

Frequently asked questions (FAQs) about the *OSHA Bloodborne Pathogen Standard* and sharps safety from the Premier Safety Institute

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Topics

Device issues

- [Blunt suture needles and safety scalpels](#)
- [Changing needles and recapping](#)
- [Device identification](#)
- [Disposal of contaminated sharps](#)
- [Reuse of phlebotomy blood tube holders](#)
- [Reuse of sharps containers](#)

Device Selection, evaluation and replacement

- [Annual requirements](#)
- [Engineering controls and safer devices](#)
- [Evaluation of devices](#)
- [Selection and replacement of devices](#)
- [Options for securing medical catheters](#)

Worker training, compliance

- [Compliance flexibility](#)
- [Frontline and contract workers](#)
- [Physician office compliance](#)
- [Worker compliance](#)

Record keeping, schedules and implementation

- [Recordkeeping rule 2002 and sharps](#)
- [Deadlines for compliance](#)
- [Successful implementation](#)
- [Location of OSHA's Bloodborne Standard](#)

OSHA resources

- [OSHA Questions and answers](#)
- [Non-Mandatory Appendix A to Subpart B -- Partially Exempt Industries](#)

Device issues

Blunt suture needles, safety scalpels and physician compliance

Does OSHA require the use of blunt suture needles and safety scalpels?

Yes, OSHA requires the use of sharps safety devices when ever there is a risk of injury from a contaminated “sharp” and safety devices are available. Blunt suture needles and safety scalpels are examples of a sharps safety device used in the operating room. Even if surgeons are not employees of the organization, OSHA may fine a hospital if the actions of non-employees (e.g., surgeons using non-safety devices) put workers at risk of exposure. The organization is required by OSHA to conduct an annual review and evaluation of available sharps safety devices for selection and adoption and document this review in the exposure control plan. If safety devices are available but not adopted, the reason must be clearly documented in the exposure control plan (such as interference with a medical procedure). There needs to be an annual reassessment of the feasibility of using these devices including an evaluation of the devices with documentation of any rationale for non-adoption. CDC/NIOSH and OSHA released an update on this issue as a joint bulletin in April 2007. Blunt suture needles: <http://www.cdc.gov/niosh/docs/2007-132/pdfs/2007-132.pdf>.

Changing needles and recapping

What are the recommendations regarding the issue of recapping and changing needles prior to patient injection?

According to OSHA’s bloodborne pathogen standard, contaminated needles are not to be recapped by hand. There are several circumstances to consider:

- Sterile/clean and non-contaminated needles: OSHA's bloodborne pathogen standard only applies to contaminated needles and does not directly address sterile or clean needles. For example, if a needle needs to be changed before an injection when the needle is still sterile or clean and has not yet been used on a patient, there are circumstances where it may have to be recapped to remove it. If the needle is contaminated (used on a patient) and recapping is required, the type of procedure and medication to be given will dictate the type of safety device that needs to be selected. Some safety devices, for example, have needle recapping mechanisms that do not lock, e.g., used for injections of medications that are given incrementally.
- Blood cultures: In the past, it was common practice to change needles on syringes after drawing the blood from the patient, and before evacuating specimens into culture bottles as a way of preserving sterility during the filling of the culture bottle. However, the Clinical and Laboratory Standards Institute (CLSI) formerly known as the National Committee for Clinical Laboratory Standards (NCCLS) does not advocate this practice because of the increased risk of accidental needlesticks, and the literature suggests that this practice does not significantly reduce contamination rates. The following three references address this issue and the use of safety devices specifically designed for transferring blood from a syringe when that becomes necessary.
 1. Dale JC, et al. Accidental needlesticks in the phlebotomy service of the Department of Laboratory Medicine and Pathology at Mayo Clinic Rochester; Mayo Clin Proc 1998 Jul;73(7):611-5.
 2. Schiffman R. et al. Blood culture contamination. Arch Pathol Lab Med 1998;122:216-221
 3. Clinical and Laboratory Standards Institute (CLSI). Procedures for the collection of diagnostic blood specimens by venipuncture. Approved standard, H3-A4, 4th ed. Villanova, PA: NCCLS; 1998.

