



STATE OF WASHINGTON  
**DEPARTMENT OF CORRECTIONS**  
P.O. Box 41100 • Olympia, Washington 98504-1100

The Department of Corrections will be updating this document, if applicable, with the most current policy updates on the third Monday of each month. This will be a temporary solution to ensure access to department policies while the department continues to work to find a permanent solution to host current agency policies on Securus tablets.



STATE OF WASHINGTON  
DEPARTMENT OF CORRECTIONS

APPLICABILITY  
**DEPARTMENT WIDE**  
FACILITY/SPANISH MANUALS

REVISION DATE  
3/20/24

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NUMBER  
**DOC 850.030**

**POLICY**

TITLE  
**RELATIONSHIPS/CONTACTS WITH INDIVIDUALS**

**REVIEW/REVISION HISTORY:**

- Effective: 3/1/98 DOC 801.005
- Revised: 1/12/04 DOC 850.030
- Revised: 8/21/06
- Revised: 8/21/07
- Reviewed: 8/25/08
- Revised: 6/27/11
- Revised: 1/14/14
- Revised: 6/1/20
- Revised: 3/20/24

**SUMMARY OF REVISION/REVIEW:**

Added I.B. that employees/contract staff/volunteers may share personal information and have limited, appropriate contact with individuals in the performance of their professional duties  
 Added II.A.3. that contact through appropriate professional or business networks/organizations and/or legislative activities, and/or other business organizations does not require reporting as long as it meets policy requirements  
 Added II.A.5 that employees/contract staff/volunteers may be added to an incarcerated family member's approved visit list  
 IV.A. and V.A. - Adjusted language for clarification  
 V.B.1. and VI.A. - Added clarifying language

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
Department of Corrections

2/21/24  
Date Signed



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**POLICY**

TITLE  
**RELATIONSHIPS/CONTACTS WITH INDIVIDUALS**

**REFERENCES:**

DOC 100.100 is hereby incorporated into this policy; DOC 450.300 Visits for Incarcerated Individuals; DOC 530.100 Volunteer Program

**POLICY:**

- I. Employees, contract staff, and volunteers will interact with individuals under the Department’s jurisdiction, including individuals who have been discharged within the last 6 months, and their known immediate family/associates, in a professional manner consistent with law, correctional practice(s), and Department policies and procedures.

**DIRECTIVE:**

- I. General Requirements
  - A. Employees, contract staff, and volunteers will maintain the highest standards of professionalism and will be mindful of improper association.
  - B. Employees/contract staff/volunteers may:
    - 1. Share personal (e.g., favorite sports team, hobbies) but not private information (e.g., family/financial details, health problems) with individuals.
    - 2. Have limited and appropriate physical contact (e.g., shaking hands, fist bumps, high fives, pats on the back or shoulder) with individuals in the performance of their professional duties.
  - C. Association beyond what is required in the performance of official duties is prohibited except as approved per DOC 530.100 Volunteer Program.
- II. Reporting Requirements
  - A. Employees, contract staff, and volunteers will report significant or ongoing contact with individuals under the Department’s jurisdiction or their known immediate family/associates outside of official duties to their Appointing Authority no later than the next business day using DOC 03-039 Report of Contact/Relationship.
    - 1. Pre-existing family or personal relationships with individuals under the Department’s jurisdiction must be reported.
    - 2. Casual or unintentional contact (e.g., greeting while passing on the street) does not require reporting.



# POLICY

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- 3. Contact with individuals through appropriate professional or business networks/organizations (e.g., LinkedIn, Rotary, Toastmasters) and/or legislative activities does not require reporting as long as it meets policy requirements.
  - 4. Exceptions for ongoing contact require approval from the Secretary/designee.
  - 5. Employees/contract staff/volunteers with an approved DOC 03-039 Report of Contact/Relationship may be added to an incarcerated family member's approved visit list per DOC 450.300 Visits for Incarcerated Individuals.
- B. Employees, contract staff, and volunteers will report to their supervisor when they or their immediate family have been the victim of an individual under the Department's jurisdiction.
  - C. The Appointing Authority has the discretion to reassign an employee or individual under the Department's jurisdiction on a case-by-case basis to avoid potential conflicts.
    - 1. The employee may request to be reassigned.
    - 2. Efforts to reassign the individual may be made before reassigning the employee.

### III. Messages and Articles of Property

- A. Employees/contract staff/volunteers will not:
  - 1. Transmit messages, mail, or property for or to individuals under the Department's jurisdiction or their known immediate family/associates, except when authorized as part of their official duties.
  - 2. Give or accept gifts/gratuities/favors, barter, or have any financial dealings with or for individuals under the Department's jurisdiction or their known immediate family/associates.

### IV. Writs, Petitions, and Legal Concerns

- A. Employees/contract staff/volunteers will not assist, advise, advocate for, or counsel individuals under the Department's jurisdiction in their preparation of writs, appeals, or petitions for legal concerns, including clemency. Individuals may be referred to the appropriate legal service agency/person for assistance.

### V. Sponsorship and References



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# POLICY

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- A. Employees, contract staff, and volunteers will only provide a residence or serve as a release, furlough, or personal outing sponsor with prior written approval from the Appointing Authority.
- B. Employees, contract staff, and volunteers may provide the following references for education/employment/vocational training. All other references require prior written approval from the Appointing Authority.
  - 1. Certification(s) completed during incarceration, including a brief description of the course,
  - 2. Training or program participation within the facility, and/or
  - 3. Experience gained during incarceration based on observation(s) or a performance evaluation(s).

## VI. Violations

- A. Violations of this policy, providing false/misleading information, or failing to report known relationships/contacts may result in corrective or disciplinary action, up to and including dismissal.

### DEFINITIONS:

The following words/terms are important to this policy and are defined in the glossary section of the Policy Manual: Immediate Family. Other words/terms appearing in this policy may also be defined in the glossary.

### ATTACHMENTS:

None

### DOC FORMS:

DOC 03-039 Report of Contact/Relationship



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**DOC 890.000**

**POLICY**

TITLE  
**SAFETY PROGRAM**

**REVIEW/REVISION HISTORY:**

- Effective: 4/3/06
- Revised: 4/30/07
- Revised: 2/13/09
- Revised: 9/1/10
- Revised: 9/26/11
- Revised: 1/1/13
- Revised: 6/1/15
- Revised: 3/19/20
- Revised: 2/11/22

**SUMMARY OF REVISION/REVIEW:**


Updated terminology throughout  
Added VII.A.3. that quarterly Headquarters inspections will be documented

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
Department of Corrections

1/28/22  
\_\_\_\_\_  
Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-24](#); [WAC 296-800](#); DOC 890.380 Fire Prevention Plan; Exposure Control Guide; [Facility Contract Safety Plans Development Guide](#); Safety Program Manual; [Records Retention Schedule](#)

**POLICY:**

- I. The Department has a safety program to provide a safe environment for employees, contract staff, volunteers, individuals under the Department’s jurisdiction, and visitors, and to comply with Washington Industrial Safety and Health Act (WISHA) rules.
- II. This policy, in conjunction with the Safety Program Manual, constitutes the Department’s Safety and Accident Prevention Program.
- III. Department facilities and offices, Community Justice Centers, and Correctional Industries (CI) sites will conduct and monitor safety and sanitation inspections to provide a safe and sanitary environment.

**DIRECTIVE:**

- I. Responsibilities
  - A. The Litigation Administrator and Regional Safety Managers will oversee implementation of the Safety Program.
    1. The assigned Safety Officer/representative will assist facilities, offices, and CI operations in implementing the Safety Program.
  - B. Administrators/managers will ensure implementation of the Safety Program in the regional offices, Community Justice Centers, CI Headquarters, and Department Headquarters.
  - C. Superintendents, Community Corrections Supervisors (CCSs), and CI General Managers will implement the Safety Program within their assigned area of responsibility consistent with this policy, the Safety Program Manual, and applicable WISHA rules.
    1. Each Department facility, office, Community Justice Center, and CI worksite will maintain a current and accessible Safety Program Manual.
  - D. Each CI Manager will develop and implement an ongoing safety program appropriate to the environment and needs of the specific operation type.

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- E. Employees, contract staff, volunteers, and workers under the Department’s supervision are essential and active participants in the Safety Program and will be responsible for complying with all safety and health standards applicable to their own activities in the worksite.
- F. An active safety bulletin board will be maintained at each Department worksite, consistent with the requirements identified in the Safety Program Manual.


II. Safety Program Audits

- A. The Department’s Safety Unit will ensure safety program audits and inspections are conducted.
  - 1. Biennial Safety Program audits will be conducted in each Prison, Reentry Center, and each CI worksite in a Prison.
  - 2. Biennial Safety Program audit/inspections will be conducted at each Field Office by local site employees/contract staff.
- B. Appointing Authorities will be responsible for corrective action plans resulting from Safety Program audits/inspections. Plans will be tracked and reported by the assigned Safety Officer/representative until completion.

III. Accident/Injury Reporting

- A. Employees, volunteers, contract staff, visitors, and individuals under the Department’s jurisdiction will report all injuries and accidents, no matter how slight, including those with no apparent injuries, to the appropriate supervisor immediately, but no later than 24 hours after the incident.
  - 1. For incidents where the injured person does not have access to the Department’s electronic accident reporting system (e.g., incarcerated workers, volunteers, visitors), the injured person will provide the supervisor, escort, or liaison with a completed and signed hard copy of DOC 03-133 Accident/Injury Report. The recipient will enter the details as written into the electronic reporting system and attach the signed hard copy.
    - a. The supervisor or training instructor (i.e., if the injury occurred during training) at the site of the incident will conduct a thorough review and document any findings on the electronic DOC 03-133 Accident/Injury Report.



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- b. The Safety Officer will review and investigate the reports, identify causes, recommend preventive measures, and assist with trend analysis upon the Appointing Authority's request.

#### IV. Reporting On-the-Job Fatality, Inpatient Hospitalization, Amputation, or Loss of an Eye

- A. Superintendents, Field Administrators, CCSs, and/or the CI Director will ensure the Department of Labor and Industries (L&I) is notified of any work-related death or inpatient hospitalization of any employee or Class II or Class IV incarcerated worker within 8 hours of the incident. Notification will be made to L&I within 24 hours of an amputation or the loss of an eye that doesn't result in inpatient hospitalization.
  1. Required reports will be made per [L&I's Job Safety and Health Law](#), which is posted on all Department safety bulletin boards.
  2. For Class IV workers, the escorting employee/contract staff will notify the parent facility's Superintendent/designee so appropriate notification can be made.
  3. Upon completion of notification to L&I, the Safety Unit will be notified.

#### V. Hazard Reporting and Prevention

- A. Employees, contract staff, volunteers, and incarcerated workers will identify and immediately report all known and potential workplace hazards to their immediate supervisors.
  1. Hazards should be resolved and corrected immediately at the lowest level.
  2. When a hazard cannot be immediately corrected, the hazard will be isolated, and the employee/contract staff/volunteer or supervisor will submit a work order to address repairs and maintenance issues.
  3. If the hazard is more complex, is not being effectively addressed, or increased awareness of the hazard could improve workplace safety, the employee/contract staff/volunteer or supervisor will report the hazard as follows:
    - a. Department of Natural Resources (DNR) Class IV workers will report hazards directly to DNR.
    - b. Employees, contract staff, volunteers, and all other workers will use DOC 03-151 Hazard Report.

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- 1) Written instructions on how to obtain hazard report forms will be available on each safety bulletin board.
4. Employees, contract staff, and incarcerated workers will be notified of the resolution of corrective action taken in response to the reported hazard.

## VI. Safety Committee

- A. Each Prison and Field Office will have a Safety Committee consistent with WAC 296-800-13020.
  1. Membership for facility Safety Committees in Prisons with a Class II industry will include a CI Class II Supervisor/Manager.
- B. Each CI Class II Manager will have a Safety Committee consistent with WAC 296-800-13020.
  1. When necessary, the CI Class II Manager may hold a safety meeting in lieu of a Safety Committee per the Safety Program Manual.
- C. Each Reentry Center will have a Safety Committee and/or safety meetings and participate in the Regional Safety Committee with representation.
- D. Each Field Office will participate in the Regional Safety Committee with representation.
- E. All other Department offices of 11 or more employees, including Department Headquarters, will have a Safety Committee.
  1. Meeting minutes for Safety Committees will be recorded on DOC 03-085 Monthly/Quarterly Safety Committee Minutes.
  2. CI safety meeting minutes will be recorded on DOC 03-473 Correctional Industries Safety Meeting Minutes.
- F. If the Safety Committee does not have the authority to implement its recommended change, the Safety Committee Chair will escalate the recommendation as required for final determination.

