

Safety Committee Procedures and Administrative Policies

Reporting to OSHA Policy

All serious accidents resulting in fatalities or in the hospitalization of three or more employees must be reported within 48 hours of occurrence.

The Administrative Director or Safety Chairman will notify OSHA via the OSHA phone number 1-800-321-6742.

Managing Latex Allergy

I. INTRODUCTION:

Latex allergy is a reaction to proteins which are in natural rubber. Allergic reactions to these proteins are usually immediate but may be delayed in some instances.

Approximately 8-12% of health care workers are sensitized to latex. People who are most at risk are people who have tendencies toward allergic conditions, people with spina bifida and people who have food allergies. Risk is minimized by using powder free gloves and avoiding using oil-based hand creams when wearing latex gloves.

II. GOALS:

The goal of this policy is to minimize the risk of allergic sensitization and to manage the allergy in employees that are (and will become) sensitized.

III. POLICY and PROCEDURE:

It is the policy of the Pathology Department to minimize risk of allergic sensitization to latex by the following techniques:

Powder free latex gloves:

The Pathology Department will use powder free latex gloves which are shown to reduce the risk of allergic sensitization.

Training:

The Pathology Department will train employees to identify risk factors, avoid risk, recognize signs and symptoms of sensitization and in the available allergy management methods.

Signs and Symptoms of Sensitization:

Skin rash	Hives	Flushing
Itching	Asthma	Shock

Managing latex allergy:

Employees who recognize signs and symptoms of sensitization should not contact latex products until they see a physician. Consultation is available in Employee Health. Latex-free gloves and other products are available and will be provided to those who require them.

Departmental Safety Training

I. INTRODUCTION:

Safety training in the Pathology Department is accomplished by training received at new employee orientation (Staff Development) , by participation in required in-services , quarterly safety meetings, periodic safety bulletins and activities on special topics. The safety committee oversees the content and administration of the training program and maintains statistics of attendance. Lab supervisors maintain participants records.

II. GOALS:

The following policies and practices and intended to ensure proper orientation and continued refresher instruction pertaining to safety in the work-place.

III. POLICY and PROCEDURE:

Participation in required in-services is enforced by the Laboratory Manager, Departmental Director or Associate Director via personnel actions in accordance with Civil Service Rules and Regulations. Compliance is verified and monitored by the annual report of the Safety Committee.

It is the policy of the Pathology Department to require attendance and participation in the in-services designated as mandatory by the Joint Commission on Accreditation of Health-care Organizations or by the Medical Center's Administration. These include but are not limited to: Fire, Electrical Safety and Infection Control practices and they are required on employment (at new employee orientation by Staff Development) and once per fiscal year. In-service topics are systematically handled in the quarterly safety meeting program . The employee must provide documentation of attendance. The safety coordinators will maintain records of attendance and will report to the Laboratory Manager , Departmental Director or Associate Director for initiation of disciplinary action when appropriate.

In-services:

It is the policy of the Pathology Department to encourage employee attendance in safety related in-services and to provide materials and activities for these purposes. The Safety Committee will review, select and procure materials for these purposes and schedule and present these periodically. The criteria for selection of materials include: need (as indicated by accident report review) and to ensure compliance with accreditation agencies. Documentation of participation will be reviewed annually to monitor employee participation and to identify weak areas and communicate with the Section Directors and Supervisors to facilitate participation.

Quarterly Safety Meetings:

The Quarterly Safety Meeting is intended to promote safety education throughout the year rather than concentrate training in one annual session. It is a mechanism for constant communication of changing safety concepts and needs. The meetings are to be conducted by the Unit or Shift Supervisor so that all personnel are reached and can participate. The meeting agenda is somewhat controlled, in that particular topics must be discussed and particular teaching objectives must be met. Beyond the formal agenda, employees are encouraged to ask questions, raise concerns and discuss and propose solutions to existing and potential safety problems. In this manner, issues may be communicated to the Department Safety Committee for consideration or action.

Instructions:

1. Take roll and circulate an attendance sheet.
2. Announce the meeting's title and review the instructional objectives.
3. Discuss the topics listed on the meeting form.
4. Allow time for questions and answers and carefully note on the form, any questions or concerns that prove difficult or require further actions or information. It is often essential to take the group to the appropriate safety equipment for demonstration purposes (e.g. the stairwell if discussing evacuation procedure, the fire blanket for smoke containment, spill kit for spill control).
5. Verbally ask the questions supplied with the lesson and randomly ask personnel to answer them. Correct any and all inappropriate responses. Relate the questions to the instructional objectives.
6. Open the meeting to input on any safety concern and take notes on the form. The supervisor should indicate which if any issues require action by the safety committee but supervisors are encouraged to find internal solutions to problems. The form allows for documentation and communication of problems and corrective actions.
7. Make a copy for your records and return the form and sign-in sheet to the Safety Chairman.