Device identification

Where can I obtain information on what safety devices are available on the market?

There are a variety of sharps safety devices lists that are currently available:

Sources for comprehensive lists of sharps safety devices

Electronic lists	Location
California Department of Health Services: <i>List of Needles with Engineered Sharps Injury Protection</i>	http://www.sharpslist.org/
International Healthcare Worker Safety Center, University of Virginia: <i>Safety Engineered Sharps Device List</i>	www.med.virginia.edu/epinet
International Sharps Injury Prevention Society: <i>Safety Product List</i>	http://www.isips.org/safety_product_list.html
Books	Ordering information
ECRI Institute Sharps Safety & Needlestick Prevention Guide, 2004: <i>Lists and product evaluations</i>	www.ecri.org

Disposal of contaminated sharps

Can the syringe or needle sheath be considered its own sharps container if the contaminated needle is covered permanently?

No. The 2001 revised Enforcement Procedures (CPL 2-2.69) clarify this issue and state the needle sheath is not to be considered a waste container because it is viewed as a temporary measure. All sharps safety devices must be disposed of in an appropriate sharps container.

Reuse of phlebotomy blood tube holders

Does OSHA allow reuse of phlebotomy blood tube holders?

No. Reuse of standard phlebotomy tube holders has been a common practice and hotly debated over the past year as a practice that poses a potential risk of injury. OSHA has determined that removal of the needle from a phlebotomy tube holder for the purpose of reusing the holder poses a risk of injury from the "back end" needle, regardless of the technique used. As such, OSHA prohibits removal of contaminated needles from the phlebotomy tube holder unless medically indicated. Medical indication for needle removal would need to be specified in the exposure control plan. OSHA has indicated that medically indicated exceptions would not include the need for reusable holders to reduce the amount of waste, for example. OSHA has published a Letter of Interpretation regarding "reuse of phlebotomy tube holders" that clarifies the requirements and expectations for compliance.

Go to: <http://www.osha.gov/dts/shib/shib101503.html>

Is it acceptable to reuse sharps containers?

- Yes, sharps disposal (disposable and reusable) containers must receive 510K clearance from the Food and Drug Administration (FDA) and also meet OSHA requirements under the Bloodborne Pathogen Standard. There are similar requirements from both FDA and OSHA for sharps disposal containers, including:
- closable, puncture resistant, leak proof
- appropriately labeled and color-coded
- designed with an opening that is large enough to accommodate disposal of an entire blood collection assembly (i.e., blood tube holder and needle)
- easily accessible to the immediate area where sharps are used
- easily portable if employees travel from one location to another

Reusable sharps containers should never be opened, emptied or cleaned manually or in any other manner than would expose workers to percutaneous injuries or blood. Reusable sharps containers are transported within the facility and often stored while awaiting pick-up by outside company. As such, the containers must be leak proof. Facilities that wish to use reusable sharps disposal containers and systems should evaluate the quality and reliability of the company's processes used to transport and reprocess the containers.

Device Selection, evaluation and replacement

Annual requirements

I would like clarification regarding need for continual (annual) evaluation of new devices. If the injury rate has been reduced and there are no reports of employee dissatisfaction, what is our obligation to review/consider a different device?

The Bloodborne pathogen standard is a "performance oriented" standard, providing the opportunity for employers to determine the most appropriate methods to reduce hazards. As such, OSHA does not tell an organization exactly what it needs to do in an annual review. The intent of the review is to make sure that the devices being used remain appropriate, control the hazard and reduce risks to workers. The type of review should be determined by the employer and outlined in the exposure control plan. The intent is that you would not choose a device and keep using it year after year despite employee complaints and documented ongoing problems with the device. Nor does it mean you evaluate every device on the market every year. Rather, you would conduct an annual review of your program that would include a review of your devices. For example, your exposure control plan could outline which factors or data you would review/consider in your annual review. The precise type of annual review (and what data will be reviewed and by whom) and what devices are evaluated, if necessary, should be outlined in your plan.

