Exposure Control Policy

POLICY:

To maintain a clean environment for patients and minimize the risk of patient and healthcare personnel exposure to potentially infectious microorganisms; through training, use of personal protective equipment, hand hygiene, environmental cleaning, exposure management and return to work protocols.

PROCEDURE:

Training

All employees who have occupational exposure to pathogens receive initial and annual training supervised by Dr Name.

All employees who have occupational exposure to pathogens receive training on the epidemiology, symptoms, and transmission of pathogen diseases. In addition, the training program covers, at a minimum, the following elements:

- a copy and explanation of the OSHA and CDC standards regarding the pathogen
- an explanation of this exposure control policy and how to obtain a copy
- an explanation of methods to recognize tasks and other activities that may involve exposure to blood and other potentially infectious materials (OPIM), including what constitutes an exposure incident
- an explanation of the use and limitations of engineering controls, work practices, and personal protective equipment (PPE)
- an explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
- an explanation of the basis for PPE selection
- information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM
- 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 employer is required to provide for the employee following an exposure incident
- an opportunity for interactive questions and answers with the person conducting the training session.

Training materials for this facility are available at ChiroArmor. (COVID-19: https://bestpracticesacademy.com/covid-19-resources/

Personal Protective Equipment (PPE)

PPE is provided to our employees at no cost to them. Training in the use of the appropriate PPE for specific tasks or procedures is provided by Dr Name.

The type of PPE available to employees are gloves and face masks. Gloves and facemasks are located (List location) and may be obtained through Dr Name. All chiropractic assistants and doctors will obtain and use gloves and facemasks and Dr Name is responsible for ensuring that gloves, facemasks, and any other appropriate PPE is available.

All employees using PPE must observe the following precautions:

- Wash hands immediately or as soon as feasible after removing gloves or other PPE.
- Remove PPE after it becomes contaminated and before leaving the work area.
- Used PPE may be disposed of in a plastic bag lined wastebasket for disposal.
- Wear appropriate gloves when it is reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured or contaminated, or if their ability to function as a barrier is compromised.
- Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
- Never wash or decontaminate disposable gloves for reuse.
- Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eye, nose, or mouth.
- Remove immediately or as soon as feasible any garment contaminated by blood or OPIM, in such a way as to avoid contact with the outer surface.

Procedure for Handling Used PPE

A. Housekeeping

Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded (see the following section "Labels"), and closed prior to removal to prevent spillage or protrusion of contents during handling. All PPE should be tracked and inventory replenished on a regular basis.

The procedure for handling other regulated waste is: Dr Name will oversee disposal of used PPE in usual garbage disposal with plastic garbage bags securely tied closed.

Broken glassware that may be contaminated is only picked up using mechanical means, such as a brush and dustpan.

B. Laundry

The following contaminated articles will be laundered by this company:

Laundering will be performed by Dr Name at (vendor/location).

The following laundering requirements must be met:

- handle contaminated laundry as little as possible, with minimal agitation
- place wet contaminated laundry in leak-proof, labeled or color-coded (red) containers before transport. Use a unique bag for this purpose.
- wear the following PPE when handling and/or sorting contaminated laundry: disposable gloves.

C. Labels

The following should be labeled in this facility:

Plastic garbage bags containing regulated waste

Dr Name is responsible for ensuring that **warning labels are affixed or red bags** are used as required if regulated waste or contaminated equipment is brought into the facility.
Employees are to notify Dr Name if they discover regulated waste containers, refrigerators containing blood or OPIM, contaminated equipment, etc., without proper labels.

Hand Hygiene Policy and Procedure

Effective hand hygiene reduces the incidence of healthcare-associated infections. All members of the healthcare team will comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Glossary of Commonly Used Hand Hygiene Terms

Alcohol-based hand rub. An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%–95% ethanol or isopropanol.

Antimicrobial soap. Soap (i.e., detergent) containing an antiseptic agent.

Antiseptic agent. Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, and triclosan.

Antiseptic handwash. Washing hands with water and soap or other detergents containing an antiseptic agent.

