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Objectives

1. Describe key steps for building an exposure assessment plan
2. Define in the Exposure Control Plan for adapting to current and future pandemics
3. Assessments using the Hierarchy of Controls
4. Exposure Control Plan and Recordkeeping can be adapted into proactive, real-time controls
Federal & State Standards
• Procedures in place for evaluating exposure incidents
• Ensuring a copy is accessible to employees on all shifts and in all locations
• Plan is reviewed and updated at least annually and whenever there are changes (e.g., new/revised employee positions, new potential exposures, new equipment, etc.)
• Plan must reflect changes in technology that eliminate/reduce exposure (e.g., implementation of new safety-engineered devices)
• Documentation of annual consideration of those new commercially available technologies
• Documentation of the solicitation of input from non-managerial employees who are at risk of exposures
• A list of all job classifications in which *all* employees in those job classifications have occupational exposure;
• A list of job classifications in which *some* employees have occupational exposure
• A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that is performed by employees (including those “all” and “some”)

(d) Aerosol Transmissible Diseases Exposure Control Plan.

(1) The employer shall establish, implement, and maintain an effective, written ATD Exposure Control Plan (Plan) which is specific to the work place or operation(s), and which contains all of the elements in subsection (d)(2).

EXCEPTION to subsection (d)(1): Employers with laboratory operations in which employees do not have direct patient contact may establish, implement and maintain an effective, written Biosafety Plan meeting the requirements of subsection (f) in lieu of an Exposure Control Plan for those operations.

(2) The Plan shall contain all of the following elements:

(A) The name(s) or title(s) of the person(s) responsible for administering the Plan. This person shall be knowledgeable in infection control principles and practices as they apply to the facility, service or operation.

(B) A list of all job classifications in which employees have occupational exposure.

(C) A list of all high hazard procedures performed in the facility, service or operation, and the job classifications and operations in which employees are exposed to those procedures.

(D) A list of all assignments or tasks requiring personal or respiratory protection.

(E) The methods of implementation of subsections (e), (g), (h), (i) and (j) as they apply to that facility, service or work operation. Specific control measures shall be listed for each operation or work area in which occupational exposure occurs. These measures shall include applicable engineering and work practice controls, cleaning and decontamination procedures, and personal protective equipment and respiratory protection. In establishments where the Plan pertains to laboratory operations, it also shall contain the methods of implementation for subsection (f), unless those operations are included in a Biosafety Plan.

(F) A description of the source control measures to be implemented in the facility, service or operation, and the method of informing people entering the work setting of the source control measures.

(G) The procedures the employer will use to identify, temporarily isolate, and refer or transfer AirID cases or suspected cases to All rooms, areas or facilities. These procedures shall include the methods the employer will use to limit employee exposure to these persons during periods when they are not in airborne infection isolation rooms or areas. These procedures shall also include the methods the employer will use to document medical decisions not to transfer patients in need of AirID in accordance with subsection (e)(5)(B).

(H) The procedures the employer will use to provide medical services, including recommended vaccinations and follow-up, as required in subsection (h). This shall include the procedures the employer will use to document the lack of availability of a recommended vaccine.

(I) The procedures for employees and supervisors to follow in the event of an exposure incident, including how the employer will determine which employees had a significant exposure, in accordance with subsections (h)(6) through (h)(9).

(J) The procedures the employer will use to evaluate each exposure incident, to determine the cause, and to revise existing procedures to prevent future incidents.
(c) Written COVID-19 Prevention Program. Employers shall establish, implement, and maintain an effective written COVID-19 Prevention Program, which may be integrated into the employer's Injury and Illness Program required by section 3203, or be maintained in a separate document. The written elements of a COVID-19 Prevention Program shall include:

