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Ground-Breaking Citations Issued By OSHA For Failure to Use Safety Devices

Maximum Penalty Issued to Nursing Home for "Willful" Violation

By Jane Perry, M.A., and Janine Jagger, M.P.H., Ph.D.

TWO CITATIONS ISSUED BY THE OCCUPATIONAL Safety and Health Administration (OSHA) in the last six months—to Beaver Valley Nursing and Rehabilitation Home (BVNRH) and its parent company Northern Health Facility, Inc., in Beaver Falls, Pennsylvania, and Montefiore Medical Center in New York City—show that the federal agency is looking for full compliance with the requirement to use safety-engineered sharp devices, and that it is willing to impose big fines when they are not implemented facility-wide. Since the bloodborne pathogens standard (BPS) was revised in 2001 to clarify and emphasize the requirement to use safety devices to reduce bloodborne pathogen exposure risk, the number of citations issued by OSHA for BPS violations has increased dramatically. These two citations, however, break new ground—one for the size of the fine imposed, the other for its detail and scope. In both cases, the facilities are contesting the citations.

Nursing Home Fined \$70,000

BVNRH was inspected in January 2003 and issued a citation on 7/28/03; \$92,500 in penalties were imposed for BPS violations (and an additional \$9,500 for violations of other standards). Of the

\$92,500, \$22,500 was assessed for "serious" violations related to deficiencies in the exposure control plan, the safety device evaluation process (i.e., not including frontline healthcare workers in selection and evaluation of devices), post-exposure counseling, and handling of sharps containers. OSHA deems a violation "serious" when there is a "substantial probability that death or serious physical harm could result from the cited condition" and "the employer knew, or should have known, of the hazard."

By far the biggest penalty—\$70,000—was for failure to use safety devices. According to the citation, "The employer did not utilize engineering controls in the form of sharps with engineered sharps injury protections that isolated or removed bloodborne pathogen hazards from the workplace when injecting medications and utilizing catheters and other medical devices." (The BPS section referenced was (d)(2)(i).) This violation was categorized as "willful," the highest degree of severity for an occupational hazard. OSHA defines a willful violation as "one committed with an intentional disregard of, or plain indifference to, the requirements of the Occupational Safety and Health Act."

(continued on page 62)

Ground-Breaking Citations

(Continued from page 61)

An OSHA official stated that \$70,000 is the maximum penalty that can be charged for willful violations—and that this marks the first time the agency has imposed it for failure to use safety devices. BVNRH was inspected by OSHA three years ago; the revised BPS and the requirement to implement safety devices were discussed with BVNRH officials at that time, according to OSHA's Pittsburgh-area office. After the earlier inspection, the facility was cited and fined for not using engineering controls, but BVNRH contested the citation and eventually it was dropped.

In the 2003 citation, the facility's exposure control plan (ECP) was found to be deficient because it "did not include ... a description of the specific types of safe needle devices used in the facility" or document "consideration of commercially available safe medical devices."

Bloodborne pathogens training was also inadequate; the employer did not ensure that it was "provided to employees, including but not limited to RNs and LPNs, at the time of initial assignment to tasks with occupational exposures," and was fined \$5,000 for this violation. An additional \$5,000 was charged because a "sharps container on [a] medication cart was filled to the top and was not removed from service and replaced"; the ECP "did not address when to replace a full sharps container" and "no employee was assigned specific responsibility for this task."

Montefiore Citation Details Procedures Where Safety Needed

Residents Say: Take Heed!

OSHA's citation of Montefiore Medical Center (MMC) in the Bronx for failure to use safety devices and other violations of the

BPS, issued in response to a complaint by MMC residents, makes clear that even facilities that have made substantial progress in implementing safety devices will be subject to fines for continuing to use conventional devices in some areas, when safety alternatives are available.

OSHA's citation of 9/30/03 fined MMC a total of \$9,000 for three serious violations of the BPS: failure to use engineering controls (with 26 specific instances listed where safety-engineered devices were not used); improper handling of contaminated reusable sharps;



Steve Cha, M.D.

and failure to make available or to use personal protective equipment.

There were also five violations categorized as "other than serious," all having to do with recordkeeping or documentation required by OSHA: one related to the OSHA 300 log, three to the ECP (failure to review and update it to reflect evaluation and implementation of safety devices), and one to the sharps injury log (with six specific instances cited of improper or incomplete documentation).

