OSHA hits needlesticks, TB with recordkeeping revisions

Revised recordkeeping rules from the Occupational Safety and Health Administration (OSHA) will bring more focus to health care worker safety, particularly when it comes to needlesticks.

For the first time, hospitals will have to record all potentially infectious sharps injuries on their work-related injury and illness logs. This log, usually called the OSHA 200 Log, will become the OSHA 300 Log on January 1, 2002, when the provisions of the new record-keeping rule (29 CFR Parts 1904 and 1952) go into effect. For a look at the OSHA 300 Log, see p. 6.

Separate from the 300 Log will be the 300-A summary form, which replaces the summary portion of the 200 Log. Also, OSHA Form 101, an injury and illness record for individual incidents, will become OSHA Form 301 and will include more data on how the injury or illness occurred.

Under the revised rule, it is also likely that hospitals will have to maintain a fourth form that contains information on confidential cases, such as needlesticks. This new provision allows

Ergonomics tips while you wait

Steps you can take now

The eyes of the health care industry—from the hospital administrators to the safety officers—are still on President Bush, watching to see what he will do to the ergonomics standard.

As more and more lawsuits pile up against the regulations from the Occupational Safety and Health Administration (OSHA), Bush and his administration must decide whether repetitive motion injuries are worth a political fight.

Bush has three options, according to OSHA:

1. He can do nothing and let the standard stand
2. He could attempt to rescind the standard through rulemaking, which is a formal process that can take some time to complete
3. He could issue an “administrative stay”—a move that would at least temporarily stop the provisions of the standard from taking effect

Any of the groups or organizations that filed suit to block
Concurrent validation surveys to hit IL, MI, and CA
Criticism of accreditation process fuels further HCFA involvement

The follow-up validation survey process will take a twist for some accredited hospitals in a trio of states.

As of January 17, the Health Care Financing Administration (HCFA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) launched a pilot program to conduct simultaneous surveys at given sites.

The initial targets are hospitals with at least 150 Medicare-certified beds in Illinois, Michigan, and California—and any chosen site can expect much tougher visits with these concurrent surveys.

“They are starting with 150 beds and up because you have to have a big enough physical plant to accommodate all these people,” says a JCAHO surveyor who didn’t want to be identified. “You can’t have two survey teams in a 30-bed hospital, in addition to observers . . . For the survey coordinators, it will be hard on them. They will have a double set of eyes in there at the same time.”

The ‘lucky’ draw
Two hospitals each in Illinois and Michigan will get the dual validation surveys during the first-quarter survey cycle, though officials could visit more hospitals if they want, according to information obtained by BHS. A larger number of hospitals will undergo the concurrent visits in California.

Once the first-quarter pilots are complete, plans are to conduct one concurrent survey in each of the remaining 47 states during the last three quarters of 2001.

JCAHO surveyors learned of the developments in early January at their conference in Chicago. HCFA confirmed the pilot program but hadn’t made a formal announcement at press time.

HCFA surveyors will be trained in JCAHO procedures prior to the visits, though validation findings may not be shared with the JCAHO surveyors at that time. Disparities in findings between the two surveys will eventually be calculated and reported to Congress, according to one source not with either group. (For more about who might show up to do these surveys, see the related story to the left.)

Deeming authority explained
Typically, HCFA conducts follow-up validation surveys for about 5% of all health care sites the JCAHO accredits, but a 1999 government report rebuked...
HCFA for not doing more to validate Joint Commission surveys. Many in the health care industry consider HCFA’s surveys more detailed.

The JCAHO has “deeming authority” from HCFA, meaning that because it enforces standards that meet federal requirements for organizations to receive Medicare payments, it is granted authority to conduct surveys on behalf of HCFA.

These concurrent surveys could inflame an old controversy about the Life Safety Code. HCFA and the Joint Commission require compliance with the code, though HCFA recognizes the 1985 edition, while the JCAHO uses the 1997 version. This arrangement leads to confusion during inspections of hospitals.