1. System for communicating. The employer shall do all of the following in a form readily understandable by employees:
   a. Ask employees to report to the employer, without fear of reprisal, COVID-19 symptoms, possible COVID-19 exposures, and possible COVID-19 hazards at the workplace.
   b. Describe procedures or policies for accommodating employees with medical or other conditions that put them at increased risk of severe COVID-19 illness.
   c. Provide information about access to COVID-19 testing. If testing is required under this section, section 3205.1, or section 3205.2, the employer shall inform affected employees of the reason for the COVID-19 testing and the possible consequences of a positive test.
   d. In accordance with subsection (c)(3)(B), communicate information about COVID-19 hazards and the employer's COVID-19 policies and procedures to employees and to other employers, persons, and entities within or in contact with the employer's workplace.

2. Identification and evaluation of COVID-19 hazards:
   a. The employer shall allow for employee and authorized employee representative participation in the identification and evaluation of COVID-19 hazards.
   b. The employer shall develop and implement a process for screening employees for and responding to employees with COVID-19 symptoms. The employer may ask employees to evaluate their own symptoms before reporting to work. If the employer conducts screening at the workplace, the employer shall ensure that face coverings are
(D) No employer shall prevent any employee from wearing a face covering when not required by this section, unless it would create a safety hazard, such as interfering with the safe operation of equipment.

(E) Employers shall implement measures to communicate to non-employees the face coverings requirements on their premises.

(F) The employer shall develop COVID-19 policies and procedures to minimize employee exposure to COVID-19 hazards originating from any person not wearing a face covering, including a member of the public.

(8) Other engineering controls, administrative controls, and personal protective equipment.

(A) At fixed work locations where it is not possible to maintain the physical distancing requirement at all times, the employer shall install cleanable solid partitions that effectively reduce aerosol transmission between the employee and other persons.

(B) For buildings with mechanical or natural ventilation, or both, employers shall maximize the quantity of outside air provided to the extent feasible, except when the United States Environmental Protection Agency (EPA) Air Quality Index is greater than 100 for any pollutant or if opening windows or letting in outdoor air by other means would cause a hazard to employees, for instance from excessive heat or cold.

(C) Employers shall implement cleaning and disinfecting procedures, which require:

1. Identifying and regularly cleaning and disinfecting frequently touched surfaces and objects, such as doorknobs, elevator buttons, equipment, tools, handrails, handles, controls, bathroom surfaces, and steering wheels. The employer shall inform
Assessment Completion Details

**Business/Employer Name**

Completed by (name):  name of person

Date:

Job title:  of person completing assessment

Contact information:  for person completing assessment

**Employee job classifications evaluated in this assessment:**


**Questions and Answers**

Can employees telework or otherwise work remotely? How are employees encouraged or empowered to use those distance work options to reduce COVID-19 transmission at the workplace?

What are the anticipated working distances between employees? How might those physical working distances change during non-routine work activities?

COVID-19 Infection Control Plan

Oregon OSHA’s temporary rule for COVID-19 (OAR 437-001-0744) requires all employers to develop and implement an infection control plan. This plan builds upon each employer’s exposure risk assessment, which the rule also requires, and aims to eliminate or otherwise minimize worker exposure to COVID-19. The specific requirements for this COVID-19 infection control plan are outlined under subsection 437-001-0744(3)(h). This plan does not include the additional elements required for exceptional risk workplaces.

| Business/Employer Name | Date: / / |

**All job assignments or worker tasks requiring the use of personal protective equipment (including respirators) necessary to minimize employee exposure to COVID-19.**

List job assignments or tasks here

---

**The procedures we will use to ensure that there is an adequate supply of masks, face coverings, or face shields and personal protective equipment (including respirators) necessary to minimize employee exposure to COVID-19.**

Document the procedures here

---

**The specific hazard control measures that we installed, implemented, or developed to minimize employee exposure to COVID-19, listed and described.**

List and describe here

https://osha.oregon.gov/covid19/Pages/default.aspx
16VAC25-220. Mandatory requirements for all employers.

