Meeting HAZWOPER requirements
Part one: Know what you can handle

In early February, a truck carrying sodium hydroxide had to suddenly brake as it approached Ruby Memorial Hospital in Morgantown, WV.

The jolt tipped over a 55-gallon drum, spilling more than half its contents near the facility. Authorities feared the sodium hydroxide might mix with other chemicals on the truck and cause a reaction.

Luckily, firefighters contained the spill until a cleanup crew arrived and the chemical didn’t contaminate any water resources, according to the Charleston Gazette.

Could your hospital handle an unanticipated hazardous materials (hazmat) incident like this one? If not, it may be time to start thinking ahead, because when you talk about the need for hazmat response plans, you don’t want to hear someone say, “But nothing’s happened yet.”

“Don’t say ‘yet’ with hazardous materials. Nobody tells you when ‘yet’ is. There is something bad associated with ‘yet,’” explains Michael Callan, president of Callan & Company Ltd., a hazardous materials training company in Middlefield, CT.

Forensic staff policy can make treating inmates risk-free

The door to the emergency department slides open and in walks a man wearing an orange prison jump suit and handcuffs. He’s accompanied by a uniformed guard. What should your emergency department staff do?

Having a well-thought-out policy for dealing with prisoners will not only satisfy the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but could also help your facility avert real trouble.

The JCAHO addresses the requirement for care of inmates and a forensic staff policy under several standards. Leadership (LD) standard LD.1.1.3 and human resources (HR) standards HR.3 and HR.3.1 deal with ensuring clinical staff are educated about special considerations when caring for prisoners.

And HR.4.1 lays out requirements for educating forensic staff—in other words, nonclinical staff, usually nonemployees, who provide security duty for prisoners visiting the facility.
When everyone knows what's expected in treating prisoners, the chances of trouble cropping up, whether it's a disruptive inmate or a physician not being able to deliver appropriate care, can be minimized.

Policy planning
The first step in either developing or reviewing the forensics policy is bringing together the appropriate people. This would include security personnel, risk managers, nursing, and, if possible, outside police or corrections agencies.

This is where all parties should bring forward their concerns, says Fredrick G. Roll, CHPA-F, CPP, executive vice president of Healthcare Security Services, a division of Hospital Shared Services in Denver, which provides security services to hospitals nationwide.

Nursing will need to ensure that the policy reflects patient needs. If a patient has a dislocated arm, for instance, and a physician needs to have him or her unshackled for examination, there needs to be a policy for how this will work.

The JCAHO wants to see that security requirements do not prevent quality care. That's not to say security is sacrificed, but rather that it accommodates clinical needs.

Security concerns
Here are some questions for security managers to consider:

• How many guards will be required to accompany a patient during hospitalization and how will this number be determined? A violent criminal needs more surveillance than someone whose offense is passing bad checks. But who makes that call?

• What qualifications are required of guards? Training requirements for guards can be addressed with the agencies that will send the prisoners.

• Must guards be armed? In some cases, either the hospital or the agency may want to require that guards be armed. This should be included in discussions with the agencies.

These are all issues that can be addressed with the agencies that will be bringing inmates to the hospital. And they can be documented by having the patient's guard sign and attest to the agreed-upon conditions.

In addition, Roll says the facility should plan for the practical concerns involved in guarding a patient.

Guards can take bathroom breaks while monitoring a patient if they are in very close proximity to the patient and a staff member acts as their eyes and ears when the guard leaves the room. Someone must be assigned to provide food and drink for guards who cannot leave a prisoner.

Further, hospital employees should be told whom to notify in the event of lapses in security or when the forensic policy is not being followed.

Implementing your policy
The next element of a proper forensics policy is implementation. Someone must monitor prisoner stays and arrivals to see that policies are adhered to and to ensure that forensic staff members understand the policies and their responsibilities.

