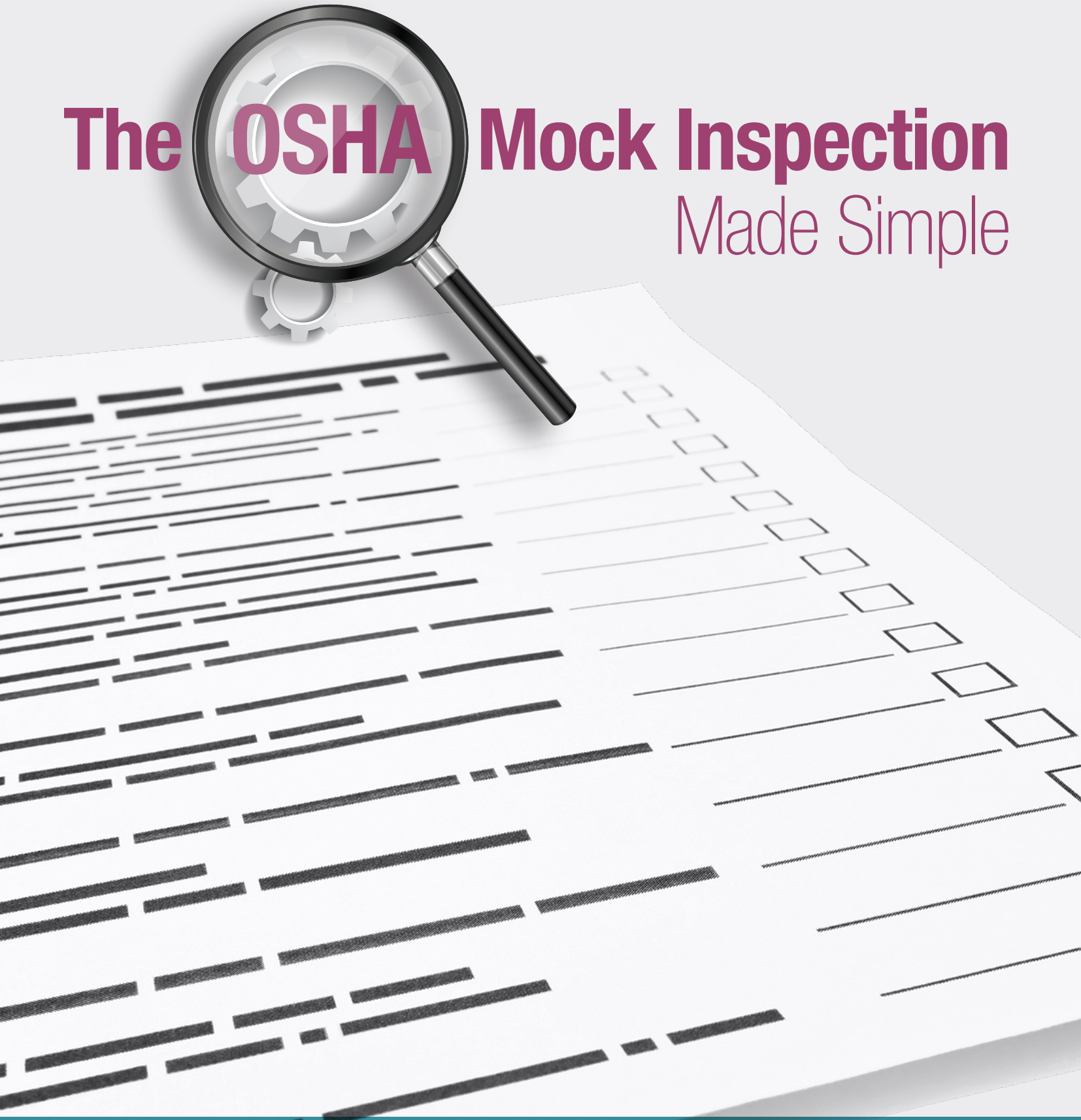
The OSHA Mock Inspection Made Simple



Sarah Alholm, MAS

The OSHA Mock Inspection
Made Simple

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HCPro
a division of BLR

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Introduction

This book is designed to be a comprehensive self-inspection guide for outpatient medical practices. If you are the safety officer at your facility, you can use the tools contained here to evaluate your own program. If you are the manager of a multi-location practice, you will find this resource invaluable for assessing facilities during short site visits.

This volume is data-driven. Each topic covered stems from real citations issued to ambulatory medical facilities within the past two years. These are the areas where OSHA inspectors focus and fine. Consequently, you will want to pay attention to these specific subjects as well. Not all of the areas will apply to each organization; you'll have to use your knowledge of your organization's operations to say for certain whether attention is needed for each standard listed. But I'll make sure you have enough background information to make that determination.

The first four chapters cover detailed occupational safety information, so you will gain the background knowledge on what an OSHA-compliant worker safety program looks like. Checklists compiled in Chapters 5 and 6 facilitate effective records reviews and facility walk-through evaluations. The appendices lay out templates for many of the written documents OSHA requires you to maintain, a help to local or corporate-level managers who need to provide them. Here you'll also find state-specific information and a game plan for post-inspection actions.

If you need to brush up on a specific issue, use the chapter summary section at the start of each chapter to find the subject you're looking for quickly. Read the background information to get a handle on the topic, then hit the assessment bullet questions to be sure the relevant compliance details are locked into your memory. Inset boxes feature real-world questions and experiences from

medical facilities all over the U.S. Finally, tables and web addresses included throughout tell you where to go to get more in-depth information, should you need it.

What's included? Here's a quick glance:

- Chapter 1 covers why OSHA inspects medical clinics (here's a hint: employee complaints!) and the most common and expensive citations. You will also find out what you—or your local facility's designated representative—can expect during an OSHA inspection.
- Chapter 2 is full of details on what is needed for compliance with the two "biggies" at medical facilities: the *Bloodborne pathogens* standard and the *Hazard communication* standard. These two standards account for approximately 80% of the violations and fines OSHA issues to ambulatory healthcare.
- Chapter 3 tells you what to do to meet OSHA's "general" safety requirements. This is the work all businesses need to do for employee safety—whether the business is a medical office, a retail establishment, or a manufacturing facility. Whether exit routes, fire alarms, or electrical safety, the subjects here apply to workplaces of all types.
- Chapter 4 covers the "maybes." This chapter walks you through additional OSHA regulations that might apply to your facility. Perhaps you provide ambulance services, have a pathology lab that uses formaldehyde, take x-rays, or perform laser-based surgery. This chapter takes a hazard-by-hazard approach and covers the basics of what OSHA's standards require in each instance. The good news: Not a large percentage of citations or fines come from these violations. The bad news: If your facility is in that small percentage, you've got a problem. Tables, figures, and lots of additional information resources help you ensure each area that might come under scrutiny is ship shape.
- Chapter 5 guides you through the records review portion of your OSHA mock inspection. Use the evaluation form provided as you go through each area listed to assess whether your organization is squared away for compliance or whether some areas need improvement. Download and print as many copies of the evaluation form as you need to cover all of your locations or to perform additional follow-up mock inspections.
- Chapter 6 is your reference for the walk-though portion of your self-assessment. It's a rinse and repeat of Chapter 5, but as related to the physical facility. The chapter ends with questions you should use to interview both frontline and management staff to grasp the true status of your training and compliance programs.
- The appendices explain OSHA state programs, provide templates for written plans you'll need to customize and have in place, and take you through the dispute process should you disagree with an OSHA inspector's findings.

I hope you'll find this OSHA mock inspection guide to be thorough yet straightforward and a valuable compliance resource.

