



Medical Environment UPDATE

A Service for Healthcare Providers Responsible for Occupational Safety and Health Compliance

Volume 21 • No. 1 • January 2011

AN HCPRO PUBLICATION

Conference focuses on current and future needlestick safety

NIOSH director calls for redoubling strategies to bring worker safety in line with patient safety

When needlestick prevention advocates observe an anniversary, there's a lot of substance to go along with style.

Last month, **Medical Environment Update** reported on the 10th anniversary of the Needlestick Safety and Prevention Act (NSPA) through the eyes of one of its leading advocates, Karen Daly, president of the American Nurses Association.

This month, we are reporting on a gathering of needlestick prevention experts at a conference for needlestick prevention and safety, "Mapping Progress and Charting a Future Path." The November 2010 conference was hosted by the International Healthcare Worker Safety Center at the University of Virginia and sponsored in part by a grant from NIOSH.

The law vs. other incentives

John Howard, MD, MPH, JD, LLM, director of NIOSH,

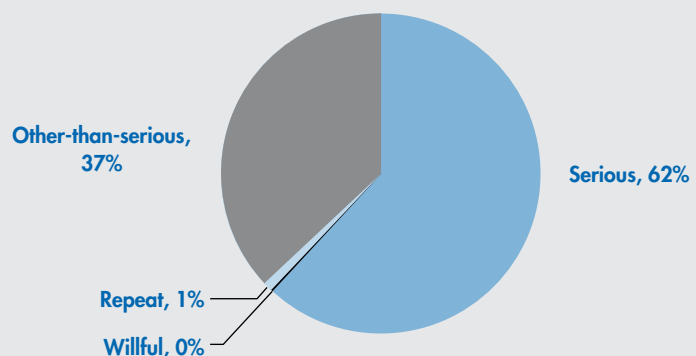
presented the keynote address that asked: Have we achieved all that is needed to protect healthcare workers from sharps injuries? Howard—who also served as chief of the Division of Occupational Safety and Health in the California Department of Industrial Relations from 1991 to 2002 and who was instrumental in creating California's needlestick

safety legislation that preceded the federal NSPA—said there is more to be done. Definitional changes to the current regulation, enforcement strategy enhancements, technology design strategies, and compliance incentives in home care and third-world countries are some of the areas Howard identified for future efforts. > p. 2

Vital stats: Data for better OSHA compliance

Last year, OSHA issued 3,674 citations to healthcare facilities; the majority of those violations (62%) were characterized as serious. Serious violations are issued when death or serious physical harm could result and the employer knew or should have known about the hazard. Other-than-serious violations are issued for situations that may cause a minor accident or illness but not death or serious physical harm. Both types of fines can be as high as \$7,000 per violation. Repeat violations are issued when the same, or very similar, violations are found for the second time in three years. Repeat violations can be as high as \$70,000.

Types of OSHA violations in healthcare facilities, 2010



Source: OSHA Office of Management Systems.

INSIDE THIS ISSUE:

- ▶ **OSH** 1-5
- ▶ **Self-inspection notes** 6
- ▶ **For your information** 7
- ▶ **Questions & answers** 8

QUESTIONS? CALL OUR HOTLINE 800/650-6787

Occupational safety and health news continued

Conference *cont. from p. 1*

Ten years after the NSPA, we may be facing a persistence issue, said Howard, where the numbers of sharps injuries aren't continuing to decrease as we would like. Ultimately it is a behavioral change, and there are limits to how far a law can be effective; after a point, other incentive strategies are needed.

Howard identified a market strategy for aligning needlestick safety incentives with reimbursements as having the potential to change behaviors.

Professional incentives are another strategy. "We need to look at what class of healthcare workers are most resistant in terms of educational and compliance inducements," said Howard. Drill down on this and you will find that professional strategies differ between nurses and physicians and even with physicians among different specialties. Howard helped the audience read between the lines of this remark by alluding to his many surgeon and anesthesiologist friends who may not adhere to the NSPA as closely as other healthcare professionals.

Howard concluded by noting that there was an important

balance between patient and worker safety that was at the core of the Bloodborne Pathogens standard and later in the multi-state needlestick prevention laws that culminated with the federal NSPA. That balance, which is good and essential for the healthcare industry, seems to be carrying through with the recent California aerosol transmissible disease standard and the current OSHA regulatory agenda in assessing the need of an infectious disease standard.

OSHA presents needlestick-related inspection data

One of the presentations given at the conference was by **Dionne Williams, MPH**, OSHA's national bloodborne pathogens coordinator in the

Medical Environment Update

(ISSN: 1520-8222 [print]; 1934-5453 [online])
Published 12 times per year by

HCPPro, Inc.

75 Sylvan St., Suite A-101 • Danvers, MA 01923
Tel 800/650-6787 • Fax 800/639-8511

Group Publisher: Emily Sheahan

Editor: David LaHoda, dlahoda@hcpro.com

Advisory board:

Terry Jo Gile,
MT(ASCP), MA Ed
President
The Safety Lady, LLC
North Ft. Myers, FL

Peggy Prinz-Luebbert,
MS, MT(ASCP),
CIC, CHSP
Healthcare
Interventions, Inc.
Omaha, NE

Steven MacArthur
Consultant
The Greeley Company
Danvers, MA

Douglas Salvador,
MD, MPH
Associate Chief
Medical Officer/
Patient Safety Officer
Maine Medical Center
Medical Affairs
22 Bramhall Street
Portland, ME

Single issues available from the publisher.
Multiple subscription rates available.