Much of the compliance monitoring can be left to staff, but remember that if your policy calls for nurses to be watching for this, then the JCAHO surveyors will likely ask them whether they know their role in the forensic staff policy. In addition, expect that the JCAHO will want to see that clinical em-
When coming in with a prisoner, forensic officers should be given an overview of the following subjects:

**Confidentiality**—Guards must not repeat what they see or hear about the condition or identity of hospital patients.

**Names of nurses**—Guards must familiarize themselves with which nurses are in charge of the patient’s care while he or she is in the hospital, and must understand limitations placed on patient restraint that are mandated by clinical considerations.

**Change in patient condition**—Guards must know how and when to report changes to the prisoner’s condition.

**Cardiac arrest**—Guards are told what to expect if this code is called and what it means and also are oriented to general hospital procedures they will encounter.

**Universal precautions**—Guards are given a basic orientation about bloodborne pathogens, the ways in which disease can be spread, and how to protect themselves.

**Fire plan**—Guards must know how to respond to a fire alarm or actual fire, with particular emphasis on how to handle the restrained prisoner at the time of the incident.

**Security**—Guards must know whom to notify if a security incident occurs and how they will be expected to respond.

**Hazardous materials spill**—Guards must know how to appropriately respond in the event of a hazardous release.

**Smoking policy**—This simply informs guards that no smoking is allowed in the hospital.

---

Orienting prisoner guards in your hospital

When coming in with a prisoner, forensic officers should be given an overview of the following subjects:

**Confidentiality**—Guards must not repeat what they see or hear about the condition or identity of hospital patients.

**Names of nurses**—Guards must familiarize themselves with which nurses are in charge of the patient’s care while he or she is in the hospital, and must understand limitations placed on patient restraint that are mandated by clinical considerations.

**Change in patient condition**—Guards must know how and when to report changes to the prisoner’s condition.

**Cardiac arrest**—Guards are told what to expect if this code is called and what it means and also are oriented to general hospital procedures they will encounter.

**Universal precautions**—Guards are given a basic orientation about bloodborne pathogens, the ways in which disease can be spread, and how to protect themselves.

**Fire plan**—Guards must know how to respond to a fire alarm or actual fire, with particular emphasis on how to handle the restrained prisoner at the time of the incident.

**Security**—Guards must know whom to notify if a security incident occurs and how they will be expected to respond.

**Hazardous materials spill**—Guards must know how to appropriately respond in the event of a hazardous release.

**Smoking policy**—This simply informs guards that no smoking is allowed in the hospital.

**Source:** Fredrick G. Roll, CHPA-F, CPP, of Health-care Security Services
Ergonomics rule falters, but don’t dismiss the issue

Though the ergonomics standard got axed by Congress, that does not mean that you can forget concerns like musculoskeletal disorders (MSDs). Regardless of federal rules, dealing with repetitive motion injuries will remain a part of your job.

At press time in early March, lawmakers had just voted to issue a “joint resolution of disapproval” on the ergonomics rule, which basically opens the door to have the standard repealed.

Lawmakers used a little-known political tool called the Congressional Review Act, which allows Congress to strike down an agency rule with limited floor debate on the issue.

President Bush was expected to sign the resolution.

There are indications that the embattled Occupational Safety and Health Administration (OSHA) will return with another version of an ergonomics standard in the future.

Secretary of Labor Elaine Chao—a Bush appointee—said in a letter to a senator that if the resolution goes forward, “I intend to pursue a comprehensive approach to ergonomics, which may include new rule-making, that addresses the concerns levied against the current standard.”

In other words, federal ergonomics regulations will probably be in force at one point or another in hospitals.

OSHA could also potentially cite ergonomics violations through its general duty clause, which says that businesses must be free of safety hazards to workers.

How can you address MSD hazards?

If and when you determine that a job activity has a musculoskeletal disorder (MSD) risk, there are three methods you can use to attack the problem, said ergonomics expert Guy Fragala, PhD, PE, CSP. Those steps include the following:

1. Start with engineering controls—Engineering controls are physical changes to a job that reduce MSD hazards, such as redesigning work stations or buying new equipment.

    When it comes to engineering controls, ask yourself these questions:
    
    • Can we eliminate the hazards, such as moving patients from a bed to a chair in a better way?
    • Can we redesign the activity, such as by using mechanical lifting devices?
    • Can we use a device to aid us in the activity, such as a lateral bed-to-gurney transfer with a friction-reducing board?