About the author

Sarah Alholm has applied her safety knowledge at organizations large and small for more than 10 years. Before partnering with HCPro, she was the lead OSHA technical expert at Quality America, Inc., a healthcare consulting firm that helps medical and dental practices comply with OSHA regulations. She also worked at Baxter Healthcare Corporation, where she implemented procedural and engineering controls that reduced occupational risk for laboratory personnel. She has developed successful safety training programs for both the healthcare and aviation industries. Her experience also includes developing and executing curriculum to address communication among members of high-performance teams, risk management, and OSHA hazard communication.

Alholm received her Master's degree in Human Factors from Embry-Riddle Aeronautical University in 2002. Human factors is a multidisciplinary field incorporating contributions from psychology, engineering, industrial design, statistics, and operations research that involves the study of how we relate to the world around us, with the aim of improving operational performance and safety. She earned her Bachelor's degree in Biology from the United States Air Force Academy. She also holds continuing education certificates in Human Performance Enhancement, Safety Program Management, Accident Investigation and Prevention, Alertness Management, and Crew Resource Management. She currently resides with her family near Asheville, North Carolina, where she provides safety-related healthcare consulting services and training. She may be contacted through the publisher.

Chapter 1

OSHA 101: On employee safety, inspections, and violations

This chapter introduces those not familiar with OSHA's mission and organization to the agency's goals and practices. Next up is why medical facilities are most likely to be inspected—based upon actual inspection data from 200 recent medical office inspections.

In this chapter, you'll find information about:

- How OSHA promotes and ensures employee safety
- Why OSHA inspects medical facilities
- The most common OSHA violations and fines
- Defining corporate versus local facility safety program responsibilities
- Developing a safety culture
- What to expect during an inspection
- Post-inspection procedures following citations
- Understanding which OSHA regulations apply to your facilities

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What is OSHA?

In 1970, the United States Congress passed laws requiring workers in this country be provided with **safe and healthful working conditions**. These laws created the Occupational Safety and Health Administration (OSHA), which is a **federal government agency**. OSHA is part of the U.S.

Department of Labor and sets and enforces laws, called "standards", regarding workplace safety for employees.

The federal regulations that created OSHA also **allow and encourage states to develop and operate their own job safety and health programs**. Federal OSHA approves and monitors state plans and provides up to 50% of the state's operating costs.[1] States may choose to use a state plan to focus on local industry, and also because the regulatory process can work more quickly at the state level than it can at the federal level.[2]

The regulations enacted by individual states under a **state plan must be at least as effective** at protecting workers as the federal regulations pertaining to the same topic. As they relate to outpatient medical facilities, state and federal requirements are nearly identical. Currently, 27 states and territories operate OSHA state plans. Specific information on the OSHA state plans, and how some differ, can be found in Appendix A.

The states and territories with OSHA state plans are:

- Alaska
- Arizona
- California
- Connecticut*
- Hawaii
- Illinois*
- Indiana
- Iowa
- Kentucky
- Maryland
- Michigan
- Minnesota
- Nevada
- New Jersey*
- New Mexico
- New York*
- North Carolina
- Oregon
- Puerto Rico
- South Carolina
- Tennessee
- Utah
- Vermont
- Virgin Islands*
- Virginia
- Washington

**The Connecticut, Illinois, New Jersey, New York, and Virgin Islands State Plans cover public sector (state and local government) workers only. Private corporations in these states fall under the jurisdiction of federal OSHA.*

OSHA is only concerned with employee safety—the safety of healthcare workers such as nurses, doctors, lab techs, medical assistants, phlebotomists, and clerical staff—while employees are on the job at medical facilities across the country. OSHA has nothing to do with—and does not issue or enforce requirements surrounding—patient safety. OSHA requires employers in all fields, including the medical field, to provide safe workplaces to their employees. Key employer responsibilities[3] include:

- Provide a workplace free from recognized hazards.
- Follow all relevant OSHA safety and health standards.
- Examine workplace conditions to make sure that they conform to applicable OSHA standards, rules, and regulations.
- Use color codes, posters, labels, or signs to warn employees of potential hazards.
- Establish safety procedures and communicate them so employees follow safety and health requirements.
- Provide safety training in a language and vocabulary that workers can understand.
- Provide personal protective equipment at no cost to employees.
- Post in prominent locations the OSHA "Job Safety and Health—It's The Law" poster (or a poster from the state-plan equivalent) informing employees of their rights and responsibilities
- Report within eight hours any fatal accident. Report within 24 hours an accident that results in the hospitalization of one or more employees, an amputation, or the loss of an eye.
- Provide employees with access to their own employee medical and exposure records.
- Refrain from discriminating against employees who exercise their rights under OSHA.

As mentioned, OSHA sets standards, or rules and regulations, to ensure that employees have safe working conditions. There are hundreds of published OSHA standards covering all types of workplaces. One of the main purposes of this book is to clarify which OSHA standards are actually applicable to healthcare settings and to assist you in internally evaluating your organization's compliance with these rules. From an external standpoint, these regulations are enforced through unannounced inspections by OSHA Compliance Safety and Health Officers (CSHO), typically referred to as OSHA inspectors.

Why does OSHA inspect?

Not all of the 111 million workplaces covered in the United States can be inspected regularly. Obviously, the most dangerous situations need the most attention, so OSHA established a system of inspection priorities.[4]

Imminent danger situations receive top inspection priority. An imminent danger is any condition in which there is reasonable certainty a danger exists that can be expected to cause death or serious physical harm immediately. Imminent danger concerns typically don't occur in outpatient medical facilities.

Second priority goes to the investigation of **catastrophes and fatal accidents,** which includes accidents resulting in a death or hospitalization, an amputation, or the loss of an eye. Again, these situations aren't frequent in healthcare settings. However, they do occur occasionally, especially as related to cardiac arrest or workplace violence.

Third priority goes to formal employee **complaints** of unsafe or unhealthful working conditions and **referrals** from any source about a workplace hazard.[5] Referrals also may come from other federal or state agencies, individuals (possibly patients), or the media.[6] An OSHA inspection at one of your locations would **most likely fall into this category**. As illustrated in Figure 1.1, employee **complaints** account for nearly **50% of inspections** at doctor's offices, and **referrals account for an additional 7%.**

Frustrated employees?

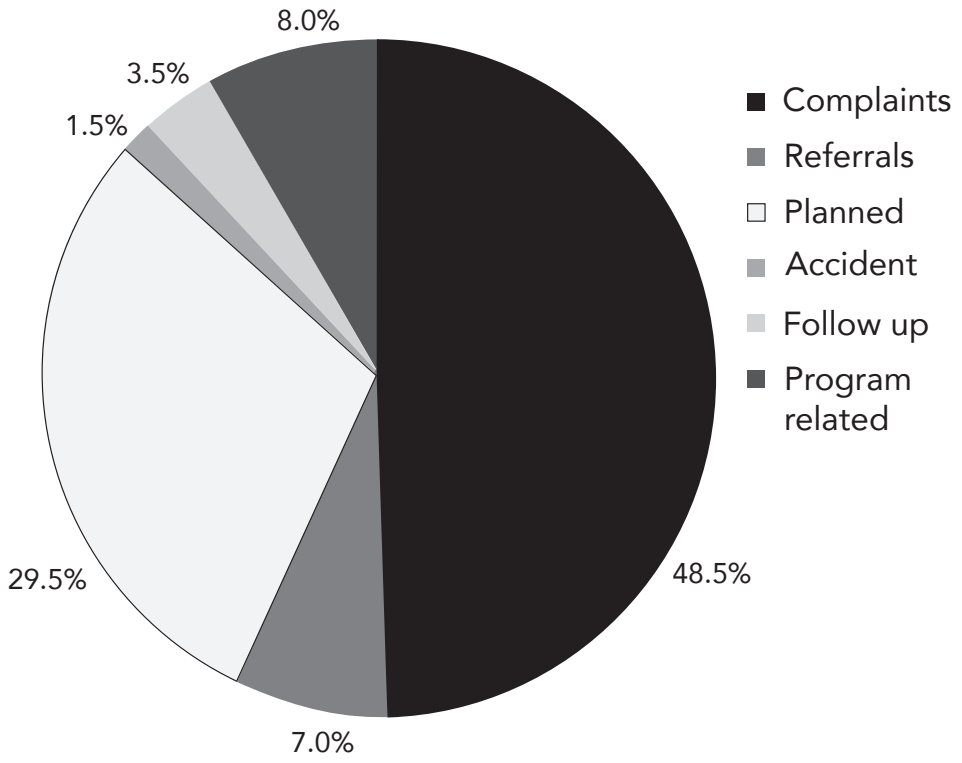
Employee complaints account for nearly 50% of inspections at medical offices. One way to reduce your organization's risk of OSHA inspections is to develop a culture that takes employee input seriously. If employees don't feel valued, appreciated, or trusted, they are more likely to take their frustrations to those outside your organization than to those within. Therefore, when making safety decisions, involve workers who will be affected, and listen to their ideas. In some areas, such when selecting safer sharps, non-managerial participation is actually required by OSHA. Complaints employees make to OSHA are confidential, so I can't say for sure, but I would bet some complaint-based OSHA inspections (and fines!) I've seen for issues like asbestos in the facility (see Figure 1.3) or broken air conditioning (see Chapter 4, General Duty Clause) were brought up to someone in the organization before the call to OSHA was made. For more about developing a safety culture, see p. 14.