(For more about this aspect of the concurrent surveys, see the February issue of Healthcare Life Safety Compliance, a sister newsletter to BHS.)

Survey criticism lurks
No one should lose sight of what contributed to these new surveys: a lack of confidence in the JCAHO’s accreditation process, says Ray Moughalian, BSIE, ASAE, president of RM Associates in Haverhill, MA, a facilities management consulting firm.

In 1999, the Department of Health and Human Services’ Office of Inspector General released a report that concluded that while the JCAHO’s surveys reduce risk and foster hospital care improvement, they are unlikely to detect substandard patterns of care.

Moughalian says that he recalls finding an alleged 140 Statement of Conditions (SOC) deficiencies at a hospital after an earlier accreditation survey only turned up 10. “There were many deficiencies that weren’t noted,” he says.

Many of the deficiencies affected the hospital’s ability to evacuate people to a safe haven on the same floor, he adds. “Is that serious? I think so. Without those compartments, you can have smoke [spread] to other parts of the hospital,” he says.

Although there may be some problems, the SOC program has been quite successful, says life safety consultant James Lathrop, vice president of Koffel Associates Inc. in Niantic, CT.

“It has forced management to look closer at the physical plant,” Lathrop says. “Anyone who has not seen a significant improvement in their facility over the last 10 years either had a very good facility to start with or has not been doing their job.”

Success may spread . . . slowly
Depending on how everything goes, the concurrent validation survey program could go nationwide, says another JCAHO insider.

The ultimate goal may be to have concurrent visits for 20% to 40% of all validation surveys for hospitals with at least 150 beds.

But any successes won’t result in automatic changes. “If the pilot works out . . . it will have to be reviewed by [HCFA] general counsel, and everyone else and his mother, before it goes out” as a new policy, a Medicare source says. —

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sharps injuries to be recorded on the 300 Log without an employee’s name being entered, thus keeping privacy concerns intact in the event the worker contracts HIV, for example.

Now may be a good time to reinforce to all employees in the hospital the importance of the OSHA injury log and what it can tell staff members about injury trends, says Peg Luebbert, MS, MT(ASCP), SC, CIC, risk management specialist at Alegent Health-Bergen Mercy Medical Center in Omaha, NE.

The recordkeeping rule, which OSHA published in the Federal Register on January 19, continues to apply to all employers who have more than 10 employees, though there is an exemption list that has been expanded to include some health care settings (see the related story on p. 5).

Combining needlestick requirements
One nice thing coming out of these changes is that hospitals—already required under federal law to keep needlestick injury logs—can do so while also maintaining the OSHA logs, says Jim Maddux, a statistician with the agency and the primary author of the recordkeeping rule.

“If people want to, they can [basically] use the same form to meet both requirements,” Maddux says. He recommends using a separate OSHA 300 page for the needlestick log when it comes time to switch to the new form.

Along with needlesticks, the revised rule also hits two other hot spots in hospital safety: tuberculosis (TB) and ergonomics. Here is a look at how these three areas fit into the revisions:

1. Needlesticks
OSHA wants to see a record of all punctures and cuts caused by needles or other sharp objects that are contaminated—or potentially contaminated—with blood or other infectious material.

“Needlesticks are something that we had Congress leaning on us to do for a while,” Maddux says. “There might be 600,000 [needlestick injuries annually], so it’s good to have specific advice on this.”

Hospitals don’t have to record all sticks. For example, getting cut with a knife that does not have blood on it would generally not be recorded under the rule.

OSHA makes provisions for keeping the identities of needlestick sufferers anonymous on the 300 Log, particularly when an injured employee seroconverts. In such cases, employers must have a separate, confidential file with case numbers and names.

2. TB infections
Cases of TB acquired in the workplace are clearly meant to be recorded on injury logs, OSHA says. Health care workers are at greatly increased risk of contracting the disease due to the nature of their work.

Hospitals must record a case of TB if the employee has active TB or a positive TB skin test.

The case is work-related if the employee has been occupationally exposed at work to another person with a known, active case of the disease. The hospi-
tal can remove the log entry if it determines that the TB was from a nonwork exposure.