2. Administrative controls—If engineering controls are not an option, try administrative controls, which are changes in a way an employee performs the physical activities of a job, such as having extra staffing help or taking more breaks.

    For example, you could make a policy to have a certain number of employees available for every lift, or have designated lift teams.

3. Personal protective equipment—Fragala said the use of this equipment would apply in very few ergonomics cases in health care facilities and as such, should be considered a last resort. He saw the potential for personal protective equipment to prevent housekeeping injuries, such as kneepads for janitorial personnel who have to scrape or clean floors.
Look for help in-house

So you still want to keep up on the safety principles behind the ergonomics standard one way or the other. And there may be help for you right down the hall.

Instead of focusing on the specifics, look at the intent of the former ergonomics rule and how you can meet its provisions with what you already have in your hospital, said Guy Fragala, PhD, PE, CSP, director of environmental health and safety for the teaching hospitals at the University of Massachusetts Memorial Healthcare System in Worcester.

For example, use your safety committee as a starting point to develop an ergonomics strategy.

Within the group, consider forming a task force or subcommittee on ergonomics, which will report to the full committee. Members of this task force should know about ergonomic risks on the job.

Rehab is a good starting point

If you have a rehabilitation department in your hospital, you probably have ready-made, in-house ergonomics experts who can help with this task force, says Steven Bryant, practice director of accreditation services for The Greeley Company, a division of HCPro, in Marblehead, MA.

Beyond the rehab workers, think about employees in occupational health and nursing who might have knowledge about MSDs. “Use that expertise,” Fragala said. “Use the resources that you have.”

He and Bryant spoke at “Understanding OSHA’s Ergonomics Management Program Standard,” an audioconference presented by The Greeley Company, a division of HCPro, in Marblehead, MA, on February 14. The Greeley Company is a sister company to Opus Communications, publisher of BHS.

JCAHO involvement looms

With the continuing partnership between OSHA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), you can expect survey visits to include ergonomics, Fragala and Bryant said.

The JCAHO’s retooled environment of care (EC) standards include a new provision under EC.1.1.1 that calls for hospitals to keep workers safe.

The Joint Commission could also look at ergonomics under EC.2.8c, said Janet McIntyre, a spokesperson for the JCAHO. Under that item, hospitals must take actions to eliminate, minimize, or report safety risks.

Safety plan efforts

Bryant reminds you that the JCAHO requires an annual evaluation of your facility’s safety plan. So if you include ergonomics as part of your safety plan, you must review ergonomics efforts each year as well.

Further, Fragala said an ergonomics program offers you a chance to conduct performance improvements, which the JCAHO likes to see.

He said that because ergonomics is a multidisciplinary issue and it also involves specific steps that you can track improvements on, it is a good area to undertake performance improvement initiatives.

Final IOM report focuses on systems

The Institute of Medicine (IOM) released its final report on the quality of health care in early March. The report takes a broader focus on improving quality, rather than only focusing on patient safety, as the first IOM report did.

The new study urges providers to use science advances and technology to lessen pain, suffering, and disability, and to offer greater longevity and a more productive work force.

Much of the report has a long-range, speculative tone. But changes can be made right now to improve quality, coauthor Donald Berwick, MD, said. These changes include establishing e-mail exchanges with a subset of patients, letting patients see all of their records, and converting to paperless records.

Read the report, Crossing the Quality Chasm: A New Health System for the 21st Century, at www.nap.edu/books/0309072808/html
HAZWOPER

For instance, your hospital may not yet know how it will handle a given hazmat spill. Will the employees near the spill area be able to handle it themselves? Will they need to call for help? The Occupational Safety and Health Administration (OSHA) requires employers to answer these types of questions.

Some of the answers are found in OSHA’s hazardous waste site operations and emergency response standard (1910.120)—otherwise known as HAZWOPER. Section Q, which addresses emergency responses to hazmat spills, is what hospitals will likely need to pay attention to.