Next in priority are **programmed inspections** and **planned inspections**, aimed at specific industries, workplaces, or occupations identified in OSHA's current inspection procedures. Recently, ambulatory surgery centers were the focus of a number of planned inspections in Tennessee. Planned inspections may cover a specific medical specialty or may include all medical facilities in a specific geographic area. Sometimes, before conducting planned inspections, the OSHA area office will send a letter informing facilities of the inspection's focus and anticipated time frame. Other times, the inspections will occur without this type of warning letter. OSHA currently has 11 national emphasis programs, including nursing and residential care facilities, and 140 regional and local emphasis programs.[7] At least two current OSHA Local Emphasis Program (LEP) focus on bloodborne pathogens.[8] Planned and programmed inspections account for about 38% of OSHA visits to outpatient medical facilities.

A **follow-up** inspection determines whether the employer has corrected previously cited violations. Therefore, if you have received a citation, be prepared; OSHA may undertake a follow-up inspection to verify your compliance.

Got the six general reasons OSHA inspects? Great! Now let's talk specifics as they relate to medical facilities. Of the 200 most recent OSHA inspections at medical offices, from May 2013 until July 2014, the vast majority occurred as a result of employee complaints. Figure 1.1 lays out other common reasons an OSHA inspector might pay a visit to one of your facilities.

Figure 1.1: Reasons for OSHA inspections at medical facilities



Telephone/fax inspections

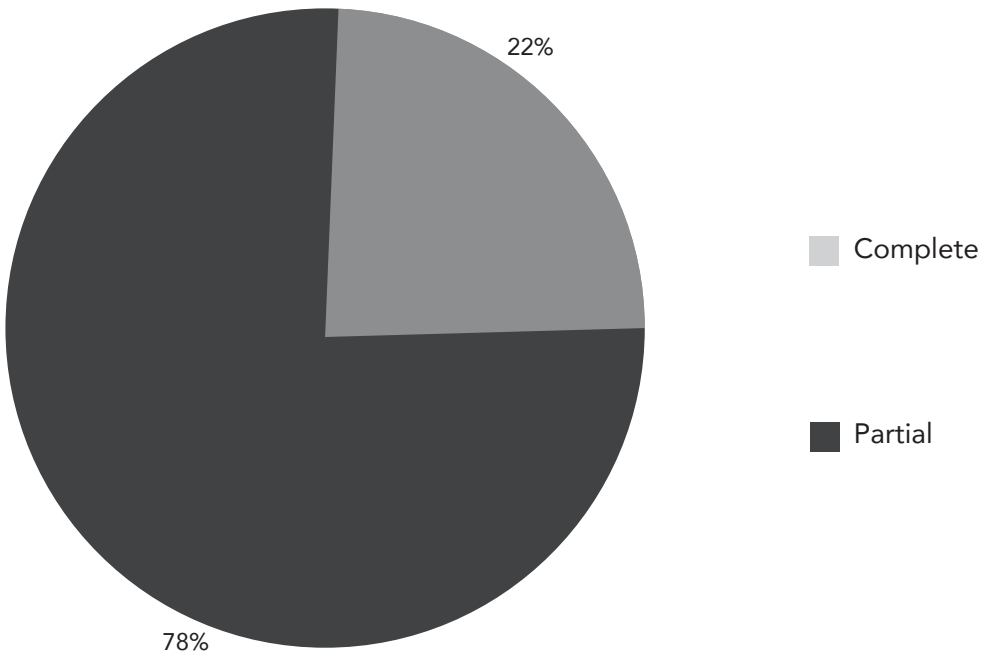
For a lower priority hazard, OSHA may call an employer and describe the alleged hazard(s) at the facility rather than visit unannounced. In that case, OSHA may follow the call with a fax summarizing the allegations. Your organization must respond in writing within five days, noting any problems found and corrective actions taken. If the response is adequate and the complainant satisfied, OSHA generally will not conduct a site visit. If you fail to respond, you can expect OSHA to proceed with a site-based inspection.[9]

Scope of inspections

The fact that an OSHA inspector arrives at the door doesn't necessarily mean he wants to see the

whole place front-to-back, top-to-bottom. In fact, it's much more likely the inspector will request to see only what's specifically related to the complaint, referral, or planned emphasis area. In the 200 most recent inspections, as illustrated in Figure 1.2, only around 20% of the inspections were designated as "complete" in scope. If your facility is one of the 80% that experience a "partial" inspection, keep the inspection on task. Train your local safety representative and staff to not volunteer additional information to the inspector about unrelated areas.

Figure 1.2: OSHA inspection scope: Complete versus partial



What are the most common violations?

Of facilities inspected, 113, or 56.5%, received at least one citation, or violation, from OSHA. Most facilities with citations received one or two violations. In about 5% of cases, five or more citations were issued. Often, a single violation will be broken down into subparts. Each subpart lists individually the specific paragraph of the standard that the organization will need to fix. It's common for a single citation to have two to four subparts listed. I have even seen a single citation with subparts up to the letter M—that's 13 specific areas needing remedy under one violation!

Severity of violations

Each OSHA citation includes a determination of the severity of the violation. Although OSHA uses the five categories below, most citations for medical facilities fall in **serious** or **other-than-serious** category. The maximum penalty OSHA can assess, regardless of the circumstances, is $7,000 for each

serious violation and $70,000 for a repeated or willful violation.[10]
A **willful violation** is defined as a violation in which the employer either knowingly failed to comply with a legal requirement (purposeful disregard) or acted with plain indifference to employee safety.

A **serious violation** exists when the workplace hazard could cause an accident or illness that would most likely result in death or serious physical harm.

An employer may be cited for **a repeated violation** if the employer has been cited previously for the same or a substantially similar condition. Within the past few years, OSHA has drastically increased its emphasis on repeat violations. Healthcare organizations with multiple facilities must be aware of this trend.

A violation that has a direct relationship to job safety and health, but is not serious in nature, is classified as an **"other-than-serious" violation**.

De minimis violations are violations of standards that have no direct or immediate relationship to safety or health. Whenever de minimis conditions are found during an inspection, they are documented in the same way as any other violation, but they are not included on the citation.

OSHA's new approach to repeat violations

The most significant trend impacting organizations with multiple locations is OSHA's recent interest in **follow-up inspections** and **repeat** citations. Since fines for repeat violations are authorized to be 10 times as much as fines for serious citations, by actively pursuing more repeat violations, OSHA is able to issue much higher penalties.

