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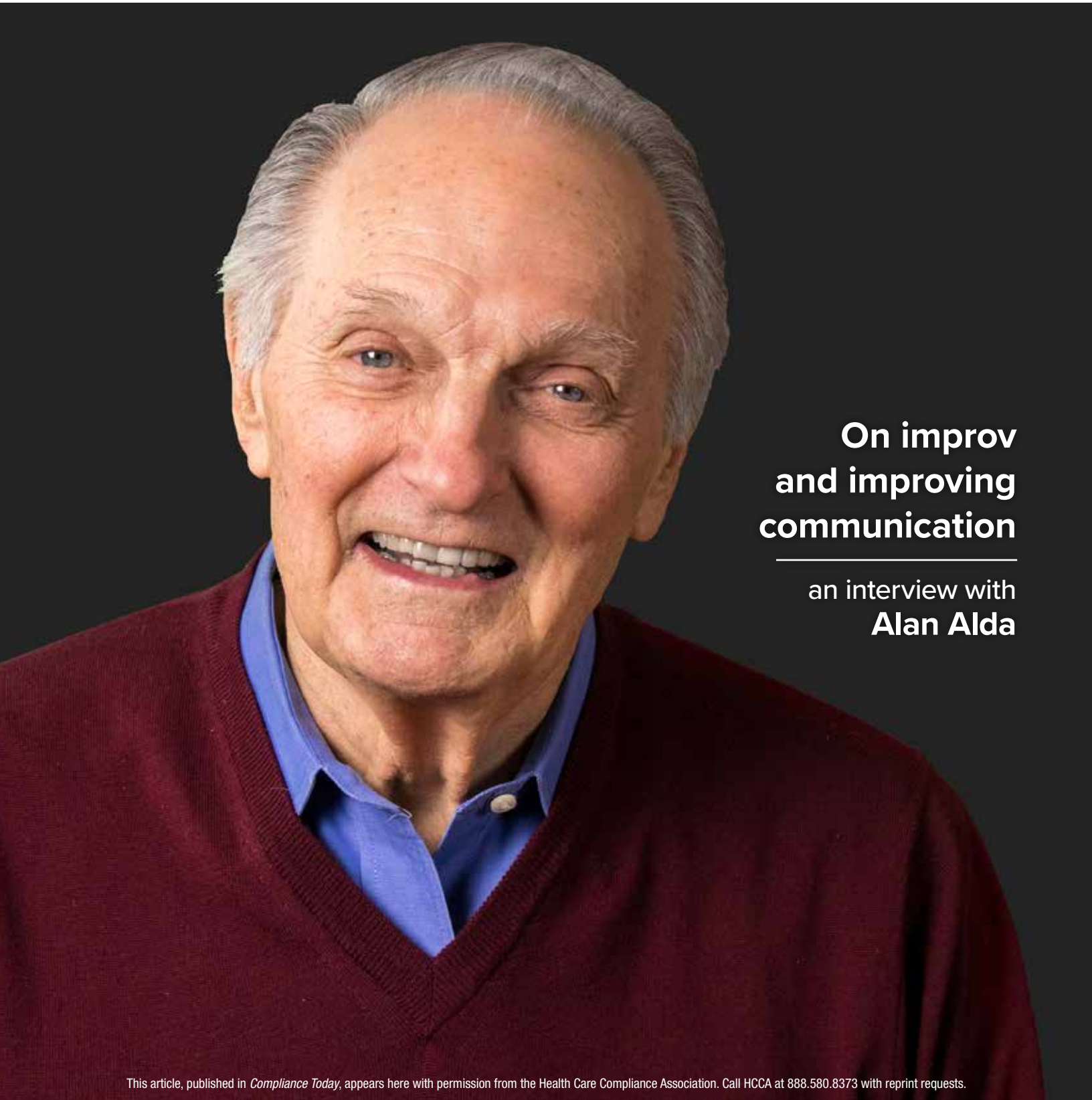

On improv and improving communication

an interview with
Alan Alda

by Dale Sanders, DO, DHA; and Tom Ealey

Safety is the law: Occupational safety compliance

» Safety management and compliance are multi-faceted, and all facets are important.
» The enforcing agency (state or federal) can examine the entire safety culture and operation.
» Policies based on legal requirements must be written for ease of communications and training.
» Employees have a right to be whistleblowers, without fear of retaliation.
» There are significant negative consequences from safety failures for both employee and employer.