Antiseptic hand rub. Applying an antiseptic hand rub product to all surfaces of the hands to reduce the number of microorganisms present.

Cumulative effect. A progressive decrease in the numbers of microorganisms recovered after repeated applications of a test material.

Decontaminate hands. To reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic handwash.

Detergent. Detergents (i.e., surfactants) are compounds that possess a cleaning action. They are composed of both hydrophilic and lipophilic parts and can be divided into four groups: anionic, cationic, amphoteric, and nonionic detergents. Although products used for handwashing or antiseptic hand wash in health-care settings represent various types of detergents, the term "soap" is used to refer to such detergents in this guideline.

Hand antisepsis. Refers to either antiseptic hand wash or antiseptic hand rub.

Hand hygiene. A general term that applies to either handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Handwashing. Washing hands with plain (i.e., non-antimicrobial) soap and water.

Persistent activity. Persistent activity is defined as the prolonged or extended antimicrobial activity that prevents or inhibits the proliferation or survival of microorganisms after application of the product. This activity may be demonstrated by sampling a site several minutes or hours after application and demonstrating bacterial antimicrobial effectiveness when compared with a baseline level. This property also has been referred to as "residual activity." Both substantive and nonsubstantive active ingredients can show a persistent effect if they substantially lower the number of bacteria during the wash period.

Plain soap. Plain soap refers to detergents that do not contain antimicrobial agents or contain low concentrations of antimicrobial agents that are effective solely as preservatives.

Substantivity. Substantivity is an attribute of certain active ingredients that adhere to the stratum corneum (i.e., remain on the skin after rinsing or drying) to provide an inhibitory effect on the growth of bacteria remaining on the skin.

Surgical hand antisepsis. Antiseptic hand wash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient and reduce resident hand flora. Antiseptic detergent preparations often have persistent antimicrobial activity.

Visibly soiled hands. Hands showing visible dirt or visibly contaminated with proteinaceous material, blood, or other body fluids (e.g., fecal material or urine).

Waterless antiseptic agent. An antiseptic agent that does not require use of exogenous water. After applying such an agent, the hands are rubbed together until the agent has dried.

Indications for Handwashing and Hand-rubbing

A. Indications for Handwashing

1. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.
2. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.
3. Handwashing may also be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care

- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- After removing gloves

B. Indications for Hand-rubbing

If hands are ***not visibly soiled***, an alcohol-based hand rub may be used for routinely decontaminating hands in the following clinical situations:

- Before having direct contact with patients
- After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)
- After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, only if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- After removing gloves

Non-Surgical Hand Hygiene Technique

A. Handwashing with soap and water (either non-antimicrobial or antimicrobial)

1. Wet hands with running water
2. Apply hand washing agent to hand
3. Vigorously rub hands together for at least 15 seconds, covering all surfaces of hands and fingers
4. Rinse hands thoroughly with water and with hands angled down in the sink
5. Dry hands thoroughly with a disposable towel(s)
6. Use disposable towel to turn off the water

B. Alcohol-based hand rub

1. Apply product to palm of one hand
2. Rub hands together, covering all surfaces of hands and fingers
3. Continue to rub until hands are dry

Nails

1. Artificial fingernails or extenders may not be worn if duties include direct contact with patients
2. Natural nail tips shall be less than ¼ inch long

Gloves and Hand Hygiene

Gloves reduce hand contamination by 70 – 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. However, the use of gloves does not eliminate the need for hand hygiene.

1. Wear gloves when contact with blood or other potentially infectious materials (other body fluids, secretions and excretions), mucous membranes, non-intact skin and contaminated items will or could occur.
2. Change gloves during patient care if moving from a contaminated body site to a clean body site.
3. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient.
4. Decontaminate hands after removing gloves.

References

To access the CDC's hand hygiene guidelines in their entirety, see the CDC website at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm

Environmental Cleaning: Policy and Procedure

The patient care environment throughout the facility will be maintained in a state of cleanliness that meets professional standards in order to protect patients and healthcare personnel from potentially infectious microorganisms. Environmental cleaning is a team effort. Personnel responsible for cleaning the environment and equipment will receive education and training on proper environmental cleaning and disinfection methods, agent use and selection, and safety precautions.