Under the current regulations, which the new rule will replace on January 1, 2002, an employer has to record active cases of TB or positive skin tests, and if the employee worked in one of five high-risk industries, it was assumed the case was work-related. The revised rule eliminates the high-risk presumption.

3. Ergonomics
The new OSHA 300 Log will have a column for musculoskeletal disorders (MSDs)—in other words, workplace injuries caused by ergonomics hazards.

The recordkeeping rule borrows the definition of an MSD from the agency’s ergonomics standard by qualifying it as an injury or disorder of the muscles, nerves, tendons, ligaments, joints, cartilage, and spinal discs.

The new rule also simplifies how to record an MSD, basically requiring a log entry for MSDs that result in days away from work, restricted work, job transfer, or medical treatment beyond first aid.

What should you do now?
At this point, OSHA says employers must continue to observe the provisions of the current rule until January 1, 2002. The agency published the new rule with so much lead time in order to give companies and organizations a chance to learn the new requirements.

“This is such a large change in the way things are going to be booked that it has to be released now,” says John Murray Jr., CHMM, CSP, safety director at Baystate Health System in Springfield, MA.

Murray urges hospitals to look at their software and database programs now to see whether they can handle the changes.

However, you shouldn’t chuck your OSHA 200 Log yet. “It’s very important to recognize that you need to keep your 200 Log until the end of the year,” Maddux says. “The new standard goes into effect next January 1.”

In the meantime, take a cursory look at the new requirements in the rule. In the fall, undertake a stronger, more nuts-and-bolts review of the provisions, Maddux recommends. -成熟的-

Editor’s note: To read the full rule online, go to OSHA’s recordkeeping Web site at www.osha-slc.gov/recordkeeping/index.html.

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### New rule adds health care exemptions

The revised recordkeeping rule adds industry exemptions for several health care settings. Hospitals are not exempt from the rule, so don’t toss the regulations in the trash if you’re a hospital safety officer.

However, the following health care settings are exempt from the revised rule: offices and clinics of medical doctors, offices and clinics of dentists, offices of osteopathic physicians, offices of other health practitioners, medical and dental laboratories, and health and allied services.

None of the above items are exempt under the current rule. The current regulations phase out on January 1, 2002, when the revised rule goes into effect.

Also, if any of the above settings are physically in a hospital—for example, a hospital lab—the revised rule still covers them, says Jim Maddux, a statistician with the Occupational Safety and Health Administration.

“The lab is covered, the emergency room is covered, the laundry room is covered,” says Maddux. “Once it’s inside the establishment, it’s covered.”

The lab exemption applies to freestanding labs, such as reference labs that receive tests from numerous hospitals, Maddux adds. -成熟的-
## OSHA's Form 300
### Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restriction of activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.6 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 101) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

### Identify the person

<table>
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<th>Case no.</th>
<th>Employee's name</th>
<th>Job title (e.g., Welder)</th>
<th>Date of injury or onset of illness (e.g., Loading dock work end)</th>
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### Describe the case

- Describe injury or illness, parts of body affected, and object/ substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acid/steam)

### Classify the case

Using these four categories, check ONLY the most serious result for each case:

- Death
- Days away from work
- Job transfer or restriction
- Other

Check the "Injury" column or choose one type of illness:

### Page totals

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-2544, 200 Constitution Avenue, N.W., Washington, DC 20210. Do not send completed forms to this office.
the rule could request that Bush issue an administrative stay until the lawsuits go before a court.

If the president denies a requested administrative stay, the groups could seek a court hearing and try to show that the standard poses irreparable harm. However, an OSHA spokesperson says that because many of the provisions of the ergonomics rule don’t begin until October, it might be hard to prove any immediate harm from the rule.

Adding to the ergonomics maelstrom is that lawmakers approved the nomination of new Labor Secretary Elaine Chao, who said during her confirmation hearings that the ergonomics provisions are complicated but wouldn’t commit to whether she would try to rescind the standard.