Until recently, repeat violations were rarely issued because OSHA:

- Historically treated workplaces as individual, independent establishments
- Limited review for past violations to three years back
- Picked inspection targets reactively (i.e., following incidents and complaints), so OSHA was less likely to revisit a workplace within a few years

Today, OSHA:

- Treats related workplaces within a corporate family as one workplace for purposes of repeat violations
- Looks back five years for past violations to form the basis for repeats
- Proactively selects inspection targets at the same or related facilities within a corporate family

As a result of OSHA's new approach to repeat violations, OSHA increased the number of willful and repeat violations issued by more than 215% from 2006 to 2010. Because of these changes, organizations operating multiple sites must take every citation they receive seriously and consider company-wide corrective actions to mitigate costly fines that may arise during follow-up inspections at related facilities.

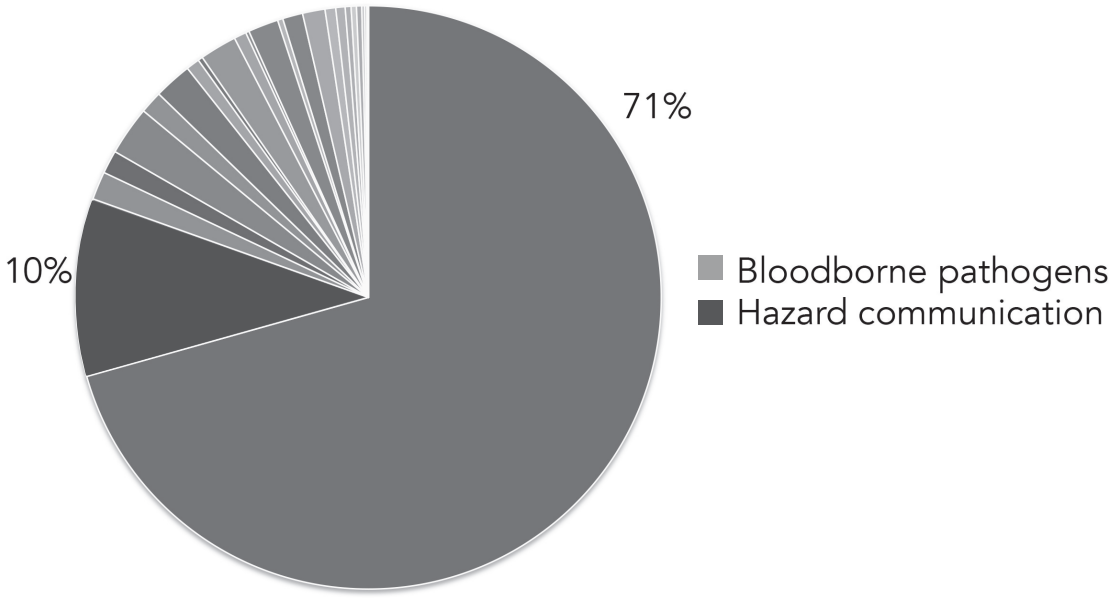
Source: OSHA Law Update
www.oshalawupdate.com/2012/02/29/enterprise-enforcement-oshas-attack-on-employers-with-multiple-locations/

Most common standards cited

The good news is, for the most part, fines issued to outpatient medical facilities average closer to $700 per citation than to $7,000. In the larger picture, all ambulatory healthcare facilities were issued 971 OSHA citations in 259 inspections from October 2012 until September 2013 (the last year with published aggregate data). These citations resulted in total fines of $680,816. As you can see in Figure 1.3, the vast majority of both citations and fines came from OSHA's *Bloodborne pathogens* standard. Bloodborne pathogens violations were responsible for 64% of citations and 71% of fines, totaling $479,499. OSHA's *Hazard communication* standard was next most frequently cited, accounting for 17% of citations but only around 10% of fines at $66,905. The remaining 20% of fines were divided between 26 additional OSHA areas, some with multiple relevant standards, and the General Duty Clause as shown in Figure 1.4 on p. 10. Although the General Duty Clause was only cited twice in this time period, it resulted in $8,428 of fines.[11]

When we move from the broader category of all ambulatory medical facilities to the narrower category specifically of physician's offices, we find OSHA's focus even more tightly concentrated on *Bloodborne pathogens* compliance, at 66% of citations and 86% of fines. *Hazard communication* again follows, with 21% of citations representing 7% of fines.[12]

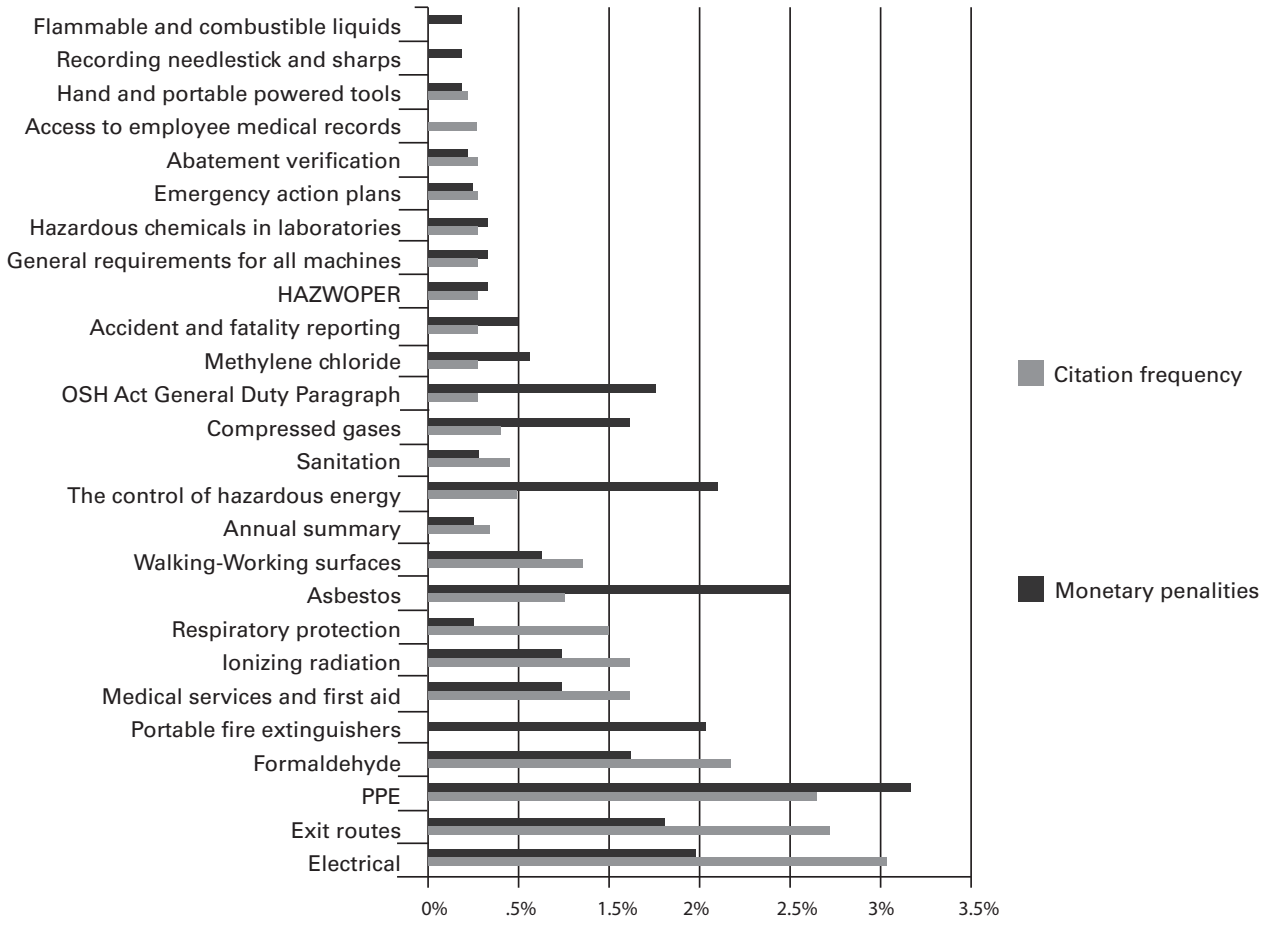
Figure 1.3: Standards contributing to fines in recent OSHA inspections