## VII. Safety Inspections

- A. Safety and sanitation inspections of all Department facilities, offices, and CI sites will be conducted. Inspectors and Safety Committee members who are assigned to conduct safety and sanitation inspections must have documented, completed Inspector Qualification training.


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1. Monthly inspections will be documented on DOC 16-347 Monthly Safety and Sanitation Inspection by:
    - a. Safety Officers and/or Safety Committee Representatives in Prisons.
    - b. Local site employees/contract staff designated by the CCS in Reentry Centers.
  2. Quarterly inspections for Field Offices will be documented on DOC 16-348 Quarterly Safety and Sanitation Inspection by Safety Committee Representatives from Field Offices.
  3. Quarterly inspections for Department Headquarters will be documented on DOC 16-348HQ Headquarters Quarterly Safety and Sanitation Inspection by Headquarters Safety Committee Representatives.
- B. Area supervisors will be informed of any deficiencies noted during the inspections to ensure they are corrected.
  - C. The applicable Safety Committee will review identified deficiencies and corrective actions and track until completed. Reviews, findings, and completed actions will be documented in the meeting minutes.
  - D. Records of annual inspections of Prisons and Reentry Centers by the Department of Health will be maintained and accessible onsite.
  - E. Annual fire inspections will be completed per DOC 890.380 Fire Prevention Plan.

## VIII. Training

### A. Safety Training

1. New Employee Safety training will be provided to each employee consistent with the Safety Program Manual.
2. Supervisors will ensure employees, contract staff, volunteers, and incarcerated workers are provided additional job-specific training on machinery, industrial equipment, and special use vehicles to ensure safe operation and compliance with specific policy and WISHA requirements.
  - a. On-the-job worker safety training will be documented on DOC 10-116 Job Specialty Training Record and/or DOC 10-122 Tool/Equipment/Process Specialty Training Outline.

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3. All employee safety training will be documented and submitted to the Training and Development Unit.

**B. Safety Orientation**

1. Each facility supervisor, Field Office, CCS, and/or Safety Representative will provide an initial site-specific orientation to each employee, volunteer, contract staff, and Department supervised worker new to the work area.
  - a. The orientation will include information on local emergency procedures, first aid, chemical HAZCOM, slip, trip, and fall, and other relevant site safety information.
  - b. Employee, contract staff, and volunteer orientation will be documented using DOC 03-474 Safety Orientation Site Specific or DOC 03-161 Volunteer Safety Orientation Information.
  - c. Incarcerated worker orientation will be documented using DOC 10-118 Shop Rules and Requirements.
2. Each CI General Manager will provide and document safety orientation training on DOC 10-117 Safety Orientation Worksheet.

**IX. Facility Contract Safety Plans**

- A. The Plant Manager and/or designated construction project managers will develop and maintain a Facility Contract Safety Plan for each Capital facility contract project that uses a labor force of incarcerated workers.
  1. The plan will include:
    - a. Completing a project checklist(s).
    - b. Providing and documenting worker training consistent with the Facility Contract Safety Plan notebook checklist(s).
    - c. Completing and documenting weekly site inspections.
    - d. Completing and documenting weekly safety meetings.
  2. After completion of the project, the original Facility Contract Safety Plan will be forwarded to Capital Programs, which will be retained in the contract file per the Records Retention Schedule.

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- a. The Plant Manager will maintain a copy of the Facility Contract Safety Plan documents for 3 years after completion of the project.

**DEFINITIONS:**

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

**ATTACHMENTS:**

None

**DOC FORMS:**

- DOC 03-085 Monthly/Quarterly Safety Committee Minutes
- DOC 03-133 Accident/Injury Report
- DOC 03-151 Hazard Report
- DOC 03-161 Volunteer Safety Orientation Information
- DOC 03-473 Correctional Industries Safety Meeting Minutes
- DOC 03-474 Safety Orientation Site Specific
- DOC 10-116 Job Specialty Training Record
- DOC 10-117 Safety Orientation Worksheet
- DOC 10-118 Shop Rules and Requirements
- DOC 10-122 Tool/Equipment/Process Specialty Training Outline
- DOC 16-347 Monthly Safety and Sanitation Inspection
- DOC 16-348 Quarterly Safety and Sanitation Inspection
- DOC 16-348HQ Headquarters Quarterly Safety and Sanitation Inspection



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**DOC 890.020**

**POLICY**

TITLE  
**CONFINED SPACE PROGRAM**

**REVIEW/REVISION HISTORY:**

Effective: 10/24/97  
 Revised: 12/24/04  
 Revised: 5/7/08  
 Revised: 7/23/10  
 Revised: 5/21/12  
 Revised: 8/18/14  
 Revised: 2/3/21

**SUMMARY OF REVISION/REVIEW:**


Major changes to include the addition of site specific training and updated applicability. Read carefully!

**APPROVED:**

Signature on file

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**STEPHEN SINCLAIR**, Secretary  
 Department of Corrections

1/6/21  
 \_\_\_\_\_  
 Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-155](#); [WAC 296-809-600](#); [WAC 296-803](#); [WAC 296-809](#); [WAC 296-817](#); [WAC 296-841](#); DOC 890.110 Fall Protection Program; DOC 890.120 Lockout/Tagout Program; [Confined Space Entry Handbook](#); [Records Retention Schedule](#)

**POLICY:**

- I. The Department recognizes the inherent dangers associated with entering confined spaces. The Confined Space Program has been established to protect employees, contract staff, and incarcerated workers from the potential hazards associated with confined space entry.
- II. The Confined Space Program includes this policy and the Confined Space Entry Handbook.
- III. For the purposes of this policy, a confined space:
  - A. Is large enough and arranged so an individual could fully enter the space,
  - B. Has limited or restricted entry or exit, and
  - C. Is not primarily designed for continuous human occupancy.


**DIRECTIVE:**

- I. Responsibility
  - A. No one will enter a confined space in which potential or identified hazards have not been controlled or eliminated.
  - B. The Superintendent of each facility with confined spaces will designate a Confined Space Program Manager, who will:
    1. Designate an Entry Supervisor(s).
    2. Develop the facility's Confined Space Program.
    3. Identify and maintain a list of permit-required confined spaces, to include the hazard type and safety procedures to control or eliminate exposure.
      - a. Confined spaces will be considered permit-required unless it has been determined they meet non-permit qualifications.
    4. Maintain a map showing the locations of each identified confined space.

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5. Take effective measures to prevent unauthorized entry, including labeling entrances to permit-required confined spaces.
  6. Ensure initial awareness and site specific training is conducted and documented for all workers involved in confined space activities.
  7. Establish procedures for safe entry of permit-required confined spaces and ensure:
    - a. Confined space equipment is available and operational.
    - b. Adequate rescue and emergency services are available during permit-required confined space entry.
    - c. Contract staff, who do not normally work at the facility, are informed that the workplace contains permit-required confined spaces and entry is allowed only when applicable requirements of WAC 296-809 have been met.
  8. Review and sign canceled entry permits within one year after each confined space entry.
    - a. A single annual review may be done covering all entries performed during a 12 month period.
  9. Retain the completed DOC 03-201 Confined Space Entry Permit and DOC 03-202 Hot Work Permit per the Records Retention Schedule.
- C. The Entry Supervisor will:
1. Evaluate, plan, and implement the procedures necessary to control or eliminate hazards for safe entry into permit-required confined spaces.
  2. Ensure the following tasks have been completed before entry into a permit-required confined space:
    - a. DOC 03-201 Confined Space Entry Permit and DOC 03-202 Hot Work Permit are sequentially numbered and completed as necessary.
      - 1) The hot work permit will be completed when authorization is needed to perform operations that can potentially provide a source of ignition (e.g., riveting, welding, cutting, burning, heating).




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- b. Workers are trained on each confined space entry, including:
  - 1) Hazards associated with entry
  - 2) Correct procedures for entry
  - 3) Procedures to be activated in the event of an emergency
  - 4) Responsibilities of the Entry Supervisor, attendant, and entrant
- c. Verify rescue and emergency services are available during permit-required confined space entry operations.
- 3. Ensure that entry operations and conditions for permit-required confined spaces remain consistent with the terms of the permit.
- 4. Ensure unauthorized individuals do not enter or attempt to enter the confined space during entry operations.
- 5. Terminate entry and cancel the permit when:
  - a. The assigned task or job has been completed, or
  - b. A condition in the space that is not covered by the entry permit is discovered.
- 6. Ensure lockout/tagout procedures are available and followed for each confined space where lockout/tagout is necessary per DOC 890.120 Lockout/Tagout Program.
- 7. Ensure fall protection work plan procedures are completed for each confined space per DOC 890.110 Fall Protection Plan, where applicable.
- 8. Meet the requirements of WAC 296-809-600 if alternate entry procedures are necessary.

## II. Emergency Rescue Requirements

- A. Employees assigned to provide rescue and emergency services will be:
  - 1. Adequately trained and equipped for rescue operations.
  - 2. Proficient in the use of Personal Protective Equipment (PPE) and other equipment.
  - 3. Proficient as an entrant of permit-required confined spaces.
  - 4. Able to safely perform rescue and assigned duties.
  - 5. Certified in basic first aid and cardiopulmonary resuscitation (CPR).
- B. Emergency rescue procedures will be practiced at least once a year.

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- C. Whenever possible, non-entry retrieval systems/methods to rescue entrants will be used first.
- D. Incarcerated workers will not be used to perform entry rescue.

### III. Training

- A. Training will be provided to anyone involved in confined space activities to ensure they acquire the understanding, knowledge, and skills necessary to safely perform assigned duties.
  - 1. Initial awareness training will be conducted before performing any confined space related duties.
    - a. Employee/contract staff training will be documented in the training database managed by the Department’s Training and Development Unit.
    - b. Incarcerated worker training will be documented on the class roster and in the electronic file.
  - 2. Site-specific training will be completed prior to performing any permit required entry and documented on one of the following, as applicable:
    - a. DOC 03-472 Confined Space Entry Site-Specific Training - Employee
    - b. DOC 03-472A Confined Space Entry Site-Specific Training - Incarcerated Worker
- B. The Confined Space Program Manager will determine when refresher training is required.

### DEFINITIONS:

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

### ATTACHMENTS:

None

### DOC FORMS:

DOC 03-201 Confined Space Entry Permit



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APPLICABILITY  
**PRISON**  
OFFENDER MANUAL

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**DOC 890.020**

# POLICY

TITLE  
**CONFINED SPACE PROGRAM**

DOC 03-202 Hot Work Permit

DOC 03-472 Confined Space Entry Site-Specific Training - Employee

DOC 03-472A Confined Space Entry Site-Specific Training - Incarcerated Worker



STATE OF WASHINGTON  
DEPARTMENT OF CORRECTIONS

APPLICABILITY  
**DEPARTMENT WIDE**  
FACILITY/SPANISH MANUAL

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NUMBER  
**DOC 890.030**

**POLICY**

TITLE  
**HAZARDOUS/DANGEROUS WASTE MANAGEMENT**

**REVIEW/REVISION HISTORY:**

Effective: 12/4/98  
 Revised: 1/18/00  
 Revised: 11/22/06  
 Revised: 11/4/08  
 Reviewed: 1/29/10  
 Reviewed: 8/23/10  
 Revised: 10/15/12  
 Revised: 5/2/17  
 Revised: 11/15/21

**SUMMARY OF REVISION/REVIEW:**


Updated terminology throughout  
 I.A.1.a. - Removed unnecessary language

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
 Department of Corrections

11/1/21  
 \_\_\_\_\_  
 Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [RCW 18.64.610](#); [RCW 70A.300](#); [WAC 173-303](#); DOC 410.390 Hazardous Material Emergency (RESTRICTED); DOC 650.055 Needles, Syringes, and Hazardous Medical and Dental Instruments (RESTRICTED); DOC 890.000 Safety Program; DOC 890.070 Chemical Control and HAZCOM; [29 CFR 1910](#); [40 CFR 239-282](#); [40 CFR 372](#); [49 CFR 171](#); [United States Department of Transportation Emergency Response Guidebook](#)

**POLICY:**

- I. The Department will:
  - A. Protect itself, the public, employees, individuals under Department jurisdiction, and the environment from the dangers associated with hazardous/dangerous waste.
  - B. Ensure facilities provide for an approved waste disposal system per federal, state, and local jurisdictions.
- II. Hazardous/dangerous waste emergencies will be handled per DOC 410.390 Hazardous Material Emergency (RESTRICTED).