Different situations and responses

Hospitals encounter a gray area when dealing with hazmat response. Callan illustrates the difference with the following scenarios:

- Incidental release—A spill in a work area that an employee caused and is trained to clean up. For instance, a laboratory technician drops a vial of potentially infectious blood. He or she uses a blood cleanup kit to handle the spill.

- Emergency response—A spill that results in a request for help from a remote site, such as a fire department hazmat team. For example, a lab worker knocks over a liter of formaldehyde and then runs from the room after being overcome. “That situation got out of control,” Callan says.

The HAZWOPER standard is different from OSHA’s hazard communication standard (1910.1200) that hospitals are familiar with.

Simply put, in terms of hazardous spills at hospitals, the HAZWOPER requirements would affect those people designated to handle the spill, while the hazard communication rules are meant to alert all hospital employees about potentially hazardous chemicals in the building, Callan says.

If your hospital has, or plans to develop, an internal hazmat response team, you need to comply with HAZWOPER requirements, he adds.

Among those requirements is the need to have a written emergency response plan to handle anticipated hazmat spills.

NFPA guidance available

Another document beyond HAZWOPER that may provide some help comes from the National Fire Protection Association (NFPA). You can classify incident conditions into three levels of severity, according to NFPA 471, Recommended Practice for Responding to Hazardous Materials Incidents.

Level one, the least severe, would be spills from small containers (such as a pail or bag) that have low fire/explosion potential, little or no release of materials, no life-threatening situations, minimal environmental impact, and no container damage.

Callan says level one incidents can usually be handled internally by a hospital.

However, beyond that stage, you probably will have to contact the fire department or a regional hazmat team. For example, level two conditions include leaks that may not be controllable without special resources, and life safety threats in the spill area.

Don’t get caught up in spill size or volume, Callan recommends. Instead, think of a spill in terms of “Can I handle it?” or “Do I need help?”

Training concerns for hospitals

Another important point to remember is that as far as OSHA is concerned, when you decide that a spill needs an emergency response, you are in essence saying the magnitude of the event has grown and that someone with required training needs to help you.

Hospitals should not be complacent or assume they have people who can do this, Callan says. If a maintenance worker responds to a spill, be careful about what they handle relative to their training, he adds.

Even if someone has experience in personal protective equipment for hazmat, it may not make him or
her qualified to be an emergency responder under federal requirements.

**Eight hours minimum**

OSHA makes it clear in section Q(6) of the HAZWOPER standard what the various levels of training are for hazmat response. Workers who merely note a spill has occurred and then page the internal hazmat team or alert authorities do not need a specified amount of training, but should nonetheless be aware of the hazards they work near and be able to identify a problem. (See the breakdown of responsibilities under the HAZWOPER standard below.)

Callan suggests that before you begin thinking about training for hazmat response, ask yourself the following questions:

- What do I want my employees to do during a spill?
- Where will I send my employees to learn these skills?
- Will I provide personal protective equipment for a spill cleanup?

*Coming in the next issue: In part two of our package, we look at what OSHA wants to see in your written hazmat response plans. To read the HAZWOPER requirements online, go to www.healthsafetyinfo.com/resources/osha.cfm.*

---

**Training for hazmat emergency response**

Here are the levels of hazardous materials (hazmat) emergency response personnel and what the Occupational Safety and Health Administrations (OSHA) expects in their training:

**First responders, awareness level**—People likely to witness or discover a hazmat spill or release. They must have an understanding of hazardous substances and be trained to initiate an emergency response. OSHA does not require any hourly training.

**First responders, operations level**—People who respond to a hazmat spill as part of the initial emergency response. They must be trained in defensive techniques, such as protecting nearby people, containing the release from a safe distance, and basic decontamination. OSHA requires eight hours of training.

**Hazmat technicians**—People who assume a more aggressive role in stopping a release. They are versed in many aspects of advanced control and containment, implementing an incident command system, and the use of personal protective equipment. OSHA requires 24 hours of training equal to the first responder, operations level, in addition to the duties just mentioned.