In some small facilities or departments, where sharps injuries are rare, there might not be a need for a formal meeting. Instead, the exposure control plan might outline an ongoing assessment and review of any injuries or exposures to determine if a change in a device or procedure is necessary.

The annual review could be as simple as a review of data and discussion at a safety or infection control-related meeting, with documentation in minutes. It might include documentation, for example, of your sharps injury data and mention of any considerations in the annual review (e.g., feedback from staff on acceptance of current device, etc.) such as:

- If injuries are identified, they need to be assessed to determine if the injury is from the device or perhaps some other issue like overfilled disposal containers that needs to be addressed.
- If no injuries have occurred with a particular device or injury rates are reduced, it may be determined that a review of a new device is not needed.
- If there is an increase in injuries from a specific device and all the injuries occur during activation of the safety mechanism, it might indicate the need to evaluate a different device.

It is important to evaluate the nature and circumstances of sharps-related injuries that occur and not attempt to calculate injury rates to compare safety devices. Extremely large sample sizes, e.g., more than 500,000 devices, may be needed to show any statistically significant information. Rather, you should look at trends and nature and circumstances of specific injuries to glean important information.

This is a performance-oriented standard, not a "specification standard." As such, each work site needs to develop and modify, if needed, their exposure control plan based on their worksite data. The plan will include information on how their program is managed, including the annual review, and method for selection of devices with frontline worker input. This plan will vary with each facility and depend on the types of risks, review of institutional-based injury data, types of procedures performed, patient populations, and other considerations. All device selection and evaluation will be done with frontline worker input.

Engineering controls and safer devices

If there is a safety device available for a particular procedure does it have to be used?

If there are safety devices available for a particular procedure, they should be evaluated by frontline workers and one selected for use to reduce risks. The only exception to the use of a safety device, when available, is if the device(s) interferes with a clinical procedure and cannot be used without compromising the procedure or increasing the risk to the patient. In this case, the specific reason for not selecting and using the device needs to be documented in the exposure control plan. As part of the annual review, there should be an evaluation of any other newer devices that might be available that might not interfere with the specific procedure. This review, and the results of the evaluation should be documented; that is, either the adoption of device, or an explanation of why the device (s) interferes with a specific clinical procedure and/or increases risk to the patient.

Evaluation of Devices

Do formal evaluations need to be conducted for all safety devices?

The employer may determine the type of evaluation that should be conducted that solicits representative input from the frontline users of the device. This may be done formally or informally. A formal evaluation might include a pilot study on a particular unit with written evaluation forms being completed by each worker. An informal evaluation might include sample devices being brought to the department or setting for a representative sample of frontline workers chosen to evaluate the device and provide informal feedback. In this case, you might choose to use an evaluation tool for more formal input or simply record the information from informal discussions with frontline staff.

Frontline worker involvement in the evaluation and selection of safety devices can help promote acceptance of these devices when they are implemented. Although it may not be feasible to have every worker that will use a device be involved in the selection and evaluation of a device, a representative sample of workers should be included. There is no exact formula for the number of workers that need to evaluate the device, the number of devices to be evaluated, the length of time an evaluation should be conducted or the percentage of the workers that must agree on the device to be selected. What will be important is that a mechanism is in place to solicit input from a representative group of frontline workers.

In addition, there should be a mechanism in place for soliciting input from frontline workers on an ongoing basis regarding their needs and preferences for safety devices. This input will be combined with exposure data, e.g., data from the sharps injury log, and be used to guide future decisions on the selection and implementation of safety devices. In some cases, it may be necessary to replace the device that was originally selected with a more suitable device. This determination can only be made by the individual facility or work-site based on their data and experience.