**DIRECTIVE:**


- I. General Responsibilities
  - A. Hazardous/dangerous waste is defined and managed per WAC 173-303.
    1. Pharmaceutical waste will be managed in accordance with the Department of Ecology’s [Dangerous Waste Pharmaceuticals Guide](#), regardless of generator status.
      - a. Except Prisons, facilities/offices will manage pharmaceutical waste as household waste per WAC 173-303-071(3)(c).
    2. Resource Conservation and Recovery Act (RCRA) wastes are federally regulated, hazardous wastes.
    3. Except Prisons, all other waste will be managed as household waste. Facilities/offices will consult the Headquarters Capital Programs and Development Environmental Manager if hazardous/dangerous waste is accumulated and requires disposal.

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- B. Facilities that generate waste must have a current Environmental Protection Agency (EPA)/State identification number.
- C. Each Superintendent/Reentry Center Community Corrections Supervisor (CCS) will designate a Hazardous Waste Coordinator to manage the storage and/or disposal of hazardous/dangerous waste. The Hazardous Waste Coordinator will be accountable for the solid waste stream (i.e., from the time waste is created until disposal) and must be informed of all new waste generating processes.
- D. Facilities will manage pharmaceutical waste in consultation with the Director of Pharmacy/designee.
  - 1. Pharmaceuticals are considered waste when they are non-creditable (i.e., cannot be used, sold, or returned to a manufacturer, wholesaler, or reverse distributor for credit).
  - 2. Creditable pharmaceuticals that have left the Pharmacy but have not left the control of health services employees/contract staff, will be returned to the Pharmacy to determine if the items are suitable for re-distribution per WAC 246-869-130.
    - a. Creditable controlled substances will not be returned to the Pharmacy.

## II. Generator Status

- A. The Hazardous Waste Coordinator will determine the facility's generator status based on a review of the amount of dangerous waste generated each month and the aggregate volume of hazardous waste stored onsite at any one time.
  - 1. Large quantity generators produce more than 2,200 pounds of dangerous waste or 2.2 pounds of acute hazardous waste per month or hold more than 2,200 pounds of dangerous waste onsite at any one time.
  - 2. Medium quantity generators produce between 220 pounds and 2,200 pounds of dangerous waste per month and hold less than 2,200 pounds of dangerous waste onsite at any one time.
  - 3. Small quantity generators produce less than 220 pounds of dangerous waste or 2.2 pounds of acute hazardous waste per month.
- B. Many state/federal regulations do not apply to small quantity generators. In these cases, the Hazardous Waste Coordinator, Superintendent/CCS, and the

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Director of Pharmacy will be responsible for ensuring that wastes are properly managed per local regulations and do not pose a health or environmental threat.

### III. Handling

- A. Movement of hazardous/dangerous waste containers requires Hazardous Waste Coordinator approval.
  - 1. For medium and large quantity generators, containers will be moved to the facility's designated Accumulation and Transfer Site, which must be located outside of the building, within 3 days of total accumulation of 55 gallons.
    - a. The site must be well marked within the facility and in a secure place, restricted to authorized employees only.
    - b. Containers will be accompanied by DOC 16-333 Hazardous/Dangerous Waste Inventory Log.
- B. Containers that hold hazardous/dangerous waste will be managed per WAC 173-303-630.
  - 1. Sharps containers will be handled as biohazardous medical waste per DOC 650.055 Needles, Syringes, and Hazardous Medical and Dental Instruments (RESTRICTED).
- C. Health Services will coordinate with the Hazardous Waste Coordinator prior to movement of RCRA pharmaceutical waste or removal of RCRA pharmaceutical waste by the Department authorized vendor.
- D. Oily/flammable rags will be properly stored in covered metal containers that are emptied daily. Contaminated flammable rags will be stored in a tight sealing, covered metal container at the Accumulation and Transfer Site.

### IV. Empty Container Management


- A. Empty hazardous/dangerous waste containers will be managed per WAC 173-303-160.
- B. Empty containers will be taken to the designated Accumulation and Transfer Site for disposition or disposal.
  - 1. Empty containers may be recycled or re-used provided they have been properly cleaned and rinsed, to prevent the mixing of incompatible materials, and all original identification labels have been removed.

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V. Labeling of Known Hazardous/Dangerous Waste Materials

- A. Hazardous/dangerous waste labels and risk labels (e.g., “Ignitable”, “Corrosive”, “Toxic”) are available on the Department of Ecology website at: [http://www.ecy.wa.gov/programs/hwtr/hw\\_labels/](http://www.ecy.wa.gov/programs/hwtr/hw_labels/)
- B. Supervisors/managers, in conjunction with the Hazardous Waste Coordinator, will label the container prior to adding waste to avoid mixing incompatible substances. Names of individuals under Department jurisdiction will not be listed on any inventory log or label.
  - 1. Medium and large quantity generators will use a hazardous/dangerous waste label and an associated risk label for each container per WAC 173-303-200(1)(c) and WAC 173-303-200(1)(d). The accumulation start date will be documented on the label when the container is moved to the Accumulation and Transfer Site.
  - 2. RCRA wastes must be segregated from other wastes per 40 CFR 239-282 and will be stored in a container with the major risk label and the accumulation start date.
    - a. In addition, RCRA pharmaceutical wastes will be labeled “Hazardous Pharmaceutical Waste.”
      - 1) A sample list of RCRA pharmaceutical waste is available on the Pharmacy SharePoint site.
  - 3. Hazardous/dangerous waste placed into containers will be documented on DOC 16-333 Hazardous/Dangerous Waste Inventory Log. Only the Hazardous Waste Coordinator can authorize changes to the inventory log.
  - 4. Conditionally excluded dangerous pharmaceutical wastes will be stored in a container labeled “Dangerous Pharmaceutical Waste” and documented on DOC 16-334 Conditionally Excluded Dangerous Pharmaceutical Waste Log.
    - a. In addition, the accumulation start date and the major risk label will be documented on the container.
    - b. Loose pills, not designated as RCRA waste, may be included in the container in a zip-locked bag but do not need to be logged.
  - 5. Inventory logs will be placed on or adjacent to the containers.



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6. Labels will include the appropriate waste codes.

- a. Dangerous waste codes are defined per WAC 173-303-100.
- b. RCRA waste codes are defined per WAC 173-303-80 and WAC 173-303-090.
- c. State-only dangerous waste codes are defined per WAC 173-303-104.

C. Containers will remain at the Accumulation and Transfer Site with limited access until transferred to the Treatment, Storage, and Disposal facility.

D. Health services employees/contract staff will coordinate with the Hazardous Waste Coordinator to designate pharmaceutical waste or other chemicals purchased from sources other than the Pharmacy or authorized external pharmacies.


#### VI. Identification and Labeling of Unknown Hazardous/Dangerous Waste

A. All unknown substances will be treated as hazardous/dangerous waste until they have been identified per WAC 173-303-90 and WAC 173-303-100.

B. Supervisors/managers, in conjunction with the Hazardous Waste Coordinator, will:

1. Test all containers of unknown substances as follows:

- a. Label each container "Waste Pending Analysis" with the discovery or accumulation date.
- b. Consult a Department of Ecology certified laboratory on the sample volume needed to accurately identify the waste. Certified laboratories are located on the Department of Ecology website at: <https://fortress.wa.gov/ecy/laboratorysearch/>
- c. Label the sample jar with the sample date and identification number used on the container and complete the chain of custody form provided by the laboratory or vendor.
- d. Send the sample to a certified laboratory, requesting the following tests:
  - 1) Characteristics of ignitability, corrosivity, reactivity, toxicity, and federal hazardous,


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- 2) State-only toxic dangerous waste (e.g., Aquatic Bioassay), and
- 3) State-only persistent dangerous waste.

2. Upon receipt of laboratory results, properly designate the waste and label and manage the container.


## VII. Shipping and Disposal

- A. Hazardous/dangerous waste, except conditionally excluded dangerous pharmaceutical waste, will be shipped to a Treatment, Storage, and Disposal facility by a Department authorized vendor.
  1. Accumulation time limits for dangerous waste must be shipped off-site within 90 days for large quantity generators and 180 days for medium quantity generators, or when the waste has reached the facility's designated weight limit (i.e., generator status).
  2. RCRA pharmaceutical waste must be shipped off-site within 180 days, regardless of accumulation weight, to an RCRA permitted incinerator.
  3. Pharmacy employees/contract staff will transport conditionally excluded dangerous pharmaceutical waste to an incinerator meeting the requirements per WAC 173-303-071(3)(nn).
- B. Conditionally excluded dangerous pharmaceutical waste will be shipped to the Pharmacy for disposal within 180 days of the accumulation start date. The waste will be collected in plastic bags and packaged in boxes using a dual witness process for accountability purposes and to ensure RCRA waste is not included. Boxes will not be sent without a plastic bag liner.
  1. Boxes will be shipped by the Department authorized shipping vendor. Shipment will not be made through the U.S. Postal Service.
    - a. Liquid medications must be packaged in a way to avoid breakage and leaks.
    - b. Before sealing each box, the generating facility will ensure:
      - 1) The box is not marked waste and does not include any RCRA waste, including loose pills.
      - 2) Weight does not exceed 20 pounds.

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- 3) A copy of the completed DOC 16-334 Conditionally Excluded Dangerous Pharmaceutical Waste Log is in the box.
  - c. Box labels will only include the following address and the quantity of boxes sent (e.g., 1/1, 1/2, 2/2):
 

DOC Pharmacy Services  
Attn: Destruction  
20311 Old Hwy 9 SW  
Centralia, WA 98531
2. The generating facility will email the completed DOC 16-334 Conditionally Excluded Dangerous Pharmaceutical Waste Log to [DOC Pharmacy Destruction](#) with the subject line “Conditionally Excluded Dangerous Pharmaceutical Waste,” the number of boxes, and the facility name.
3. The Pharmacy will email the generating facility confirmation of the receiving shipment and segregate the waste for destruction.
- C. The EPA/State identification number will be documented on all transportation bills of lading and manifests.
- D. Only a reverse distributor (i.e., vendor that may accept creditable pharmaceuticals in exchange for credit) will be authorized to manage destruction/return of creditable pharmaceuticals and non-creditable controlled substances.
  1. Employees/contract staff will consult with the Director of Pharmacy/designee prior to contacting the reverse distributor.
  2. A complete list of conditionally excluded dangerous pharmaceutical waste will be provided to the reverse distributor at the time of disposal.
  3. The reverse distributor will provide the generating facility with documentation of manufacturer credit and/or a manifest/bill of lading certifying destruction within 20 days of receiving the pharmaceuticals or controlled substances.
- E. The Hazardous Waste Coordinator will prepare [EPA Form 8700-22 Uniform Hazardous Waste Manifest](#) per WAC 173-303-180 for shipment of hazardous/dangerous wastes from medium and large quantity generators. All sections of the shipping manifest will be completed as required.

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1. The generating facility will retain one signed copy of the manifest and the remaining signed copies are sent with the vendor.
2. If the manifest is not received within 45 days of shipment, the Hazardous Waste Coordinator must submit an exception report to the Department of Ecology, including a copy of the original manifest and the date disposal or storage was to occur.

#### VIII. Inspection Requirements

- A. Each facility will routinely inspect Accumulation and Transfer Sites using DOC 16-349 Weekly Inspection Checklist for Hazardous/Dangerous Waste.
  1. Inspections are required weekly per WAC 173-303-630(6) for medium and large quantity generators.
- B. Each facility will routinely inspect satellite accumulation areas.

#### IX. Reporting and Recordkeeping

- A. The following records pertaining to hazardous/dangerous waste will be retained for a minimum of 5 years, unless otherwise specified per WAC 173-303-210 and WAC 173-303-630(6):
  1. Copies of all manifests/bills of lading, by date,
  2. Copies of all laboratory test results,
  3. Records of any onsite visits by the Department of Ecology or other agencies reviewing hazardous/dangerous waste material activities,
  4. Completed DOC 16-333 Hazardous/Dangerous Waste Inventory Log,
  5. Completed DOC 16-334 Conditionally Excluded Dangerous Pharmaceutical Waste Log, and
  6. Reverse distributor receipts, invoices, and credits.
- B. The Hazardous Waste Coordinator will retain records pertaining to hazardous/dangerous waste. Pharmaceutical waste records will be retained by health services employees/contract staff at the generating facility.
- C. Facilities will submit an annual report to the Department of Ecology per WAC 173-303-230 no later than March 1<sup>st</sup>.
- D. The Hazardous Waste Coordinator will annually verify with the Department of Ecology the Treatment, Storage, and Disposal facility is in compliance with all applicable regulations.