Personal protective equipment (PPE) must be worn according to the Occupational Safety and Health Administration (OSHA) when disposing of waste that could result in exposure to bloodborne or other potentially infectious microorganisms and hazardous material.

1. Routine/terminal cleaning and disinfection procedures (e.g., applying an EPA-registered disinfectant to frequently touched surfaces or objects). Refer to for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2 (List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2).

2. Cleaning of treatment room daily or when incidents require it.

    - Prepare disinfectant solution according to manufacturer's instructions.
    - Collect and remove waste
    - Collect and remove all soiled linen
    - Use a cloth dampened in disinfectant solution to clean and disinfect horizontal surfaces that have come in contact with a patient or body fluids, including blood pressure cuffs.
    - Clean and disinfect treatment tables
    - Insert new waste liner bags if needed

<u>How long does an examination room need to remain vacant after being occupied by a patient with confirmed or suspected COVID-19?</u>

For a patient who was not coughing or sneezing and occupied the room for a short period of time (e.g., a few minutes), any risk to HCP and subsequent patients likely dissipates over a matter of minutes. However, for a patient who was coughing and remained in the room for a longer period of time, the risk period is likely longer.

3. Terminal cleaning of each treatment room will be completed daily when the scheduled procedures are completed for the day.

    - Collect and remove waste
    - Collect and remove all soiled linen
    - Clean and disinfect all exterior surfaces of machines and equipment
    - Clean and disinfect all horizontal surfaces
    - Clean and disinfect treatment tables
    - Replace all furniture and equipment to its proper location

- Clean and store cleaning equipment
- Report any needed repairs

a. Disposal

- Place soiled cloths in designated container for laundering or dispose
- Remove soiled linen if bag is full
- Place obvious waste in receptacles
- Remove waste

b. Clean hands; if hands are visibly soiled, wash with soap and water

c. Replenish supplies as required (e.g., gloves, alcohol-based hand rub (ABHR), soap, paper towel)

3. Clean bathrooms, working from clean areas to dirty areas.

- Wash hands and put on gloves
- Clean door handle and frame, light switch
- Clean wall attachments
- Clean inside and outside of sink, sink faucets and mirror; wipe plumbing under the sink; apply disinfectant to interior of sink; ensure sufficient contact time with disinfectant; rinse sink and dry fixtures
- Clean all dispensers and frames
- Clean support railings, ledges/shelves
- Clean walls and railing, scrubbing as required to remove soil; ensure sufficient contact time for disinfectant; rinse and wipe dry
- Change all waste bags, clean waste can if dirty
- Remove gloves and wash hands
- Replenish paper towel, toilet paper, waste bag, soap and ABHR as required 4. Personnel responsible for cleaning must perform hand hygiene:

a. Before initial patient environment contact (e.g., before coming into the patient space);

b. After potential body fluid exposure (e.g., after cleaning bathroom, handling soiled linen, equipment or waste); and

c. After patient environment contact (e.g., after cleaning patient space; after cleaning equipment such as adjustment tables; after changing mop heads).

d. Gloves (when used) must be removed on leaving each patient space. Personnel must **clean hands after removing gloves** as gloves do not provide complete protection against hand contamination.

Exposure Management and Return to Work

Practice Name will provide immediate and efficient care and follow-up to employees, patients, and volunteers who have been exposed to blood, body fluids or OPIM (other potentially infectious material) while working in our facilities.

IMPLEMENTATION:

1.Treatment of Exposure Site

- Wash wounds and skin sites with soap and water
- Flush mucous membranes with water
- Uses of antiseptics are not contraindicated but there is no evidence that it will further reduce risk of transmission. Avoid use of caustic agents (e.g. bleach).

2.Immediately report the incident to your supervisor and complete the incident report.