A. Employers in all exposure risk levels shall ensure compliance with the requirements in this section to protect employees from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease.

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs of an oncoming illness.


A. Employers with hazards or job tasks classified as:

1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan;

2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.
laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures:

1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus;

2. Collecting or handling specimens from a patient or person known or suspected to be infected with the SARS-CoV-2 virus (e.g., manipulating cultures from patients known or suspected to be infected with the SARS-CoV-2 virus); and

3. Performing an autopsy that involves aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.
Sample Plans
Preventing Occupational Exposures to Infectious Disease in Health Care

A Practical Guide

Authors: Mitchell, Amber Hogan

Is the first-known single-volume practical guide for professionals with responsibility for infection prevention and control and occupational health and safety programs.
### Table 7.1  Job hazard analysis matrix

<table>
<thead>
<tr>
<th>Frequency of occurrence resulting in risk</th>
<th>Risk hazard category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical</strong></td>
<td><strong>Serious</strong></td>
</tr>
<tr>
<td>Frequent/often</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>Occasional</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>Sporadic/sometimes</td>
<td>Unacceptable</td>
</tr>
<tr>
<td>Probable/infrequent</td>
<td>Moderate</td>
</tr>
<tr>
<td>Remote/improbable</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
For every identified hazard affecting a specific portion of the body, indicate the likelihood of an exposure and rate it on a scale of 0 to 5 (0 = no/low risk and 5 = probable ongoing risk):

0: Exposure is infeasible
1: Exposure is improbable/unexpected
2: Exposure possible, but unlikely
3: Exposure probable/expected
4: Multiple exposures probable/expected
5: Continuous exposure probable/expected
<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Exposure (Nose, Eyes, Mouth, Non-Intact Skin, Other)</th>
<th>Work Area, Department, or Unit Where Exposure Occurred</th>
<th>Brief Description of Exposure Incident</th>
<th>Type of PPE Worn During Exposure (Eye Protection, Mask, Respirator, Gown, etc.)</th>
<th>Would Institution of an Additional Control have Prevented the Exposure? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Table 7.4  Occupational infection prevention and control rounding checklist

<table>
<thead>
<tr>
<th>Strong (S)</th>
<th>Department/Unit</th>
<th>Responsible Person</th>
<th>Engineering Control (e.g. Safer Medical Device) Use</th>
<th>PPE Placement/Use</th>
<th>Infectious/Medical/Sharps Waste Program</th>
<th>Training &amp; Education</th>
<th>Changes Needed/Revision? (e.g. new procedure, phased out process)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Operating Room (OR)</td>
<td>A. Mitchell</td>
<td>Safety scalpels in place since 2014, introducing new skin closure technologies. Revisit in 2 months.</td>
<td>All in place and disposal adequate. No changes needed.</td>
<td>All in place. Sharps injury from suture left on floor, work with OR manager to identify better disposal practice.</td>
<td>Annual training in place. When new skin closure devices are incorporated, recheck on effectiveness of training program.</td>
<td>New skin closure safety devices. Ensure process is in place for employee feedback/evaluation of device.</td>
<td>Dr. Safety is retiring in 2018, make sure continuity plan is in place prior to her departure.</td>
</tr>
</tbody>
</table>


Box 7.1 Sample Simple Job Hazard Analysis Form

| Job location: Emergency department | Analyst: Jane Safety | Date: |

1. Task Description: Clinician performs blood collection procedure.
2. Hazard Description: Drawing capillary, venous, or arterial blood samples using a needle. Using a blood collection device (straight needle on vacuum tube or butterfly/winged steel needle or lancet), while drawing blood can result in a contaminated needlestick and exposure to a bloodborne or infectious pathogen.
3. Hazard Controls:
   1. Alert others nearby that a procedure is being performed.
   2. Alert the patient that they will feel a stick and must stay still.
   3. Don gloves.
   4. Evaluate and use a blood collection device with a injury prevention-engineered feature attached.
   5. Activate the safety feature upon completion of the procedure.
   6. Immediately dispose of the used device in a sharps container.
### Table 7.3  Risk assessment for infectious diseases