**Hazmat specialists**—People who respond with and support hazmat technicians and have a specific knowledge of the chemicals involved in the spill. They develop a site safety plan and understand in-depth hazard strategies. OSHA requires 24 hours of training equal to the hazmat specialist level, in addition to the duties just mentioned.

**Incident commanders**—People who assume control of the spill scene. They are able to implement the incident command system; the employer’s emergency response plan; and any local, state, or federal strategies. They understand the risks of employees working in personal protective equipment and clothing. OSHA requires 24 hours of training equal to the first responder, operations level, in addition to the duties just mentioned.

*Sources: OSHA and Mike Callan of Callan & Company Ltd.*
New book excerpt: Roof fire tests hospital staff

Editor’s note: This excerpt from our new book, When Disaster Strikes, offers lessons one hospital learned during a roof fire.

Even something as mundane as getting a building’s roof repaired can have serious potential consequences from a life safety standpoint.

Take the case of Children’s Mercy Hospital, a 177-bed facility in Kansas City, MO, that was 90% occupied with patients on January 28, 1999, when a fire broke out on the rooftop. There were no injuries during the fire, although staff members evacuated patients from the five-story hospital to the outside. The top floor sustained water and smoke damage.

Local authorities believe new tar- ring on the roof, which had just been laid by a contractor that day, somehow accidentally ignited. “The fire never entered the building at any time. It [remained] on the roof,” says Jonathan Lowe, community relations assistant at the hospital.

Evacuation planning
Employees at Children’s Mercy participate in emergency drills twice a year, including evacuation scenarios, and officials credit these practice runs for employee readiness.

“We find [drills] are very important,” says Lowe. The staff’s response to the fire “went as smoothly as it did because we do practice.”

Employees performed an evacuation of 60 patients from their rooms to the outside during the fire, Lowe adds. Staff members brought many of the patients back inside after a short time.

Apart from drills, employees wear constant reminders of fire alarm response procedures. In addition to the identification badges that they must wear at all times, personnel also carry a card that lists Children’s Mercy’s mission statement and procedures to follow in case of a fire. Among the steps listed on the card is a review of the following:

- Fire protection acronyms such as SAFE (Sound the Alarm, Fight the fire, Evacuate the patients) and PASS (extinguisher training that stands for Pull, Aim, Squeeze, Sweep)
- Emergency telephone numbers for the safety, security, and engineering offices
- The code word for a fire in the building (for example, “Doctor Red”) and how to use it

Damage and the aftermath
When you look at fire drills and disaster planning, make sure to consider the aftermath, particularly whether your facility is prepared to handle cleanup of smoke stains, odors, pools of water, and drenched carpeting.

Cleanup went smoothly at Children’s Mercy, thanks to a dedicated team that quickly went into action. A 22-member night crew, including personnel from the environmental services department, worked overnight to clean up the damaged areas. Within 24 hours of the fire, the facility re-opened all but the most damaged areas. The hospital never fully closed down in the fire’s aftermath.

Environmental services employees cleaned room walls, carpets, drapes, and cubicles, and also used a special chemical to remove smoke odors, Lowe says.

Make sure you consider the aftermath of a fire, particularly whether your facility is prepared to handle cleanup.

When Disaster Strikes includes chapters on a variety of disasters and emergencies, as well as sample forms and policies. You can order the book for $79 plus shipping and handling by calling 800/650-6787 or going online to www.healthsafetyinfo.com.
Knock, knock. Who’s there?

How about seven state surveyors on behalf of the Health Care Financing Administration (HCFA), three from the Joint Commission on Accreditation of Health-care Organizations (JCAHO), a JCAHO central office observer, and two HCFA regional administrators who also served as observers.

That’s who showed up at St. Margaret’s Hospital in Spring Valley, IL. St. Margaret’s was the first hospital in the country to undergo the concurrent pilot survey program, where HCFA performs a validation survey at the same time as the JCAHO triennial visit.

HCFA and the JCAHO are pilot testing the concurrent survey during the first quarter of 2001 as a new approach to survey validation (see story on p. 2 of the March issue of BHS for a rundown of the program).