Dale Sanders *(sandersdl@alma.edu) is a professor at Alma College in Alma, Michigan and Director of the Health Care Administration program.*
Tom Ealey *(ealey@alma.edu) is a professor at Alma College in Alma, Michigan, and has decades of experience in healthcare consulting and administration, including regulatory compliance and risk management.*

Prior to 1970, workplace safety was somewhat ad hoc—employers responded to state regulations, workers compensation costs, liability concerns, and contract language. In 1970, the federal Occupational Safety and Health Act (OSH Act or the Act) was passed and the Occupational Safety and Health Administration (OSHA)[1] was created.[2]

The Act allows a state agency to supersede OSHA if the state agency has regulations more stringent than OSHA.[3] Employers should be aware of which agency is the authorized enforcement agency and the details of the regulations.

For editorial purposes we will refer to OSHA and OSHA regulations. The first step for the organization is to determine which agency enforces safety practices in your state. We will focus on the federal regulations, but each organization should build a reference collection of applicable federal and/or state regulations.

The healthcare scene


Sanders

As modern medicine developed, so did modern safety practices and especially infection controls. Workplace safety became a political issue and was formalized into law in 1970. The next wave of regulation came during the AIDS/HIV crisis, when universal precautions and related practices were formalized into law.


Ealey

The AIDS/HIV crisis created a new concern—working in healthcare can have lethal consequences. There was a necessary and quick improvement in medical safety practices, and these practices were quickly codified into the blood-borne pathogen standards.

With more than 40 years since the passage of the OSH Act and about 30 years since universal precautions were codified, every health organization should be in a best practices state of operations. Time pressures, resource pressures, and just the daily rush of practice operations may put safety on a back burner. Constant efforts should be made to review and refresh safety practices.

The General Duty clause

This is the "everything else" section of the law that covers the types of safety issues applicable to all employers, regardless of industry (Section 5.(a)).[4] These regulations cover everything from trip-and-fall to electric shock to burn hazards, and all other common means of workplace injury (e.g., falling objects, vehicles, lifting injuries, ladder issues, pinching and cutting injuries).

Ever walk into a room and find an employee using an office chair as a step ladder? Probably yes. Ever seen the multi-plug turned wiring octopus? No doubt. The employer is always responsible for bad outcomes.

Liability for general duty violations follows this checklist:

1. A hazard exists
2. The hazard is likely to cause harm
3. The employer knew or should have known of the hazard
4. An incident was foreseeable
5. Workers were exposed to the hazard
6. Injury occurs and is reported to OSHA

With the General Duty clause, the recognition of a hazard is always established if the employer knew about the hazard. An employee, supervisor, or a compliance officer may put the organization on notice.

This section interacts with the local fire and building codes as well as with the Americans with Disabilities Act (ADA). If leasing, be certain responsibility for fire and building codes are clearly assigned. Know if your facility is accredited with any relevant accreditation standards. Your workers compensation and general liability carrier may also have guidelines and standards.

Mandatory postings

Federal and state safety agencies require the postings of regulatory notices. Your advertising mail and email will likely have a steady stream of ads for the mandatory posters in your state. Not to make you uneasy, but the posters will include 800 call-the-feds numbers and whistleblower information.

And speaking of whistleblowers, retaliating against an employee who files a complaint is a very serious offense.

Rights and responsibilities

This section is straightforward: Employees have rights and employers have responsibilities.[5] Employees have a right to a safe workplace, a healthy workplace, hazardous materials warnings, access to Safety Data Sheets (SDS, formerly MSDS), training and updates, personal protective equipment, necessary supplies, a right to complain, and a route to being a protected whistleblower.

Employers have the responsibility to provide all of the above, keep required records and file required reports, respond to incidents and mitigate damages, abate known violations, and refrain from retaliating against whistleblowers. Beyond all of this is a "duty to supervise," the employer is responsible for failures to perform.

