Dear Reader,

Survey responses from you have shown that the Q&A section on p. 8 of Medical Environment Update is one of the most popular features of the newsletter. That is because the questions and answers, which come through the OSHA Consultation Hotline, reflect real problem-solving and compliance issues that you, the safety officer, face in administering your facility’s occupational safety and health program.

Over many years, the OSHA Consultation Hotline, which is a benefit to Medical Environment Update subscribers, has fielded thousands of questions about OSHA compliance and employee safety matters for healthcare facilities. Although some questions are unique to a particular type of practice, a set of unusual circumstances, or an individual worker, most pertain to the common OSHA compliance challenges you face:

- Bloodborne pathogens
- Needle and sharps injuries
- Hazardous chemicals and drugs
- Personal protective equipment, including respiratory protection
- Recordkeeping and documentation

Whether your inquiries come from an on-the-spot safety incident, a what-if scenario, or a prove-it-to-me challenge from an employee or supervisor, the OSHA Consultation Hotline strives to not only respond quickly with helpful information but also provide references and citations from regulators to support the information.

I hope you find this compilation of FAQs helpful in refreshing your own OSHA compliance expertise as well as a useful resource to the safety and health program in your workplace. Should you have a question not covered in this special report, or need clarification on an answer, don’t hesitate to call or e-mail me through the contact information below.

Sincerely,

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General OSHA questions concerning healthcare facilities

What OSHA standards are important for compliance in medical practices?

The OSHA publication *Medical & Dental Offices: A Guide to Compliance with OSHA Standards* offers a “glimpse of the most frequently found hazards” in those types of businesses. The list includes:

- Bloodborne pathogens standard (29 CFR 1910.1030)
- Hazard communication (29 CFR 1910.1200)
- Ionizing radiation (29 CFR 1910.1096)
- Electrical (Subpart S-Electrical 29 CFR 1010.301 to 29 CFR 1910.399)
- Reporting occupational injuries and illnesses (29 CFR 1904)
- OSHA poster requirements

OSHA cautions that other standards may apply in medical and dental workplaces. It is the employer’s responsibility to identify hazards and to be in compliance with relevant standards.

What OSHA standards are cited most frequently in physician office inspections?

Bloodborne pathogens and hazard communication are by far the most frequently cited standards for physician offices and clinics. Less frequently cited standards are sanitation, means of egress, personal protective equipment, respiratory protection, and medical services and first aid, according to OSHA inspection data.

What are the requirements for displaying the OSHA poster?

OSHA requires employers to continuously display a poster prepared by the U.S. Department of Labor that informs employees of protections afforded under the Occupational Safety and Health Act of 1970. Display the poster in a conspicuous place where employees as well as applicants for employment can view it. Employers may download the OSHA workplace poster (also available in Spanish) or order it free at www.osha.gov/pls/publications/pubindex.list. Employers subject to state-administered occupational safety and health plans should obtain and post the state’s equivalent poster.

What types of healthcare facilities are exempt from federal OSHA recordkeeping requirements?

OSHA does not require the following types of healthcare facilities to keep injury and illness records (OSHA 300 and 300A forms):

- Offices and clinics of medical doctors
- Offices and clinics of dentists
- Offices of osteopathic physicians
- Offices of other healthcare practitioners
- Medical and dental laboratories
- Health and allied services not elsewhere classified

Most states operating their own job safety and health programs have adopted federal recordkeeping exemptions, but first check your state plan at www.osha.gov/fso/osp/faq.html#oshaprogram.

What hazards does the OSHA General Duty Clause cover?

Because of the catchall nature of the General Duty Clause, violations are possible in any physical location of a healthcare facility. OSHA cited healthcare employers for unsafe storage, TB, eyewash stations, burns, electric hazards, falls, machine guarding, crushing, and chemical hazards in recent years. The OSHA guidelines include workplace violence and ergonomics as possible General Duty Clause violations.

How long must the safety officer keep OSHA training records on file?

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OSHA requires employers to keep training records on file for three years. Training records shall include the following:

- Dates of the training sessions
- Contents or a summary of the training sessions
- Names and qualifications of persons conducting the training
- Names and job titles of all persons who attend the training sessions

Are student interns covered under OSHA?