12 issues: \$179 • 24 issues: \$322

Some information contained in the **Medical Environment Update** is carefully gathered from sources we believe to be reliable, but we cannot guarantee the accuracy of all information.

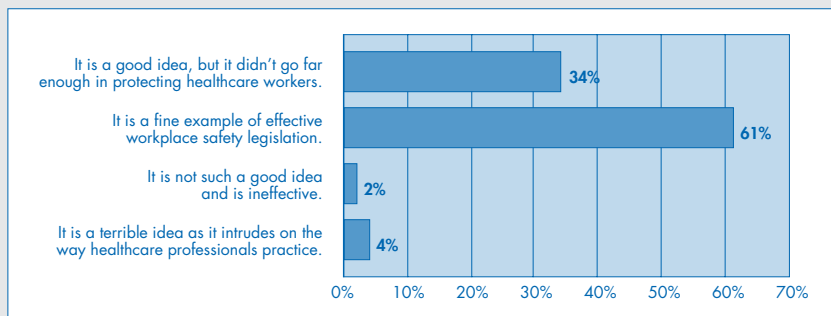
No part of this newsletter may be reproduced in any form without written permission from the publisher.

Copyright © 2011 by HCPPro, Inc.
All rights reserved.

HCPPro

Poll results: Overwhelming in favor of needlestick law

Last month, we called on **Medical Environment Update** readers to respond to our **OSHA Healthcare Advisor** poll, which asked, "What is your opinion of the Needlestick Safety and Prevention Act now that you have had 10 years of it?" The results are below.



Look for a new **OSHA Healthcare Advisor** poll every week by visiting www.oshahealthcareadvisor.com. **BLOG**

Occupational safety and health news continued

Office of Health Enforcement, who compared OSHA inspections and violations in health-care before and after the NSPA took effect.

For the eight years before the passage of the NSPA (1992–2000), only one-third of OSHA inspections citing bloodborne pathogens violations at health-care facilities were planned, meaning that the other inspections were unplanned and resulted from reports or complaints. Since the passage of the NSPA (2001–2010), the percentage of unplanned to planned inspections in which bloodborne pathogens violations occurred has evened out, according to Williams’ data. The total number of inspections with bloodborne pathogens violations cited have also increased during the post-NSPA period.

Prior to the NSPA, personal care facilities such as nursing and long-term care led in number of inspections by healthcare facility type, with hospitals following in second place. After the NSPA, physician offices took over the second-place spot, due mostly to a substantial increase in unplanned inspections.

Williams also shared inspection data on the most frequently cited sections of the Bloodborne Pathogens standard pre-NSPA vs. post-NSPA. Before the law, not having a written exposure control plan (ECP) topped the list, whereas the violation

concerning not using engineering controls such as safety devices was never ranked higher than 15th on the list.

Since the NSPA’s passage, sections of the standard created or fortified by the law now occupy three of the top four most frequently cited violations: reviewing and updating the ECP with regard to engineering controls; using engineering controls; and soliciting input from employees on safety devices.

Williams concluded the presentation by addressing future OSHA enforcement in healthcare segments with recognized gaps in the NSPA. These included surgical settings/ORs and non-compliance in smaller healthcare settings such as dental practices and home health care.

The video of Howard’s keynote address and Williams’ and other speakers’ PowerPoint® presentations are available on the International Healthcare Worker Safety Center’s website at www.healthsystem.virginia.edu/internet/epinet. ■

CDC: Healthcare worker meningitis infection points to infection control gaps

Lack of communication and inadequate infection control practices probably contributed to the meningitis infection of healthcare workers and police officers December 2009 in California.

“Occupational Transmission of *Neisseria meningitidis*—2009” in the *Morbidity and Mortality Weekly Report (MMWR)* November 19, 2010, examines the occupational transmission of *N. meningitidis* and measures to control and prevent secondary transmission of it. “Breaches in infection control, notification delays, and lack of worker exposure assessment and postexposure chemoprophylaxis (PEP) likely contributed to secondary cases,” according to the report.

The case involves police and fire emergency > p. 4

Enclosed with this issue

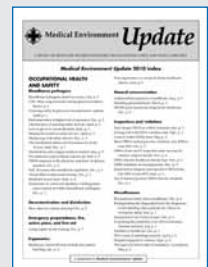
Medical Environment Update 2010 index

Trying to find a back-issue article or a Q&A that will provide the authoritative answer to a workplace safety concern? Check out the **Medical Environment Update 2010 index**.

The four-page index is organized alphabetically by OSHA standard and safety sections of the newsletter. It also identifies the update inserts to your OSHA manual for the past year.

Use your account name and password to log on to the HCPro safety page at www.hcpro.com/safety to obtain back issues in electronic format.

Still can’t find the information you need? Don’t hesitate to call the hotline at 781/639-1872 or e-mail dlahoda@hcpro.com.