Safety enforcement

An organization may never see an OSHA inspector. Or one walks through the door tomorrow. OSHA has a very broad enforcement mandate, access rights to your facility, permission to speak with your employees (and you may not retaliate), and power to review your paperwork, including required policies and procedures.

Two responses to an OSHA visit are critical—first, cooperate and second, call your lawyer. Cooperate unless your lawyer tells you to stop. The enforcement agency is enabled to levy penalties, and penalties can go all the way to criminal prosecution (although this is somewhat rare).

Safety enforcement actions are public record and may end up in the local newspaper. Not the sort of brand enhancement the organization is seeking.

Workplace violence

Almost monthly we turn on the news to a gruesome workplace shooting spree. OSHA requires each employer to have a workplace violence plan in place, with the requisite employee training.

If your facility has narcotics, or even if someone might think your facility has narcotics, there is an armed robbery risk. Minimizing cash on hand is a good practice. Protocols must be set, hardware (security cameras) put in place, and employees trained, because the unthinkable is thinkable.

Ergonomics

OSHA has an ergonomics safety standard aimed at reducing the incidents of work-related musculoskeletal disorders (MSDs), both accidental injury incidents and repetitive motion injuries. Management has a responsibility to analyze each job and determine the risks.

Healthcare is notorious for back injuries suffered while lifting and positioning patients and for slip-and-fall accidents on highly polished floors. OSHA requires engineering controls, work practice controls, and personal protective equipment, all appropriate to the site. Appropriate training is required, and there should be a feedback loop. Injuries should be analyzed with an eye toward preventing future injuries.

Blood-borne pathogens

Universal precautions became a major issue during the HIV/AIDS crisis, and by the late 1980s, universal precautions were in place as law.

Blood-borne pathogens are infectious microorganisms in human blood that can cause disease in humans. The practice has a very definite duty to protect employees from these hazards, and also patients from secondarily acquired infections.

On a typical day, a healthcare facility is rushed; on a non-typical day, chaos ensues. Clinical staffers are almost always rushed, phones are ringing, computers are beeping, and patients are getting impatient. It is certainly easy to miss putting on a pair of gloves. Or pass the hand washing sink.

Universal precautions are designed primarily to protect your employees, with a secondary emphasis on protecting patients by preventing cross contamination. And there is a lot more to universal precautions than hands and gloves.

The regulations

Regulations and informational materials for the entire OSH Act and especially blood-borne pathogens are readily available online,[6] as are state-specific regulations for states, which supersede federal regulations.

The Centers for Disease Control (CDC) has recommendations and research available, and recommends "standard precautions" that are more conservative than universal precautions. The regulations sort bodily fluids and wastes into two categories: (1) blood and blood products, and (2) other potentially infectious materials (OPIM).

The blood category includes blood, components of blood, and products made with blood. OPIM is defined by OSHA as:

> …semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body (sic) fluid that is visibly contaminated with blood, and all body fluids in situations

where it is difficult or impossible to differentiate between body fluids;

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

(3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

As the CDC points out in standard precaution protocols, since it is nearly impossible to know if OPIM contains any blood, effectively *all of these should be treated as infectious at all times.*

Human sweat is not considered OPIM unless a known infection is present.

Work process (engineering) controls

Management must design work process controls, train employees to use them, and supervise their use. Hand sanitation is a typical work process control. A critical control is the sharps injury prevention program, the controls designed to prevent needle sticks and other percutaneous injuries.

Also crucial to the controls are personal protective equipment (PPE). The employer is responsible for having the proper equipment available at all times, for training, and for supervising the staff and physicians.

Exposure control plan

Having determined the employees who have occupational exposure by job category, the practice must prepare an exposure control plan and train the employees on the plan protocols. In many practices, the common exposures come from bleeding, splashing, and needle sticks, but other events may occur.

The plan should cover all anticipated employee exposures and be broad enough to cover unusual incidents. The plan should include a feedback loop—all incidents should be analyzed in light of patterns of incidents and possible points for improvement. Employees must be trained to report all exposures immediately, and supervisors must be trained in proper responses. Physicians are also subject to these protocols.

Hepatitis B

There is a significant risk of transmission of Hepatitis B pathogens during an exposure incident.