Montefiore has two teaching facilities—MMC/Moses Division and Weiler Hospital at the Albert Einstein College of Medicine—

with a total of 1,126 beds; both facilities were included in the citations. In a statement, MMC said it has "a long-standing and exceptional program to protect its employees from occupational exposure to bloodborne pathogens." But OSHA's citations appear to indicate it has not done enough.

MMC chief medical resident Stephen Cha, M.D., one of the residents who filed the complaint, observes: "In terms of implementing safety, Montefiore has certainly made progress. [MMC] is probably pretty typical of many large teaching hospitals in that respect—it's done a fairly good job with safety. But I think the message here is that 'pretty good' is not good enough."

Cha, who has worked at MMC since 1999, says that in their complaint the residents tried to "focus on devices that are used everyday, throughout the hospital, for common procedures. We also tried to give OSHA as much detail as possible on how and where non-safety devices are used." The most "problematic" areas, according to the complaint, were the intensive care/critical care units, surgery, and the emergency department. The complaint also noted that sharps injuries had increased at MMC in the previous two years—by 5% in 2001, and 7.3% in 2002.

Shortly after OSHA issued the citation, Cha, along with other MMC residents, the president of the American Medical Students Association, and the consumer advocacy group Public Citizen, wrote a letter to the American Hospital Association (AHA) urging that it notify member hospitals about OSHA's action. "Because we believe that conditions similar to those at Montefiore likely exist at most hospitals in the U.S., many AHA members currently risk OSHA sanctions," the letter states. "More importantly, because there are safer al-

(continued on page 63)

Ground-Breaking Citations

(Continued from page 62)

ternatives to many of the devices currently in use in U.S. hospitals, nurses, residents, medical students and other hospital staff are placed at unnecessary risk of acquiring potentially fatal infections due to needlestick injuries.”

The letter asked the AHA to “facilitate compliance of your member institutions with current OSHA standards by writing to each of them informing them of this landmark OSHA ruling.” And it warned that, “In the alternative, medical students and residents stand ready to file institution-by-institution complaints against violating hospitals.”

If residents carry out similar actions in hospitals across the country, it would mark the first time a group of physicians took national-level action against healthcare facilities to bring about compliance with the bloodborne pathogens standard. “We hope that hospitals across the country take heed of what happened here at Montefiore and work harder toward the goal of full conversion to safety-engineered devices,” Cha commented.

Asked why physicians, on the whole, haven’t been more supportive of the conversion to safety devices, Cha responded, “Sometimes physicians have been left out of the loop in terms of evaluating safety devices. Their input is definitely needed in this process. Sometimes it’s a matter of safety devices not working as well as the conventional ones they’re used to. But safety devices continue to improve, and we need to get the message out to all physicians that these devices often work just as well as their conventional counterparts *and* provide protection to healthcare workers.”

Cha emphasized, again, that “the remarkable facet of this cita-

tion is that Montefiore is typical, not that Montefiore is aberrant. This means that hospitals across the country likely utilize these same unsafe practices and are at risk for citation. These practices are dangerous and cost the health system money, since the average needlestick costs the institution at least \$500 to \$1000.”

In response to the residents’ letter, the AHA said it has actively supported needlestick prevention initiatives, including the Needlestick Safety and Prevention Act, and had sent out “multiple advisories on the topic [of sharps injury prevention] to hospitals across the country.” It did not indicate that it would take any further action in response to the letter.

Where is safety needed? *Everywhere.*

OSHA’s citation of Montefiore Medical Center listed 26 separate instances in which safety devices should have been, but were not, used. These included:

- administering subcutaneous and intramuscular injections
- placing catheters, including:
 - ◆ central venous catheter lines
 - ◆ peripherally inserted central catheter lines
 - ◆ hemodialysis catheter lines
 - ◆ Swan-Ganz catheter lines
- securing catheter lines using suture needles (rather than needle-free catheter secure devices)
- placing umbilical arterial and venous lines
- drawing umbilical cord blood
- using a needle on a syringe to transfer blood to a blood tube or blood culture bottle
- collecting blood for arterial blood gas analysis, including from femoral arteries
- administering intravenous push medication
- performing paracentesis and thoracentesis procedures
- accessing subcutaneous vascular access ports (using non-safety Huber needles)
- gaining IV access for obtaining platelet-rich plasma (using angiocatheters) in dental clinics
- performing wound irrigation without a product to protect from splashing and spraying

The citation also listed surgical procedures for which safety scalpels should have been—but were not—used:

- incision and drainage procedures
- chest tube insertions
- perionychium infection procedures
- appendectomies
- tracheostomies
- inguinal hernia procedures

Despite widespread conversion to safety devices in the U.S., market data indicate that the process is not yet complete [see *AEP vol. 6, no. 5, p. 58*]. Some clinical areas, such as anesthesia and surgery, have been particularly slow to convert to safety.