Occupational safety and health news *continued*

Infection *cont. from p. 3*

responders and hospital workers responding to a 36-year-old man found unconscious at home, who was eventually treated in the emergency department (ED) and admitted to an ICU with the probable diagnosis of meningococcal disease, 2009 pandemic influenza A (H1N1), or community-acquired pneumonia.

A few days after the man was diagnosed with *N. meningitidis*, a police officer who was part of the original response team and a respiratory therapist who was “present during airway suctioning and assisted with endotracheal tube placement in the ED at hospital” also tested positive for *N. meningitidis*, says the report. The police officer was hospitalized for five days; the respiratory therapist was hospitalized for 11 days.

In all, 23 workers, including police officers, firefighters, paramedics, and healthcare workers, were involved in the case, with 10 workers having been within 3 ft. of the patient when providing care.

Among these 10 care providers, the police officer wore only gloves, and although two firefighters and two paramedics donned N95 respirators, the respiratory therapist in the ED did not, according to the report.

“Lack of PPE availability in the field and lack of knowledge

regarding where respirators and surgical masks were located in the ED were cited as two reasons why appropriate PPE was not worn by healthcare workers,” states *MMWR*.

The report concludes by recommending that healthcare facilities should:

- Review local health authority reporting procedures to ensure timely reporting of notifiable diseases, such as *N. meningitidis*
- Provide infection control training and PPE to potentially exposed workers
- Conduct timely and thorough investigations to identify and evaluate workers potentially exposed to a patient suspected to have meningococcal disease

The case-fatality rate for meningococcal disease is 10%–14%; survivors can experience brain damage, hearing loss, limb loss, and learning disabilities, according to the CDC.

From OSHA Healthcare Advisor

Regulatory nuances of electronic MSDS

by Steve MacArthur, safety consultant for The Greeley Company

Many healthcare facilities have switched to an electronic MSDS system because of its ease of use and functionality. I often get questions about having a backup, including paper copies, and what regulators such as


OSHA or The Joint Commission would say.

The important thing to remember is that the Hazard Communication standard is a performance standard, so there is some leeway in how you administer the MSDS program, as long as you are able to maintain access pretty much constantly.

This benchmark of perfection (or pretty close to it) is what generally drives the decision to maintain at least one “real” copy of the MSDS inventory—that way you have a backup in the event that the electronic process is otherwise unavailable.

It’s not so much that you “need” to maintain paper copies, but it’s as close to a foolproof backup as you can get—although you can certainly look at technology solutions. Having your inventory on a laptop is one idea; however, you need to be able to maintain power to it.

OSHA and The Joint Commission have had a semiformal relationship going back several years, and there is recent indication that there will be more of an effort to educate the surveyors relative to the important OSHA concerns, including Hazcom, workplace violence, and blood-borne pathogens.

For more on this subject, download the special report “What you need to know about electronic material safety data sheets” from the **OSHA Healthcare Advisor Tools** page at www.oshahealthcareadvisor.com. 

Occupational safety and health news continued

New law makes violence against nurses a felony

Handling difficult patients is expected by those going into the nursing profession, but most don't expect to be physically attacked. Nurses are routinely spit on, kicked, shoved, and verbally abused by patients, and a recent law in New York now classifies such actions as felonies.

On November 2, 2010, the Violence Against Nurses law went into effect in New York state, offering nurses the same protection provided to police officers, fire-fighters, and emergency medical technicians, reports the (Albany) *Times-Union*. Patients who physically attack nurses could serve seven years in prison.

Eileen Avery, associate director of education, practice, and research at the New York Nurses Association, believes nurses are going to feel empowered by this new law, while also acknowledging that nurses know that physical altercations come with the profession.

A study conducted in September 2010 by the Emergency Nurses Association in Des Plaines, IL, found that 8%–13% of emergency department nurses experience physical violence each week from their patients, the *Times-Union* reported. It also found that having safety precautions such as panic buttons and alarms reduced physical violence, and areas that were well lit decreased acts of violence. ■



**Remember to
DOWNLOAD your
UPDATES**

Hazardous drug list, flu declination form, safe injection practices, chances of infection after exposure

This issue of **Medical Environment Update** provides an updated list of hazardous drugs recently posted by NIOSH and additional CDC recommendations for safe injection practices for fingerstick and blood monitoring devices to the medical *OSHA Program Manual*.

Users of both the medical and dental manuals can remove the declination form specific for H1N1. The influenza vaccination for 2010–2011 includes protection from seasonal and H1N1 influenza and only one declination form is needed, which has been updated.

Finally, a number of readers have asked about the chance of bloodborne pathogen infections to mucous membrane and eye exposures. Although these types of exposures are less likely than percutaneous exposures, they still require a response as part of the exposure control plan. Mucous membrane and eye exposure infectivity have been added to the quick reference bloodborne pathogen infectivity table on p. 5-8 of the medical manual and p. 5-7 of the dental manual.

Here's how to get your updates. These instructions are applicable to both medical and dental practices.

Note (for new customers only): Check your manual first to see whether you need these updates. If the number 11A is indicated on the title page in the lower right corner of the title page box, your manual already includes these updates.