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X. Training

- A. Safety training will be provided per DOC 890.000 Safety Program.
- B. HAZCOM training will be provided per DOC 890.070 Chemical Control and HAZCOM.
- C. Additional training for persons handling hazardous/dangerous waste will include:
  - 1. Overview on manifesting,
  - 2. Contingency plan in case of a spill, and
  - 3. Waste designation.

**DEFINITIONS:**

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

**ATTACHMENTS:**

None

**DOC FORMS:**

- DOC 16-333 Hazardous/Dangerous Waste Inventory Log
- DOC 16-334 Conditionally Excluded Dangerous Pharmaceutical Waste Log
- DOC 16-349 Weekly Inspection Checklist for Hazardous/Dangerous Waste



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**DOC 890.070**

# POLICY

TITLE  
**CHEMICAL CONTROL AND HAZCOM**

## REVIEW/REVISION HISTORY:

Effective: 1/31/98  
Revised: 1/15/04  
Revised: 11/27/06  
Revised: 8/6/08  
Revised: 11/16/09  
Revised: 11/29/10  
Revised: 5/1/14  
Revised: 7/10/20

## SUMMARY OF REVISION/REVIEW:


Major changes to include updating terminology, replacing Material Safety Data Sheets with Safety Data Sheets, and removing references to Hazardous Material Identification System. Read carefully!

## APPROVED:

Signature on file

\_\_\_\_\_  
**STEPHEN SINCLAIR**, Secretary  
Department of Corrections

6/5/20  
Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [RCW 49.70](#); [WAC 173-303-9904](#); [WAC 296-901](#); [42 U.S.C. 116](#); [40 CFR 156.62](#); [40 CFR 370](#); DOC 410.390 Hazardous Material Emergency (RESTRICTED); [DOC 890.000 Safety Program](#); [DOC 890.030 Hazardous/Dangerous Waste Management](#); [DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment](#); [DOC 890.620 Emergency Medical Treatment](#); [Chemical Control Reference Table](#); [HAZCOM Manual](#); [Globally Harmonized System \(GHS\) of Classification and Labeling of Chemicals](#); [Records Retention Schedule](#)

**POLICY:**

- I. The Department has established procedures for handling, controlling, and using chemicals in Department facilities/offices. This policy, in conjunction with the Hazard Communication (HAZCOM) Manual, constitutes the Department’s written Chemical Hazard Communication Program.
  - A. This policy does not apply to personal use chemicals or substances exempted from HAZCOM rules per WAC 296-901-14004(6), except:
    1. Prison employees/contract staff/volunteers will be limited to one small container of alcohol-based hand sanitizer, which must remain in the owner’s control while in the facility.
- II. Employees, contract staff, volunteers, visitors, and workers will be informed about and/or have ready access to the hazard information for chemicals to which they are exposed in their work or may come in contact with while at a Department facility/office. The public will be informed about hazardous chemicals present at Department facilities/offices located in the community.

**DIRECTIVE:**

- I. Responsibilities
  - A. Each facility/office will have a HAZCOM Coordinator, designated in writing, who will:
    1. Ensure that procedures are established for handling, controlling, and using chemicals in compliance with this policy and applicable regulations.
    2. Coordinate with employees and contract staff before any work is performed in a facility/office to ensure that a Safety Data Sheet (SDS) is maintained and available for all products/substances that contain a chemical regulated by HAZCOM rules.

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3. Complete and post a HAZCOM bulletin on the facility/office's safety bulletin board advising persons of their rights under the HAZCOM rules.

B. Supervisors will ensure:

1. Chemicals in their zone of control are:
  - a. Stored and handled per this policy, DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment, the HAZCOM Manual, the manufacturer's label instructions, and the current SDS or product label.
  - b. Disposed of per DOC 890.030 Hazardous/Dangerous Waste Management.
2. Incarcerated workers only use controlled chemicals (i.e., chemicals requiring an FTCM log) when under close supervision (e.g., line of sight at all times) by qualified employees/contract staff.
3. All required records are readily available for review and retained per the Records Retention Schedule.

C. Each Prison will have a Chemical Review Committee that will meet as necessary to review new chemical submissions, either in person or remotely (e.g., by email, WebEx). Committee members will include at least 4 of the following:


1. Safety Officer/designee
2. Local Business Advisor
3. Warehouse Manager
4. Facility Manager/designee
5. Captain/Lieutenant/designee
6. Associate Superintendent/designee
7. Correctional Industries representative
8. Others as designated

II. Reporting Requirements

A. The HAZCOM Coordinator will submit the following to the State Emergency Response Commission (SERC), Local Emergency Planning Committee (LEPC), and fire department with jurisdiction over the facility/office:

1. An SDS for, or a list of, the hazardous chemicals present onsite in amounts exceeding the threshold level per 42 U.S.C. 116 (i.e., the Emergency Planning and Community Right-to-Understand Act).



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a. Facilities must submit updated documentation within 3 months of:

- 1) A hazardous chemical first becoming present in an amount exceeding the threshold level, or
- 2) Discovering significant new information on a previously declared hazardous chemical.


2. An [EPA 8700-30 Tier Two Emergency and Hazardous Chemical Inventory](#) must be submitted annually by March 1 for each hazardous chemical that was present in the facility/office in an amount exceeding the threshold level at any time during the previous calendar year. Inventories may be submitted electronically on the Department of Ecology's website.

### III. Approved Chemical List (ACL)

- A. Each HAZCOM Coordinator will maintain a master ACL of all chemicals approved for use in the facility/office. Area specific ACL(s) will also be maintained in each area of the facility/office listing the chemicals approved for use in that area. The ACL will include:
  1. Product name,
  2. Signal word (i.e., DANGER, WARNING), if applicable,
  3. Indication of where the chemical is authorized for use, and
  4. Indication of Flammable, Toxic, or Caustic Material (FTCM) chemicals and hazard statement, if applicable.
- B. The current SDS for each listed chemical will be hyperlinked to the ACL or printed and maintained with the paper list.
- C. An annual review of ACLs will be conducted and updated as needed by the HAZCOM Coordinator or, in Prisons, Chemical Review Committee.

### IV. Flammable, Toxic, or Caustic Material (FTCM) Log

- A. DOC 21-764 Flammable, Toxic, or Caustic Material (FTCM) log must be maintained for all chemicals used or accessible by incarcerated workers that have a:
  1. SDS and/or label marked "DANGER",
  2. SDS and/or label marked "WARNING", only as required per the Chemical Control Reference Table, or
  3. Toxicity Category of I, II, or III per 40 CFR. 156.62 and label marked "CAUTION".

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B. FTCM logs will be filled out and reconciled as products are added and/or used.

V. Chemical Review, Approval, and Evaluation Process

A. All chemicals must be reviewed, evaluated, and approved before being used onsite.

B. Requests for review will be submitted to the HAZCOM Coordinator using DOC 03-388 Chemical Request Application, with the product's label information and current SDS attached.

1. Before submitting, the requester will review the current facility/office ACL to ensure the chemical has not already been approved or a similar product is not available. Certain chemicals approved on the ACL may have restricted guidelines and accessibility.

2. In Prisons, the request will be forwarded to the Chemical Review Committee.

C. Each chemical will be reviewed to determine:

1. Security concerns and the appropriateness for use in the facility/office.

2. Industrial hygiene and handling requirements.

3. The level of control and whether DOC 21-764 Flammable, Toxic, and Caustic Material (FTCM) Log is required.

4. Regulatory reporting requirements.

5. Disposal requirements.


6. Possible alternatives, including less hazardous substitutes and changes in process that would achieve the same result.

7. Requests of pre-approved, restricted chemicals that will require development of an assigned work plan for its use.

D. The HAZCOM Coordinator and/or Chemical Review Committee will approve/deny the request. Additional information or modifications may be requested.

E. The requester will be notified of the decision and reason(s) in writing.

VI. Container Labeling

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- A. Containers will be clearly labeled consistent with the labeling guidelines per the HAZCOM Manual.
  - 1. Labels will only be valid if consistent with the Globally Harmonized System (GHS) of Classification and Labeling of Chemicals.
- B. Original labels must not be covered or changed. Products with a legible manufacturer's label do not need additional labeling. Illegible labels must be replaced.
- C. Products with an EPA registration number will not be stored in secondary/ aftermarket containers.
- D. Secondary/aftermarket containers will be labeled with the following information, at a minimum.
  - 1. Product identifier
  - 2. Signal word, if applicable
  - 3. Hazard statement(s) or corresponding H-code(s) per WAC 173-303-9904
  - 4. Pictogram(s)

VII. Accidental Exposure/Release

- A. In the event of an accidental exposure to a chemical, the exposure control will be handled per DOC 890.620 Emergency Medical Treatment, DOC 890.000 Safety Program, and the current SDS or product label.
- B. Accidental release of chemicals will be addressed per DOC 410.390 Hazardous Material Emergency (RESTRICTED) and the current SDS or product label.

VIII. Training

- A. Approved HAZCOM training will be provided to:
  - 1. Incarcerated workers using DOC 21-565 Hazard Communication Label and Safety Data Sheet Training.
  - 2. New employees/contract staff during New Employee Orientation/ Correctional Worker Core.
    - a. GHS/HAZCOM specific training will be provided during In-Service training.
- B. HAZCOM training is required when new hazardous chemicals are brought into an employee/contract staff/incarcerated worker area.

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C. Training will be documented for:

1. Incarcerated workers in the individual's electronic file.
2. Employees/contract staff in the training database managed by the Department's Training and Development Unit.

**DEFINITIONS:**

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

**ATTACHMENTS:**

None

**DOC FORMS:**

[DOC 03-388 Chemical Request Application](#)

[DOC 21-565 Hazard Communication Label and Safety Data Sheet Training](#)

[DOC 21-764 Flammable, Toxic, and Caustic Material \(FTCM\) Log](#)



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# POLICY

TITLE  
**RESPIRATOR PROGRAM**

## REVIEW/REVISION HISTORY:

- Effective: 1/15/97
- Revised: 5/1/01
- Revised: 6/19/08
- Revised: 1/10/11
- Revised: 11/26/12
- Revised: 7/20/18
- Revised: 3/29/19
- Revised: 2/11/22

## SUMMARY OF REVISION/REVIEW:

Updated terminology throughout  
 II.D.1.b. - Added language for clarification

## APPROVED:


Signature on file

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**CHERYL STRANGE**, Secretary  
 Department of Corrections

1/28/22  
 Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-800](#); [WAC 296-842](#); DOC 670.000 Communicable Disease, Infection Prevention, and Immunization Program; DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment; [Records Retention Schedule](#)

**POLICY:**

- I. Employees, contract staff, and incarcerated workers will use respirators to reduce their exposure to hazardous airborne contaminants and hazardous environments.
- II. The Department has established procedures for the proper fit and maintenance of respirators to contribute significantly to a safe and healthy working environment.

**DIRECTIVE:**


- I. General Requirements
  - A. Respirators will be selected based on the hazard assessment and equipment selection criteria procedures in DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment and WAC 296-842-13005.
    1. Employees, contract staff, and incarcerated workers will be required to use adequate protection while performing tasks in hazardous atmospheres that exceed Permissible Exposure Limit (PEL) or Immediately Dangerous to Life and Health (IDLH) atmospheres.
    2. Respirators will be selected according to:
      - a. Nature of the hazard,
      - b. Capabilities and limitations of the respirator,
      - c. Ability to obtain a satisfactory fit,
      - d. Comfort,
      - e. Breathing resistance, performance,
      - f. Fatigue,
      - g. Peripheral vision impairment,
      - h. Restriction of movement,
      - i. Interference with job, and
      - j. Overall user satisfaction and confidence.
  - B. Only employees, contract staff, and incarcerated workers that are medically cleared with current fit testing will be permitted to wear respirators.

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- C. Modification(s) to a respirator are prohibited and may result in corrective/disciplinary action.
- D. Employees, contract staff, and incarcerated workers will not use any respiratory protection equipment that is not provided by the Department.