Where do we start in determining which devices to evaluate?

The revised OSHA standard requires that employers solicit frontline worker input and hospitals must evaluate devices identified by frontline workers. If a health care facility is part of a group purchasing organization, all devices identified by frontline workers must be evaluated regardless if they are under the group purchasing contracts. The final decision on which devices are selected as appropriate for adoption will be made by each organization based on their clinical environment, procedures being performed, the patient population and the needs and preferences of the frontline workers.

Where can I get feedback on what other practitioners are doing to implement specific safety devices?

The Association for Professionals in Infection Control and Epidemiology (APIC) has an electronic mail list that provides a network through which infection control professionals can share information and exchange ideas on safety and preventing infections in patients and workers. The list is open to anyone with an interest in safety and infection control, and membership in APIC is not required for participation. To search the APICList archives for specific topics, go to APIC's website at www.apic.org Go to "APIC List Archives" and search.

Can we be cited if we do not have safety devices in every area in the organization?

OSHA's position is that the revised OSHA standard **does not change anything** regarding the requirement for use of safety devices, and that hospitals should have been using sharps safety devices since the compliance directive was revised in November 1999. We know that hospitals are currently being cited for lack of safety devices in California under CAL-OSHA. Some hospitals in states under federal jurisdiction have reported that OSHA has inspected their facility and **did not issue** a citation because they were able to show evidence of adoption of safety devices in some clinical areas and uses and evidence of a written plan with a realistic timeline that outlines how they will complete their selection, evaluation, and adoption of safety devices. Other hospitals have reported citations for not using safety devices across the board in all areas. There will likely continue to be variations from state to state and inspector to inspector regarding the interpretation and the flexibility in giving citations. What is important is that each facility documents its plan in writing with a realistic timeline, adheres to the plan and adopts safety devices as quickly as feasible.

Selection and replacement of devices

If you have already implemented a safety device, do you have to go back and start all over and re-evaluate and select new devices in every category?

No, you do not have to go back and start all over. However, you should have an ongoing assessment of any problems that may occur with the devices that are being used. This information should be used to determine if any changes in devices are needed. Employee input and sharps injury data should always be used on an ongoing basis to guide your sharps injury prevention program and this should all be documented in your exposure control plan. Employers need to keep abreast of new technology and document this on annual basis so that staff can consider additional options if the current product selected has been improved or if some newer technology has been show to offer better protection.

Can cost be a consideration in the process of selection of a safety device and still meet the intent of OSHA?

Cost is certainly an important consideration as is the cost-effectiveness in choosing a safety device. However, it cannot be the only consideration. The most important consideration, according to OSHA, is that front line workers are involved in choosing the device, as opposed to the employer selecting a device just because it is the lowest in cost. There may be opportunities for cost-effective devices under a group purchasing contract; however, the devices chosen by the front line worker must be implemented whether or not they are covered by a group purchasing contract.

Does OSHA require ALL "sharps" that pose a risk of percutaneous injury be replaced with a safety device?

No, OSHA requires that safety devices replace only those sharps that have the potential to expose a worker to an injury from contaminated sharp devices, (i.e., potentially contaminated with bloodborne pathogens). Devices that will not be contaminated with bloodborne pathogens and thus do not pose a risk of injury from a "contaminated" sharp are not required by OSHA to be replaced with safety devices. One example would be a syringe with a needle used in pharmacy for sterile admixture procedures.

May we use up all our conventional needles prior to implementing the safety needles?

You should strongly consider the risk to the worker and the implications of a worker who develops an infection from a conventional device when safety devices are being made available. If OSHA inspects your facility, you will likely be cited for using conventional devices, especially if you have already evaluated and selected a replacement safety device. Some hospitals have chosen to use up their stock of conventional needle devices, such as syringes, in departments that use syringes for clean procedures (e.g., sterile admixtures in pharmacy) that do not pose a risk of needlestick from a contaminated sharp used on a patient.