1. Log into your HCPro account on your **Medical Environment Update** subscription page at www.hcpro.com/login-3265. If you have not established a username/password or have forgotten it, you may retrieve it by clicking the link on this page.
2. Once logged in to the **Medical Environment Update** subscription page, open the most recent issue. There you will find an update file.
3. Open the file and choose the appropriate PDF to download for your manual (medical or dental). You also have the choice of printing your update pages one-sided or two-sided, depending on your printing capabilities.
4. Print the updated pages and replace the old pages.
5. Document revisions on Form 3, Annual OSHA Safety Program (Exposure Control Plan) Review Form. Summarize the revisions (or write "update to plan"), indicate page numbers, and sign the form.

Should you have difficulty logging in or accessing the updated pages, contact HCPro customer service:

- Tel: 800/650-6787
- E-mail: customerservice@hcpro.com



Self-inspection notes

Ring in the new year with a walk-through inspection

The beginning of the year is a good time to reaffirm your safety program, which should include regularly scheduled walk-through inspections or audits. (The *OSHA Program Manual* provides annual, monthly, and weekly checklists.)

Conducting an inspection with checklist in hand is a good way for the safety officer to keep the program in tip-top compliance shape.

Even though OSHA does not specifically require these periodic walk-through audits, it is good practice to keep the checklists on file for safety inspectors, insurance audits, and even your performance evaluation to show that your safety duties are a year-round responsibility.

The annual checklist below is adapted from the *OSHA Program Manual*. The original version also covers other areas to annually audit, including administration/business office, check-in and reception, break rooms, cleaning/decontamination, and storage areas.



Annual safety checklist

General facility safety

- The OSHA poster "It's the Law" (or state equivalent poster) is visible to all employees
- Exit doors are free of blockage, clearly marked, and unlocked
- Exit signs are properly lit and backup lights/batteries are functioning
- If your facility has 10 or more employees, a written evacuation plan/route is available
- Medical equipment cords have grounded three-pronged plugs
- Extension cords are being used properly (not as permanent wiring)
- Electrical cords are managed to prevent tripping hazards (not placed under rugs or across doorways)
- Electrical cords are in good condition (no frays, defects, etc.)
- The fire alarm is in proper working order
- An appropriate number of fire extinguishers are present/accessible
- The fire extinguishers have been inspected and tagged within the past 12 months and are fully charged
- Panic buttons, or public address systems, are in working order
- The work site is maintained in a clean and sanitary condition
- Restricted areas (lab, decontamination room, etc.) are designated with signage

Exam rooms/clinical areas

- All eyewash stations are in proper working order
- Universal precautions are used when handling all blood and OPIM
- Hand washing facilities (e.g., sinks with soap or alcohol gels) are available in all areas where biohazards and patients are encountered
- The biohazard symbol/label is used to indicate the potential presence of bloodborne pathogens for all blood and OPIM
- Contaminated items and regulated waste are placed into approved biohazard bags and containers
- Biohazard waste bags/storage bins are located in every area where blood or OPIM are encountered
- PPE (e.g., gloves, gowns, masks, goggles/face shields) is in the proper location, is available in the correct sizes and amounts, and functions properly
- Sharps containers are in the proper locations and positioned firmly so they cannot be knocked over
- Sharps containers are replaced as soon as they reach the "fill line" and not filled past two-thirds full
- The most effective engineering controls are available and functioning correctly (e.g., safety needles, sharps containers, fume hoods, splash shields)
- Employees decontaminate and clean work surfaces as soon as contaminated and at the end of every shift with an appropriate disinfectant

Source: OSHA Program Manual for Medical Facilities, HCPro, Inc.

FOR YOUR INFORMATION

Unsafe injections still occurring in healthcare settings

Despite reports of patient infections and the CDC's aggressive "One and Only" campaign, healthcare workers are still giving unsafe injections by using syringes and medication vials on more than one patient, according to a study by the Premier Safety Institute.

The study, which appeared in the December *American Journal of Infection Control (AJIC)*, inquired about the injection practices of healthcare professionals and found evidence of unsafe procedures that could cause patient-to-patient transmission of bloodborne pathogens such as hepatitis C.

The study surveyed 5,446 healthcare workers who prepare or give parenteral medications, reported *AJIC*. Although the majority of respondents said that their injection practices were reliable, some indicated recent lapses in safe injection practices, including:

- Sometimes or always use single-dose/single-use vials for more than one patient (6%)
- Sometimes or always reuse a syringe but change the needle for use on a second patient (0.9%)
- Reuse a syringe to enter a multidose vial (15.1%) and then save that vial for use on another patient (6.5%)

To read the study, search for the article by title, "Injection practices among clinicians in U.S. health care settings," at www.premierinc.com.

Infection control tip

Buddy bias may be affecting your hand hygiene rates

Infection preventionists (IP) who use staff members or secret shoppers to conduct hand hygiene observations may be saving time at the expense of tainted data.

A new study published in the August 2010 *Infection Control*

and *Hospital Epidemiology* indicates that some bias may exist among hand hygiene compliance observers. According to the study, unit-based observers tend to favor their peers more than non-unit-based observers, highlighting the fact that non-standardized collection methods continue to plague hand hygiene reporting.

Researchers found that hand hygiene compliance rates when using unit-based observers were 79%, compared to 58.6% compliance when using non-unit-based observers.

