1. **Purpose**
   1. To outline the Safety Program in the Department of Pathology and Laboratory Medicine.
   2. To provide for a safe work environment.

**II. Scope**

1. Einstein Medical Center Laboratories are committed to providing a safe work environment for its employees, volunteers, visitors, and patients.
2. The Department of Pathology and Laboratory Medicine developed a Safety Program to provide safety guidelines for safe work practices, a safe environment, and habits that reinforce them.

**III. Procedure**

**1. Safety Management:**

**a. Network Safety Management:**

The hospital Safety Program is managed by **Network Safety Leadership:**

Director, Network Safety

Safety EC Hotline: X6-6362

**b. Laboratory Safety Leadership:**

Medical Director

Administrative Director

Section Directors

Quality Assurance Manager

**2. Responsibilities:**

a.Laboratory leadership has the overall responsibility for implementing safe practices. Evaluation for effectiveness is monitored on a monthly basis through safety audits that are e-mailed to the entire clinical laboratory and presented at the monthly QA meetings. Deviations are discussed and corrective actions are implemented as appropriate.

b. Directors and supervisors develop and implement policy and procedure appropriate for safe laboratory work.

c. Supervisors are responsible for directly overseeing that all safety policies and procedures are adhered to.

d. Employees are responsible for following all safety policies and procedures.

1. **Comprehensive Safety Policies:**

A hard copy of the Laboratory Safety Manual is available in the Lab Administration office, as well as on-line policies to all personnel. Documentation of personnel knowledge regarding contents of policies and procedures is accomplished according to policy AD02-018. The safety policies are reviewed annually by the Laboratory Department’s Director, Network Safety Coordinator, or QA Manager. The director reviews and approves all significant changes to the safety policies and procedures prior to implementation.

**4. Standard Precautions**:

Exposure Control Plan Blood-borne Pathogens SA01-024. All personnel comply with standard precautions for all work activities within the department. All blood and other potentially infectious materials are treated as if infectious for HIV, HBV, HCV or other blood borne pathogens regardless of the perceived “low risk” status of a patient or patient population.

5**. Personal Protective Equipment (PPE):** Exposure Control Plan **SA01-024.**

For anticipated occupational exposure to blood, body fluids or other potentially infectious material from job procedures or tasks the department provides readily accessible personal protective equipment in various sizes, including hypoallergenic alternatives. Personal Protective Equipment is used in occupational risk exposure areas only and is removed prior to leaving the area.

6**. Work Practice and Engineering Controls:** Exposure Control PlanSA01-024.

Safe work practices and engineering controls to reduce or eliminate the risk of occupational expo-sure are outlined in the Exposure Control Plan

**7. Treatment** / **Occupational Health Services:**

1. Safety Showers/Emergency Eyewash stations are located within the laboratory sections in which hazardous chemicals or biohazards are present. Safety showers are checked monthly by Maintenance/Engineering. The eyewash station is checked weekly by the department designee. This is recorded on the Eyewash Maintenance Form (SA01-003 Form B).
2. Basic first aid (alcohol prep, gauze, bandages) is available for immediate attention to minor cuts/scratches.
3. Live Well Employee Health Center (215-456-8484) services are provided to employees during all working shifts:
4. Employee Health – Regular business hours (Monday-Friday 08:00-17:00)
   * + 1. Annual FLU shots
       2. Annual PPD, as required.
       3. Hepatitis B Vaccination
       4. Post Exposure testing, counseling, medical evaluation and follow up
       5. Latex risk assessment (screening and management) with work practices that reduce the risk of allergic reactions
   * Powder-free gloves
   * DEHP free vinyl gloves
   * Nitrile gloves (latex free, powder free)
   * Glove liners
   * Safe Skin Synthetic Tourniquet
     + 1. Annual respiratory fit test as required. **(Micro, Gross Room & Cytology employees ONLY)**
5. Emergency Unit: After hours Monday-Friday / All day Weekend/Holiday

**8. Hazard Communication / Recognition Hazard** Communication SA01-032:

* 1. Warning labels on Chemicals /Reagents
  2. Warning Hazard Signs on Doors To Restricted Area
  3. Chemical Inventory Evaluated for potential health hazards (see also chemical hygiene plan SA01-033)

d. Hazardous Material Classification Posters

e. Worker and Community Right-To Know Poster

f. Biohazard Warning Labels on containers, specimen bags

g. Standard Precautions signs

h. MSDS on-line

## 9. Environmental Monitoring Surveillance:

1. Ongoing personal badge monitoring for formaldehyde and Xylene to ensure OSHA

Permissible Exposure Levels are not exceeded.

b. Mandatory Semi-Annual Network Safety Standards reviews are conducted. The reviews identify areas for improvement, re-educate staff and offer support to make the necessary changes that support compliance and a user-friendly work environment. Reviews/corrective actions to identified deficiencies are evaluated by the Network Safety Department (Hospital policy #A0157).

The EHN safety checklist standards contain safety questions under the following sections:

### 1) Emergency Management

### 2) General Safety

3) Hazardous Materials and Waste

4) Infection Control

5) Life Safety

6) Security

7) Utilities

c. Staff completes monthly safety tours (SA01-003 Form A2), results of which are

communicated by group email.

* 1. Waste disposal audits to eliminate the practice of disposing non-hazardous waste in hazardous waste containers.