No, OSHA standards apply only to employees. The educational program to which the intern belongs is responsible for training. To limit your facility’s liability, require confirmation from the program that the intern has received training. In the case of exposure to bloodborne pathogens, this would include training and the HBV vaccination documentation.

The same advice applies to volunteers: Either require appropriate training or restrict job duties to eliminate exposure to hazards.

Does OSHA require a medical facility to have a first aid kit for employees?

A first aid kit would be prudent, but OSHA does not require a kit unless employees do not have immediate access to an infirmary, clinic, or hospital. OSHA defines immediate access as being within a 15-minute drive to a hospital. If immediate access is not available, OSHA requires the employer to provide first aid training and supplies.

Does OSHA require a medical practice to have a safety committee?

Federal OSHA does not require a safety committee for medical practices, but a large practice with many employees and multiple offices could benefit from the safety committee model.

In the absence of requirements in standards, OSHA places the responsibility on the employer to establish a safety program to protect workers. OSHA publications referencing the usefulness of a safety committee include Creating a Safety Culture, Sample Safety and Health Program for Small Business, and Small Business Handbook.

Finally, check with state OSHA requirements if your practice is in a state that administers its own occupational safety and health plan. Oregon, for example, requires safety committees for businesses with more than 11 employees.

What is the difference between standards from OSHA and standards from the American National Standards Institute (ANSI)?

OSHA is a government regulatory agency, and the standards produced are the law. ANSI is a private nonprofit organization producing and coordinating voluntary consensus standards for safety. Because OSHA standards take a long time to change, ANSI’s guidelines are often more current. Sometimes OSHA cites ANSI standards under the General Duty Clause, so it is prudent to comply with both.

How frequently must you check fire extinguishers for compliance with OSHA?

The standard for portable fire extinguishers (1910.157) requires a visual check once per month and a maintenance check once per year.

Must a healthcare facility have a written plan for workplace violence prevention?

OSHA has guidelines for preventing workplace violence in healthcare facilities. The guidelines recommend a written plan for facilities with more than 10 employees. Although voluntary, Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers references the agency’s General Duty Clause, which says employers must provide a workplace that is safe for
employees. The guidelines are available at www.osha.gov/Publications/osha3148.pdf.

What are the OSHA fire drill requirements for physician offices?

Federal OSHA does not specifically require fire drills, but the agency’s Small Business Handbook recommends that employers “conduct frequent drills to ensure that all employees know what to do under stressful conditions.”

The National Fire Protection Association’s Life Safety Code® recommends periodic drills when 500 or more people occupy a building, or when more than 100 people occupy areas above or below street level for business occupancies. Freestanding physician practices and clinics are usually classified as business occupancies, not healthcare occupancies, as with hospitals and nursing homes. Also, it is always good to check with your fire department for local ordinances.

Does a small clinic need a written emergency action plan?

Facilities with more than 10 employees must have a written plan in the workplace that is available for employee review, according to section 1910.38(b) of the OSHA employee emergency action plans standard. Businesses “with 10 or fewer employees may communicate the plan orally to employees.”

Bloodborne pathogens

Is there a magic number of employees that exempts a medical practice from having to follow the OSHA bloodborne pathogens standard and safety needle rules?

That the OSHA bloodborne pathogens standard does not apply to small medical practices is a lingering misconception. But a January 20, 2004, OSHA letter of interpretation makes things perfectly clear.

“Bloodborne pathogens standard application to small healthcare facilities and the annual review of the exposure control plan,” states the bloodborne pathogens standard, as revised by the Needlestick Safety and Prevention Act, “applies to all employers who have employees with reasonably anticipated occupational exposure to blood or other potentially infectious materials.” This rule has been in effect since April 18, 2001.

The letter notes a recordkeeping exemption for certain types of healthcare facilities, including offices and clinics of doctors and dentists, medical and dental laboratories, and specialty outpatient facilities. But there is no exemption to the bloodborne pathogens standard based on the number of employees.

Find the letter by searching for its title on the OSHA Web site at www.osha.gov.

How frequently must I review the exposure control plan?

The minimum review requirement is once per year, but that is only if nothing has changed in your facility concerning bloodborne pathogen hazards.

Update the exposure control plan “whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure,” states section (c)(1)(iv) of the bloodborne pathogens standard.