II. Responsibilities

- A. Regional Safety Managers will monitor implementation of the Respirator Program as an element of the Department’s Safety Program.
- B. Each Superintendent or Administrator of a facility or program which requires the use of respirators will designate a Respirator Program Administrator to:
  - 1. Work with the Superintendent or Administrator to identify additional Respirator Coordinators to implement the local unit program.
    - a. Respirator Coordinators may be designated for custody, medical, maintenance, training, and/or Correctional Industries. Large facilities may consider additional Respirator Coordinators.
  - 2. Ensure the facility’s Respirator Program is in compliance with this policy and applicable WACs.
  - 3. Assist Respirator Coordinators/supervisors in establishing a routine respirator maintenance program that meets the requirements of WAC 296-842-17005.
  - 4. Ensure compliance with substance specific regulations requiring medical and bioassay surveillance (e.g., asbestos, lead), consensus recommendations from the Centers for Disease Control and Prevention, National Institute of Occupational Safety and Health, Occupational Safety and Health Administration, and/or Washington Industrial Safety and Health Act about such surveillance, and any new data on specific chemicals that indicates medical and bioassay surveillance may be necessary.
  - 5. Review program documentation of fit testing records, medical approval status, and wearer acceptance of respirators.
  - 6. Ensure appropriate action is taken to correct deficiencies.
  - 7. Establish a process to ensure cleaning and inspections are conducted for emergent use respirators after each use and recorded on DOC 03-246 Respirator Cleaning and Inspection Log.

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8. Ensure mandatory respirator posts/positions are identified in the Automated Time and Labor Advanced Scheduling (ATLAS) system, if applicable, and maintained by Human Resources with the position description.
  9. Maintain all respirator fit testing, training records, and inspections per the Records Retention Schedule.
- C. The supervisor will:
1. Conduct a hazard assessment to select the proper respirator for the task and record information on a Primary Job Safety Analysis (P-JSA) per DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment or DOC 03-247 Hazard Assessment Certification and Personal Protective Equipment (PPE) Selection Worksheet.
    - a. A copy of the P-JSA will be forwarded to the Respirator Program Administrator.
  2. Ensure respirator wearers follow this policy and related procedures.
  3. Ensure that incarcerated individuals are not involved in the management of the respirator program.
  4. Monitor respirator wearers to ensure that other Personal Protective Equipment (PPE) do not interfere with an adequate respirator face seal. Any problems must be corrected before the wearer will be allowed to use or continue to use a respirator.
    - a. When a respirator wearer advises of a condition in which it is believed continued respirator use may be harmful, respirator use will be discontinued until corrected. If the condition is considered health-related, the supervisor will direct the wearer to a Licensed Health Care Provider (LHCP) for medical release before further use will be authorized.
    - b. Any restrictions on respirator use indicated by a LHCP will be strictly followed.
  5. Periodically monitor work environments to evaluate:
    - a. Respirator fit,
    - b. Appropriate respirator selection for the hazard,
    - c. Appropriate use of respirator under workplace conditions,




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- d. Respirator maintenance, and
  - e. Wearer feedback.
6. Keep a copy of the manufacturer's manual for each respirator type used.
  7. Ensure that the service life of each respirator and maximum use limit of filter, cartridge, or canister does not exceed manufacturer's guidelines.
  8. Coordinate respirator activity with the Respirator Coordinator.
  9. Establish a clean, sanitary, secure, and convenient storage location for respirators per WAC 296-842-17010.

D. Respirator wearers will:


1. Remain clean shaven in the area of the respirator facepiece sealing surface (i.e., the area of the respirator designed to fit tightly against the skin) and will not have facial hairstyles that could interfere with respirator fit, form, or function.
  - a. Per WAC 296-842-18005, respirator use will not be permitted if wearers have a characteristic between the face and the sealing surface of the respirator that interferes with the respirator facepiece seal or valve function, including:
    - 1) Stubble
    - 2) Moustaches, including the tips
    - 3) Sideburns
    - 4) Bangs
    - 5) Hairlines
    - 6) Scars
    - 7) Beards
    - 8) Goatees
  - b. Additional information, including location of the respirator seal area on the respirator and face, is identified in the Respirator Seal Area Job Aid located on the Department's internal website.
  - c. Health services employees and contract staff may use Powered Air Purifying Respirators (PAPRs) per DOC 670.000 Communicable Disease, Infection Prevention, and Immunization Program.
    - 1) Completion of a medical questionnaire and medical clearance is required prior to training on or use of a PAPR.

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2. Inspect the respirator prior to each use to ensure it is in proper working condition per the manufacturer's guidelines.
  - a. If the respirator is damaged, soiled, or grossly contaminated, the wearer will report it to the immediate supervisor. The respirator will not be used until it has been repaired or cleaned.
3. Conduct a respirator seal check to ensure proper operation and seal of the respirator prior to each use.
4. Wash, sanitize, rinse, and dry respirators per WAC 296-842-17005 and document on DOC 03-246 Respirator Cleaning and Inspection Log.
  - a. Shared respirators (e.g., Quick Response Strike Team (QRST) members) will be cleaned after each use including when used for fit testing.
  - b. Respirators used exclusively by one person (e.g., Special/ Emergency Response Team (S/ERT) members) will be cleaned as needed.
5. Maintain respirators after use, or at least monthly, which will include:
  - a. Inspection for defects, including straps, facepiece, valve(s), and filters.
  - b. Proper storage to protect against dust, moisture, damaging chemicals, sunlight, excessive heat/cold, and physical damage.
    - 1) Assigned respirators will be stored in a bag or container and labeled to identify the wearer.

### III. Mandatory Use

- A. Respirator use is mandatory in the following identified posts and positions:
  1. Custody - All S/ERT, Inmate Recovery Team (IRT), and QRST members, and all Intensive Management Unit (IMU), Segregation, and Transportation employees.
    - a. Employees conducting medical transports will be fit tested for an N95 respirator.
  2. Health Services - All employees, contract staff, and providers involved in direct patient medical care per DOC 670.000 Communicable Disease,

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Infection Prevention, and Immunization Program. Employees and contract staff include, but will not be limited to:


- a. Nurses, Nurse Assistants, and Medical Assistants,
  - b. Mid-level providers,
  - c. Physicians,
  - d. Radiology Technicians,
  - e. Laboratory Technicians, and
  - f. Medical Technicians.
3. Non-Custody - Specific positions identified in maintenance and Correctional Industries operations.

#### IV. Voluntary Use Respirators

- A. Respirators used on a voluntary basis will be implemented per WAC 296-842-11005. The Voluntary Use statement will be posted in a conspicuous location and available to respirator wearers.

#### V. Standby Procedures for IDLH Situations


- A. The atmosphere will be considered IDLH whenever exposure cannot be measured or expected exposure cannot be reasonably estimated.
- B. At least 2 standby employees or contract staff will be outside the IDLH atmosphere whenever a person is working in IDLH atmospheres.
  1. One standby employee or contract staff is permitted when the IDLH atmosphere is well identified, hazards are addressed, and the employee/contract staff can adequately:
    - a. Monitor the person(s) in the IDLH atmosphere,
    - b. Implement communication activities, and
    - c. Initiate rescue.
- C. Visual, voice, or signal line communication must be maintained between the person(s) in the IDLH atmosphere and the standby employee(s) or contract staff.
- D. Standby employees or contract staff must be trained and equipped to provide effective emergency rescue. Equipment will include:
  1. Pressure demand or other positive pressure Self-Contained Breathing Apparatus (SCBA),

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2. A pressure demand or other positive pressure supplied air respirator with auxiliary SCBA, and
3. Either appropriate retrieval equipment or equivalent means for rescue when retrieval equipment is not necessary.
  - a. Retrieval equipment will be used when it contributes to the rescue and does not increase the overall risk resulting from entry.

#### VI. Medical Evaluation

- A. Before initial fit testing, a person's ability to wear a respirator will be medically evaluated, at no cost to the wearer, by a LHCP.
- B. The Respirator Program Administrator will ensure employees, contract staff, and incarcerated workers are provided with DOC 03-219 Respirator Medical Evaluation Questionnaire and DOC 03-314 Licensed Health Care Provider Information and Response Sheet.
  1. The wearer will complete DOC 03-219 Respirator Medical Evaluation Questionnaire.
    - a. Employees and contract staff will submit the packet within 5 days to [DOC Occupational Health and Wellness](#).
    - b. Supervisors of incarcerated workers will ensure the packet is completed and submitted to Health Services within 5 days.
      - 1) Correctional Industries Environmental Services will follow their established process.
- C. The designated LHCP will:
  1. Conduct the initial review of DOC 03-219 Respirator Medical Evaluation Questionnaire.
  2. Refer and/or ensure completion of any follow up medical evaluation with an employee, contract staff, or incarcerated worker.
    - a. If further medical evaluation is needed with another LHCP, the designated LHCP will provide:
      - 1) The completed DOC 03-219 Respirator Medical Evaluation Questionnaire

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2) DOC 03-314 Licensed Health Care Provider Information and Response Sheet

3. Certify the wearer for fit testing based on the responses given on the questionnaire and complete DOC 03-314 Licensed Health Care Provider Information and Response Sheet.
4. Based on LHCP results, coordinate with the employee, contract staff, and/or incarcerated individual, including any limitations, and distribute the completed DOC 03-314 Licensed Health Care Provider Information and Response Sheet.

D. If the LHCP finds a medical condition that may place the person’s health at increased risk if the respirator is used, a PAPR may be considered, if applicable.

1. If a subsequent LHCP evaluation finds that the person is medically able to wear a negative pressure respirator, a PAPR is no longer required.


E. An additional medical evaluation is required when:

1. The wearer reports medical signs or symptoms related to the ability to wear a respirator.
2. A LHCP, supervisor, or the Respirator Program Administrator determines that a wearer needs to be reevaluated.
3. Observations made during fit testing and program evaluations indicate a need.
4. A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on a wearer.

VII. Fit Testing

A. A minimum standard for fit testing negative pressure respirators will be qualitative fit testing. PAPR use requires an approved medical clearance and training, but does not require fit testing.


1. When a disposable respirator is worn, qualitative fit testing will follow the manufacturer’s fit testing protocol and be documented on DOC 03-243 Respirator Fit Testing and Training Acknowledgement.
2. Quantitative fit testing must be used for SCBA and when atmospheric concentrations are at or above 10 times the PEL.

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- B. If a respirator wearer notifies the LHCP or supervisor that the fit of the respirator is unacceptable, a reasonable attempt will be made to select a different respirator facepiece and the new respirator will be re-tested per WAC 296-842-15005.
- C. Each respirator wearer will receive initial fit testing:
  - 1. Prior to initial use of a respirator, or
  - 2. When using a different facepiece (e.g., size, style, model, make).
- D. Annual fit testing, within 12 months of the last fit test, will occur for all current assigned respirator wearers who use one of the following respirators:
  - 1. Full face masks,
  - 2. Half mask respirators, or
  - 3. Disposable tight-fitting respirators.
- E. Respirator wearers will also submit to fit testing when they have:
  - 1. An obvious change in body weight,
  - 2. Significant facial scarring in the area of the facepiece seal,
  - 3. Significant dental changes (i.e., multiple extractions without prosthesis or acquiring dentures),
  - 4. Reconstructive or cosmetic surgery, or
  - 5. Any other condition that may interfere with facepiece sealing.

## VIII. Training

- A. Respirator Program Administrators, Respirator Coordinators, and other employees involved in providing or conducting respirator fit testing will complete the DOC Respirator Program and Fit Test Training for Trainers.
  - 1. This training will be documented on a roster and in the Department's training system.
- B. Persons required to wear respirators will complete training consistent with DOC 03-243 Respirator Fit Testing and Training Acknowledgement before initial fit testing and within 12 months of the last fit test.
  - 1. Training will be documented on a class roster and in the Department's training system.
  - 2. Health services supervisors, employees, and contract staff required to wear PAPRs will also receive PAPR training located under Health Services on the Department's internal website.

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C. Respirator training is also required when:

1. Previous training is obsolete or incomplete based on changes in the workplace or the type of respirator.
2. The wearer's knowledge or use of the respirator indicates the wearer does not have the skill or knowledge required in WAC 296-842-16005.

**DEFINITIONS:**

The following words/terms are important to this policy and are defined in the glossary section of the Policy Manual: Bioassay, Contaminants, Hazardous Atmosphere, Immediately Dangerous to Life and Health (IDLH), Negative Pressure Respirator, Permissible Exposure Limit (PEL). Other words/terms appearing in this policy may also be defined in the glossary section.