Full Compliance Needed

An OSHA spokesperson says that “needlesticks and other sharps-related injuries ... continue to be an important public health concern,” and that “it’s well established that the implementation of effective engineering controls can reduce these types of injuries.” And he states that use of engineering controls are “imperative to ensure the safety and

(continued on page 64)

Ground-Breaking Citations

(Continued from page 63) —————

health of workers.” The Beaver Valley Nursing Home citation and the Montefiore citation highlight the need for healthcare facilities to push forward with safety device

implementation in order to reach full compliance, and to continually evaluate and update their needlestick prevention programs and monitor usage of safety devices—not just what is stocked—in all clinical areas. □

Note: Detail on the Montefiore citation is available on OSHA’s website, under its “Statistics & Data” page: www.osha.gov/oshstats/index.html. Click on “Inspection Information,” then enter the inspection (“activity”) number for the case: 305769994.

OSHA News Briefs

■ OSHA Releases Bulletin on Reuse of Blood Tube Holders

A Safety and Health Information Bulletin (SHIB) issued by OSHA on 10/15/03 restated the agency’s policy on the disposal of contaminated needles and blood tube holders following blood-drawing procedures.

“Removing contaminated needles and reusing blood tube holders can pose multiple hazards,” commented OSHA Administrator John Henshaw in a news release. “Single-use blood tube holders, when used with engineering and work practice controls, simply provide the best level of protection against needlestick injuries. That is why the standard generally prohibits removing needles and reusing blood tube holders.”

The bloodborne pathogens standard prohibits the removal of contaminated needles from medical devices unless an employer can demonstrate that it is necessary for a specific medical or dental procedure. When performing a blood-drawing procedure, OSHA requires the immediate disposal of blood tube holders, with safety needle attached, after each patient’s blood is drawn.

In the bulletin, OSHA explains that while engineering controls exist to significantly reduce injuries to healthcare workers, hazardous work practices continue to cause injuries. The manipulation required to remove a contaminated needle, even a safety-engineered one, from a blood tube holder may result in a needlestick from the back

end of the needle, which is only covered by a rubber sleeve.

The bulletin is available on-line at: www.osha.gov/dts/shib/shib101503.html. □

■ Public Employees in Federal OSHA States Now Covered by Bloodborne Pathogens Standard

The prescription drug bill passed by Congress in November 2003 included a provision that requires public hospitals in federal OSHA states to comply with the bloodborne pathogens standard (BPS) as a requirement under Medicare. The American Federation of State, County and Municipal Employees (AFSCME) worked with the American Nurses Association for several years on getting coverage for public employees in these states.

States, which are mandated by OSHA to have an occupational safety and health program, can either run their own program or, for enforcement purposes, participate in the federal OSHA program. Federal OSHA, however, cannot regulate state agencies, including state and municipal healthcare agencies. This means that, until now, public healthcare facilities in federal OSHA states were not required to comply with the BPS (as well as other OSHA standards).

A report published by the Department of Labor in February 2000 (“Evaluating the Status of Occupational Safety and Health Coverage of State and Local Government Workers in Federal OSHA States”) found that many states under fed-

eral OSHA lacked “important occupational safety and health protections for public sector workers.” Two states, Alabama and Delaware, were found to have “no recognizable occupational safety and health programs for public sector workers” at either the state or local government level, and nine states provided no protections for local government workers.

Public healthcare facilities in federal OSHA states will now be required to extend BPS protections to their employees. The only exception will be “critical access hospitals” in these states—small, mostly rural hospitals that are considered the most financially vulnerable.

Barb Coufal of AFSCME says hundreds of hospitals—and thousands of healthcare workers—will be covered under the new provision. Newly covered hospitals that receive Medicare funding must comply with the BPS or risk a fine. Workers will be able to file complaints regarding noncompliance with the Centers for Medicare and Medicaid Services of the Department of Health and Human Services, according to Coufal.

“For healthcare workers, it means that their safety no longer depends on which hospital or state they work in,” Coufal commented. “This is a big win for healthcare workers nationwide.”

(Note: The relevant provision in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is section 947, “Application of OSHA Bloodborne Pathogens Standard to Certain Hospitals.”) □