Failing to update the exposure control plan was the third most frequent bloodborne pathogen violation for healthcare facilities. Average fines were $636 per violation, as reported in the August Medical Environment Update.

What workers are covered under the bloodborne pathogens standard?

Workers with occupational exposure to bloodborne pathogens or other potentially infectious material are covered under the standard.

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To OSHA, occupational exposure “means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.”

**When does OSHA require bloodborne pathogens training?**

The standard requires training:
- At the time of initial employment
- At least annually thereafter
- Whenever a change in an employee’s responsibilities, procedures, or work situation affects the potential for occupational exposure

**Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens** instructs OSHA officers to verify compliance during an inspection.

**For a worker who received the hepatitis B vaccine prior to June 2001 and did not have a titer, is the employer obligated to draw a titer now?**

No. A November 9, 2005, OSHA letter of interpretation and the June 2001 CDC guidelines for occupational bloodborne exposures say that periodic serologic testing for antibody concentrations after completion of the three-dose series is not recommended.

In the situation you describe, an untitered worker does not need to be tested unless he or she has an exposure, according to *Hepatitis B and the Health Care Worker* by the Immunization Action Coalition, which is sponsored by the CDC.

**What is the interval for giving the HBV vaccination series a second time to a nonresponder?**

A nonresponder to the three-dose HBV vaccination should wait at least four weeks before beginning the new series, according to the U.S. Public Health Service (USPHS) guidelines for the management of occupational exposures to HBV.

If you are following the guidelines by testing the effectiveness of the vaccination one to two months after the third dose, that provides the adequate time interval before commencing the second try.

“Persons who do not respond to an initial three-dose vaccine series have a 30%–50% chance of responding to a second three-dose series,” say the USPHS guidelines.

**Are we in violation of OSHA by not offering the HBV vaccine to clerical and administrative staff?**

No, you are not violating OSHA. The bloodborne pathogens standard defines occupational exposure as “reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.” Unless you have expanded job descriptions or cross-training for clerical and administrative staff members, they aren’t subject to the standard’s requirements, including offering them the HBV vaccine.

**Because of turnover and expense considerations, our practice waits until after the new-employee probation period to offer the HBV vaccine. Is that okay?**

No, it is not compliant unless your new-employee probation period is only 10 working days. “Hepatitis B vaccination shall be made available after the employee has received the training . . . and within 10 working days of initial assignment,” according to OSHA bloodborne pathogens standard 1910.1030 (f)(2)(i).

This is one of the more frequently cited bloodborne pathogen violations during OSHA inspections (see the OSHA violation report in the August 2006 *Medical Environment Update*). It is an expensive violation, with an average initial fine of $1,717.

**What does OSHA require from an employer when a new employee fails to respond to the HBV vaccination?**

The guidelines require that employees who don’t respond to the primary vaccine series receive a second three-dose vaccine series. First-series nonresponders have a 30%-50% chance of responding to a second three-dose series.

Nonresponders to a second vaccination series who are HBV surface antigen (HBsAg)-negative are susceptible to HBV infection. These employees should receive education about preventing HBV infection and the need to obtain HBV immune globulin prophylaxis for any known or probable parenteral exposure to HBsAg-positive blood.

Nonresponders who are HBsAg-positive should receive counseling about preventing HBV transmission to others and regarding the need for medical evaluation.

Finally, have the employee sign a confidential HBV vaccination nonresponder form that documents all of the measures taken above.

Our agency is under the assumption that we can bill the employee’s insurance for the cost of the HBV vaccination. I disagree. Who is right? Where can I find a written protocol to show my boss?

You are correct. Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens states, “The employer may not permit the employee to use his or her healthcare insurance to pay for the series unless the employer pays all of the cost of the health insurance and unless there is no cost to the employee in the form of deductibles, copayments, or other expenses.”

The document explains that partial employee contribution to insurance could penalize the worker in the form of higher insurance premiums that violate the “no cost to the employee” language of the bloodborne pathogens standard.

The same reasoning applies to using a spouse’s or family member’s insurance.

May an employee refuse the HBV vaccine?

Yes, but the employer must first provide HBV vaccine information about its efficacy, safety, and method of administration, as well as the benefits of being vaccinated, and explain that the vaccine and vaccination will be offered free of charge.

If the employee refuses the offer of the vaccine, have the employee sign a statement of declination.