Which specific parts of the *Bloodborne pathogens* and *Hazardous communications* standards does OSHA cite most often? Let's take a look. The **top 10 bloodborne pathogens violations** by paragraph, in order of frequency, from most to least often cited, are:[13]

1. 1910.1030(c)(1)(iv): "The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure."
2. 1910.1030(d)(2)(i): "Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used."
3. 1910.1030(h)(2)(i)(C): [Training records shall include …] "The names and qualifications of persons conducting the training."
4. 1910.1030(h)(2)(i)(B): [Training records shall include …] "The contents or a summary of the training sessions."
5. 1910.1030(g)(2)(iv): "Annual training for all employees shall be provided within one year of their previous training."
6. 1910.1030(c)(1)(v): "An employer, who is required to establish an Exposure Control Plan shall solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the Exposure Control Plan."

Figure 1.4: Citations and penalties from less commonly cited standards



7. 1910.1030(c)(1)(i): "Each employer having an employee(s) with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure."
8. 1910.1030(c)(1)(ii)(B): "The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard, and …" [requirement (c)(1)(ii)(C) follows]
9. 1910.1030(d)(4)(iii)(A)(2): "During use, containers for contaminated sharps shall be: …" [requirements for sharps containers follow]
10. 1910.1030(g)(2)(i): "The employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program."

The **top 5 Hazard Communication violations,** also in order from most to least frequent:[14]

1. 1910.1200(e)(1): "Employers shall develop, implement, and maintain at each workplace, a written hazard communication program which at least describes how the criteria specified in paragraphs (f), (g), and (h) of this section for labels and other forms of warning, safety data sheets, and employee information and training will be met, and which also includes the following: …" [detailed requirements follow]
2. 1910.1200(h)(1): "Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment, and whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and safety data sheets."
3. 1910.1200(g)(8): "The employer shall maintain in the workplace copies of the required safety data sheets for each hazardous chemical, and shall ensure that they are readily accessible during each work shift to employees when they are in their work area(s). (Electronic access and other alternatives to maintaining paper copies of the safety data sheets are permitted as long as no barriers to immediate employee access in each workplace are created by such options.)"
4. 1910.1200(h)(3)(iv): [Employee training shall include at least:] "The details of the hazard communication program developed by the employer, including an explanation of the labels received on shipped containers and the workplace labeling system used by their employer; the safety data sheet, including the order of information and how employees can obtain and use the appropriate hazard information."
5. 1910.1200(g)(1): "Chemical manufacturers and importers shall obtain or develop a safety data sheet for each hazardous chemical they produce or import. Employers shall have a safety data sheet in the workplace for each hazardous chemical which they use."

The language found in these most frequently cited paragraphs is straightforward for some (e.g., make sure that the trainer's name is on the training record!) and quite general for others (establish a written hazard communication program ... hmm?). In general, OSHA publishes regulations that are adaptable to many different workplaces.[15] Therefore, it can be a bit tricky to know exactly what needs to happen for compliance in your particular situation. In the next chapters, we break down these regulations, and others applicable to medical facilities, so you can know exactly what your facilities need to do to be compliant. Also provided among the appendices are example written plans and programs to get you started, if your organization doesn't already have these documents.

We will discuss the entire inspection process in more detail shortly. However, now is a good time to mention, **when OSHA issues a violation and fine, it is not set in stone**. There is an appeal process, and by taking advantage of it, you may significantly reduce violations and fines.

OSHA fine reductions

Negotiating to reduce the fines OSHA has issued to your organization can pay off handsomely. Here are some examples from across the country:

» A family practice office in North Carolina reduced its fines from $23,100 to $11,900[16]
» A rehabilitation center in California reduced its fines from $8,000 to $680[17]
» A surgery center in Tennessee reduced its fines from $8,000 to $2,000[18]
» A women's health clinic in Nevada reduced its fines from $6,000 to $3,600[19]

In 20% of the 200 most recent inspections at medical offices, OSHA issued a citation but didn't fine the organization. The fines that were issued initially averaged about $2,100 per facility. After settlement negotiations, penalties were reduced to $1,500 on average.[20] About one quarter of facilities successfully reduced their fines; it's impossible to know how many more attempted to negotiate without success. However, even if the monetary reduction is minimal, negotiating to remove citations so they cannot become a basis for a repeat violation is certainly worthwhile.

Multi-location practices: Defining corporate vs. local responsibilities

Since we now have a general understanding about OSHA as well as which areas carry the greatest costs for non-compliance, it makes sense to think about how to organize your company's compliance program. There are many facets to consider, and a first big step is to determine the level of standardization among your facilities.

During your mock inspection, it will be quicker and easier to assess compliance if all facilities under your purview have the same processes in place; this approach also reduces your organization's liability for a "loose cannon" at one location. If all the facilities use the same basic bloodborne pathogens Exposure Control Plan, written hazard communication program, incidents reports, and training records, then you will be able to review them rapidly and accurately because they will be familiar.

Areas to consider standardizing between locations, whether by providing guidance, a template, or the physical item from a central corporate office, include:

- **Exposure control plan**
- **Exposure determination**—Will this be listed by name or job title? Are the same exposure-prone procedures performed at each facility?
- **Signage**—Exit, OSHA poster, eyewash, restricted assess areas, biohazard—Will your corporate offices physically provide the items, specify a distributor or item number, or allow each facility to obtain signage of their own choosing?
- **Procuring personal protective equipment (PPE)**—If no one at a particular location uses an XS or XL exam glove, will you require such gloves to be stocked? What about latex

allergies? Or various provider preferences? Will every location need to be the same across the organization? Will you specify a brand or model that all facilities must use and obtain from a common supplier? Is this an area where leeway can be provided to individual locations, as long as appropriate PPE in the correct sizes are available?

- **Written hazard communication program**
- **Safety data sheets (SDS, formerly known as MSDS)**—Do all of your facilities use the same cleaning agents, drugs, or other hazardous chemicals? Does it make sense for one person to obtain the SDSs and provide them to all locations? Does it make sense to make them available for every location electronically? If using an electronic system, what back up is available if the electronic system is down?
- **Chemical labeling**—For secondary containers, will you provide actual labels, provide a template that each location can print, or allow each facility to make its own label as long as the required elements are included? Alternatively, will you specify that original labels be reproduced (e.g., photocopied), enlarging or decreasing size as appropriate for the new containers?
- **Emergency action plans**—The actual alarms, evacuation routes, and meet-up locations will be facility specific. Will standard overhead codes be used, or will overhead codes be used at all? Which employees have rescue duties, and will this be standardized?
- **Evacuation routes**—These will need to be generated individually for each location's floor plan. But will the format and placement (e.g., each exam room, main hallways, and bathroom) be standardized?
- **First aid kits**—Will these be standardized, or will each location select their own kits based upon hazards in their workplace? How identical are the hazards that employees face in each location of your organization? Who will review the kit contents to ensure that they are adequate for foreseeable first aid situations?
- **Automated External Defibrillators (AED)**—Will your organization provide AEDs? At some locations? At all locations? Will certain/all employees be authorized to use them? How will training be provided?
- **Medical and vaccination records**—Will these be stored centrally or at individual locations? If you are inspected, OSHA will require access to these records within four hours.
- **Training**—How will training be delivered? Will safety officers at each location be responsible for providing in-person employee training at their facility, or will you use a computer-based or online system?
- **Training records**—Will these be kept at each location, or will they be stored centrally?
- **Incidents/accidents/sharps injury logs recordkeeping**—Federal exemption to keeping certain logs based upon NAICS code, but not all states allow the exemption; see Chapter 3.