If we have data that show no injuries for a certain category of devices, do we have to replace those conventional devices with sharps safety devices?

OSHA requires that engineering controls, specifically sharps safety devices, be used when there is a risk of exposure to a contaminated sharp. Thus, you must replace all your conventional devices with sharps safety devices if those devices have any risk of becoming contaminated and exposing a worker to a bloodborne pathogen.

What are the options for securing medical catheters?

Careful and thorough securement of vascular access devices is essential since ineffective securement may result in catheter dislodgment and the necessity of reinsertion with its associated needlestick risk. Some vascular access devices and chest drainage tubes have traditionally been secured with sutures, exposing the healthcare worker to a risk of needlestick injury from the suture needle.

Generally, OSHA does not require the use of specific engineering controls (e.g., products) or work practices. OSHA relies on the professional judgment of healthcare workers who insert and secure catheters to assess each situation and determine the appropriate methods and work practices to secure and stabilize catheters.

A variety of tapes, adhesive products, and catheter securement devices are available to secure and stabilize medical and vascular access catheters and reduce the risk of catheter dislodgement and the need for securement with sutures.

OSHA requires employers to annually consider and implement appropriate, available, and effective safer medical devices designed to eliminate or minimize that exposure. Engineering controls that reduce the potential for needlesticks by eliminating the need to suture medical catheters in place are one option for healthcare employers to consider. As part of their annual review of methods to reduce needlesticks, employers must review and evaluate options for reducing risks of needlestick injuries, including securing medical catheters, and consider appropriate engineering and work practice controls.

OSHA has published a fact sheet on “securing medical catheters” available at: <http://www.osha.gov/SLTC/bloodbornepathogens/index.html>

Worker training, compliance

Compliance flexibility

What exact procedures does OSHA require hospitals to use to comply with the revisions in the Bloodborne Pathogen Standard?

OSHA’s Bloodborne Pathogen Standard is a performance-oriented standard, which is intended to allow employers the flexibility to develop worker protection programs that are unique to a particular setting and consistent with the intent of the standard. The revisions to the bloodborne pathogen standard, published in the Federal Register on January 18, 2001, give numerous suggestions for meeting the intent of the standard, such as:

"The employer is permitted to determine the format in which the sharps injury log is maintained, (e.g., paper or electronic)." Evidence of input from frontline workers in the identification, evaluation and selection of devices can include, for example, "meeting minutes, copies of documents requesting employee participation, records of responses from employees" from evaluations.

OSHA does not specify the type of device that must be used. OSHA recognizes that " no one device is appropriate in all circumstances"...and "employers must choose an appropriate safer medical device...that includes only devices, whose use, based on reasonable judgment in individual cases, will not jeopardize patient or employee safety or be medically contraindicated."

Physician offices and physician compliance

Do physician offices have to use sharps safety devices?

Yes, the bloodborne pathogen standard applies to any healthcare employer, regardless of the number of employees, when job duties may result in exposure to blood. This includes physician offices, dental offices, dialysis centers and outpatient labs. Physician offices need to have a process with worker input for identifying, evaluating and selecting safety devices, even if the process is informal.

Front line and contract workers

What is the definition of "frontline worker"?

Frontline workers are those that actually use the safety devices and could be staff nurses or charge nurses, for example, not management staff that do not use these devices.

Are employers responsible for providing safety devices for contract workers?

Yes, and the employer must provide safety devices to all employees at the worksite if they are at risk of exposure to contaminated sharps, even if they are employed by another company in a contractual arrangement. For example, contract or per diem workers in a hospital are employees of the "contracting agency;" however they still must be provided with safety devices, personal protective apparel, and training for compliance with all the requirements of the bloodborne pathogen standard. In some instances, some of the requirements are managed or paid for by the "contracting agency" and not the hospital, such as Hepatitis B vaccination. However, both employers (hospital and contracting agency) are responsible for making sure that all aspects of the OSHA standard are enforced by one of the employers, and this must be clearly documented in the contract.