If an employee declines the HBV vaccine, must the employer make it available for free at a later date?

Yes, the bloodborne pathogens standard 1910.1030(f)(2)(iii) requires the employer to offer the HBV vaccination at no cost to an employee who initially declined the vaccination, provided that the employee is still potentially exposed. An OSHA violation report published in the August 2006 Medical Environment Update shows an average initial fine of $1,875 for an infraction.

Where is the regulation that requires a titer after a HBV vaccination?

The OSHA bloodborne pathogens standard 1910.1030(f)(1)(ii)(D) requires that employers follow the recommendations of the USPHS for providing the HBV vaccination.

The postvaccination testing, or titer, requirement is found in Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV, and Recommendations for Postexposure Prophylaxis, published in the June 29, 2001, Morbidity and Mortality Weekly Report. The HBV vaccination section says healthcare workers “who have contact with patients or blood and are at ongoing risk for percutaneous injuries should be tested one to two months after completion of the...

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three-dose vaccination series for anti-HBs [antibody to hepatitis B surface antigen].”

The USPHS document is available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm.

What should I do if an employee did not receive the second of the series of HBV vaccine shots on time?

The recommended vaccination schedule for employees who have occupational risk to HBV is to administer:

➤ The first dose within 10 days of initial assignment
➤ The second dose one to two months after the first dose
➤ The third dose four to six months after the first dose
➤ Serologic testing one to two months following the third dose

If the vaccination series is interrupted after the first dose, administer the second dose as soon as possible, according to the CDC. Separate the second and third doses by an interval of at least two months. If only the third dose is delayed, administer it when convenient.

For HBV vaccination and postexposure management, OSHA requires employers to follow the most current recommendations of the USPHS. The current recommendations are in Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV, and Recommendations for Postexposure Prophylaxis, published in the June 29, 2001, Morbidity and Mortality Weekly Report.

Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, the document that instructs OSHA inspectors about bloodborne pathogen matters, says it is important to investigate thoroughly regardless of whether the employer knows of the contents of the current recommendations.

What personal protective equipment (PPE) does OSHA require phlebotomists to wear when drawing blood?

When it comes to this question, OSHA is very specific. Its bloodborne pathogens standard states that “gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood . . . when performing vascular access procedures.”

Which tests are required after a blood exposure?


The guidelines call for testing the source patient for HBV surface antigen (HBsAg), antibodies to HCV (anti-HCV), and antibodies to HIV (anti-HIV). If the source patient tests negative for the three infections, baseline testing or further follow-up on the exposed healthcare worker is not necessary.

For positive source patient test results, or if the source is unknown or refuses testing, the guidelines require the following tests for the exposed healthcare worker:

➤ HBV: Test for HBsAg if the worker is not immune. No tests are needed if the worker is immune by vaccination status.
➤ HCV: Obtain baseline testing for anti-HCV and liver enzyme levels (i.e., alanine aminotransferase). Follow up at four to six months.
➤ HIV: Test for anti-HIV for at least six months postexposure (e.g., at six weeks, 12 weeks, and six months). HIV testing should be performed on any exposed worker who has an illness that is compatible with an acute retroviral syndrome, regardless of the interval since exposure.

What is the OSHA fine for an overfilled sharps container?

Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens states, “Overfilling of sharps containers should be cited under paragraph 11030 (d)(4)(iii)(A)(2)(iii).” The average initial fine for serious violations in the sharps container grouping is $540, according to a report by the OSHA Office of Management.
What certification does OSHA require for a person conducting bloodborne pathogens training?

The bloodborne pathogens standard 1910.1030 (G)(2)(viii) does not specify training certification, only that the person conducting the training is knowledgeable in the “subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.”

Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, the guiding document for OSHA inspectors, identifies infection control practitioners, nurses, physician’s assistants, occupational health professionals, and emergency medical technicians as possible trainers for the bloodborne pathogens standard.

May an employee refuse postexposure treatment after a needlestick?

Yes. Require the employee to sign an informed refusal of postexposure treatment form. In that case, employee and source testing is not required.

Obtain documentation that the employee’s bloodborne pathogens training was current. Also make sure that OSHA is satisfied that your facility did not coerce the employee to not seek treatment.

Are lab coats required when changing surgical dressings?

