fiscal year; enforcement of other 1910.134 provisions. *NOTE:* For additional guidance go to: <u>http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_i</u> <u>d=24977</u>.

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d. Sepkowitz K, Discussion at OSHA-National Institute for Occupational Safety and Health (NIOSH)-CDC Consensus Conference of Respiratory Protection in Health-care, Atlanta, November 30, December 1, 2004.

e. OSHA. Protecting Employees from Avian Flu (Avian Influenza) Viruses 3323-10N, 2006.

4. <u>Inquiries.</u> Questions regarding this Information Letter may be directed to Craig Brown (412) 822-3402, Lew Radonovich (352) 376-1611, extension 4988, and Pam Hirsch (202) 461-1042.

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