Worker compliance

What if our employees will not use safety devices?

The employer must ensure that employees follow protective measures, including the use of engineering controls such as sharps safety devices. Some facilities have made compliance with sharps safety devices a requirement for satisfactory job performance and incorporated it into the employees' performance review criteria. It is important to have a mechanism in place to identify and evaluate the reasons for non-compliance so that appropriate action can be taken, which might be additional education, changes in devices, counseling, or disciplinary action.

Deadlines for compliance

What was the official date for compliance with the revised standard?

April 18, 2001 - The published effective date for the revisions of the bloodborne pathogen standard. Requirements of the revised standard:

1. Implement sharps injury prevention devices
2. Update your exposure control plan annually to reflect these new devices
3. Involve front line workers in selection and evaluation of safety devices
4. Keep a detailed log of contaminated needlesticks (include device, manufacturer and circumstances of exposure)

Note: Requirement number one is not new—OSHA has required these safety devices since November 1999 in a revised compliance directive. Requirement number two is not new – OSHA required an annual update of the exposure control plan in the original standard in 1992 to reflect any changes, including new technology.

July 17, 2001 - Extended deadline for states under federal jurisdiction until OSHA completed outreach activities. This extension was viewed as an opportunity to implement the two new requirements (number three and four above) related to frontline worker input into selection and evaluation and the detailed sharps injury log of contaminated needlesticks. It is expected that sharps injury prevention devices have already been implemented and a plan has been revised.

October 18, 2001 - As with all revisions in federal OSHA standards, the 23 states with state-approved OSHA plans have an additional six months (from April 18) to review/revise their state OSHA regulations to include, at a minimum, the new federal OSHA requirements, but they may adopt stricter requirements. State-approved OSHA plans include: AK, AZ, CA, CT, HI, IA, IN, KY, MD, MI, MN, NV, NC, NM, NY, OR, SC, TN, UT, VA, VT, WA, and WY.

Employers in one of the 21 states with state laws on needlestick prevention may have additional requirements—the strictest rules apply. Consult your state law. (States with state laws include: AR, AL, CA, CT, GA, IA, ME, MD, MA, MN, MO, NH, NJ, NY, OH, OK, PA, RI, TN TX, WV.

In summary, all employers are required to provide sharps injury prevention devices now and OSHA has been enforcing this since November 1999. Some states with state laws may have stricter requirements. The strictest requirements apply. If applicable, consult your individual state laws and state OSHA Bloodborne Pathogen Requirements, if applicable.

Location of the Bloodborne Standard

Where can I obtain a copy of OSHA's revised Bloodborne Pathogen Standard?

The standard was published on January 18, 2001 in the *Federal Register* and is available on OSHA's website at <http://www.osha.gov>. This document and many more are easily located by going to the Index and clicking on "N" and "Needlestick injuries."

Where can I obtain additional information on compliance with OSHA's Bloodborne Pathogen Standard?

OSHA periodically updates their Enforcement Procedures for Occupational Exposure to Bloodborne Pathogen Standard to establish enforcement policies and provide clarifications to ensure uniform inspection and enforcement procedures. The most recent Enforcement Procedures were issued in November 2001 (CPL-2.269). This document is available at www.osha.gov. Go to the Index and click on "N" and "Needlestick injuries." This may also be [downloaded here](#), or from the [Downloads](#) section of Sharps Injury Prevention Resource.

Record keeping, schedules and implementation

Recordkeeping rule 2002 and sharps injury prevention

How is the new Recordkeeping rule related to the Bloodborne Pathogen rule?

All organizations that are currently required to report occupational injuries and illness under OSHA recordkeeping regulations must continue to report newly defined injuries and illness using new OSHA forms or their equivalent. The new rule requires reporting of contaminated sharps-related injuries.