The OSHA bloodborne pathogens standard requires employers to determine job classifications with risk to occupational exposure. OSHA’s definition of occupational exposure is “reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties.”

The standard then addresses PPE: “When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate PPE, such as, but not limited to, gloves, gowns, and laboratory coats.”

Check with your facility’s safety officer or the exposure control plan for the PPE requirements and work practices for your job function.

Where can I find information about nurses wearing gloves when giving injections?

The bloodborne pathogens standard 1910.1030(d) (3)(ix) states that “gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and nonintact skin; when performing vascular access procedures . . . and when handling or touching contaminated items or surfaces.” OSHA provides a reader-friendly answer in its fact sheet, Frequently Asked Questions: Bloodborne Pathogens, which states, “Gloves are not required to be worn when giving an injection as long as hand contact with blood or other potentially infectious materials is not reasonably anticipated.”


What is the OSHA fine for workers eating food in contaminated areas?

The bloodborne pathogens standard 1910.1030(d) (2)(ix) prohibits eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses “in work areas where there is a reasonable likelihood of occupational exposure.”

Violations are not frequent, but they are expensive, according to a report obtained by Medical Environment Update regarding OSHA violations in healthcare.
facilities from January 1 to June 30, 2006. The average initial fine for this violation was $850.

**Is it okay to dispose of blood and body fluids from surgical procedures down the drain?**

Generally, the discharge of blood and body fluids to the sanitary sewer is permitted. Sewer systems are designed to handle that type of waste. Sewer systems have not been designed to handle chemicals used to deactivate the waste prior to disposal. Evidence suggests that the deactivation chemicals pass untreated at wastewater plants and ultimately end up in surface waters.

Seek permission from the regulatory authority, usually the public-owned water treatment facility, for discharging anything other than domestic-generated waste into the sewer.

**Do you dispose of exam gloves as regular or red-bag trash?**

Unless soaked with blood or other potentially infectious material, used exam gloves are regular solid waste, not biohazard or red-bag waste.

Disposing regular solid waste in red bags is an expensive mistake. A report by the California Medical Waste Management Program (www.dhs.ca.gov/medicalwaste/PDFs/MedWasteReductionInterventions3.pdf) estimates that red-bag waste costs $480 per ton to process, compared to $25 per ton for solid waste.

**What is the best height for wall-mounted sharps disposal containers?**

The optimal installation height for containers is 52–56 inches above the standing surface, according to Selecting, Evaluating, and Using Sharps Disposal Containers, by NIOSH. For disposing of sharps from a seated workstation, NIOSH recommends a container installation height 38–42 inches above the floor. The NIOSH document is available at www.cdc.gov/niosh/sharps1.html.

**Is there a problem with mounting a sharps container inside a cabinet door?**

Yes. Selecting, Evaluating, and Using Sharps Disposal Containers, a NIOSH publication, identifies that location as unsafe because it requires workers “to make unnecessary movements while holding a sharp and accessing the container.”

The NIOSH publication identifies other inappropriate container locations:

- In corners of rooms
- On the backs of doors
- Under cabinets
- Under sinks
- In areas where people might sit or lie beneath the container
- Near light switches, room environmental controls, or utility system access ways
- Where the container is subject to impact and dislodgement by pedestrian traffic, moving equipment, gurneys, wheelchairs, or swinging doors

The bloodborne pathogens standard requires that sharps containers be “easily accessible to personnel,” and OSHA could reference NIOSH in a citation.

**Who is responsible for training workers from personnel or staffing agencies in bloodborne pathogens—the healthcare facility or the agency supplying the workers?**

Both the healthcare facility and the agency share responsibility, according to OSHA’s Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. The company providing the workers is responsible for basic training, vaccinations, and postexposure follow-up. You, the healthcare facility, are responsible for training in hazard prevention specific to your workplace, such as supplying safety sharps and PPE.

Make sure that the staffing agency and your employer understand this arrangement and document it.
Is a rapid HIV test required for an occupational blood exposure?

Although the bloodborne pathogens standard does not specifically identify rapid HIV test as a requirement, section (f)(3)(ii)(A) does say to test “as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity.”

Since the standard was revised in 2001, two documents have been published making it incumbent upon employers to provide rapid HIV testing for source patients as part of postexposure management.

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis issued September 2005 recommends using a rapid HIV test as it is becoming more widely used and has distinct advantages.