Don’t ignore the concerns
Regardless of what happens politically, some experts advise hospitals to become familiar with ways to prevent the musculoskeletal disorders that the standard seeks to eliminate.

“If OSHA wants to enforce ergonomics, they will find a way,” says Steven Bryant, practice director of accreditation services for The Greeley Company, a division of HCPro, in Marblehead, MA. Greeley is the sister company to Opus Communications, publisher of BHS.

And the renewed emphasis on worker safety through environment of care (EC) standard EC.1.1.1 could see the Joint Commission on Accreditation of Healthcare Organizations squeeze hospitals for ergonomics programs, too.

Facilities should begin now to review how their workers do their jobs and how they educate employees to be careful on the job, says D. Scott Jones, CHC, operations and compliance officer for Southern Regional Physician Services at Our Lady of the Lake Regional Medical Center in Baton Rouge, LA.

Jones offers the following tips on preparing health care facilities for the new ergonomics standards:

- Assess jobs that involve recurring stress or heavy work, such as lifting residents. Ask yourself, for example, what jobs exist in your billing office, care floors, laundry room, and kitchen that involve repetitive movement, lifting, working with hands over the head, and using vibrating tools or equipment.

- Carefully examine the risk for workers. Observe how workers conduct their jobs, the equipment they use, and time required for tasks. When lifting or moving patients, do staff members avoid bending at the waist and lift with a partner? Are there enough staff members in your facility to avoid harming patients while moving or lifting?

- Look at your equipment and working areas. Find out whether typing desks are the correct height, workers use wrist pads for keyboards, and patient lifts work properly. If needed, require the use of back belts or braces.

- Educate staff members about ergonomics. Employees need to know now the rules of proper lifting, how to avoid repetitive movements when possible, and how to properly care for themselves while working. Use experts inside your own organization, such as physical therapists, to get the point across. Be sure to document your training.

Illustration by
Dave Harbaugh

“I invited a JCAHO representative to address this board on EC standards, but he’s in recovery from a hit-and-run ER gurney.”
Survey monitor: Doors are a prime focus during visit

494-bed acute care hospital in the Northeast United States

The safety director at this hospital thought she had seen every nook of her building—but that was before the surveyor arrived and took his own self-guided tour.

“I’ve worked here 23 years, and I thought I knew all the stairwells,” the safety director says. “[The surveyor] took me to stairwells I never knew existed.”

This Tuesday-through-Friday survey from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) took place in November. The hospital scored a 96. There were no environment of care (EC) Type I recommendations, though the EC tour did yield a pair of supplementals:

1. In one stairwell, the surveyor found an empty linen cart. He said the cart constituted storage in an egress route. In response, the safety office removed the cart and spoke to staff members about this concern.

2. In a corridor rated for business occupancy, a merchandise display in front of the gift shop held the doors to the shop open. The display was on wheels, but the surveyor felt the display unnecessarily blocked the doors, says the safety director.

She didn’t agree with the surveyor’s finding about the gift shop doors, but the hospital’s administrators chose not to contest the supplemental.

“You couldn’t argue with [this surveyor],” the safety director recalls. “There was no discussion. He described himself as an inspector, not a surveyor. He was not educational at all. He was tough.”

Checking the doors

This surveyor knew the Life Safety Code and was big on doors. “He was a life safety nut,” the director says.

Among the door-related areas the surveyor checked out were the following:

- He wanted to see the doorways along means of egress. At this hospital, every stairway door on every floor has a sign directing people to the nearest exit, such as, “You are in stairwell B—go down to the basement level to exit.”

  The surveyor liked these signs and thought they were innovative, the safety director says, adding that the engineering department designed the signs to be simple and to help people get out of the building quickly.

- He checked the doors to dirty utility rooms, which are used to hold garbage and dirty instruments that are being disinfected. The surveyor wanted to see door closers for these rooms to ensure positive latching on the doors.

- The hospital has a floor about to be renovated that is currently in a demolished state, though no active work was going on during the visit. The surveyor checked the fire doors connected to the work area.