Review of Incidents Reports, Accidents and Unsafe Conditions and Use of the Accident Investigation Report

I. Introduction:

Review of incident reports of all accidents and unsafe conditions is an order of business at every regular Safety Committee meeting. All accidents must be documented by incident report and accompanied by an accident investigation, which is the mechanism for immediate investigation and initiation corrective action by supervisory personnel. The accident victim is routed through the Accident Room for immediate examination by a doctor and appropriate therapy. All exposures to blood or body fluids are then routed through Infection Control for surveillance and follow-up immunizations according to the OHIC accidental exposure protocol.

The reports are forwarded to Quality Assurance for review and are submitted to the Departmental and MCL Safety Committees.

There are no exceptions to this procedure. All accidents must be treated in this way.

II. Mechanisms and criteria for review:

1. Before each meeting all incidents are categorized and data entered into the accident computer file:

Name of injured

Location

Date (mo/yr)

Shift

Type of injury (e.g. eye-splash, needlestick , cut, slip or fall, abrasion)

2. At this time, the database is reviewed with the intention of answering the following questions:

Was the same person involved in other accidents?

Are accidents unique to an activity or work area or shift?

Has this happened before?

If so, what is the frequency?

III. Presentation and Review:

1. The incidents are presented to the committee and the findings of the research is presented.

2. Criteria for the review process include:
 - a. Review of the Accident Conditions.
 - Was the proper documentation procedure followed?
 - Has the accident happened before?
 - Is this person "accident prone"?
 - Is it likely to happen again?
 - Was there a breach of policy?
 - Is the procedure or policy sufficient to prevent recurrence?

 - b. Review of the Corrective Action Taken:
 - Is the immediate corrective action taken (as reported) appropriate and sufficient to prevent recurrence?
 - Has there been a change of technique or procedure?
 - Is disciplinary action indicated (i.e. for breach of policy)?

3. The Committee (by consensus or majority) rules if the corrective action was appropriate, sufficient and or require further action or a long term corrective action plan.

4. For record keeping hard copies of the incident reports and accident investigation forms are maintained in addition to the computer record.

IV. Long term corrective action plans:

Long term corrective action plans are developed by committee members and by the lab sections (as assigned) for recurring or chronic problems (e.g. needlesticks , leaky containers, etc.) as required. The plans are presented to and approved by the committee before implementation. The trigger for re-examination of a corrective action plan is future incident reports.

The problem solving mechanisms include:

- Procedural or methodology changes
- Product evaluation and selection
- Intradepartmental and interdepartmental memorandums
- In service training programs
- Disciplinary actions

Internal and External Disasters

INTRODUCTION: Plans for handling internal emergencies (fire, bomb threat, chemical spill, water outage, power outage, cooling outage, etc.) as well as external disasters (large accident, hurricane, snow, sleet, flood, or other natural disaster) depend on providing direction, personnel and utilities. The departmental goal for internal and external disasters is to provide laboratory and blood bank services to the fullest extent possible until complete normalcy is restored. The Medical Center manual describes the role that the department will play in disasters. This document describes the mechanisms for accomplishing that task.

Direction:

The ranking administrative officer (on site or on call) will direct the departmental activities in all emergencies.

Personnel:

All personnel are required to make a good-faith effort to report for duty in case of emergency or weather difficulty, providing that conditions do not significantly threaten life or property. The administrative officer will assign available personnel as necessary to ensure that service is continued.

Communication:

On call: The department's on call mechanism includes primary, backup and Staff call schedules for clinical laboratory, autopsy, and Blood Bank problems. In addition, the department also maintains an administrative "on call" mechanism. All "on call" personnel may be reached via the facility's communication department (operator). Lists of telephone numbers of all supervisory personnel and Section Directors are maintained and distributed. Telephone numbers and addresses of all personnel are maintained in the administrative office.

Emergency Power:

Complete emergency power and lighting is provided in the Core Lab, UH Laboratories and Blood Banks. This allows for providing the essential services which are vital to the department's response to an emergency. Many other laboratory sections have limited emergency power to offer additional services as necessary. Extension cords (available from the maintenance department in emergencies) may be used in emergency situations. Emergency lighting (such as battery powered lanterns, issued by Central Materials Supply), will be used for areas not covered by the emergency lighting (e.g. entering storage areas, etc.).

Sanitation:

In response to the loss of water and sewerage the facility will provide portable toilets and water at sites on each floor. Foamed alcohol skin sanitizer will be issued for hand cleaning and disinfection.