Communication was key with triple the number of survey personnel. Marsha Cummings, RN, BSN, the hospital’s quality management director and survey preparation coordinator, met with the hospital’s medical staff, senior management, and department managers to discuss managing the new survey process.

“Our goals were to be flexible, to try to respond appropriately to surveyor requests, and to ensure there would be no disruption to patient care,” says Cummings. “And in the end, the goals were achieved.”

Space, resources pose a challenge
A big challenge was to designate meeting rooms that had convenient locations and sufficient space for the survey teams.

The detailed environment of care building tours and life safety compliance overview posed a dilemma because St. Margaret’s had only one director of maintenance and one safety director to accompany all the surveyors.

“If we were a larger facility, with more people in those areas, the building tour could have been shared among a larger group of staff members familiar with life safety and our safety programs,” Cummings says.

**What you can do**
Since many of you are waiting to hear whether you will be next for the pilot program, Cummings offers the following advice to ensure that you survive the concurrent survey:

- Get as much information as possible prior to the survey about what documentation the survey teams will need, and obtain survey agendas so you can plan accordingly.

- Set up separate teams of facility staff for each surveying group with designated team leaders and establish internal lines of communication. Make sure team leaders understand their roles and are familiar with the other team agendas.

---

**Briefings on Hospital Safety Subscriber Services Coupon**

- Start my subscription to BHS immediately. Please include a $15.00 shipping and handling charge (option 1 or option 3 only). Delivery options (please select one only):
  - Option 1: Print subscription (just $249 for 12 full issues) BHSP
  - Option 2: Electronic subscription (just $249 for 12 full issues) BHSE
  - Option 3: Print and Electronic subscription (just $312 for 12 full issues of each) BHSPE

To activate your subscription immediately, order at www.hcpro.com/onlinepubs
**Feds say nuclear contamination not reported**

Here’s a happy thought: The government and officials at Community Medical Center in Toms River, NJ, were set to meet in late February to discuss an incident from two years ago, when radioactive material may have contaminated a room during a patient’s cancer therapy.

The Nuclear Regulatory Commission says it found out about the spill in December during a routine inspection. Subsequently, the agency identified four possible violations by Community Medical, including failing to report the contamination within 24 hours and failing to provide specific safety training to workers using a substance called phosphorous-32.

The original alleged incident occurred in August 1999 when workers injected phosphorous-32 into the patient during radiation treatment. After the two sides meet, the government will decide whether there was in fact a violation and whether to cite or fine the hospital.

**Behave or no TB drugs for you, mister**

Expressing concern for employee and patient safety, officials at a Florida hospital planned to assign their own close supervision to a tuberculosis (TB) patient who they say has previously been rowdy during visits.

A judge ordered the patient, who has a criminal background, to receive treatment at A.G. Holley State Tuberculosis Hospital in Palm Beach County rather than being forced to receive the treatment in jail. The man is not currently serving a sentence but allegedly has not completed past TB drug regimens at the hospital, according to the *Orlando Sentinel*.

Officials at A.G. Holley requested an emergency hearing to oppose the order, saying the prisoner was allegedly physically and verbally abusive during prior stays at the hospital, the *Sentinel* reports. However, a judge denied the request and also refused to have the county pay for 24-hour, one-on-one supervision of the patient.

**Nurse survey points to staffing concerns**

Do you feel you’re alert on the job when you’re working overtime or without a lunch break?

If not, you probably can relate to some of the findings of a national nursing survey, which indicates that most nurses often feel exhausted and stressed on the job, and will skip meals and breaks to instead care for patients.

The survey, commissioned by the American Nurses Association (ANA), polled 7,299 registered nurses in December and January about staffing concerns.

“These findings reinforce what we already know: that today’s nurses not only are frustrated, but that many soon will be retiring, and that younger people will not choose nursing as a career unless we improve working conditions and compensation, and address health and safety concerns,” ANA President Mary Foley, MS, RN, said in a statement.

Recommendations coming out of the survey include a reduction in mandatory overtime and legislation to protect health care workers against retaliatory or punitive actions from employers for reporting safety and quality concerns.