What is the minimum amount of information that must be collected on sharps-related injuries?

All contaminated sharps-related injuries must be recorded in a log that contains information on the type and brand of device involved, the department where the incident occurred, and an explanation of how the injury occurred.

Do I have to use the new OSHA 300 log to report contaminated sharps injuries?

All contaminated sharps injuries, like all reportable injuries, must be recorded and must include all the information requested on the forms identified as the 300 Log, 301 Incident report and 300-A Summary. In addition, the revised Bloodborne Pathogen Standard requires that a **sharps injury log** be kept that contains **specific** information on contaminated sharps injuries related to 1.) type and brand of the device involved, 2.) the department where the incident occurred, and 3.) an explanation of how the injury occurred. All required information related to contaminated sharps injuries may be combined and maintained on computers or equivalent forms, as long as all the essential information is readily

retrievable. In addition, the **specific** information required by the Bloodborne Pathogen Standard revision to be kept on a sharps injury log may be combined with other sharps injury data as long as the **specific** information can be separately analyzed from all the other information for the purpose of evaluation of risk and device effectiveness. The confidentiality of the injured employee must be maintained throughout the process.

OSHA provides a series of FAQs related to CFR 1904, Recording and Reporting Occupational Injuries and Illness on its Web site and selected questions related to Forms (Standard 1904.29) are quoted directly as follows:

Basic requirement [1904.29(a)] You must use OSHA 300, 300-A, and 301 forms, or equivalent forms, for recordable injuries and illnesses. The OSHA 300 form is called the Log of Work-Related Injuries and Illnesses, the 300-A is the Summary of Work-Related Injuries and Illnesses, and the OSHA 301 form is called the Injury and Illness Incident Report.

What is an equivalent form? [1904.29(b)(4)] An equivalent form is one that has the same information, is as readable and understandable, and is completed using the same instructions as the OSHA form it replaces. Many employers use an insurance form instead of the OSHA 301 Incident Report, or supplement an insurance form by adding any additional information required by OSHA.

May I keep my records on a computer? [1904.29(b)(5)] Yes, if the computer can produce equivalent forms when they are needed, as described under §§ 1904.35 and 1904.40, you may keep your records using the computer system.

Are there situations where I do not put the employee's name on the forms for privacy reasons? 1904.29(b)(6) Yes, if you have a "privacy concern case," you may not enter the employee's name on the OSHA 300 Log. Instead, enter "privacy case" in the space normally used for the employee's name. This will protect the privacy of the injured or ill employee when another employee, a former employee, or an authorized employee representative is provided access to the OSHA 300 Log under § 1904.35(b)(2). You must keep a separate, confidential list of the case numbers and employee names for your privacy concern cases so you can update the cases and provide the information to the government if asked to do so.

Do Physician office practices have to report contaminated sharps injuries?

The bloodborne pathogen standard applies to all healthcare employers with employees that have exposure to blood or potentially infectious body fluids, including contaminated sharps. However, the requirement for reporting any occupational injury or illness including contaminated sharps will vary by employer.

In the past, there was a recordkeeping exemption for worksites that had 10 or fewer employees. However, OSHA's recordkeeping standard (29 CFR Part 1904) was revised in 2002. This revision specifies that recordkeeping exemptions now apply to employers based on their SIC (standard industry classification). For example, the SIC category "offices and clinics of medical doctors (SIC 801) is exempt from recordkeeping reporting requirements unless an incident results in a fatality or hospitalization of three or more workers. This means, in this example, that the recordkeeping exemption for offices and clinics of medical doctors would include an exemption for maintaining a sharps injury log. Refer to the SIC table in Appendix at the end of this document.

However, all employers are encouraged to track injuries for internal purposes related to development of safer work practices and evaluation and selection of safety devices.