- In all, the surveyor tried about 80 doors in the facility and spent time feeling partitions between connected buildings. However, he did not roll any quarters under doors to check for undercut clearances.

Medical equipment scrutinized

The surveyor spent a long time checking on clinical medical equipment records.

He quizzed the medical equipment manager for biomedicine about past and future preventive maintenance checks, as well as the location of specific pieces.

“He asked for [details on] 28 pieces of equipment, not just one or two,” the safety director recalls.

Luckily, the equipment manager uses a computer program to track this information, so she was able to
easily provide answers for the surveyor.

Safety committee on the spot
The surveyor surprised members of the hospital’s safety committee a little bit. At one point he was chatting with the safety director and several members of the committee.

The surveyor asked about attendance at the safety committee meetings and was told people faithfully show up. He then proceeded to ask committee members who were in the room what they presented at the last meeting, and then asked them to provide him with verbal reports, the director says.

Although the committee members responded appropriately, they were caught off guard by the question, she adds.

However, when it came to EC documentation, there were no problems, and the safety director credits the members of the safety committee for that. The five subcommittees of the main group give her written reports quarterly that include performance indicators.

“We find out right away what our issues are and we all work together,” she says. She also works closely with the hospital’s facilities manager, which she says is a necessity to ensure that safety concerns mesh with building operations.

Conflicts over drills
Fire drills were a problem. The safety director and the surveyor did not share views on how the JCAHO’s fire drill standard applied, the director says.

At the time of the survey, fire drill standard EC.2.10 (now EC.2.9.2) required drill monitors to observe either all areas of a building during a drill or a sampling of those locations (including the smoke compartment where the drill started, an adjacent compartment on the same floor; another compartment on a different floor either immediately above or below, and an additional random 20% of remaining compartments).

The safety director says the surveyor wanted to see compartments monitored to the left and right of the compartment where the drill started, whereas she believes the standard intended a compartment to the left or right, but not both.

The surveyor’s position appears puzzling, since the standard removed the wording on observing adjacent compartments on July 1, 2000. It now says that all personnel must participate in fire drills “to the extent called for in the facility fire plan.”

Experts indicate that this change helps facilities with a large number of smoke compartments cope with fire drill observations.

The surveyor also wanted to see written fire drill critiques from the drill observers. The hospital uses a drill form that notes the responses of participating staff members to drill criteria specified by the safety committee.

Next stop: vacant unit
One of the staff members casually mentioned there was a vacant surgery unit in the hospital—take a guess where the surveyor’s next stop was.

“He wanted to make sure . . . we wouldn’t drop our standards” for the vacant unit in case the hospital ever needs to reopen it quickly, the safety director says.

The surveyor went through the unit to make sure that it was clean, it wasn’t used as a storage room, its toilets were flushed frequently, the call buttons worked, the refrigerator worked properly, and stray medications weren’t left lying around.

Survey at a glance . . .
Hot spots: Doors, Life Safety Code, medical equipment
EC Type I’s: None
EC supplementals: Storage in egress stairwell; blocking open gift shop doors
Quote of note: “He described himself as an inspector, not a surveyor.”
Lax tissue bank oversight boosts risk of disease, report says
If you work in a tissue bank and your feelings have been hurt because you thought government investigators didn’t care about you, well, you were just plain wrong.

There’s a need for caution if a hospital uses donated human tissue in operations, says a new report on federal oversight of tissue banks.

Human tissue can transmit diseases such as HIV or hepatitis, although federal officials have not received any reports of infections since 1993, the Department of Health and Human Services’ Office of Inspector General (OIG) says in Oversight of Tissue Banking.

No news is good news, the OIG says. But inspectors from the Food and Drug Administration (FDA) have found deficiencies in banks’ screening and testing practices. Some facilities have failed to meet accreditation standards, and some states have received reports of adverse events.

No one knows how many tissue banks exist, the report says. The OIG found 154. The FDA has never inspected 36 of those facilities.

