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SHEA News

THE SOCIETY FOR HOSPITAL EPIDEMIOLOGY OF AMERICA

President's Message

Strong leadership by past presidents and officers of SHEA has led to many changes in the past year. Fundamental to these changes has been the recognition that the future of SHEA depends on far more than the accomplishments of its members—as important as these are-in advancing the scientific foundation of hospital epidemiology. SHEA must also identify and serve the needs of its members, and communication is vital to this process. The new freestanding newsletter is the first step in enhancing membership services, and feedback is vital. Expanded involvement and participation by the membership must be achieved if the goals of the Society are to be realized.

The Society's move to professional management, its improved relationship with its journal, its commitment to an annual scientific meeting, and its enhanced education programs through the SHEA/CDC/AHA courses have all helped to assure SHEA's continuance as the one organization best equipped to speak for clinically based hospital epidemiology. However, as Glen Mayhall noted in his president's message last year, interest in the quality of healthcare has greatly expanded, and SHEA's success in this new "marketplace" depends on firm support from its membership, especially in the recruitment of new members and in efforts to make our society more interdisciplinary in nature.

In the past, the interdisciplinary nature of infection control recognized the important collaboration of infection control practitioners, microbiologists, and physician epidemiologists. Today, the interdisciplinary nature of hospital epidemiology includes far more diverse groups. These include sophisticated professionals in medical informatics and computer-based hospital information systems, in medical decision analysis, in outcomes and effectiveness research, and in quality management.

The SHEA leadership remains committed to the prevention and control of infectious disease. The leadership also is convinced of the need to provide organizational support for its members involved in epidemiologic assessment of other clinical processes. For many, this involves significant "i-e-tooling," and through its annual meeting and educational courses, SHEA will make these tools and experts from other domains more accessible to the membership.

John P. Burke, MD
President, SHEA

OSHA Bloodborne Hazard Standard

Dr. Michael Decker has followed the development of the Occupational Safety and Health Administration's (OSHA) Blood- borne Hazard Standard closely and has responded on behalf of SHEA with specific suggestions and comments to OSHA after the publication of proposed standards in 1989 (see SHEA *News, March 1990). Dr. Decker now offers these comments on the final regulations; his more detailed review will* appear *in the quarterly* SHEA Newsletter.

On December 6, 1991-some 30 months after publication of the proposed regulations and following review of one of the most voluminous public comment dockets in OSHA history-OSHA published final rules and regulations for its Bloodborne Hazard Standard *(Federal Register.* 56:64003-64174; 29 CFR 1910.1030.) The final regulations differ only modestly from those initially proposed.

Those aspects of the Bloodborne Hazard Standard concerning methods for protecting employees from bloodborne hazards are generally reasonable and consistent with existing

recommendations from the Centers for Disease Control (CDC), the American Hospital Association (AHA), and various professional societies. With respect to many substantive issues, OSHA responded favorably to comments from SHEA, the Association for Practitioners in Infection Control (APIC), and others, and incorporated language that clarified or enhanced the regulations.

Unfortunately, it appears that OSHA found little merit in comments aimed at curbing documentation, recordkeeping, and other bureaucratic concerns. Especially for hospitals, some of these requirements remain extraordinarily burdensome and wasteful, with little apparent benefit. A particularly telling example is the "Exposure Determination" requirement for the "Exposure Control Plan," in which each employer (hospital) must list all job classifications in which some employees have occupational exposure to blood, and then list every task and procedure performed by employees in those job classifications, in which occupational exposure occurs. For those job classifications in which all employees have exposure, no task list is required. One can only hope that the AHA or another national organization prepare a model set of lists that hospitals could modify and adopt.

The final regulations become effective in stages on March 6, May 5, June 4, and July 6, 1992; ironically, the bureaucratic provisions take effect earlier, the substantive regulations later. Key provision and their effective dates include:

- Exposure Control Plan: by March 6, mandatory University Precautions must be implements, including an overall schedule of implementation and procedures for dealing with exposure incidents.
- Exposure Determination: by May 5, this requirement must be met.
- Information, Training, and Recordkeeping: by June 4, these requirements must be implemented. Training sessions must include, at a minimum, 14 mandated components. For current employees, training must occur within 90 days of June 4 for those components not covered in a training session during the prior year. The training must be repeated at least annually, with special interim training for new exposures. New hires must receive the training at the time of initial assignment. The employer must maintain records documenting all required training for three years.
- The employer is required to maintain medical records for each affected employee for the duration of employment plus 30 years. These records must contain a series of mandated components and may not be disclosed or reported to anyone within or outside the workplace except as required by law.

All remaining provisions become effective July 6, 1992. They include:

- Engineering and work practice controls, including specific requirements for handwashing, sharps management, and disposal; employee conduct in areas of exposure; and management, storage, and shipping of specimens.
- Requirements for appropriate personal protective equipment. Equipment must be readily available. Employees must know how to use it, know when to use it, and use it. Any cleaning, laundering, repair, or replacement is the employers responsibility. Of note, phlebotomists no longer have discretion regarding glove use, which is required for all phlebotomy (except under special circumstances in volunteer blood donation centers).
- Detailed housekeeping standards. These are largely unremarkable except for requirements for special handling and bagging of "contaminated" laundry. There are particularly detailed requirements for sharps.
- Hepatitis B immunization and postexposure evaluation and followup. In contrast to the draft standards, free hepatitis B immunization is now required for all employees with any exposure. Prevaccination screening cannot be required. Those declining vaccination must sign an "Informed Refusal," whose language is specified in the Standard. Employees involved in an exposure incident must receive evaluation and follow-up from a "healthcare professional" (was "physician" in the draft) that complies with a series of detailed requirements, including protocols for testing source individuals and the employee, and the provision of postexposure prophylaxis. With respect to all these medical interventions, OSHA has established an obligatory federal standard of practice; current recommendations of the US Public Health Service must be followed (apparently, even if outdated or if contradicted by other authoritative recommendations).
- Requirements for "biohazard" labels and signs. In many cases, red bags or containers are allowed to substitute for the biohazard label. OSHA responded to suggestions from SHEA and others by dropping the labelling requirement for decontaminated waste and for individual blood tubes placed in a labelled container,

Most hospitals should already

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be substantially compliant with the risk-reduction components of the Standard. Nonetheless, full compliance with the Standard on schedule will require concerted effort in most institutions, and our readers are likely to shoulder a large portion of the responsibility for these efforts. It is imperative that the actual text of the Standard be obtained from the *Federal Register* or, once available, from OSHA. Clearly, though, further help will be needed. We will try to provide some guidance in the next quarterly *SHEA* Newsletter, but for further assistance, we all look to:

- The local or regional office of the Federal OSHA (also, in those states that have established agencies to which OSHA has delegated its enforcement duties, the offices of such agencies).
- The AHA. Useful materials include AHA's book on Universal Precautions and the recently telecast video conference on the OSHA standard, which will be available soon on videocassette. Be sure your "front office" knows to copy relevant AHA announcements to you.

SHEA Annual Meeting Registration

You still have time to register for the SHEA Annual Scientific Meeting, and if you register by February 28, 1992, you will qualify for the reduced "Early Bird" rate. So get to it! The meeting will be held April 12-14, 1992, in Baltimore, Maryland. If you need further information, call the SHEA Meetings Department at (609) 845-7220.

Brief items of interest for the SHEA News or Newsletter may be sent to Robert A. Weinstein, MD, SHEA, Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Lake Shore Drive at 31st St., Chicago, IL 60616; FAX (312) 791-3577. Copy must be typed, doublespaced, and may not exceed five pages.