<table>
<thead>
<tr>
<th>Step</th>
<th>Main qualitative assessment(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Defining the event</td>
<td>Natural disaster</td>
</tr>
<tr>
<td></td>
<td>Outbreak</td>
</tr>
<tr>
<td></td>
<td>Epidemic</td>
</tr>
<tr>
<td></td>
<td>Pandemic</td>
</tr>
<tr>
<td></td>
<td>Terrorism</td>
</tr>
<tr>
<td></td>
<td>Spill, off-gas (e.g., laboratory-based)</td>
</tr>
<tr>
<td></td>
<td>Seasonal (e.g., flu)</td>
</tr>
<tr>
<td>2. Threat</td>
<td>Employee</td>
</tr>
<tr>
<td>Likelihood of impact/illness/infection</td>
<td>Job/task</td>
</tr>
<tr>
<td></td>
<td>Frequency of exposure (work, home)</td>
</tr>
<tr>
<td></td>
<td>Vaccine, immunization status</td>
</tr>
<tr>
<td></td>
<td>Work practices</td>
</tr>
<tr>
<td></td>
<td>Personal practices</td>
</tr>
<tr>
<td></td>
<td>Availability of PPE</td>
</tr>
<tr>
<td></td>
<td>Ongoing access to education, training</td>
</tr>
<tr>
<td></td>
<td>Underlying health effects, comorbidities</td>
</tr>
<tr>
<td></td>
<td>Agent/microorganism</td>
</tr>
<tr>
<td></td>
<td>Contact, environmental heartiness/persistence</td>
</tr>
<tr>
<td></td>
<td>Aerosol, airborne</td>
</tr>
<tr>
<td></td>
<td>Seasonal? Epidemic, pandemic</td>
</tr>
<tr>
<td></td>
<td>Resistance to treatment, disinfectant</td>
</tr>
<tr>
<td></td>
<td>Work-related, community-associated</td>
</tr>
<tr>
<td></td>
<td>Location-specific (heat, humidity, water, etc.)</td>
</tr>
</tbody>
</table>
| 3. Environmental/institutional Facility-based risk | Hierarchy of controls  
Institutional culture of safety  
Administrative controls, staffing  
Air exchanges, ventilation  
Availability of engineering controls  
Availability of PPE  
Access to PPE  
Education, training  
Waste disposal  
Robustness of occupational/employee health programs  
Incident/exposure surveillance  
Purchasing, supply chain |
|--------------------------------------------------|---------------------------------------------------------------|
| 4. Assigning risk, mobilizing action             | Using considerations of above to assess risk  
Critical/catastrophic  
High  
Moderate  
Low  
None  
Unknown |


Creating a plan to protect workers and prevent the spread of COVID-19 on construction job sites

The Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) recommend that companies develop a plan to protect their employees and prevent the spread of COVID-19. This free COVID-19 Exposure Control Planning Tool takes you step-by-step through developing your plan, including what to consider when conducting a job hazard analysis for COVID-19, selecting appropriate controls, screening workers and visitors, training employees, and implementing the plan. Remember to take advantage of your employees’ knowledge of job site conditions as you develop your plan.

At the end of the steps, you will have a written plan tailored for your job that can be saved, printed, and emailed. There is an option to confidentially register if you want to save and edit your plan(s) at a later time, but registration is not required to use this free tool.

Begin Your Plan
Step 1: Identify where your employees could be exposed to COVID-19 and the control measures that will be used to protect them and prevent exposure.

The following is a list of areas on a job site and in an office/trailer where individuals may be exposed to COVID-19 in the air and/or on surfaces. Select all the exposure risks that you expect will be present on your job site. As you select an exposure risk, a list of possible controls to prevent exposure will appear. Please select all the controls that you will use. If an exposure risk or control is not listed, please use the ‘Other’ option to fill in ones of your own and use the text box to include additional information on the location of the risks and how controls will be implemented. The blue information icon will take you to additional information on the risk or control measure.