As you can imagine, there must be paperwork involved: A draft FDA rule would require registration of tissue banks and improved testing and screening, and would prescribe a set of best practices. The OIG urges officials to release the rule soon.

You can read the new report under “What’s New” at www.hhs.gov/oig. The FDA’s proposed rule is online at www.fda.gov/cber/rules/gtp010801pr.htm.

Researchers trace HCV to hospital employee
You can almost imagine the conversation: “I didn’t want to wear my gloves, blah, blah, blah.”

It seems that five people with hepatitis C virus (HCV) contracted the disease from a German anesthesiology assistant who allegedly did not use adequate barrier protection when treating patients, according to researchers quoted in the Boston Globe.

The researchers were able to isolate the strain of HCV and trace it back to the caregiver, who refused to use gloves when administering anesthesia because they diminished his sense of feeling.

The assistant apparently contracted the liver disease, which can be fatal, from a patient. He had a cut on his hand and did not wear protective gloves while administering anesthesia, the paper reports.

Nurse accuses hospital of negligence
A nurse who was attacked and raped by a patient at a hospital in Whitfield, MS, has sued the facility, its director, several employees, and the Department of Mental Health, according to the Associated Press.

In the lawsuit, the nurse accuses the hospital and its management of gross negligence for not providing adequate security. A second person, who helped the nurse during the attack, is also suing for the same reasons.

In the time since the attack, the hospital has taken steps to prevent such incidents from recurring, including giving staff members personal alarms for direct communication with hospital security officers, the Associated Press reports.

Lights, camera . . . fire!
Never mind the patients and staff members—are the actors okay?

A mechanical room fire at a medical center in Los Angeles forced the evacuation of dozens of patients and employees in January. The blaze also halted filming of the TV show Diagnosis Murder, which was shooting a stunt scene in a parking garage behind the medical center, according to the Daily News of Los Angeles.

The cause of the fire remained under investigation, though luckily no one was injured. Sorry, no autographs were available from the show’s star, Dick.
Van Dyke, who was not there at the time.

Mercury thermometer legislation is coming. If you’re a big fan of mercury, please skip this brief.

U.S. Senator Susan Collins (R-ME) plans to introduce legislation soon to ban nationwide the sale of mercury thermometers, unless a doctor prescribes the use of such equipment.

Collins said that environmental concerns are behind her proposal.

“A mercury fever thermometer contains about a gram of mercury,” she said in a statement. “One gram of mercury per year is enough to contaminate all the fish in a lake with a surface area of 20 acres.”

Some hospitals have dealt with nightmarish cleanup efforts when a thermometer or other mercury-containing item broke, spilling the contents onto the floor.

Praise for Collins’ plan came quickly from Health Care Without Harm, a coalition that wants to curb environmental damage from the health care industry, such as improper disposal of mercury thermometers.

On a related note, the California Department of Toxic Substances Control has a “Guide to Mercury Assessment and Elimination in Healthcare Facilities” available to download at www.dtsc.ca.gov/sppt/pptd/pp/.

Alleged criminal past mars ‘Mother Anna’

An FBI fugitive nicknamed “Mother Anna” raised security issues after she allegedly worked as a home health employee for a Midwest hospital prior to being arrested in December.

The news, which the Associated Press reported in late January, came as a shock to the coworkers and patients of the woman, who had been wanted in connection with a child abuse case in Florida.

The suspect had suddenly stopped working at St. Mary’s Hospital in East St. Louis, IL, and a few weeks later an employee at the hospital saw a tabloid story about her alleged criminal actions.

Police arrested her shortly afterward.

Hospital officials told the Associated Press that they did a thorough background check on the woman before she was hired.

FDA warns providers about allegedly substandard drugs

The Food and Drug Administration (FDA) issued a warning to health care providers on January 29 about certain injectable drugs marketed by Phyne Pharmaceuticals of Scottsdale, AZ.

The FDA issued the warning because Phyne allegedly has delayed taking prompt action to remove these products from the market.