Why this unit-based observer bias may exist isn't easy to pinpoint, according to the study, nor is it something that can be stopped, and IPs need to be aware that this hand hygiene observation bias may exist, further emphasizing the imperfect nature of those data. ■

Your virtual safety officer

OSHA compliance assistance is just a phone call away



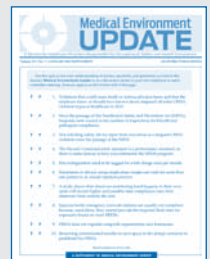
Compliance is no place for guesswork—especially when the safety of your coworkers is at stake.

David LaHoda, **Medical Environment Update** editor and OSHA expert, mans the Compliance Hotline, a key benefit for subscribers.

Call him toll-free at **800/650-6787** with your difficult occupational health and safety issues. Questions from subscribers range from how to read a material safety data sheet to what to do for an employee needlestick exposure. If LaHoda can't answer your question, he'll direct you to an appropriate resource.

January quiz inserted in this issue

Included in this issue is a quiz of 10 true-or-false questions. The quiz is designed to test your understanding of OSHA standards and



government regulatory guidelines that apply to healthcare facilities.

Use the quiz as a pre- or post-test for yourself or as a discussion starter in your next safety committee meeting or training session.

Answers are on the back side of the insert.

QUESTIONS & ANSWERS

A key benefit for subscribers to **Medical Environment Update** is access to the free OSHA Compliance Hotline. Below is a sample of the frequent or intriguing calls received in the past month. If you have an OSHA consultation question, call the hotline at 800/650-6787. More detailed answers to some of these questions can be found on OSHA Healthcare Advisor at www.oshahealthcareadvisor.com. **BLOG**

? We are establishing a chemotherapy suite for our practice. Are the portable squeeze bottle eyewash units we already use okay for this new area?

Squeeze bottle emergency eyewash stations are usually not compliant because, used alone, they cannot provide the required flush time for exposures found on most MSDSs. They are mostly used as an emergency measure to get workers to a plumbed eyewash station.

Check the MSDS for the hazardous substances present in the new area, including hazardous drugs, to determine how long a flush is required for exposure to eyes and mucous membranes. That flush time is what the eyewash station is required to provide to be OSHA compliant.

? The administrator for our nonprofit long-term care facility said that we are not regulated by OSHA. Where can I show her that all healthcare facilities are regulated by OSHA guidelines?

Your administrator is wrong, and she should be grateful for your questioning since it could save your facility a stiff OSHA fine.

Unless your facility is municipal-, state-, or federally owned, it is subject to OSHA regulations as long as it has employees. Non-profit status or number of employees does not exempt a business from OSHA compliance.

The OSHA website (www.osha.gov/about.html) says this about coverage: "The OSH Act covers employers and their employees either directly through federal OSHA or through an OSHA-approved state program. State programs must meet or exceed federal OSHA standards for workplace safety and health." More details on coverage are explained at www.osha.gov/workers.html#3.

Even if you are government-owned, it is unlikely that you are totally without occupational health and safety oversight.

? It is standard procedure to remove contaminated needles to save space in the sharps container. Is this a legal practice?

This is absolutely illegal! Check out the OSHA Healthcare Advisor article "Pardon my exclamation, but DON'T REMOVE DIRTY NEEDLES!" for details and comments on this hazardous practice. ■

MEU Subscriber Services Coupon

Start my subscription to MEU immediately.

Options	No. of issues	Cost	Shipping	Total
<input type="checkbox"/> Print & Electronic	12 issues of each	\$179 (MEUPE)	\$24.00	
<input type="checkbox"/> Electronic	12 issues	\$179 (MEUE)	N/A	

Order online at www.hcmarketplace.com.
Be sure to enter source code N0001 at checkout!

Sales tax
(see tax information below)*

Grand total

For discount bulk rates, call toll-free at 888/209-6554.



***Tax Information**

Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CO, CT, FL, GA, IL, IN, KY, LA, MA, MD, ME, MI, MN, MO, NC, NJ, NM, NV, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV. State that taxes products only: AZ. Please include \$27.00 for shipping to AK, HI, or PR.

Your source code: N0001

Name _____

Title _____

Organization _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

E-mail address

(Required for electronic subscriptions)

Payment enclosed. Please bill me.

Please bill my organization using PO # _____

Charge my: AmEx MasterCard VISA Discover

Signature _____

(Required for authorization)

Card # _____ Expires _____

(Your credit card bill will reflect a charge to HCPro, the publisher of MEU.)

Mail to: HCPro, P.O. Box 3049, Peabody, MA 01961-3049 Tel: 800/650-6787 Fax: 800/639-8511 E-mail: customerservice@hcpro.com Web: www.hcmarketplace.com



Medical Environment UPDATE

A Service for Healthcare Providers Responsible for Occupational Safety and Health Compliance

Volume 21 • No. 1 • JANUARY 2011 SUPPLEMENT

AN HCPRO PUBLICATION

Use this quiz to test your understanding of articles, standards, and guidelines covered in the January **Medical Environment Update** or as a discussion starter in your next employee or safety committee meeting. Answers appear on the reverse side of the page.