**JOB SITE EXPOSURE RISKS AND CONTROLS**

<table>
<thead>
<tr>
<th>Risk Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airborne Exposures Outdoors - General Work Areas</td>
</tr>
<tr>
<td>Airborne Exposures Indoors/Enclosed Areas</td>
</tr>
<tr>
<td>Airborne &amp; Touch Exposures in Choke Points (entrances, elevators, lifts)</td>
</tr>
<tr>
<td>Touch Exposures from Lifting and Moving Materials</td>
</tr>
<tr>
<td>Touch Exposures from Sharing Hand Tools and Small Equipment</td>
</tr>
</tbody>
</table>

...
Using the Hierarchy of Controls

Fig. 11.1 Sample waiting room, triage area. (Source: Chelsey Armstrong (Artist) 2020)
Elimination

Substitution

Engineering controls

Administrative controls

PPE

Most effective
- Physically remove the hazard

Replace the hazard

Isolate workers from the hazard

Change the way work is done

Protect the worker with what they wear

Least effective
Fig. 9.1 Negative and positive pressure patient rooms (Chelsey Armstrong (artist), 2020)
Ventilation and Air Quality for Reducing Transmission of COVID-19

Good ventilation and indoor air quality are important in reducing airborne exposure to viruses, including SARS-CoV-2 that causes COVID-19, as well as other disease vectors, chemicals, and odors. However, buildings vary in design, age, Heating Ventilation and Air Conditioning (HVAC) systems, and their ability to provide adequate ventilation and air filtration.

The American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) underscores the importance of ventilation and air filtration in reducing the transmission of COVID-19 through the position statement: "Transmission of SARS-CoV-2 through the air is sufficiently likely that airborne exposure to the virus should be controlled. Changes to building operations, including the operation of heating, ventilating, and air-conditioning (HVAC) systems, can reduce airborne exposures. Ventilation and filtration provided by heating, ventilating, and air-conditioning systems can reduce the airborne concentration of SARS-CoV-2 and thus the risk of transmission through the air. Unconditioned spaces can cause thermal stress to people that may be directly life threatening and that may also lower resistance to infection. In general, disabling of heating, ventilating, and air-conditioning systems is not a recommended measure to reduce the transmission of the virus."
(Source: ASHRAE)

The main goal in reducing airborne transmission of viruses is to decrease the number of viral particles that accumulate in indoor air, by increasing the intake of outdoor air as much as possible and/or through effective air filtration. However, ventilation and air filtration are not effective alone – they are tools that must be used along with other measures such as health screenings, physical distancing, reducing building occupancy, frequent hand washing, wearing face coverings, and implementing appropriate cleaning and disinfection protocols. Additionally,
Below are some general parameters for air changes per hour (ACH), temperature, filtration, and relative humidity for non-COVID emergency surge spaces outside of a licensed hospital:

- Minimum 2 ACH Outdoor air and 2 ACH Total air, though higher total air is desired (basis is patient room from FGI 1997)
- For large volume spaces with high ceilings, such as conference centers, air changes may be calculated based on a ceiling height of 10 feet, however for supply air temperatures above room temperature, minimum OA and total ACH may be calculated as 2 ACH Outdoor divided by 0.8 ACH, or 2.5 Total air (ASHRAE 62.1 ventilation effectiveness) and supply air temperatures kept no more than 15 degrees F above room temperature to minimize stratification and short-circuiting of air within the space
- No less than MERV 13 and MERV 14 preferred for systems that are not serving specialized environments that may require even higher efficiency filtration.
- Temperature 70 – 75 degrees
- Humidity -- consider maintaining 40-60% RH. See additional information here.
- Refer also to Minnesota Department of Health, "Methods for Temporary Negative Pressure Isolation"
Using Data, Recordkeeping to Drive Change in Real Time
In use around the world since 1992.
FREE: https://internationalsafetycenter.org/use-epinet/
What is EPINet?