**ATTACHMENTS:**

None

**DOC FORMS:**

- DOC 03-219 Respirator Medical Evaluation Questionnaire
- DOC 03-243 Respirator Fit Testing and Training Acknowledgement
- DOC 03-246 Respirator Cleaning and Inspection Log
- DOC 03-247 Hazard Assessment Certification and Personal Protective Equipment (PPE) Selection Worksheet
- DOC 03-314 Licensed Health Care Provider Information and Response Sheet



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# POLICY

TITLE  
**ASBESTOS PROGRAM**

## REVIEW/REVISION HISTORY:

Effective: 10/28/08  
Revised: 11/22/10  
Revised: 5/18/15  
Revised: 6/13/16  
Revised: 1/8/20

## SUMMARY OF REVISION/REVIEW:

Policy statement I., Directive III.A., and III.A.1. - Updated terminology  
Added I.B.2. that the designated competent person will ensure DOC 16-364 Pre-Maintenance Work Asbestos Assessment Tool is completed prior to work in buildings to avoid possible asbestos exposure

## APPROVED:


Signature on file

\_\_\_\_\_  
**STEPHEN SINCLAIR**, Secretary  
Department of Corrections

12/4/19

\_\_\_\_\_  
Date Signed



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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-62](#); [WAC 296-65](#); [WAC 296-155-012](#); [WAC 296-802](#); [Facility Contract Safety Plans Development Guide](#)

**POLICY:**

- I. The Department has established an Asbestos Program to provide protection for employees, contract staff, and individuals under the Department’s jurisdiction from the risks associated with exposure to asbestos.
- II. The Asbestos Program will be implemented to reduce employee exposure to or below the Permissible Exposure Limit by means of engineering and work practice controls per WAC 296-62-07713(1), and by the use of Personal Protective Equipment and respiratory protection where required.
  - A. When a material is suspected as an Asbestos Containing Material (ACM), it will be treated as Presumed Asbestos Containing Material (PACM) until it can be tested and proven otherwise.

**DIRECTIVE:**

- I. Responsibilities
  - A. In facilities and/or job sites where there is known or suspected ACM, the Appointing Authority will designate a competent person to manage and monitor the facility Asbestos Program. The designee will meet the qualifications of a competent person per WAC 296-62-07703.
  - B. The designated competent person will ensure:
    1. Only Asbestos Hazard Emergency Response Act (AHERA) certified inspectors conduct sampling per WAC 296-62-07721.
    2. DOC 16-364 Pre-Maintenance Work Asbestos Assessment Tool is completed prior to work in buildings to avoid possible asbestos exposure.
    3. Periodic review and updating of the facility Asbestos Program as necessary.
    4. Compliance with recordkeeping requirements per WAC 296-62-07727.
    5. Proper signage is posted per WAC 296-62-07721.

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## II. General Requirements


- A. When asbestos is suspected for a project, the designated competent person will ensure a good faith inspection is conducted by an AHERA Inspector to determine the presence of any known or suspected asbestos. All required testing of air and samples will be documented.
1. A Facility Project Safety Plan will be completed per the Facility Contract Safety Plans Development Guide.
  2. Contact with Capital Programs should be initiated for:
    - a. Projects involving asbestos removal,
    - b. Renovation where exposure to airborne asbestos may result, and
    - c. Maintenance and repairs where asbestos is present.
  3. In Field Offices, coordination will be made through the Leased Facilities Planning and Operations Manager for Capital Programs to determine who is responsible for sampling and asbestos abatement compliance.
- B. If unknown and suspected ACM is encountered during a project, work will stop immediately and the designated competent person will contact an AHERA Inspector to sample and test the suspected ACM. If it is determined that the suspected material is ACM, an asbestos certified contractor will be brought in to complete the work.

## III. Suspected Exposure

- A. Employees, contract staff, or incarcerated individuals that have a suspected one-time exposure to PACM will immediately notify their supervisor, who will ensure DOC 03-133 Accident/Injury Report is completed.
1. Health Services will follow up with individuals, and employees/contract staff may follow up with their primary care physician.

## IV. Training

- A. Workers in facilities where ACM or PACM exists will be provided training consistent with WAC 296-62-07722. All training will be documented.
1. Workers in buildings containing ACM or PACM will be provided a Department approved local Asbestos Awareness training.
  2. Maintenance and custodial/janitorial workers involved in non-project Class IV asbestos work where they may “contact but not disturb” ACM or PACM

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	<b>TITLE</b> <b>ASBESTOS PROGRAM</b>		

will be provided the 2 hour Asbestos Class IV Awareness training annually.

V. Recordkeeping

A. The designated competent person will ensure the following documentation is maintained:

1. Site records and plans identifying all known and suspected ACMs.
2. Completed encapsulation and/or abatement project records.
3. Certifications of all buildings/sites that have been cleared of all asbestos.
4. If the facility provides fleet repair, records on the number of clutches and pairs of brakes that are inspected, disassembled, or repaired per week and the facility's compliance with WAC 296-62-07745.

**DEFINITIONS:**

Word/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

**ATTACHMENTS:**

None

**DOC FORMS:**

- [DOC 03-133 Accident/Injury Report](#)
- [DOC 16-364 Pre-Maintenance Work Asbestos Assessment Tool](#)



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**POLICY**

TITLE  
**JOB SAFETY ANALYSIS, HAZARD ASSESSMENTS,  
AND PERSONAL PROTECTIVE EQUIPMENT**

**REVIEW/REVISION HISTORY:**

Effective: 1/15/97  
 Revised: 8/22/03  
 Revised: 4/19/07  
 Revised: 4/28/08  
 Revised: 4/30/09  
 Revised: 7/1/11  
 Revised: 8/15/16  
 Revised: 4/8/20  
 Revised: 11/16/21

**SUMMARY OF REVISION/REVIEW:**


I.B. - Updated terminology

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
 Department of Corrections

11/2/21  
 \_\_\_\_\_  
 Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-800-160](#); DOC 670.000 Communicable Disease, Infection Prevention, and Immunization Program; DOC 890.000 Safety Program; DOC 890.620 Emergency Medical Treatment; DOC 890.090 Respirator Program; DOC 890.140 Electrical Safety; [Safety Program Manual](#)

**POLICY:**

- I. Workplace conditions will be assessed to identify and eliminate potential hazards. When hazards cannot be eliminated, appropriate Personal Protective Equipment (PPE) and training will be provided to protect employees, contract staff, volunteers, and incarcerated workers.

**DIRECTIVE:**

- I. General Requirements
  - A. The Regulatory and Litigation Administrator and Regional Safety Managers will oversee the Hazard Assessments, Job Safety Analysis (JSA), and PPE Program.
  - B. Each Field Administrator, Superintendent, Reentry Center Community Corrections Supervisor, and Correctional Industries Site Manager will designate an employee responsible for:
    1. Determining hazards and developing a written hazard assessment or a JSA,
    2. Assisting in the selection of appropriate PPE, and
    3. Coordinating training.
- II. Hazard Assessments and Job Safety Analysis
  - A. Supervisors will ensure an assessment of the workplace and tasks performed within the workplace is conducted to identify and document potential hazards to workers.
    1. Supervisors will determine administrative or engineering controls to reduce and/or eliminate identified hazards.
    2. When administrative or engineering controls do not sufficiently reduce and/or eliminate identified hazards, supervisors will identify and select specific PPE to protect workers from the hazards.

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- a. Assessments and PPE selection will be documented on DOC 03-247 Hazard Assessment Certification and Personal Protective Equipment (PPE) Selection Worksheet.
- b. Supervisors will consult with the Safety Officer/Representative if additional information is needed to conduct the assessment.
3. Alternatively, supervisors may use a Supplemental Job Safety Analysis (S-JSA) for identifying specific hazards and PPE associated with equipment or work environments.
  - a. S-JSAs are available through the Safety Officer/Representative or Regional Safety Manager.

### III. PPE Maintenance, Care, and Proper Use

- A. Users will properly wear assigned PPE whenever engaged in work activities that require its use.
- B. PPE will be maintained in serviceable condition.
  1. The user will clean, sanitize, and properly store PPE after use.
  2. The user will immediately report any defective or damaged PPE to the supervisor.
  3. Defective, damaged, expired, or contaminated PPE will be immediately removed and either decontaminated, discarded according to proper procedures, or repaired before being returned to service.
  4. Supervisors will confirm that PPE is periodically inspected and maintained in a clean and serviceable condition.
- C. Only Department-provided PPE is permitted.

### IV. Training

- A. Safety Officers/Representatives will provide JSA, hazard assessment, and PPE training to work supervisors.
  1. Supervisor training will be documented on a class roster and submitted to the Training and Development Unit and updated in the Learning Management System (LMS).

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- B. Supervisors will provide training on the use and care of specific PPE for employees, contract staff, volunteers, and incarcerated workers who are required to wear specific PPE.
1. Training will be documented on DOC 03-248 Personal Protective Equipment (PPE) Training Record and Certification or by a Correctional Industries supervisor on DOC 10-122 Tool/Equipment/Process Specialty Training Outline.
  2. Training will be conducted prior to an incarcerated individual performing any work per DOC 890.000 Safety Program.
- C. Supervisors will determine when a worker should be retrained. Reasons for retraining include, but are not limited to:
1. Changes in the workplace that make previous training obsolete.
  2. Changes in the types of PPE used that make previous training obsolete.
  3. The individual's demonstrated use of assigned PPE that indicates the worker has not retained the necessary knowledge or skill.
- D. PPE user training and documentation does not include the following:
1. Respirator/electrical safety protection identified in DOC 890.090 Respirator Program and DOC 890.140 Electrical Safety.
  2. First aid response equipment covered under first aid training per DOC 890.620 Emergency Medical Treatment.
  3. Personal protective belt pouch kits (PPKs) covered under infectious disease training per DOC 670.000 Communicable Disease, Infection Prevention, and Immunization Program.

#### **DEFINITIONS:**

The following words/terms are important to this policy and defined in the glossary section of the Policy Manual: Personal Protective Equipment (PPE). Other words/terms appearing in this policy may also be defined in the glossary.

#### **ATTACHMENTS:**

None

#### **DOC FORMS:**



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- DOC 03-247 Hazard Assessment Certification and Personal Protective Equipment (PPE) Selection Worksheet
- DOC 03-248 Personal Protective Equipment (PPE) Training Record and Certification
- DOC 10-122 Tool/Equipment/Process Specialty Training Outline





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**DOC 890.140**

**POLICY**

TITLE

**ELECTRICAL SAFETY**

**REVIEW/REVISION HISTORY:**

Effective: 5/21/12  
Revised: 8/1/14  
Revised: 5/24/19

**SUMMARY OF REVISION/REVIEW:**


Major changes to include information moved from DOC 700.130 Electrical Construction and Maintenance. Read carefully!

**APPROVED:**

Signature on file

\_\_\_\_\_  
**STEPHEN SINCLAIR**, Secretary  
Department of Corrections

4/23/19  
\_\_\_\_\_  
Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-24-970](#); [WAC 296-800-160](#); [DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment; Electrical Hazard Assessment and Personal Protective Equipment Table; Electrical Safety Qualified Person Training Syllabus; Records Retention Schedule](#);

**POLICY:**


- I. The Department has established a written electrical safety program to increase worker awareness of potential electrical hazards. Whenever possible, electrical hazards will be eliminated (e.g., de-energized, locked out) before any work is performed on electrical circuits.