To read more about the survey’s findings online, go to [www.ana.org/staffing/index.htm](http://www.ana.org/staffing/index.htm).
Security system challenged by homeless man

A homeless man is not a doctor in real life, but he allegedly played one at a hospital. And he had the name badge to prove it.

Could we be the only ones asking ourselves, “How did he pull that one off?”

The man somehow convinced security officials at St. Vincent’s Medical Center in Jacksonville, FL, that he lost his regular identification badge and was then able to get a temporary one. From there, the impostor proceeded to spend several days using an alias, even writing a prescription and making a house call, according to the Associated Press.

Prosecutors say the suspect also visited other hospitals during the same time, though it’s not clear whether he saw any patients.

The man pleaded not guilty to charges of practicing medicine without a license and representing himself as a physician’s assistant. Perhaps he had persuaded a university to give him a medical degree as well—just kidding.

As for the hospital, it instituted a new badge system after the incident, the Associated Press says.

Emergency management conferences coming

Hospital safety officers may be interested in two upcoming conferences on disaster planning:

• The National Hurricane Conference (April 9–13 in Washington, DC; registration $275) will offer in-depth training sessions and workshops on hurricane emergency management. For more information, call 850/906-9224 or go to www.hurricanemeeting.com.

• The International Conference on Disaster Management (August 6–10 in Orlando; registration $300) will showcase multidisciplinary solutions for natural and manmade disasters, including response strategies.

For more information, call 850/906-9221 or go to www.disastermeeting.com.

Iowa hospitals whacked for alleged safety violations

We’re not going to say anything about guilt or innocence in this situation. Rather, we give it to you as a warning.

The Iowa Occupational Safety and Health Bureau (IOSH)—which the Occupational Safety and Health Administration (OSHA) monitors as part of its state plan program—has proposed fines of $19,800 against University of Iowa Hospitals and Clinics in Iowa City for various alleged safety violations, including safety needle policy problems.

Mary Bryant, administrator of IOSH, says a five-month investigation yielded the following alleged violations:

• Lack of safety needle training—proposed fine of $4,500 for no mandatory training program on engineered safety controls
• Safety needles not mandated—proposed fine of $2,250 for not implementing the use of safety needles that have passed staff evaluation
• Employee injuries in the operating room from anesthetic and suture needles—proposed fine of $2,250 for not having a “no-hands” procedure for contaminated sharps
• OSHA 200 log problems—proposed fines totaling $10,800 for three instances of not maintaining OSHA 200 logs to show site-specific information

Bryant says that during a meeting between IOSH and University of Iowa Hospitals, the sides were unable to come to a resolution, and the university plans to appeal the violations.
Do employees speak Spanish in your facility or is that not allowed? Be careful, because poorly designed “English-only” rules can get you in trouble.

What do we mean by English-only rules? They are policies that require employees to speak English in certain situations, such as in the emergency room. Misinterpreting such a policy could result in a big lawsuit.

“The Equal Employment Opportunity Commission [EEOC] thinks that English-only rules are suspect,” says Jose J. Behar, supervisory trial attorney for the EEOC.

Hospitals have legitimate safety reasons for some English-only rules, says Ed Jepson, a partner at the law firm of Vedder Price in Chicago. When they prevent harm to patients, English-only rules may be acceptable.

If you have to use an English-only rule, make it as specific as possible. “Generally, the more narrowly you tailor an English-only policy, the more likely you are to avoid violations,” Behar says.

When considering an English-only policy, Boston employment law attorney Scott Blair gives you the following three things to think about:

1. Is English essential? Would workers’ failure to speak English create a life-threatening situation?

2. Try to accommodate. Offer instruction in English or pair employees with other employees who can translate for them.

3. Consider a case-by-case approach. The EEOC will consider whether you observe written policies. At first, you may want to handle problems as they come. -

Editor’s note: Learn what constitutes a violation at www.eeoc.gov/facts/fs-nator.html.

Tip of the month

Write ‘English-only’ safety policies fairly and appropriately

Publisher/Vice President: Suzanne Perney
Associate Executive Editor: Bob Croce
Senior Managing Editor: Scott Wallask swallask@hcpro.com