AMRAM Inc. of Rathdrum, ID, manufactured these products for Phyne, who was the sole customer. According to the FDA, on December 14 AMRAM notified Phyne that it was recalling the products under question because they were manufactured under substandard conditions.

The FDA says that it found alleged violations during the manufacturing process that showed the drugs might lack sterility and potency.

The FDA urges anyone in possession of the products to contact Phyne at 800/345-3391. Phyne had stated it would provide specific return instructions to customers by an “urgent voluntary drug recall” letter dated January 25.

To read the list of questionable drugs online, go to the FDA’s warning at www.fda.gov/bbs/topics/NEWS/2001/NEW00750.html.
Most of you probably already know that laundry activities and linen service are rife with opportunities to infect workers with a disease.

Some of the methods for keeping housekeeping staff members safe are pretty easy to grasp, such as making sure they wear gloves and other personal protective equipment when handling soiled linen.

The Centers for Disease Control and Prevention offers some other advice on your dirty laundry:

- Put all soiled linen in bags or containers at the point of collection.
- Don’t sort or rinse the laundry at the point of collection or where the linen was used, such as in a patient’s room.
- Bag linens heavily contaminated with blood or other bodily fluids and take them to the cleaning facilities in a way that prevents the materials from leaking.
- Make sure commercial washing machines use water temperatures of at least 160 degrees Fahrenheit, with a chlorine bleach mixture of 50 to 150 parts per million—this will help remove microorganisms.
- You can use water temperatures lower than 160 degrees if you have laundry chemicals suitable for low-temperature washing.

Don’t forget that once the linen is clean, you want to keep it that way.

Make sure housekeeping staff members and other employees know what linen is clean and the best ways to handle and transport it so that it doesn’t become dirty before it gets to a patient.

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**Briefings on Hospital Safety  Editor/Journalists Board**

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<td>Practice Director, Accreditation Services</td>
<td>Director of Support Services</td>
</tr>
<tr>
<td>The Greeley Company</td>
<td>Hazelden Foundation, Center City, MN</td>
</tr>
<tr>
<td>Marblehead, MA</td>
<td>Janine Jagger, MPH, PhD</td>
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<tr>
<td>Murray L. Cohen, PhD, MPH, CIH</td>
<td>Associate Professor of Neurosurgery</td>
</tr>
<tr>
<td>Risk Management Consultant</td>
<td>Director, International Health Care Worker</td>
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<tr>
<td>Atlanta, GA</td>
<td>Safety Research and Resource Center</td>
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<td></td>
<td>University of Virginia Medical Center</td>
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<td></td>
<td>Charlottesville, VA</td>
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<td></td>
<td>Linda D. Lee, MS</td>
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<td></td>
<td>Vice President, Regulatory Affairs and</td>
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<td></td>
<td>Quality Assurance</td>
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<td>Stericycle, Inc.</td>
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<td>Deerfield, IL</td>
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<td>Ray W. Moughalian</td>
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<tr>
<td></td>
<td>President</td>
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<td>RM Associates Inc.</td>
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<td>Haverhill, MA</td>
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<tr>
<td>John L. Murray Jr., CHMM, CSP</td>
<td>John L. Murray Jr., CHMM, CSP</td>
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<tr>
<td>Safety Director, Baystate Health System</td>
<td>Safety Director, Baystate Health System</td>
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<tr>
<td>Springfield, MA</td>
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<tr>
<td>Frances M. Slater, RN, MBA</td>
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<tr>
<td>Infection Control/Quality Assurance</td>
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<td>The Methodist Hospital</td>
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<tr>
<td>Houston, TX</td>
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<tr>
<td>Steven Weinstein, MT(ASCP) MPH, CIC</td>
<td>Steven Weinstein, MT(ASCP) MPH, CIC</td>
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<tr>
<td>Environmental, health, and safety specialist</td>
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<td>Abbot Laboratories</td>
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<tr>
<td>Pier-George Zanoni, PE, CSP, CIH</td>
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<td>Maintenance Supervisor</td>
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<td>Metropolitan Hospital</td>
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<td>Grand Rapids, MI</td>
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