Results from a source-patient rapid HIV test can quickly allay an exposed employee’s anxiety about contracting HIV or provide essential information about initiating prompt postexposure prophylaxis, according to the guidelines.

More recent is the January OSHA letter of interpretation, “Use of rapid HIV antibody testing on a source individual after an exposure incident.” It says that rapid HIV antibody testing—confirmation of negative HIV status in less than an hour after blood is drawn from a source individual—is widely available, easy to use, and inexpensive.

“An employer’s failure to use rapid HIV antibody testing when testing as required by paragraph 1910.1030(f)(3)(ii)(A) would usually be considered a violation of that provision,” states the letter.

To access the OSHA letter of interpretation, search for the title at www.osha.gov.

May an employee decline to use PPE by signing a waiver similar to the HBV declination form without jeopardizing the employer for noncompliance?

The answer to both parts is no. Section (d)(3)(ii) of the bloodborne pathogens standard requires employers to ensure the use of PPE. An exception to this requirement comes when there are rare and extraordinary circumstances in which PPE use for a specific instance prevents the delivery of healthcare or public safety services or poses an increased hazard to the safety of the worker or coworker. The examples of rare and extraordinary circumstances that OSHA cites in Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens are of an emergency nature, not of the planned or standard operating procedure type associated with a signed waiver.

If your employee does not understand the value of PPE in preventing exposures, OSHA will question the effectiveness of your training. If your employee refuses to adhere to your facility’s PPE rules, OSHA will expect you to make adherence a condition of employment.

Is it okay for staff members to launder scrubs and lab coats?

You are grouping garments that, in most situations, serve different functions. OSHA says that it is the employer, not the employee, who bears the responsibility for maintaining and laundering PPE.

Scrubs usually function as a uniform, not as PPE, so it’s permissible under OSHA to require staff members to maintain and launder them. If scrubs become contaminated with blood, it’s best to have them washed by the employer, and to check whether staff members used adequate PPE to prevent contamination.

An alternative to the employer laundering a scrub is to decontaminate it in a 10:1 bleach solution for 10 minutes. Then the employee can wash the garment at home without the employer incurring laundering costs or a possible OSHA violation.

Lab coats serving as PPE shouldn’t be maintained or laundered by employees, according to OSHA standards.
Needlestick safety and prevention

Must physician practices and clinics use safety needles? My doctors want to know whether these devices are necessary.

After the passage of the Needlestick Safety and Prevention Act in 2001, OSHA revised the bloodborne pathogens standard. It clarified whether employers needed to select safer needle devices and involve employees in identifying and choosing these devices. The revised standard took effect April 18, 2001.

An OSHA letter of interpretation dated January 20, 2004, affirms that the revised bloodborne pathogens standard “applies to all employers who have employees with reasonably anticipated occupational exposure to blood or other potentially infectious materials.”

The average fine for not using a safety-engineered device was $915, as reported in the August Medical Environment Update.

Is it true that medical offices are not mandated to perform a yearly evaluation of safety devices (e.g., for needles, syringes, etc.) but that it is now only suggested?

OSHA has not changed its requirement for annually evaluating sharps associated with potential bloodborne exposures. Devices not contaminated with blood or other potentially infectious material are not subject to the annual evaluation under the bloodborne pathogens standard.

However, OSHA does not require an annual evaluation for every newly introduced safety sharp. If you have adopted a safety needle for use within the past year, OSHA would like you to have a schedule of when you intend to reevaluate that device. In short, put recently evaluated safety needles on the back burner of your annual safety sharps evaluation plan.

For other nonsafety needles or sharps, OSHA expects you to evaluate new commercially feasible devices, collect data, obtain input from nonmanagerial staff, and document acceptance or rejection. In short, put these efforts on the front burner.

What reasons are acceptable to OSHA for not using a safety needle?

“If a safer medical device compromises patient safety, worker safety, or the medical integrity, its use would not be required,” states a June 3, 2005, letter of interpretation.

But there is a caveat.

The OSHA interpretation continues, stating, “Whether or not an engineering control is chosen for a specific procedure, an annual review of safer medical devices is required, and that review must be documented in the exposure control plan.”

Should all of our needles be safety needles, even the ones we use to draw up medications?