All employees in the exposed categories should be vaccinated during their initial work period. The vaccination is highly effective and need not be repeated. Appropriate records should be maintained.

The opioid crisis is creating new concerns, particularly inadvertent exposure to fentanyl, which can be fatal.

New worries

The opioid crisis is creating new concerns, particularly inadvertent exposure to fentanyl, which can be fatal. If there is any possibility of such exposure in your practice, protocols must be developed and staff and physicians *must* be trained.

Policy development

Why not just photocopy the law and pass it out to physicians and staff? Besides being too long, the law does not exactly read like poetry.

Policy and procedure statements need to be: (1) written in plain English, (2) useful for training, (3) customized to your organization,

and (4) clear enough to be useful for supervision and discipline.

Statements should be customized to the specific risks of your practice, because each type of practice has different work effort, different ancillaries, and different potential hazards.

Organizations with a surgical component, invasive procedure, or trauma care should use accreditation agency standards (e.g., surgical hand scrub procedures). Practices with imaging and/or lab facilities must be aware of all special regulations targeted at these units.

Government jargon and bureaucratic language are not helpful here; what is required are plain descriptions of what the rules are for performance in your particular setting.

Training

There may be a notion floating around that anyone more than a few months out of school already knows about universal precautions, so your new hires need no training. Not so. Initial training should take place as close as possible to the "on-boarding" date and should be integral to the orientation process. At the very least, a tour of safety logistics (e.g., red bags, sharps containers, spill kits) should take place very early on. Annual training sessions should be conducted with materials and attendance records kept on file.

Relentless supervision and performance auditing

The only way to measure performance is "eyes on," spending time in clinical areas, watching the ebb and flow of patients, and watching the performance of staff. Another source of input is patient satisfaction surveys. Many patients and families are very aware of proper precautions and failures in performance.

Formal performance audits can be structured to measure more precisely daily compliance with safety regulations. The best situation is a culture of compliance, where staff and physicians reinforce compliance with each other.

Annual compliance reviews

A review and assessment is required every year, and would be good compliance practice in any case. Scheduled reviews should include:

- assessing overall program design and effectiveness,
- scanning regulators websites for new regulations or interpretations,
- reviewing policies and procedures (e.g., up-to-date? readable? thorough? outcomes?),
- studying injury logs with emphasis on negative trends, and
- evaluating the effectiveness of training programs and training attendance logs.

Many patients and families are very aware of proper precautions and failures in performance.

Inputs should be solicited from clinical supervisors, and clinical supervisors should be evaluated for effectiveness. Injury logs and employee complaints should be sorted into departments and analyzed for causation. Injury trends will require further study and sometimes remedial action.

Employees who were subject to the exposure control plan, such as employees who suffered needle sticks, should be interviewed and their records reviewed to test the performance of the plan.

Necessary changes and updates should be prepared, reviewed through the chain of command, and implemented with appropriate

communications to employees and incorporation into future training sessions.

Conclusion

This is a complex topic with many operational and regulatory risks. Organizations must focus on the most basic of the seven elements (below) to assist management in addressing the full range of implementation options for health care facilities, regardless of size and resources:

- Standards of conduct and policies and procedures
- Designation of compliance officers
- Conducting effective training
- Effective lines of communication
- Auditing and monitoring
- Establishing disciplinary guidelines
- Responding to detected offenses and developing corrective action initiatives

The practice of medicine has inherent dangers as well as many of the same dangers as other businesses. There is an affirmative duty for employees to meet the requirements, whether from OSHA or a state affiliate.

1. U.S. Department of Labor, Occupational Safety and Health Administration website: https://www.osha.gov
2. About OSHA. Available at http://bit.ly/2DJutM6
3. U.S. Department of Labor, Office of State Plans: Frequently Asked Questions. Available at http://bit.ly/2mIWll6
4. OSHA General Duty clause available at http://bit.ly/2D3xLwM
5. U.S. Department of Labor, OSHA Administration: Job Safety and Health. Available at http://bit.ly/2D1sIw9
6. CDC, The National Institute for Occupational Safety and Health: Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C. Available at http://bit.ly/2FsHxWO