Successful implementation of safety devices

- Consider starting with devices that are the most difficult to implement, such as the IV catheters.
- Develop a simple form to collect the exposure data.
- Start with a patient care unit that has an individual willing to assist you.
- Consider using the "buddy system" for implementation of IV catheters, which often require a change in technique and thus need extra effort to overcome the resistance to change.
- When safety devices are NOT available in a particular category of devices or for a particular clinical procedure, document this information in the exposure control plan.

OSHA Resources

OSHA resources on bloodborne pathogens more questions and answers

<http://www.osha.gov/SLTC/bloodbornepathogens/index.html>

Non-Mandatory Appendix A to Subpart B -- Partially Exempt Industries ([below](#))

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The answers to these questions do not constitute legal advice. These interpretations offer a reasonable approach to implementing the revised standard. These interpretations are based on a close reading of the revised OSHA standard by the Premier Safety Institute and its intent as stated by OSHA in the *Federal Register*, January 18, 2001; 5318-5325. For additional information on compliance with federal OSHA, consult OSHA Enforcement Procedures for Occupational Exposures to Bloodborne Pathogen Standard (CPL-2.269; November 2001).

Interpretations of the standard for determining compliance may vary in states with OSHA-approved state plans and states with specific legislation on sharps safety. In these states, the stricter law or interpretation will usually apply.

Non-Mandatory Appendix A to Subpart B -- Partially Exempt Industries

Employers are not required to keep OSHA injury and illness records for any establishment classified in the following [Standard Industrial Classification \(SIC\) codes](#), unless they are asked in writing to do so by OSHA, the Bureau of Labor Statistics (BLS), or a state agency operating under the authority of OSHA or the BLS. All employers, including those partially exempted by reason of company size or industry classification, must report to OSHA any workplace incident that results in a fatality or the hospitalization of three or more employees (see [§1904.39](#)).

Table follows:

SIC code	Industry description	SIC code	Industry description
525	Hardware Stores	725	Shoe Repair and Shoeshine Parlors
542	Meat and Fish Markets	726	Funeral Service and Crematories
544	Candy, Nut, and Confectionery Stores	729	Miscellaneous Personal Services
545	Dairy Products Stores	731	Advertising Services
546	Retail Bakeries	732	Credit Reporting and Collection Services
549	Miscellaneous Food Stores	733	Mailing, Reproduction, & Stenographic Services
551	New and Used Car Dealers	737	Computer and Data Processing Services
552	Used Car Dealers	738	Miscellaneous Business Services
554	Gasoline Service Stations	764	Reupholstery and Furniture Repair
557	Motorcycle Dealers	78	Motion Picture
56	Apparel and Accessory Stores	791	Dance Studios, Schools, and Halls
573	Radio, Television, & Computer Stores	792	Producers, Orchestras, Entertainers
58	Eating and Drinking Places	793	Bowling Centers
591	Drug Stores and Proprietary Stores	801	Offices & Clinics Of Medical Doctors
592	Liquor Stores	802	Offices and Clinics Of Dentists
594	Miscellaneous Shopping Goods Stores	803	Offices Of Osteopathic Physicians
599	Retail Stores, Not Elsewhere Classified	804	Offices Of Other Health Practitioners
60	Depository Institutions (banks & savings institutions)	807	Medical and Dental Laboratories
61	Nondepository Institutions (credit institutions)	809	Health and Allied Services, Not Elsewhere Classified
62	Security and Commodity Brokers	81	Legal Services
63	Insurance Carriers	82	Educational Services (schools, colleges, universities and libraries)
64	Insurance Agents, Brokers, & Services	832	Individual and Family Services
653	Real Estate Agents and Managers	835	Child Day Care Services
654	Title Abstract Offices	839	Social Services, Not Elsewhere Classified
67	Holding and Other Investment Offices	841	Museums and Art Galleries
722	Photographic Studios, Portrait	86	Membership Organizations
723	Beauty Shops	87	Engineering, Accounting, Research, Management, and Related Services
724	Barber Shops	899	Services, not elsewhere classified