No. According to OSHA’s Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens, “needles that will not become contaminated by blood during use (e.g., those used only to draw medication from vials) are not required to have engineering controls under this standard.”

However, the needle used to administer the medication must use a safety feature. Make a notation in your exposure control plan about the use of nonsafety needles for situations not covered under the bloodborne pathogens standard.

Is it okay to remove a safety needle from the syringe for disposal in the sharps container?

Not if it is a contaminated needle. OSHA bloodborne pathogens standard 1910.1030(d)(2)(vii)(a) prohibits the removal of contaminated needles “unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.”

Average fines were $1,293, as reported in the August Medical Environment Update.
Must a medical practice have a written hazard communication plan?

If hazardous chemicals are present in the workplace, OSHA requires a written hazard communication plan. The plan must include:

- A list of hazardous chemicals (such as disinfectants, anesthetic agents, sterilants, and mercury) used or stored in the office
- Labels and other forms of warning for hazardous chemicals
- A material safety data sheet (MSDS) for each hazardous chemical (obtained from the manufacturer) used or stored in the office
- Employee training, including the need for personal protective equipment (PPE)

Not having a written plan is the most frequent hazard communication violation for healthcare facilities, according to a report from OSHA.

Does the hazard communication standard require training only on initial hiring?

The standard requires training at the time of hiring and whenever the employer introduces a new physical or health hazard into the workplace. Some situations that would require additional training include the presence of a new chemical such as a disinfectant, changes in MSDSs, or new PPE options or requirements.

How do I determine whether my facility needs an eyewash station?

Perform a risk assessment of the jobs involved and what PPE might be available to help mitigate the effects of exposure. Consider which clinical and support staff work with chemical and hazardous substances. Check MSDSs for language such as “corrosives,” “may cause permanent injury to eyes,” and “flush eyes for a minimum of 15 minutes.”

Places in which you’d normally expect to find eyewash stations are laboratories, areas engaged in high-level disinfection (especially using glutaraldehyde), areas with bulk chemical storage, and boiler plants. Placement of eyewash stations should come as the result of a considered evaluation process and documentation.

What are the rules for eyewash station location?

The American National Standards Institute, which OSHA references in letters of interpretation, requires

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eyewash stations in accessible locations and within 10 seconds’ walking time of where exposure to hazardous substances could occur.

The stations must be on the same floor or level as the hazard and in a path of travel free from obstructions that may inhibit the immediate use of the equipment.

How often do you have to replace MSDSs in your MSDS file?

OSHA requires that employers have a current MSDS for hazardous substances in the workplace. An updated MSDS included with the product can get misplaced, so routinely request a new MSDS whenever your current one becomes three years old. That’s not a requirement; it’s just practical advice.

How long do I have to keep old product MSDSs?

The quick response is at least 30 years. Under 29 CFR 1910.1020, “Access to employee exposure and medical records,” employee exposure records include MSDSs.

There is a variation to the 30-year rule that applies to superseded MSDSs. An OSHA standards interpretation letter dated October 1, 1987, says that an employer may discard an MSDS prior to the 30-year time frame “if the new data sheet includes the same hazardous chemicals as the original formulation. If the formulation is different, then the employer must maintain both data sheets for at least 30 years.”

An alternative to keeping both MSDSs is to maintain a record of the old MSDS by identifying the substances used and where and when they were used. Although employers must keep that record for 30 years, it might save more space than keeping the entire MSDS.

Aren’t there some hazardous drugs that do not require having an MSDS on file?

An August 13, 1993, OSHA letter of interpretation exempts the MSDS requirement for FDA drugs when in solid final form (i.e., tablets or pills) for direct administration to the patient.

Is receiving MSDS information by telephone an adequate backup substitute for an electronic MSDS system?

Yes. An October 13, 1998, OSHA letter of interpretation says that relaying MSDS information by telephone is acceptable, but only “as a backup system in the event of failure of the primary electronic system.” The letter also says that the employer must provide the information as soon as possible to the requesting employee.

Do we need an MSDS for the chemotherapy drugs administered to patients?

Yes, the OSHA hazard communication standard requires an MSDS in this situation. For more information and a list of hazardous drugs used in chemotherapy, see Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings (www.cdc.gov/niosh/docs/2004-165/).

Is it okay to have an MSDS computer file instead of paper files?