- T F** 1. Violations that could cause death or serious physical harm and that the employer knew or should have known about outpaced all other OSHA violation types in healthcare in 2010.
- T F** 2. Since the passage of the Needlestick Safety and Prevention Act (NSPA), hospitals rank second in the number of inspections for bloodborne pathogens compliance.
- T F** 3. Not soliciting safety device input from executives is a frequent OSHA violation since the passage of the NSPA.
- T F** 4. The Hazard Communication standard is a performance standard, so there is some leeway in how you administer the MSDS program.
- T F** 5. Fire extinguishers need to be tagged for a full charge once per month.
- T F** 6. Sometimes or always using single-dose/single-use vials for more than one patient is an unsafe injection practice.
- T F** 7. A study shows that observers monitoring hand hygiene in their own units will record higher and possible false compliance rates than observers from outside the unit.
- T F** 8. Squeeze bottle emergency eyewash stations are usually not compliant because, used alone, they cannot provide the required flush time for exposures found on most MSDSs.
- T F** 9. OSHA does not regulate nonprofit organizations and businesses.
- T F** 10. Removing contaminated needles to save space in the sharps container is prohibited by OSHA.

Answers appear on reverse side.

Quiz answers

1. **True.**
2. **False.** Since the passage of the NSPA, physician offices rank second in the number of inspections for bloodborne pathogens compliance.
3. **False.** Not soliciting safety device input from employees, not executives, is a frequent OSHA violation since the passage of the NSPA.
4. **True.**
5. **False.** Fire extinguishers are tagged for a full charge once per year.
6. **True.**
7. **True.**
8. **True.**
9. **False.** Nonprofit status or number of employees does not exempt a business from OSHA compliance.
10. **True.**

Copyright © 2011 HCPro, Inc. Current subscribers to Medical Environment Update may copy this quiz for use at their facilities. Use by others, including those who are no longer subscribers, is a violation of applicable copyright laws.



Medical Environment *Update*

A SERVICE FOR HEALTHCARE PROVIDERS RESPONSIBLE FOR OCCUPATIONAL SAFETY AND HEALTH COMPLIANCE

Medical Environment Update 2010 index

OCCUPATIONAL HEALTH AND SAFETY

Bloodborne pathogens

- Bloodborne pathogens slated for review. July, p. 5.
- CDC: Wear surgical masks during spinal procedures. March, p. 4.
- Choosing safety despite your manufacturers' options. April, p. 1.
- First responders at higher risk of exposures. Dec., p. 5.
- The four tiers of selecting safety devices. April, p. 3.
- Love to glove to cut needlesticks. Sept., p. 5.
- Making the switch to safety devices. April, p. 5.
- Monkeying with safety devices. Dec., p. 3.
- The Needlestick Safety and Prevention Act at the 10-year mark. Dec., p. 1.
- Needlesticks often plague medical students. Jan., p. 5.
- Occupational surgical sharps injuries up. May, p. 5.
- OSHA responds to the physician employer/employee question. Oct., p. 3.
- Poll: Ten years after needlestick legislation. Dec., p. 3.
- The problem of physician training. Oct., p. 2.
- Restricted access areas. Sept., p. 4.
- Sometimes an awkward situation: Getting physicians trained on OSHA bloodborne pathogens. Oct., p. 1.

Decontamination and disinfection

- How often for routine cleaning? Oct., p. 5.

Emergency preparedness, fire, action plans, and first aid

- Going digital on fire training. Oct., p. 7.

Ergonomics

- Healthcare reform bill may include safe patient handling. Jan., p. 4.

- Poor ergonomics is a recipe for home healthcare injuries. June, p. 5.

Hazard communication

- Antimicrobial exposures in healthcare. Aug., p. 5.
- Handling glutaraldehyde. March, p. 3.
- NIOSH posts hazardous drug list for healthcare. Dec., p. 3.

Inspections and violations

- Don't tempt OSHA on willful violations. Jan., p. 5.
- Getting real with OSHA violation data. Sept., p. 1.
- Look for stiffer OSHA fines. May, p. 4.
- More OSHA medical practice violations, July 2009 to June 2010. Oct., p. 5.
- OSHA closes out FY inspection stats; increase for medical, drop for dental. Nov., p. 4.
- OSHA fines by healthcare facility type. Nov., p. 1.
- OSHA relentless on nursing homes. Dec., p. 5.
- Quick look at frequent and expensive OSHA fines, July 2009 to June 2010. Sept., p. 3.
- Top 10 medical practice OSHA fines by standard. Dec., p. 1.

Miscellaneous

- BLS analyzes safety data in healthcare. Oct., p. 4.
- Distinguishing the disgruntled from the dangerous: Understanding when patients are a threat to workplace safety. June, p. 1.
- Employment Law Guide revised. Feb., p. 5.
- Evaluating the possibility of an OSHA infectious diseases standard. July, p. 1.
- Fatalities in healthcare. Oct., p. 1.
- FDA warns of centrifuge hazards. April, p. 5.
- Hospital slapped for violence. Sept., p. 4.
- The legal and ethical side of mandatory vaccinations. May, p. 3.