**10. Reporting Events:**

In accordance with network events, accidents, unusual occurrences policy HR093

### It is a network requirement that all laboratory occurrences be documented:

* + - 1. Employees complete an *Employee Event Report* detailing the incident and the treatment location.
      2. Following care management, the physician-signed reports are given to the supervisor.
      3. Copies of the Employee Event Report, along with signed physician report, are sent to Occupational Health Office.
      4. The supervisor report is e-mailed to the employee’s supervisor and returned on-line.
      5. A Copy is sent to Protective Services (as warranted).
      6. A copy is sent to the Administrative Technical Assistant for file. Some incidents may require additional follow-up in order to prevent them from recurring-trip/fall/spillage/leaking/fire/fumes/ etc.
      7. A Copy is placed into employee files.

h. Patient, volunteer, visitor related occurrences are reported electronically through PSN and are tracked and investigated by Risk Management.

**11**. **Waste Disposal:** Disposal of Hazardous Waste SA01-025.

1. Disposal of Sharps – Sharps containers for specimen tubes, slides, pipettes, etc., are removed by a contracted vendor.
2. Disposable Biohazard Waste – Red Bag Trash containers are collected daily by hospital environmental services personnel.
3. Municipal and Recycle Waste - picked up daily by hospital environmental services personnel.
4. Disposal of Formalin – Use of aldex neutralizes more than 99% of the formaldehyde present in 10% formalin. The formalin is rendered non-hazardous waste and is disposed of by being poured down the drain.

**12.** **Hazardous Waste Reduction:** Disposal of Hazardous Waste SA01-025.

a. **Recycle** –Xylene

b. **Mercury Reduction: (Hospital Policy #A0176)**

The laboratory supports the hospital’s mercury reduction program by:

1. Replacing Mercury containing thermometers
2. Recycling mercury-containing batteries

c. Use of alternative to B-5 fixative

d. Compliance with use of the appropriate waste disposal by employees.

**13. Effective Enforcement:**

a. Observation:

* + 1. Supervisors observe employees’ safe work practices (e.g., wearing appropriate PPE).
    2. Staff members identify observed safety issues which are reported during the monthly Quality Assurance meetings.

b. Environment of Care Survey:

1) Supervisors and staff members survey departments to assess the level of general safety and compliance with waste stream disposal.

## 14. Comprehensive Training Program:

1. Safety Information is part of Employee Orientation
2. The network mandatory annual compliance training program consists of interactive training modules with quiz question/answer sheet. Some topics covered in the modules are:
3. Radiation Safety
4. Blood-borne Pathogens and other Infectious Agents / Standard Precautions
5. Risk Management / Event Reports
6. Emergency Management (Code Yellow, Internal/External Disaster)
7. Fire Safety
8. General Safety / Ergonomics
9. Hand Hygiene / Gloves
10. Hazardous Materials
11. Impaired Employees
12. Latex Allergy
13. Sharps Safety
14. Laboratory Fire Safety Drills and Evacuation

1) A Laboratory EXIT Fire Drill is conducted at least annually within the department during each shift. Personnel exit the laboratory during first and second shift. A Protective Service Officer conducts a drill within the department for the third shift. Third shift employees participate in a Walk-About” which include proceeding to all evacuation routes, pull stations, fire extinguisher location along with review of RACE, PASS and other safety information.

2) Network Fire Drills held in other locations are observed when the fire alarm sounds and the operator announces:

1. Close all doors
2. Remain where you are
3. Wait for instructions from the supervisor
4. Listen for “All CLEAR” announcement

**15. Safety Meetings:**

* 1. Network Safety meetings are held monthly. These meeting review/discuss/plan corrective action for any identified safety conditions, review Disaster Plan (EOP), discuss findings of network safety audits, etc.
  2. Network Emergency Management meetings are held bi-monthly.
  3. Infection Control Meetings are held monthly. The Infection Control Meeting is attended by Microbiology representation
  4. Environment of Care Hazardous Materials meeting are held every other month.
  5. Laboratory Staff conduct the Network Semi-Annual safety audits. Information is communicated to the section supervisors during the departmental monthly quality assessment meeting and/or monthly supervisory meetings. Supervisors inform staff during section meetings

**IV. Reporting Results**

1. Safety issues and meeting information is communicated and discussed during monthly quality assessment meetings. Safety issues are communicated to employees by bulletin board posting and/or e-mail.
2. Weekly Safety Inspections are done at EMCP, and monthly inspections are done at EMCEP. This is done on a rotating schedule by designated staff members. The schedule for the inspections is located on the share drive. The results are recorded on the share drive using SA01-003 Form A1. The results are communicated to all employees through email. The results are also reported at the monthly QA meetings.

**V. References**

Laboratory Policy and Procedure

Network EOC Policies and Procedures

**Approval Signatures:**

|  |  |  |
| --- | --- | --- |
| **Date:** | **Printed Name:** | **Signature:** |
| 8/22/2013 | Nancy A. Young, M.D.  Medical Director | New Leadership- NA |
| 9/24/2014 | Jaclene Kokoszka Quality Manager |  |

**History Review**

|  |  |  |
| --- | --- | --- |
| **Date:** | **Reviewed by** | **Revision:** |
| 12/23/13 | NM | Added verbiage to section 11. volunteers, visitors, and patients |
| 12/22/14 | JK | Updated Safety Form to version A1. |
| 1/23/15 | JK | Minor changes- addition to III.7.c.1.f & III.3. |
| 2/23/2015 | JK | Minor change to verbiage and hospital policy numbers added. |
| 9/25/2015 | JK | Updated Form A1 to A2- included the items on the Daily CMS Checklist that were missing. |
| 1/29/16 | SV | No revisons |
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