If employees can obtain MSDS information while in the work area, computer MSDS files meet the accessibility requirements, according to an OSHA fact sheet (www.osha.gov/html/faq-hazcom.html) concerning the hazard communication standard. Having the employees leave the work area to access MSDS information would not be compliant.

Also, make sure your hazard communication employee education and training covers how to access electronic MSDSs and what to do in the case of system failure.

Must my office have MSDSs for household products used in the workplace?

OSHA FAQ: Compliance for Ambulatory Healthcare Settings
This is a common question; the classic examples being glass cleaners such as Windex and correction fluid such as Wite-Out.

An MSDS is not necessary for a household product if employees use the product “where the duration and frequency of use (and therefore exposure) is not greater than what the typical consumer would experience,” according to an OSHA fact sheet (www.osha.gov/html/faq-hazcom.html) concerning the hazard communication standard.

The key point is how the product is actually used. If employees are spending eight hours a day scrubbing windows with Windex or painting memos with Wite-Out, you must have an MSDS for those products.

Respiratory protection

How do I determine my facility’s risk classification for TB exposure?

Assuming that you are in an outpatient healthcare setting, determine the number of active TB cases encountered in the office.

In its guidelines for TB prevention in healthcare settings, the CDC provides the following TB risk classification criteria:

- **Low risk:** fewer than three active cases per year
- **Medium risk:** more than or equal to three cases per year
- **Potential ongoing transmission:** evidence of either transmission within the past year or staff with confirmed diagnosis of active TB

Also take into consideration the TB risk level in the surrounding community. Check with your local or state health department to find out the number of TB cases in the community.

See the TB risk assessment worksheet in the guidelines at www.cdc.gov/mmwr/pdf/rr/rr5417.pdf.

What OSHA standards apply to hazards from TB?

The General Duty Clause of the Occupational Safety and Health Act of 1970 requires employers to provide a place of employment free from recognized hazards that cause or are likely to cause death or serious physical harm to employees. The clause applies to TB hazards.

Other standards that relate to TB are recording and reporting occupational injuries and illnesses, respiratory protection, and accident prevention signs and tags. The same standards would apply to other airborne hazards such as severe acute respiratory syndrome and smallpox.

Must the employer pay for employee TB skin tests?

Yes, if the tests are part of the facility’s TB exposure control plan. OSHA’s Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis says that if you require TB skin tests, the tests and any follow-up surveillance, such as a chest x-ray, shall be offered at no cost to the worker.

Must the employer provide an annual chest x-ray for a worker who has a positive TB skin test?

No, annual chest radiography is not required, according to Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, published in the December 30, 2005, Morbidity and Mortality Weekly Report.

Healthcare workers who have a positive baseline tuberculin skin test (TST) or a newly positive TST should receive one chest radiograph. If the results are negative, “repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph,” say the guidelines.

Does OSHA require our facility to offer volunteers free TB PPD skin testing as we do our employees?

OSHA regulations usually do not cover volunteers. Section 4 of the Occupational Safety and Health Act

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of 1970 states, “This Act shall apply . . . to employment performed in a workplace.”

Volunteers do not receive monetary compensation for their services. For example, a student who receives academic credit for services is a volunteer. However, an uncompensated individual who works off a debt—for example, a monetary fine—is an employee and not a volunteer.

Your facility may have infection control, risk management, or accreditation-related reasons to provide protection for volunteers, but OSHA does not obligate you to do so.

Do the N95 respirators recommended for protection against pandemic and avian influenza require a fit-test?

Yes, employees required to wear respiratory protection must be fit-tested “prior to initial use, whenever a different respirator facepiece is used, and at least annually thereafter,” according to OSHA’s Respiratory Protection Frequently Asked Questions Web page (www.osha.gov/SLTC/etools/respiratory).

Additional fit-testing must be performed “whenever there are changes in the user’s physical condition that could affect respirator fit (e.g., facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight).”

A qualitative fit-test usually takes 20–30 minutes for each employee. The fit-test requirements are explained in Appendix A: Fit Testing Procedures of the Respiratory Protection Standard, 1910.134.

For employees wearing an N95 on a voluntary basis, the employer is required to provide Appendix D: Information for Employees Using Respirators When Not Required Under Standard. You can find Appendixes A and D at www.osha.gov/SLTC/respiratoryprotection/index.html.