We will cover each of these areas, and others, in more depth over the next few chapters. As you read about each compliance topic, keep in mind whether it makes sense for your organization to set guidance in that area, and how specific that guidance will be. Standardization is usually helpful, but there can be pitfalls if all the relevant factors are not considered when creating a standardized

program. If you have some facilities operating in state-plan states with more strict requirements (note recordkeeping and hazardous chemicals are the big areas where state differences crop up), will you have all of your facilities adopt the more strict standard, and ensuing additional workload, even though it isn't required across the board?

Developing a safety culture

Both OSHA and independent research show developing a strong safety culture has the single greatest impact on accident reduction. Thus, developing these cultures should be a top priority for all managers and supervisors.[21]

As a leader in your organization regarding OSHA compliance, you have a unique role: You have access to organizational leadership and can demonstrate the benefits gained by instilling a safety culture. You also have access to all the workplaces in your organization to evaluate employee and local management attitudes regarding safety. Finally, you can note whether certain locations excel or lag behind.

Culture is the sum of the attitudes, beliefs, perceptions, and values that shape the work atmosphere of a company. Safety culture is the beliefs, practices, and attitudes an organization values surrounding safe practices in the workplace. An organization's safety culture is the result of a number of factors, such as:

- Management and employee norms, assumptions, and beliefs
- Management and employee attitudes
- Values, myths, and stories
- Policies and procedures
- Supervisor priorities, responsibilities, and accountability
- Bottom line/time pressure vs. importance of quality
- Actions or lack of action to correct unsafe behaviors
- Employee training and motivation
- Employee involvement or "buy-in"

In a strong safety culture, everyone feels responsible for safety and pursues it on a daily basis. Employees go beyond "the call of duty" to identify unsafe conditions and behaviors and to intervene to correct them. The organizational characteristics, along with representative thoughts and beliefs that staff members hold in a strong safety culture, are illustrated in Figure 1.5.

Figure 1.5: Characteristics of a safety culture

Adapted from *www.coresafety.org/resources/module7/nmasafetytoolbox/inside_safetyculture/safety culture_incontext/safetyculture_inmining.html*

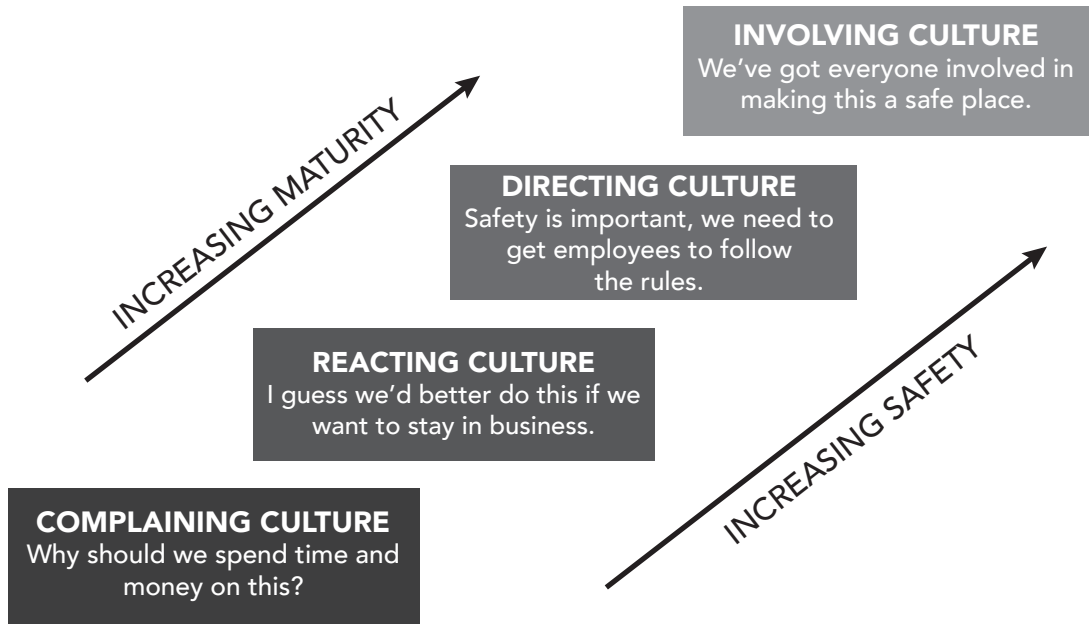
Of course, safety cultures don't just happen. Building a safety culture takes leadership commitment, involvement, and time. The management processes typically addressed when cultivating safety cultures include:[22]

- Defining safety responsibilities for all levels of the organization.
- Developing upstream measures, such as tracking the number of reports on hazards, number of suggestions for safety improvements, etc.
- Aligning management and supervisors through establishing a shared vision of safety and health goals and objectives.
- Implementing a process that holds managers and supervisors accountable for visibly being involved, setting the proper example, and leading in safety and health.
- Ensuring that the safety committee (e.g., membership, responsibilities/functions, authority, meeting management skills, etc.) is functioning appropriately.
- Providing multiple paths for employees to bring suggestions, concerns, or problems forward. One mechanism should use the chain of command and ensure no repercussions. Hold supervisors and middle managers accountable for being responsive.

- Developing a system that tracks and ensures timeliness in hazard correction.
- Evaluating and rebuilding any incentives and disciplinary systems for safety and health, as necessary.
- Ensuring reporting for injuries, first aids, and near misses. Educating employees on the accident pyramid (e.g., many near misses, and minor incidents for each major accident) and importance of reporting minor incidents. Prepare management for an initial increase in incidents and rise in rates, which will occur if under-reporting exists in the organization. It will level off and then decline as the system changes take hold.
- Evaluating and rebuilding the incident investigation system as necessary to ensure it is timely, complete, and effective. It should get to the root causes and avoid blaming workers.

Creating a safety cultures is a growing process. At first, there may be resistance to changing how things have been done. Occasionally, some areas receive lots of attention and compliance (e.g., safety sharps are used religiously), but boxes block an exit hallway because the safety program hasn't emphasized that area as important. You may find some of your locations at varying levels of maturity in their development of attitudes surrounding safety, illustrated in Figure 1.6. Ideally, you can take the lessons learned from one location and apply them to other facilities in your organization to improve safety overall.

Figure 1.6: Organizational attitudes toward safety



Source: *www.therisktoolboxshop.com/_blog/The_Risk_Management_Tool_Box_Blog/post/Safety_Cultture_Measurement/*

The OSHA inspection

Creating and embracing a safety culture will help reduce the likelihood of an employee complaint to OSHA, thus reducing your risk for a complaint-based OSHA inspection. Still, you may find that the "knock on the door" comes as the result of a planned or programmed inspection, referral, or (perish the thought) even an employee complaint. What should you do? More likely than not, as a corporate manager, you personally will not be on-site at the time. So long before the inspector shows up, ensure you have a staff member at each location designated as your safety representative or local safety officer. Train this individual on what to do and expect—covered next. You may wish to conduct your mock inspection in the exact same manner as an actual OSHA inspection, or you may choose to be more educational in your approach.

The knock on the door

Typically, the receptionist will be the first person who has contact with an OSHA inspector. Never, ever let an inspector roam unescorted. Instead, have the receptionist politely ask him or her to take a seat in the waiting area, saying, "The safety officer will be out in just a few minutes."