Looking back in order to look forward on OSHA standards. July, p. 4.
A matter of opinion on infectious diseases standard. July, p. 1.
Michaels clears Senate, now leads OSHA. Jan., p. 4.
Not so home-sweet-home healthcare. Feb., p. 5.
OSHA adds infectious disease standard to regulatory agenda. June, p. 5.
OSHA as repo man. March, p. 5.
OSHA may regulate physician working hours. Oct., p. 4.
Special report: Lettering in OSHA Compliance. Nov. supplement.
Tech sentenced for hepatitis infections. May, p. 7.
U.S. healthcare worker safeguards not world class. Sept., p. 5.
Violence in the workplace: Safety tips for healthcare workers. June, p. 3.
Workplace safety covered in healthcare reform. May, p. 4.

Respiratory hazards and protection

Another test for TB. Aug., p. 5.
Breaking down the OSHA directive on N95s. Jan., p. 1.
California recalls N95 flu respirators. Feb., p. 4.
CDC: Change N95 use for flu protection. Nov., p. 4.
Draft guidelines to ease up on N95 use. Aug., p. 5.
Generic N95 fit-testing record card available. Jan., p. 5.
Get the goods on office flu prevention. Dec., p. 5.
Implementing the hierarchy of controls. Jan., p. 3.
N95 woes ding Washington facility. April, p. 4.
OSHA posts respirator safety video clips. March, p. 4.
Proving your good faith with OSHA. Jan., p. 2.

GENERAL SAFETY

Determining hazard severity. Aug., p. 3.
Risk assessments: The catch-all for hazard analysis. Aug., p. 1.
Sample hazard assessment form. Aug., p. 4.

HAZARDOUS WASTE

Disposing of extra costs in RMW contracts. Nov., p. 2.
Doing your own thing, RMW-wise. Nov., p. 3.
Wasting away in regulated medical waste land. Nov., p. 1.

INFECTION CONTROL

AORN approves new surgical attire laundering guidelines. Dec., p. 7.
AORN nixes home scrubs laundering. June, p. 7.
Best practices for multidose vials. Sept., p. 7.

Brooms a no-no in healthcare. March, p. 7.
CDC closes the book on Las Vegas hepatitis C outbreak. Feb., p. 7.
CDC posts flu shot recommendations from ACIP. Sept., p. 7.
Considering ADA regulations. Feb., p. 1.
Don't autoclave disposable devices. March, p. 4.
Don't lose sight of clean privacy curtains. Dec., p. 7.
Dressing your stethoscope for success. May, p. 7.
Evaluating decontamination procedures prior to sterilization. March, p. 1.
FDA alerts Steris customers about processor concerns. Jan., p. 7.
FDA posts alternatives for STERIS System 1. Feb., p. 7.
FDA warns on fingerstick devices. Oct., p. 7.
IC ambulatory standards top Joint Commission list. Nov., p. 7.
IC struggles in ambulatory surgery centers. May, p. 7.
Implementing mandatory flu shots: Two systems share their stories. May, p. 1.
Managing healthcare workers with bloodborne diseases. Feb., p. 1.
More federal funds allocated for ASC surveys. Jan., p. 7.
More resources and fallout from hepatitis outbreak. July, p. 7.
MRSA rates climbing in outpatient settings. Jan., p. 7.
Next year, one flu shot, not two. April, p. 7.
Norovirus prevention advice on the horizon. Aug., p. 7.
Protecting cancer patients from H1N1. Feb., p. 7.
Rebate for STERIS customers. June, p. 7.
Seeing is achieving with hand sanitizers. Nov., p. 7.
SHEA set to update its position paper workers with bloodborne diseases. Feb., p. 1.
Smartphone app promotes safe injection practices. Nov., p. 7.
Spiking IV bags. Aug., p. 7.
Steps to ensure adequate precleaning. March, p. 1.
STERIS saga continues with FDA extension. March, p. 7.
Template offers PCP, pandemic assistance. April, p. 7.
Unclean dental equipment linked to possible HIV exposures. Aug., p. 7.
Unclean waiting room hazards. April, p. 7.
Unsafe injection practice even more dangerous than needlesticks. March, p. 7.
Webcast tool offers IC advice for ASCs. July, p. 7.

MISCELLANEOUS

Jury finds propofol makers liable. June, p. 7.
Pharmacy alert on epinephrine shortage. Aug., p. 7.

TJC issues Flu Vaccination Challenge. Oct., p. 7.
Use your iPhone to track the flu. Jan., p. 7.
You can trust Twitter ... maybe? July, p. 7.

Q&A FROM THE OSHA CONSULTATION HOTLINE

Bloodborne pathogens

Are bites employee exposure incidents and covered under OSHA standards? Jan., p. 8.

How long must we keep OSHA records for employees who have never had injuries and for employees with needlesticks from positive and negative source patients? June, p. 8.

I know that some facilities allow beverages at nurses' stations if there is a lid on the cup. To me, there is no difference between drinking from the rim of a cup vs. a little hole on top of the cup. Is this still an OSHA violation? June, p. 8.

If a healthcare worker did not have a titer drawn after the HBV vaccine was completed, how long afterward could we assume responder/nonresponder status? What about titrating periodically? Oct., p. 8.

If an employee leaves the practice and is rehired within one year, are we required to retrain and produce new OSHA documentation? Feb., p. 8.

Is the use of safety needles optional in a group medical practice, or must the employer require the use of safety needles? Oct., p. 8.