**DIRECTIVE:**

- I. General Requirements
  - A. Regional Safety Managers will monitor implementation of the electrical safety program.
  - B. Electrical work performed in Department facilities/offices must be coordinated with the Facilities/Plant Manager or Electrical Safety Coordinator.
  - C. Facilities/offices where assigned workers may be exposed to and/or perform work on energized electrical circuits 50 volts or above will designate a Labor and Industries (L&I) certified electrician or qualified person as the Electrical Safety Coordinator to:
    1. Oversee local implementation of this policy,
    2. Ensure a job safety analysis and/or electrical safety hazard assessment is conducted and documented,
    3. Select, acquire, maintain, and replace appropriate Personal Protective Equipment (PPE) and high voltage equipment/tools at warranty expiration,
    4. Coordinate and document local Electrical Safety Qualified Person training for qualified persons,
    5. Maintain a current list of L&I certified electricians and qualified persons,
    6. Manage and ensure use and approval of DOC 16-356 Energized Electrical Work Permit,

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7. Review and update local practices to keep qualified persons trained in any changes to local electrical safety hazards and required PPE, and
  8. Ensure that required inspections are completed by the inspecting authority and all local electrical program records are retained, including safety records.
- D. L&I certified electricians/trainees will not work with high voltage (i.e., 600 volts and above) or perform electrical work or preventive maintenance on high voltage equipment, whether energized or de-energized.
- E. L&I certified electricians/trainees may perform scheduled work on energized electrical circuits 50 volts or above that:
1. Does not involve coming in contact with energized electrical conductors or parts.
  2. Involves using meter probes only when making contact with energized electrical conductors or parts.
- F. L&I certified electricians can perform scheduled work on energized electrical circuits 50 volts or above that involves making contact with energized electrical conductors and parts using insulated tools per the Electrical Hazard Assessment and Personal Protective Equipment Table pending their current qualifications.
1. Work crews will not work on energized circuits requiring the use of insulated tools.
- G. L&I certified electricians/trainees and qualified persons will wear required PPE and use protective shields and insulating materials appropriate to the work or testing being performed.
1. Conductive jewelry and clothing (e.g., rings, necklaces, watches, cloth with conductive thread, metal headgear) will not be worn if they may contact exposed energized parts.
  2. While working on energized electrical circuits 50 volts or above, clothing must comply with the National Electrical Code per the National Fire Protection Association.
- II. Job Safety Analysis and Hazard Assessment

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- A. A job safety analysis and/or assessment for potential arc flash and shock hazards will be conducted before authorizing any work on energized electrical circuits 50 volts or above.
  - 1. L&I certified electricians and qualified persons will refer to the Electrical Hazard Assessment and Personal Protective Equipment Table.
- B. Assessments will be documented per DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment and address:
  - 1. Arc flash boundaries and shock hazard potential for each potential exposure.
  - 2. Selection of required PPE and consideration of shock hazard mat use.


### III. Energized Electrical Work Permit

- A. Any work on energized electrical circuits 50 volts or above is prohibited until a DOC 16-356 Energized Electrical Work Permit has been completed and approved for the specific work project.
  - 1. L&I certified electricians and qualified persons are permitted to conduct testing and troubleshooting on energized circuits without a permit.
- B. The Electrical Safety Coordinator will retain the permit on file per the Records Retention Schedule.

### IV. Qualified Person Training

- A. Employees expected to be qualified persons and L&I certified electricians/trainees will be provided initial Electrical Safety Qualified Person training consistent with the Electrical Safety Qualified Person Training Syllabus.
- B. L&I certified electricians will be provided refresher Electrical Safety Qualified Person training only when local program changes occur or as identified by the Electrical Safety Coordinator. All other qualified persons will receive annual Electrical Safety Qualified Person training.
- C. Employee training will be documented on a class roster and in the database managed by the Training and Development Unit.
- D. Work crew training will be documented on a training roster and maintained with the local electrical safety program records.

### DEFINITIONS:

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The following words/terms are important to this policy and defined in the glossary section of the Policy Manual: Labor and Industries (L&I) Certified Electricians, Personal Protective Equipment (PPE), Qualified Persons. Other words/terms appearing in this policy may also be defined in the glossary.

**ATTACHMENTS:**

None

**DOC FORMS:**

[DOC 16-356 Energized Electrical Work Permit](#)



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**DOC 890.170**

# POLICY

TITLE  
**OUTDOOR HEAT EXPOSURE**

## REVIEW/REVISION HISTORY:

Effective: 1/16/12  
Revised: 11/9/15  
Revised: 11/18/19  
Revised: 7/22/24

## SUMMARY OF REVISION/REVIEW:


Major changes to include alignment with regulatory changes. Read carefully!

## APPROVED:

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
Department of Corrections

6/20/24  
\_\_\_\_\_  
Date Signed

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	<p>TITLE <b>OUTDOOR HEAT EXPOSURE</b></p>		

**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; [WAC 296-62-095](#)

**POLICY:**

- I. The Department recognizes the danger associated with outdoor work (i.e., more than 15 minutes in any 60 minute period) during periods of extreme heat and has developed procedures to protect workers from the potential effects of heat-related illness when:
  - A. The temperature is at or above 52°F when a worker is wearing non-breathable clothing or clothing that provides a vapor barrier (e.g., rain gear or chemical-resistant suits), and
  - B. At or above 80°F when a worker is wearing any other type of clothing.

**DIRECTIVE:**

- I. General Requirements
  - A. The Safety Unit will monitor the implementation of this policy as part of the Department’s Safety Program.
  - B. Each Superintendent, Reentry Center Manager, Field Administrator, and Correctional Industries Site Manager will designate employees responsible for the development of local procedures, consistent with the requirements of WAC 296-62-095.
  - C. Supervisors and workers are responsible for monitoring personal risk factors for heat-related illness to include:
    - 1. Sufficient quantities of suitably cool drinking water must be readily available, and workers will be encouraged to stay hydrated.
      - a. All workers must have the opportunity to drink at least one quart of drinking water or other acceptable beverage to ensure hydration each hour.
    - 2. Shade or other sufficient means for cooling down (e.g., misting stations, cooling vests, or air-conditioned areas) must be provided any time workers are exposed to outdoor heat.
      - a. The amount of shade present must be large enough to accommodate the number of workers on a meal or rest period.

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3. Cool-down rest periods must be 10 minutes every 2 hours when the temperature is at or above 90°F and 15 minutes every hour when the temperature is at or above 100°F.
  - a. Workers will be encouraged to take voluntary, preventative cool-down rest periods.
4. Close observation (e.g., buddy system, regular communication via radio/phone, or other effective means of observation) of:
  - a. New workers
  - b. Workers not acclimatized to outdoor heat
  - c. Workers returning from absences of 7 days or more
  - d. All workers during a heat wave (i.e., temperature is at least 10°F higher than the preceding 5-day average highs)
5. Monitoring signs and symptoms of heat related illness (e.g., heat rash, heat cramps, heat exhaustion, heat stroke) and take appropriate action.

D. Workers showing signs or demonstrating symptoms of heat-related illness must be relieved from duty, provided with sufficient means to reduce body temperature, and be monitored to determine if medical attention is necessary.

## II. Training

- A. Supervisors, employees, contract staff, and volunteers will be provided initial and annual training consistent with WAC 296-62-09560 which will be maintained in the Department's electronic training system.
- B. Supervisors will provide annual training to workers under the Department's jurisdiction using DOC 16-352 Outdoor Heat Exposure Awareness Training which will be maintained by the Supervisor, and a copy provided to the worker.

### DEFINITIONS:

Word/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

### ATTACHMENTS:

None

### DOC FORMS:

DOC 16-352 Outdoor Heat Exposure Awareness Training

Rev. (10/24)





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**DOC 890.380**

**POLICY**

TITLE  
**FIRE PREVENTION PLAN**

**REVIEW/REVISION HISTORY:**

- Effective: 12/6/99
- Revised: 3/5/04
- Revised: 7/31/06
- Revised: 9/11/07
- Revised: 1/23/09
- Revised: 11/7/11
- Revised: 1/1/14
- Revised: 12/20/18
- Revised: 1/20/22
- Revised: 11/23/23

**SUMMARY OF REVISION/REVIEW:**


I.D.2. - Added clarifying language  
III.A.2.c. - Adjusted language for clarification

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
Department of Corrections

10/19/23  
\_\_\_\_\_  
Date Signed

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**REFERENCES:**


DOC 100.100 is hereby incorporated into this policy; 890.000 Safety Program; [2018 International Fire Code](#); [Records Retention Schedule](#)

**POLICY:**

- I. The Department will maintain fire safe practices that comply with fire prevention codes and standards to promote the safety of employees, contract staff, volunteers, those under the jurisdiction of the Department, and visitors. Any variances from these standards will be approved in writing by the fire authority having jurisdiction.

**DIRECTIVE:**


- I. Fire Prevention in Facilities
  - A. The Superintendent/Reentry Center Manager (RCM) will designate a Fire Prevention Plan Coordinator, who will be responsible for ensuring facility compliance with this policy and serve as a liaison with local fire response agencies.
  - B. Furnishings and bedding will be consistent with fire/safety performance requirements and will be rated noncombustible or fire resistant, when required.
  - C. Hazards will be reported and immediately corrected or repaired.
  - D. An onsite fire safety inspection will be conducted annually at each facility.
    - 1. The Fire Prevention Plan Coordinator will contact the fire authority having jurisdiction to schedule the inspections.
    - 2. A copy of the inspection report, along with a facility-generated corrective action plan, will be forwarded to the appropriate Deputy Assistant Secretary or Reentry Center Administrator through the chain of command.
- II. Fire Drills
  - A. Fire drills will be conducted and documented on DOC 21-734 Fire Drill Report and retained per the Records Retention Schedule.
    - 1. Prisons will conduct fire drills at least quarterly on each shift in all occupied areas of the facility, including administrative areas.

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- a. Custody employees will coordinate with Intensive Management and Inpatient Unit employees/contract staff to conduct a functional drill quarterly on each shift.
2. Reentry Centers will conduct fire drills at least quarterly on each shift and in all occupied facility locations, including administrative areas.
3. Field Offices will conduct fire drills at least quarterly.
4. Headquarters and other Department offices will conduct fire drills compliant with the fire authority having jurisdiction.

### III. Emergency Plans

- A. Department facilities will have a written emergency plan, which includes an evacuation procedure for use in the event of a major emergency.
  1. Department facilities/offices will post evacuation maps in each building and use exit signs and directional arrows that are easily seen/read.
    - a. Posted facility evacuation maps will identify:
      - 1) All exits,
      - 2) First aid kits,
      - 3) Fire extinguishers,
      - 4) Fire hose receptacles, if applicable
      - 5) Locations of fire alarm stations,
      - 6) Primary and secondary evacuation routes, and
      - 7) A "You Are Here" symbol to indicate the person's location.
    - b. Maps will represent the actual floor arrangement and be posted so the top of the diagram is oriented in the direction the reader is facing.
  2. The emergency plan will be reviewed annually and updated as necessary, and will include:
    - a. Location of building and room floor plans,
    - b. Locations of posted evacuation maps, and
    - c. Procedures for the safe evacuation of everyone, including disabled persons.
  3. The emergency plan will be reviewed and approved by the fire authority having jurisdiction during the facility's annual fire safety inspection.

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a. Documentation of the approval will be maintained onsite, including initial review, annual review, and reissue whenever the procedures are revised.

B. The Headquarters emergency plan will be coordinated through Management Services and managed by the building owner.


IV. Equipment Tests, Maintenance, and Inspections

A. Fire alarm detection and suppression equipment and systems will be maintained in proper working condition and inspected as required by the fire authority having jurisdiction.


1. Maintenance, testing, and service inspections of fire equipment and systems will be performed and documented by a qualified employee/contract staff or contract vendor.
2. A corrective action plan will be developed and tracked by the Fire Prevention Plan Coordinator to ensure action is taken within a reasonable timeframe to repair or replace defective equipment and address any other deficiencies identified during maintenance, testing, or service.
  - a. The plan will be submitted to the Superintendent/RCM and fire authority having jurisdiction and updated quarterly until all identified deficiencies have been corrected.
  - b. When all identified deficiencies have been corrected, a letter of concurrence will be requested from the fire authority having jurisdiction, which will be filed with the completed plan.
3. Before testing systems and alarms, notifications will be made to prevent unnecessary responses.

B. Fire Extinguishers

1. Monthly visual inspections of all fire extinguishers will be conducted and documented on the inspection tag by a trained and qualified employee, who has successfully completed Safety and Sanitation Inspector Qualifications training.
2. Annual service/maintenance inspections of fire extinguishers will be conducted and documented on the inspection tag by a trained and certified employee/contract staff and/or service provider who has access to the manufacturer's service manual.

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3. Servicing, testing, and recharging of extinguishers will be conducted per the manufacturer instructions.
- C. Hose Systems in Facilities
1. Hose systems will be equipped with shutoff type nozzles.
  2. Hose systems will be inspected at least annually to ensure they are in proper working condition and in designated locations.
    - a. Hemp or linen hoses will be taken off the rack and physically inspected for deterioration or damage. A different fold pattern will be used when placing the hose back on the rack.
    - b. Hoses will be replaced when deterioration or damage is noted.
- D. Automatic Water Sprinkler Systems in Facilities
1. An annual main drain flow test will be performed on each system.
  2. The inspected test valve will be opened at least every 2 years to ensure the sprinkler system operates properly.
    - a. Electronic water bell system test valves will be inspected semi-annually or as required by the fire authority having jurisdiction.
- E. Fixed Extinguishing Systems in Facilities
1. Fixed extinguishing systems will be inspected annually by a qualified person knowledgeable in the design and function of the system.
  2. Fixed extinguishing systems that use containers (i.e., refillable or non-refillable) will be inspected semi-annually.
- F. Fire Alarm and Detection Systems in Facilities
1. Service, maintenance, and testing of fire alarm and detection systems, including cleaning and necessary sensitivity adjustments, will be performed and documented by trained persons knowledgeable in the operation and function of the system.
  2. A quarterly visual inspection of all smoke and heat detectors will be completed to identify:
    - a. Missing detectors,

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- b. Detectors with impeded smoke entry,
  - c. Abnormally dirty detectors,
  - d. Detectors no longer suitably located due to occupancy or structural changes, and
  - e. That they have not been painted over or have physical damage that would prevent proper operation.
3. Annual fire alarm tests will be conducted on each system. At least one device in each fire zone will be activated to test its operation (e.g., alarm transmittal, supervisory circuits, audibility).
  4. Batteries will be changed annually in all detectors that require a backup battery power source.