All right, deep breath, your local safety officer is now on deck. He or she should:

- Call you at the corporate office to give the heads up.
- Verify the person in the waiting room is a bona fide inspector by requesting a photo identification. Confirm the OSHA Compliance Safety and Health Officer (CSHO), commonly known as the inspector, is actually an employee of the OSHA division of the U.S. Department of Labor or an equivalent state agency, if under a state OSHA program. Some unscrupulous companies have been known to send out "inspectors" who barge into a medical facility and then press to become your consultants or threaten to blow the whistle if they aren't hired.
- To try to figure out why the inspector is at your facility, the safety officer should:
  - » Ask the purpose of the inspection, its scope, and its anticipated length.
  - » Determine which documents the inspector wishes to inspect.
  - » If possible, determine which employees the inspector intends to interview and what areas of the workplace he or she would like to inspect.
  - » If the inspection is based on a complaint, ask to see and copy the written complaint. Although the identity of the person making the complaint will be withheld, the information will be helpful.

On search warrants

You have the constitutional right to require the inspector to obtain a search warrant before inspecting your facility. However, an inspector could see this requirement as indication you have something to hide, and it will likely increase tensions. Requiring the inspector to obtain a warrant may help delay an inspection, but it will not avoid one. Unless there are really unusual circumstances, it's preferable to agree voluntarily to being inspected. If you do decide to go the route of a warrant, you will not need to provide records not specified on the warrant.

During the inspection

A typical OSHA inspection begins with an **opening conference:**

1. The purpose for the visit is explained.
2. OSHA inspectors are usually interested in (and legally entitled to) review of:
    - Bloodborne pathogens exposure control plan
    - Written hazard communication program/SDS
    - Posters and logs (e.g., It's the Law Poster, Annual Injury Logs and Sharps Injury Logs, where applicable, etc.)
    - Hepatitis B vaccination records
    - OSHA training records
    - General safety records (e.g., fire extinguisher inspections, evacuation plan)

Be careful about providing OSHA with documents not directly related to your safety practices, and don't volunteer information! Each OSHA inspector is an individual and will focus on different aspects of a healthcare facility, depending on his or her expertise or the content of the complaint (if applicable). The inspector may conduct a wall-to-wall inspection, but it's much more likely he or she will simply focus on one specific matter (see Figure 1.2).

Next, the **tour of the facility** usually takes place. During this part of the inspection:

1. Safety practices are observed, and employees will likely be interviewed.
2. The inspector specifies the areas or work activities to be examined. If the OSHA inspector wants to see a specific area, go there using the most direct route.
3. Do not let the OSHA inspector out of sight!
4. If not reviewed during the opening conference, the list of hazardous chemicals, along with SDS and chemical labels, may be evaluated now.
5. The inspector may:
    - Talk with employees
    - Take notes
    - Take instrument readings

- Take photos
- Use a video camera

6. The local safety officer should make notes of everything the inspector does, including:
   - Inspector's name
   - Date
   - Times
   - Measuring techniques
   - Equipment used
   - Calibration dates and procedures
   - Who said or did what
   - Who was present
   - Duplicate any photos the inspector takes (Tip: Phone-based cameras make this quick and easy)
7. Employees are usually interviewed as part of the inspection. Staff members must answer all questions honestly, but instruct them not to volunteer additional information.
8. The inspector may consult with employees as long as it does not interfere with work operations and the employee does not object.
9. If the employer refuses such interviews, the OSHA inspector can contact employees at home.
10. Typically, OSHA inspectors ask employees questions along the lines of:
    - Are you familiar with your facility's safety policies and procedures?
    - Do you comply with these policies and procedures? How do you comply?
    - Can you tell me the actions you need to take in the event of an emergency?
    - Are aware of the hazards of the products with which you work?
11. OSHA doesn't permit the safety officer to be present during interviews of frontline non-supervisory employees. The safety officer may attend, or designate a representative to attend, interviews with supervisors.
12. You are not required to allow use of your copying equipment.

Your facility safety officers do NOT need to be able to answer every question asked by the OSHA inspector, and they should not try. In particular, no guessing at answers! Instead, they should write down the question and later use reference materials to obtain the appropriate response. For example, safety officers will need to show the OSHA inspector various items, like your SDS. They don't need to know all the details about a particular chemical—they only need to explain they would to go to the SDS to find those details.

Remember! Once the OSHA inspector is past the reception area, NEVER, EVER leave him or her unaccompanied.

Everything said will be carefully noted by the inspector and could be used in a violation finding. It's imperative for your local safety officer especially, as well as for all other staff, to think before speaking when engaging the inspector. Even an innocent comment may be perceived as an admission of a specific violation. When answering questions, staff shouldn't offer estimates if they don't have accurate information. Again, if your local safety officers have difficulty responding to a question, train them to politely tell the inspector, "I'll need to consult my resources and get back to you."

During the inspection, the inspector may point out any unsafe working conditions and mention possible corrective measures that can be taken. Train staff not to agree these are violations, or your organization could be cited and fined. If your safety officers can correct obvious violations on the spot, they may do so, but your organization may still receive a citation and penalty.

If your safety officers feel that it's necessary, encourage them to guide the inspector back to the waiting room for a quick break. If things seem to be going poorly or they feel overstressed, they may use the break to phone you or your corporate attorney for advice.

At the completion of an inspection, a closing conference is held. During this meeting, the inspector will:

1. Advise your safety officer of the conditions observed in the facility.
2. Obtain further information.
3. Relate any possible citations that may be issued.
4. Explain your right to appeal alleged violations, and provide information on appeal time limits.
5. Answer questions.
6. Inform your safety officer of any apparent violations for which a citation may be issued or recommended. However, dollar amounts for the penalties are given later on the final mailed citation.

At this time, have your safety officers ask questions and get as much information as possible about the facts of alleged violations and the specific standards (including the paragraph number of those standards) the OSHA inspector believes to have been violated. Also have your safety officers ask about the degree of seriousness of the alleged violations and the recommended solutions.

OSHA allows the opportunity for an employer to correct minor violations on the spot. If it applies, be sure the inspector states—before he or she leaves the premises and with a witness present—the violations have been abated, with date, time, and place.

Not every potential citation discussed at the closing conference will be included in the final written citation; the inspector's supervisors will review the proposed citations and decide whether to revise or even drop them. Rarely will citations be added that were not discussed at the closing conference.

Responding to violations

For OSHA to cite your organization with a violation, the agency must prove all four of the following elements:

1. The standard applies to your working conditions
2. The standard's requirements were not met
3. Employees had access to the hazardous conditions
4. The employer knew of the hazardous conditions or could have known through the exercise of reasonable diligence

After the closing conference, have your local safety officer debrief you about the inspection. If he or she thinks your practice might be cited by OSHA, have her compile all of the relevant information while it is still fresh in her memory. Most likely, you or your corporate attorney will be responsible for preparing the response and taking care of any other post-inspection actions. To prepare, you will want copies of the notes taken throughout the inspection, along with any measurements and relevant photos.

The OSHA area director reviews the inspector's full report and determines whether citations will be issued and what penalties will be proposed.[23] Citations and penalties are then sent to your medical facility by certified mail up to six months after the inspection. Federal OSHA uses a standard form called the OSHA-2H, Notice of Unsafe or Unhealthful Working Conditions (commonly called the OSHA Notice), that explains in detail the exact nature of the citations. It indicates which regulations have been violated and the time frame allowed for their correction. Your facility safety officer will need to post each OSHA Notice (or a copy of it) at or near the place where the violation occurred for three days or until the violation is corrected, whichever is longer.

There is a 15-day response period during which you will need to correct, or abate, violations you do not contest. Make the necessary changes by the specified dates, and provide proof to OSHA in writing that you have done so. There is a Sample Abatement Certification letter in Appendix E.[24] For violations you plan to contest, schedule an informal conference with the OSHA area director early, so you will have time to file your Notice of Intent to Contest before the 15 days are up. Post-inspection, it is very important not to let critical response dates get away from you, so set calendar reminders as necessary. Again, refer to Appendix E for an in-depth explanation on postinspection actions and timeframes.