✓ A surveillance system database disseminated by the International Safety Center
✓ Microsoft Access Database that can be emailed to any user that has a Microsoft Office package
✓ It is not software and does not require IT support
✓ It is free to use
✓ Individual employee needlestick, sharp object injuries, and blood and body fluid exposures are entered by a series of dropdown menus
✓ Customized, de-identified reports can be generated by the facility
EPINet Sharps Injury and Blood and Body Fluid Data Reports

Since 1992, hospitals have submitted data on occupational exposures to blood and body fluids.

This group, known as the U.S. EPINet Sharps Injury and Blood and Body Fluid Exposure Surveillance Research Group (or EPINet Research Group), originally included three distinct groups of healthcare facilities:

www.internationalsafetycenter.org
Needlestick and Sharp Object Injuries
Sharp Object Injury & Needlestick Summary Data; N=36 US Health Systems, EPINet 2019

- Nurse: 34.8%
- Doctor Attending: 16.4%
- Doctor Resident/Intern: 16.8%
- Medical Student
- Nursing Student
- Other
- Clinical Lab
- Phlebotomist/Med Tech
- C.N.A or HHA
- Technologist
- Surg Attend
- Other
Only 52.2% indicate they were using a sharp with injury protection (engineering control); 71.6% did NOT activate safety feature.

41.7% in OR
26% in Patient/Exam Room

17.7% Insulin
18.9% 24/25G Syringes
Moving the Sharps Safety in Healthcare Agenda Forward in the United States:
2020 Consensus Statement and Call to Action

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https://internationalsafetycenter.org/wp-content/uploads/2020/12/Moving_The_Sharps_Safety_In_Healthcare_Agenda_Forward_In_The_US.pdf
Blood & Body Fluid Exposure (BBFE) Incidents

Non-Sharps
Blood & Body Fluid Exposure Incident Summary Data; N=36 facilities, EPINet 2019

- Eyes: 48.1% (+multiple locations)
- Intact Skin
- Non-Intact Skin
- Mouth
- Nose
- Other
Eyes Only by Percent Compared to all Other BBFE Incidents

\[ y = -4.49x + 70.59 \]

\[ y = -0.57x + 6.83 \]
### Which barrier garments were worn at the time of exposure?

<table>
<thead>
<tr>
<th>Garment</th>
<th>% of Total Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single pair of gloves</td>
<td>31.2%</td>
</tr>
<tr>
<td>Double pair of gloves</td>
<td>4.7%</td>
</tr>
<tr>
<td>Protective Eyewear / Goggles</td>
<td>0.8%</td>
</tr>
<tr>
<td>Eyeglasses (not protective)</td>
<td>6.0%</td>
</tr>
<tr>
<td>Eyeglasses with sideshields</td>
<td>1.1%</td>
</tr>
<tr>
<td>Faceshield</td>
<td>1.7%</td>
</tr>
<tr>
<td>Surgical mask</td>
<td>3.3%</td>
</tr>
<tr>
<td>Surgical gown</td>
<td>0%</td>
</tr>
<tr>
<td>Plastic apron</td>
<td>0.3%</td>
</tr>
<tr>
<td>Labcoat / Scrub Jacket, cloth, (not protective)</td>
<td>0%</td>
</tr>
<tr>
<td>Respirator</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

**3.6%**
Wearing appropriate eye protection

How will this change in 2020, given SARS-CoV-2/COVID19??
Challenges During a Pandemic

Use data; incidents, exposures to drive adaptation and change

More focus on what we know we can prevent?

Improvements in PPE compliance, accessibility?

Will 2020 exposures look very different than the last 5 years?

What else?
Tools and Resources