V. Training

- A. Evacuation procedures will be reviewed with all employees, contract staff, volunteers, and incarcerated individuals during initial orientation and documented per 890.000 Safety Program.
- B. Fire Extinguisher training, consistent with the Fire Extinguisher Lesson Plan, will be provided to employees at New Employee Orientation, Correctional Worker Core, and annual In-Service.
- C. Training will be documented in the training database managed by the Department's Training and Development Unit.

**DEFINITIONS:**

Words/terms appearing in this policy may be defined in the glossary section of the Policy Manual.

**ATTACHMENTS:**

None

**DOC FORMS:**

DOC 21-734 Fire Drill Report



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**POLICY**

TITLE  
**BLOODBORNE PATHOGEN PROTECTION  
AND EXPOSURE RESPONSE**

**REVIEW/REVISION HISTORY:**

- Effective: 9/1/91
- Revised: 2/15/94
- Revised: 4/1/94
- Revised: 12/31/95
- Revised: 1/31/98
- Revised: 2/25/04
- Revised: 8/14/06
- Revised: 8/14/07
- Reviewed: 8/13/08
- Revised: 7/16/09
- Revised: 2/13/12
- Revised: 8/25/14
- Revised: 7/20/15
- Revised: 10/23/20
- Revised: 9/6/21

**SUMMARY OF REVISION/REVIEW:**


II.A.2. - Adjusted language for clarification  
 II.A.3. - Added language for clarification  
 V.B.1.b., VI.B.1.a., and VII.A. - Adjusted for person-centered language

**APPROVED:**

Signature on file

\_\_\_\_\_  
**CHERYL STRANGE**, Secretary  
 Department of Corrections

8/23/21  
 Date Signed

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**REFERENCES:**

DOC 100.100 is hereby incorporated into this policy; [RCW 70.24.340](#); [RCW 70.24.370](#); [WAC 137-100](#); [WAC 246-100](#); [WAC 296-823](#); DOC 620.020 Non-Consensual Blood Draws; DOC 890.000 Safety Program; DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment; DOC 890.200 Employee Occupational Health Records; Exposure Control Guide; [Records Retention Schedule](#)


**POLICY:**

- I. The Department will take reasonable steps to provide protection to employees, contract staff, volunteers, and workers under the Department’s jurisdiction who are at possible risk of exposure to Bloodborne Pathogens (BBPs).
- II. The BBP status of an individual under the Department’s jurisdiction may be disclosed to an employee/contract staff/volunteer who has experienced an event presenting a possible risk of exposure and has requested source person testing.
  - A. Events presenting possible risk may include, but are not limited to:
    1. Mucous membrane or non-intact skin exposure to blood, semen, and/or vaginal fluids.
    2. A needle puncture or penetrating wound resulting in exposure to blood, semen, and/or vaginal fluids.
- III. Implementation of infection control will be consistent with the Exposure Control Guide.

**DIRECTIVE:**

- I. Mandatory Education and Training
  - A. All employees, contract staff, volunteers, and porters will be provided initial training in BBP protection and exposure response upon hire/assignment, followed by annual refresher training.
- II. Personal Protective Equipment (PPE)
  - A. PPE and immediate access to protective clothing will be available as needed to all employees, contract staff, volunteers, and workers under the Department’s jurisdiction who are at possible risk of exposure to blood and/or other body fluids. PPE belt pouch kits will be issued as specified in the Exposure Control Guide.
    1. Issued PPE belt pouch kits will be worn at all times by custody and recreation employees, and readily available for all other personnel.



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2. Superintendents, the Reentry Center Administrator, and Field Administrators will establish procedures for replacing the contents of the PPE belt pouch kit.

a. The PPE belt pouch kit will contain at a minimum:

- 1) Protective disposable gloves,
- 2) Face shield for eye/nose/mouth protection,
- 3) One-way valve mask for resuscitation, and
- 4) Antimicrobial or germicidal hand wipes or towelettes (e.g., VioNex).

3. PPE will be used as outlined in the Exposure Control Guide located on the Department's internal website and DOC 890.130 Job Safety Analysis, Hazard Assessments, and Personal Protective Equipment.

### III. Hepatitis B Virus (HBV) Vaccination

A. The HBV vaccination series will be offered at no cost to all employees whose normal job duties, as identified in the Exposure Control Guide, carry potential for exposure to BBP. Completion of the vaccination series will be documented on DOC 03-172 Hepatitis B Vaccine Consent/Waiver and Vaccination Record.


1. There is no time limit for an employee to request the vaccination.
2. Future vaccines and boosters will be provided according to the [Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices](#).

B. Contract staff and volunteers will not be provided hepatitis B vaccination at Department expense and will be encouraged to obtain vaccination through their health care provider or employer.

C. Hepatitis B titer testing (i.e., blood test that measures the presence and amount of antibodies in the blood) will be suggested upon completion of the vaccination series, but will not be provided at Department expense. Employees, contract staff, and volunteers should request titer testing from their health care provider.

### IV. Post-Exposure Follow-Up

A. When an employee, contract staff, or volunteer experiences an event presenting possible risk of exposure, the person will be provided:

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1. Resources to clean up and conduct an assessment to determine the extent of exposure.
  2. Clean clothing, as needed.
  3. A red biowaste bag(s) for disposal of items such as severely contaminated PPE and/or clothing.
  4. Rice bags and/or yellow bags for contaminated clothing that can be laundered onsite.
  5. A mechanism for disposal of contaminated items consistent with the Exposure Control Guide.
  6. The opportunity to seek immediate medical care.
- B. Supervisors will relieve any person exposed from duty to seek immediate medical care.
- C. If there has been an occupational exposure to blood or body fluids, any employee, contract staff, or volunteer must be provided post-exposure follow-up.
1. Post-exposure information is available at the Blood and Body Fluid Exposures page on the Department's internal website.
  2. Questions about post-exposure follow-up should be directed to the Occupational Nurse Consultant (ONC) or the exposed person's health care provider.
- D. Post-Exposure Reporting
1. Employees, contract staff, or volunteers will complete an electronic version of DOC 03-133 Accident/Injury Report per DOC 890.000 Safety Program and notify their supervisor as soon as possible of the exposure event.
  2. Employees, contract staff, and volunteers may also submit DOC 03-269 Request for Source Person Testing/Test Results.
- E. The Regional Safety Manager will be notified of an incident through the electronic imaging file and record the exposure event on the OSHA 300 Log.
- V. Source Person Testing in Prisons



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- A. Questions about source person testing should be directed to the local Infection Prevention Nurse (IPN)/designee.
- B. If the IPN/designee concludes that a possible exposure to a BBP has occurred involving an incarcerated individual, the individual will be asked to consent to testing for BBP including HIV, hepatitis B, and hepatitis C. DOC 13-035 Authorization for Disclosure of Health Information will be completed to release the test results.
  - 1. The IPN/designee will:
    - a. Review requests to determine if a possible exposure to a BBP has occurred and respond to the requester within 72 hours.
    - b. Arrange for BBP testing of the incarcerated individual. Previous test results may be considered adequate per consultation with the Chief Medical Officer (CMO).
    - c. Communicate the following with the exposed person and advise to discuss results with the person’s health care provider.
      - 1) The results of the test/when the results will be available, or
      - 2) An explanation of why testing and/or disclosure are not authorized.
    - d. Document the verbal disclosure of source person testing on DOC 03-269 Request for Source Person Testing/Test Results.
      - 1) The source person’s BBP status and/or test results should also be released without identifying information (e.g., birth date, name, DOC number) to the exposed person’s health care provider.
  - 2. The requester may appeal a refusal to authorize testing or disclosure of test results to the CMO/designee within 7 days of the exposure event.
    - a. If the CMO/designee denies the appeal, the exposed person may request the local health department order testing per RCW 70.24.340.
- C. Involuntary Testing
  - 1. In the event an incarcerated individual does not consent to BBP testing and disclosure of the test results, and the exposure resulted from the

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individual's behavior, the Secretary/Superintendent/designee may order BBP testing only if determined, per consultation with the CMO/designee, that the exposure event created a possible risk to the exposed person.

- a. If the incarcerated individual still refuses, the individual may submit written objection within 24 hours to the Secretary/Superintendent/designee, who will review and consider the objection before BBP testing occurs.
  - 1) The Secretary/Superintendent/designee may rescind an order for BBP testing after reviewing and considering the written objection.
- b. The details of the exposure will be shared with the incarcerated individual, including an explanation of why it presents a possible risk of BBP transmission to the exposed person.
  - 1) The CMO/designee will document on DOC 13-435 Primary Encounter Report and send it electronically to the facility IPN, who will ensure it is filed in the appropriate section of the health record.
2. If the incarcerated individual does not consent to BBP testing and disclosure of the test results, and the exposure was accidental (i.e., not related to the individual's behavior), the CMO/designee may be contacted to facilitate a court order for involuntary BBP testing.
  - a. When a court order for involuntary BBP testing is obtained, the Secretary/Superintendent/designee will facilitate involuntary testing.
3. Involuntary testing, if necessary, will be conducted per DOC 620.020 Non-Consensual Blood Draws.
4. The Secretary/Superintendent/designee will provide the results of testing to the exposed person.
  - a. The verbal disclosure of source person BBP testing results will be documented on DOC 03-269 Request for Source Person Testing/ Test Results.
5. At the time of disclosure, the exposed person will be advised to discuss the results with the person's health care provider.

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- a. The source person's BBP status and/or test results should also be released without identifying information (e.g., birth date, name, DOC number) to the exposed person's health care provider.


#### VI. Source Person Testing for Non-Prison Facilities/Offices

- A. Questions about source person testing should be directed to the local ONC/designee.
- B. After the ONC/designee consults with the CMO/designee, and it is determined that a possible exposure to a BBP has occurred involving an individual under the Department's jurisdiction, the individual will be asked by the Field Administrator/designee to consent to testing for BBP, including HIV, hepatitis B, and hepatitis C, and will complete DOC 13-035 Authorization for Disclosure of Health Information to release the test results.
  1. Upon receipt of the authorization for disclosure, the ONC/designee will:
    - a. Help facilitate BBP testing with a community provider if feasible. Previous test results may be considered adequate per consultation with the CMO/designee.
    - b. Communicate test results with the exposed person and advise them to discuss the results with the person's health care provider.
      - 1) The source person's BBP status and/or test results should also be released without identifying information (e.g., birth date, name, DOC number) to the exposed person's health care provider.
  2. If the individual does not consent to BBP testing and disclosure of the test results, the CMO/designee may be contacted to facilitate a court order for involuntary BBP testing.

#### VII. Confidentiality

- A. It is a violation of state law to disclose another person's BBP testing results or harass or otherwise discriminate against that person. Any employee, contract staff, or volunteer who discloses confidential information relating to test results, without authorization per this policy, is subject to disciplinary action, civil liability, and/or criminal sanctions.

#### VIII. Recordkeeping

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- A. Records will be maintained as required by confidentiality laws and DOC 890.200 Employee Occupational Health Records.
- B. Completed, applicable exposure forms will be maintained in the Employee Occupational Health Record per the Records Retention Schedule.

**DEFINITIONS:**

The following words/terms are important to this policy and are defined in the glossary section of the Policy Manual: Bloodborne Pathogen; Body Fluids; Health Care Provider; Human Immunodeficiency Virus (HIV); Personal Protective Equipment (PPE). Other words/terms appearing in this policy may also be defined in the glossary.

**ATTACHMENTS:**

None

**DOC FORMS:**

- DOC 03-133 Accident/Injury Report
- DOC 03-172 Hepatitis B Vaccine Consent/Waiver and Vaccination Record
- DOC 03-269 Request for Source Person Testing/Test Results
- DOC 13-035 Authorization for Disclosure of Health Information
- DOC 13-435 Primary Encounter Report