Understanding which OSHA regulations apply to your facilities

There are thousands upon thousands of pages of OSHA regulations that cover construction, general industry, maritime operations, and agriculture. The next part of this manual focuses on narrowing down all of these requirements to just what is relevant to an outpatient medical setting.

As mentioned previously when discussing OSHA violations fines, the two most important standards for medical settings are the *Bloodborne pathogens* and the *Hazard communication* standards. These standards are both part of the 1910 numbered series, which are also called the general industry standards. Healthcare facilities are considered by OSHA to be part of "general industry," so these regulations apply. A listing of all the standards that frequently apply to medical facilities (i.e., those for which healthcare organizations have received citations in the past two years) can be found in Figure 1.7. Standards likely to apply to all practices are listed first. Regulations toward the bottom of the list are less likely to apply universally and should be considered based upon the specifics of your situation. Commonly used alternate names are included in the third column.

Figure 1.7: Relevant standards and associated regulation numbers

Standard name	Standard number	Also referred to as:
Bloodborne pathogens	29 CFR 1910.1030	BBP
Hazard communication	29 CFR 1910.1200	HazCom, Right-to-know
Personal protective equipment, general requirements	29 CFR 1910.132	PPE
Eye and face protection	29 CFR 1910.133	
Hand protections	29 CFR 1910.138	
Emergency action plans	29 CFR 1910.38	
Portable fire extinguishers	29 CFR 1910.157	
Fire protection	29 CFR 1910 Subpart L	
Medical services and first aid	29 CFR 1910.151	First aid kits
Electrical	29 CFR 1910 Subpart S	
Walking-working surfaces	29 CFR 1910.22 29 CFR 1910.23 29 CFR 1910.24	Slips, trips, and falls
Sanitation	29 CFR 1910.141	
Specifications for accident prevention signs and tags	29 CFR 1910.145	
General duty clause	29 USC 654 Section 5	
Access to employee exposure and medical records	29 CFR 1910.1020	
Recordkeeping*	29 CFR 1904	300 log, injury and illness annual summary, recordkeeping forms
The control of hazardous energy*	29 CFR 1910.147	Lockout/Tagout
Hazardous waste operations and emergency response*	29 CFR 1910.120	HAZWOPER
Ionizing radiation*	29 CFR 1910.1096	

Respiratory protection*	29 CFR 1910.134	
Compressed gases*	29 CFR 1910.101	
Flammable liquids*	29 CFR 1910.106	
Ethylene oxide*	29 CFR 1910.1047	
Formaldehyde*	29 CFR 1910.1048	
Meythlene chloride*	29 CFR 1910.1052	
Occupational exposure to hazardous chemicals in laboratories*	29 CFR 1910.1450	Chemical hygiene
Machine guarding*	29 CFR 1910.212	
Hand and portable powered tools*	29 CFR 1910.242	
Abatement verification*	29 CFR 1903.19	

** Will depend upon situation; will not necessarily apply in every outpatient setting*

This list of nearly 30 OSHA standards can seem overwhelming at first, but many of the standards act in concert, or support each other in creating a safe workplace. For example, various PPE requirements are listed in each of the first five standards in the table, but how it works in reality includes a lot of overlap in the requirements. Broken down into plain English, it becomes pretty straightforward:

1. Does your organization determine what PPE is needed to protect employees?
2. Does your organization provide this PPE free of charge?
3. Does your organization provide PPE that fits?
4. Does your organization provide PPE that is appropriate (e.g., fluid-resistant)?
5. Does your organization provide alternate PPE for employees with allergies to the regular PPE (e.g., latex allergy)?
6. Does your organization train employees on how to wear the PPE?
7. Does your organization train employees on when to wear the PPE?
8. Does your organization launder washable PPE?
9. Does your organization dispose of disposable PPE?

Throughout the next chapter, we will take the individual requirements from these standards and break them down into simple questions. Once you have the foundation material under your belt, you will understand exactly what you're looking for when assessing your facilities. The records review and walk-through assessment checklists in Chapters 5 and 6 will make documenting the mock inspection flow smoothly. The assessment form is available for download at *www.hcpro.com/downloads/12340* as well so you can print a copy to mark up when you are on site.

One important note: The **General Duty Clause** can be used as the basis for a citation when there is no specific standard to apply. For examples of General Duty Clause violations, see the General Duty Clause section of Chapter 4. Often managers ask the question, "Is that actually *required* or just *recommended*?" When it comes to OSHA compliance, there is often very little difference, since the General Duty Clause can make recommended protections requirements in an instant.

The General Duty Clause allows OSHA to cite, and fine, for noncompliance with recommendations by other agencies, such as the Centers for Disease Control and Prevention.

Finally, I have tried to capture every standard for which OSHA has issued a violation to a medical practice for noncompliance in the past several years. However, certain situations are unique beyond the necessity of detailed inclusion in this text. Suffice it to say, if your facility is under construction, or in remediation for asbestos or lead, ensure your construction contractor abides by the requirements found in OSHA's construction standards. If they do not, and your employees could be exposed to the hazards, your facility may be cited alongside the construction contractor.

Endnotes

1. *www.osha.gov/dcsp/osp/faq.html#oshaprogram*
2. *www.osha.gov/dcsp/osp/statestandards.html*
3. *www.osha.gov/as/opa/worker/employer-responsibility.html*
4. *www.osha.gov/Publications/osha2098.pdf*
5. *www.osha.gov/as/opa/worker/handling.html*
6. *www.osha.gov/OshDoc/data_General_Facts/factsheet-inspections.pdf*
7. *www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=23502)*
8. *www.osha.gov/dep/leps/leps.html*
9. *www.osha.gov/OshDoc/data_General_Facts/factsheet-inspections.pdf*
10. *www.osha.gov/OSHA_FAQs.html*
11. *www.osha.gov/pls/imis/citedstandard.naics?p_esize=&p_state=FEFederal&p_naics=621*
12. *www.osha.gov/pls/imis/citedstandard.naics?p_esize=&p_state=FEFederal&p_naics=621111*
13. *www.osha.gov/pls/imis/industry.html#disclaim*
14. *www.osha.gov/pls/imis/industry.html#disclaim*
15. *www.osha.gov/dcsp/smallbusiness/index.html*
16. *www.osha.gov/pls/imis/establishment.inspection_detail?id=317280956*
17. *www.osha.gov/pls/imis/establishment.inspection_detail?id=314763020*
18. *www.osha.gov/pls/imis/establishment.inspection_detail?id=317243434*
19. *www.osha.gov/pls/imis/establishment.inspection_detail?id=317369114*
20. *www.osha.gov/pls/imis/industry.html#disclaim*
21. *www.osha.gov/SLTC/etools/safetyhealth/mod4_factsheets_culture.html*
22. *www.osha.gov/SLTC/etools/safetyhealth/mod4_factsheets_culture.html*
23. *www.osha.gov/Publications/osha3000.pdf*
24. *www.osha.gov/Publications/Abate/abate.html*

The OSHA Mock Inspection Made Simple

Sarah Alholm, MAS

This concise primer provides specific methods to train staff, identify hazards, and document accurately, saving safety professionals the hassle of interpreting vague OSHA standards and allowing them to focus on implementing compliant solutions.

The OSHA Mock Inspection Made Simple is a comprehensive self-inspection guide for outpatient medical practices. Safety officers can use the tools provided to evaluate their program and identify opportunities for improvement and education. Managers of multi-location practices will find this resource invaluable for conducting a thorough compliance assessment of remote physician offices, clinics, and other facilities that are assessed less regularly.

This book will walk you through your facility and guide you through assessing both patient care areas and those without direct patient care (e.g., offices and waiting areas).

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