Is there a reporting mechanism for a defective sharps container? A fine needle was dropped into this particular container and went right through the bottom of the container. The company that made the product did not respond. Aug., p. 8.

Many of our safety needles are more than 10 years old. Is there a list identifying old safety devices that should be replaced? May, p. 8.

May we conduct bloodborne pathogens training before or after office hours so as not to disrupt patient scheduling? Jan., p. 8.

The medical practice where I work does its own blood testing for needlestick injuries, and I'm opposed to it. Wouldn't OSHA confidentiality rules prohibit that policy? March, p. 8.

Must the employer pay for the titer that comes after the hepatitis B vaccination? Nov., p. 8.

Must we use a safety needle if it is not to be used to administer to the patient, for example, when drawing up medication? Jan., p. 8.

What is the time limit for storing medical waste? We are considering the use of a system that stores our waste on-site and is then transported monthly through the mail. June, p. 8.

What test do we perform/order following the hepatitis B vaccination to confirm immunity? July, p. 8.

When transporting/delivering specimens within a physician office (blood draws, for example), does the specimen have to be placed in a secondary container that is marked with the biohazard sign before being taken to the lab processing area, which is also located within the same physician office? July, p. 8.

Emergency and fire

We are updating our evacuation exit route maps. Can you tell me what the regulations are for, how many to post, and where? April, p. 8.

What does OSHA say about prohibiting candles in a doctor's office? We have nurses who like to have them burning, but the smell from them is awful. So how can I get them out of the office? Nov., p. 8.

Hazard communication

How long do you have to keep MSDS files for products no longer used in the health center? Oct., p. 8.

Is it okay to have separate MSDS files for chemicals and hazardous drugs? May, p. 8.

Is there a recommended flush time or amount of water to use when using the emergency eyewash station? Sept., p. 8.

Must we create and maintain a hazardous chemical list for our practice? It seems like a lot of extra work considering that we already have the MSDS list. July, p. 8.

We changed to a different manufacturer for the purchase of isopropyl rubbing alcohol in our practice. Is it okay to use the old MSDS, or do we have to request a new one? Dec., p. 8.

Infection control

How many years should we keep sterilizer and equipment records and logs? Feb., p. 8.

Our accreditation organization wants us to use only EPA-registered disinfectants. Is alcohol EPA-registered as a disinfectant? Nov., p. 8.

What is the optimal method for instrument cleaning between patients in our outpatient facility: steam or cold soaking? April, p. 8.

Inspections

When OSHA cites a business, does the fine go to OSHA for operating expenses? Sept., p. 8.

Miscellaneous

I cannot find any OSHA standards regarding the use of anti-fatigue floor mats. Are there any such regulations or guidelines? Sept., p. 8.

I work in a clinic and was told by a manager that no employees in the facility are covered under federal OSHA directives or guidelines. Could this be true? Feb., p. 8.

Is there an OSHA regulation against using those scented plug-in air freshener devices in our practice? March, p. 8.

My practice wants to do laundry on-site. Are there OSHA rules regarding placement of washers and dryers? Aug., p. 8.

Our medical practice has fewer than 10 workers. Aren't there some OSHA standards that we would not have to follow because of our size? Aug., p. 8.

Recordkeeping

If an employee has an unprotected exposure to mucous membranes or non-intact skin, are these exposures recordable on the OSHA 300 log regardless of the source's HIV, HBV, or HCV status? Sept., p. 8.

I'm confused. Is our physician-owned lab exempt from keeping the OSHA 300 log or just from posting it? Dec., p. 8.

Respiratory protection

Are the paper masks we use for handling glutaraldehyde the same to use for protection from vapors during a major spill cleanup? May, p. 8.

Does OSHA require that employees accept a flu shot for H1N1? March, p. 8.

If an employee has a positive skin test but negative chest x-ray, is this employee exempt from future annual testing and x-rays? April, p. 8.

SELF-INSPECTION NOTES AND CHECKLIST

Bookmarking your way to OSHA compliance.

Oct., p. 6.

Check this list for substances requiring an MSDS.

Nov., p. 6.

Dealing with chemical spills. Feb., p. 6.

Glove safety is literally in your hands. May, p. 6.

The OSHA man cometh: An inspection checklist.

Sept., p. 6.

OSHA: Safety training can no longer be lost in translation. June, p. 6.

The paper chase of MSDS compliance. July, p. 7.

Simple steps can avoid computer vision syndrome.

Aug., p. 6.

Staying clear of whistleblower infractions. Jan., p. 6.

There's no place like home for home healthcare worker hazards. March, p. 6.

When the earth moves under your feet, or earthquake!

April, p. 6.

Year-end OSHA training program assessment.

Dec., p. 6.

OSHA MANUAL UPDATES

February: OSHA enforcement and pandemic influenza plans.

March: Bloodborne pathogens compliance checklist, interactive training requirements, and surgical fires prevention.

May: Safety checklists, postexposure confidentiality, MSDS charts, and respiratory protection training.

July: Eyewash station check log, students and volunteers, fire drills, food and drink in restricted areas.

September: Hepatitis B vaccinations, bloodborne pathogens fines, recordkeeping exemptions, and acronyms.

November: Postexposure evaluations and follow-up, respiratory protection for influenza, MSDS retention. ■