3.Assess level of risk category and respond accordingly:

Defining Exposure Risk Category for COVID-19

High-Risk Exposure

High-risk exposures refer to HCP who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

Medium-Risk Exposure

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some *low-risk* exposures are considered *medium-risk* depending on the type of care activity performed. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure. If an aerosol-generating procedure had not been performed, they would have been considered *low-risk*. See Table 1 for additional examples.

Low-Risk Exposure

Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.

No-Risk Exposure

HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have *no identifiable risk*.)

See table below https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was wearing a facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None
Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e., no source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 *(until 14 days after last potential exposure)*	Work Restrictions for Asymptomatic HCP
			after last exposure
HCP PPE: Not wearing eye protection[b]	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self with delegated supervision	None

HCP=healthcare personnel; PPE=personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

[b]The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.

Documentation and Monitoring

All documentation of this incident will be made to HCP's employee health file in H.R.

Recommendations for Monitoring Based on COVID-19 Exposure Risk

HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work

1. ***High- and Medium-risk*** **Exposure Category**
   HCP in the high- or medium-risk category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature >100.0oF or subjective fever) OR respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)* they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and

healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

2. ***Low-risk* Exposure Category**
   HCP in the *low-risk* category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)*. They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature ≥ 100.0 °F or subjective fever) OR respiratory symptoms they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.
3. **HCP who Adhere to All Recommended Infection Prevention and Control Practices**
   Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.
4. ***No Identifiable risk* Exposure Category**
   HCP in the *no identifiable risk* category do not require monitoring or restriction from work.
5. **Community or travel-associated exposures**
   HCP with potential exposures to COVID-19 in community settings, should have their exposure risk assessed according to CDC guidance. HCP should inform their facility's occupational health program that they have had a community or travel-associated exposure. HCP who have a community or travel-associated exposure should undergo monitoring as defined by that guidance. Those who fall into the *high-* or *medium-risk* category described there should be excluded from work in a healthcare setting until 14 days after their exposure. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

Report case to worker's compensation carrier.

5. Monitoring

Practice Name will conduct **self-monitoring with delegated supervision** during pandemic situations (COVID-19).

- Self-observation means people should remain alert for subjective fever, cough, or difficulty breathing.
- Self-monitoring means people should monitor themselves for fever by taking their temperatures twice a day and remain alert for cough or difficulty breathing.
- **Self-monitoring with delegated supervision means, for certain occupational groups (e.g., healthcare providers), self-monitoring with oversight by the appropriate internal infection control program in coordination with the health department of jurisdiction. On days staff/doctors are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms twice daily (prior to starting work and end of the work shift). Staff and doctors should record/report temperature and absence of symptoms.**
- Self-monitoring with public health supervision means public health authorities assume the responsibility for oversight of self-monitoring for certain groups of people.
- Active monitoring means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever, cough, or difficulty breathing.

6. Return to Work Determination

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Practice Name will use one of the below strategies to determine when HCP may return to work in healthcare settings:

Test-based Strategy

Exclude from work until:

- Resolution of fever without the use of fever-reducing medications and
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
- Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

Non-test-based Strategy

Exclude from work until:

- At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
- At least 7 days have passed since symptoms first appeared

Return to Work Practices and Work Restrictions

After returning to work, the health care personal should:

- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms and seek re-evaluation from primary care provider if respiratory symptoms recur or worsen and inform the doctor.

Effective Date:		**Revised Date(s):**
Reviewed/approved by:		**Reviewed/approved by:**
Applies To: All Staff/ All Locations		

Further References

To access the CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities in its entirety, see the CDC website at:
http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf

To access the December 2009 version of the Provincial Infectious Diseases Advisory Committee's (PIDAC) Best Practices for Environmental Cleaning for Infection Prevention and Control in All Health Care Settings, see the PIDAC website at:
http://www.health.gov.on.ca/english/providers/program/infectious/diseases/best_prac/bp_enviro_clean.pdf

To access OSHA requirements: https://www.osha.gov/laws-regs/regulations/standardnumber/1910

CDC Bloodborne Pathogen Standard.
To access training videos specific to COVID-19: https://bestpracticesacademy.com/covid-19-resources/