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Our firm...

Hospital Waste Management is committed to assisting healthcare facilities in complying with hazardous material management and waste disposal regulations and better managing their wastes. Our clients are hospitals, clinics, and medical labs.

Our services include conducting dangerous, solid, radioactive, and regulated medical waste audits; risk assessment; hazmat audits; developing waste management plans for Joint Commission compliance; hazmat emergency response training; and annual dangerous waste and Pollution Prevention reporting.

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Ecology Reversal: SQGs Can Once Again Treat Dangerous Waste Onsite Without Penalty

Interim Guidance will likely be Finalized with No Substantive Changes

It was just 18 months ago that Ecology discovered that its policy of allowing Small Quantity Generators to treat dangerous waste (DW) onsite appeared to violate federal law. As an immediate consequence of that discovery, many SQGs had to choose between sending their DW offsite for treatment or re-designating as a Regulated Generator with all of its attendant paperwork.

After realizing how many SQGs that decision impacted and investigating how other states have found ways to allow SQGs to treat their own waste, Ecology has issued interim guidance which once again restores the allowance for SQGs to treat their own DW onsite without becoming a Regulated Generator. It is likely that when this interim guidance is finalized, nothing substantive will change.

The new interim guidance on Treatment by Generator was issued August 2012 and is a Technical Information Memorandum, Ecology Publication No. 96-412. You can download the six-page document from http://www.ecy.wa.gov/programs/hwtr/manage_waste/treatment_by_generator.html.

Treatment by Generator (TBG) is a policy that allows a generator of DW to neutralize, evaporate, separate, solidify, filter or absorb DW in order to render some or all of the waste suitable for disposal in the trash or sewer, provided it no longer designates as DW. Many small businesses, including hospitals, have traditionally employed TBG to manage their DW. Hospitals have used TBG to neutralize spent formalin, gluteraldehyde and o-phthalaldehyde (OPA) and then sewer the resulting harmless solution.

TBG requires the generator to treat DW in a suitable container or tank and to log each batch of treated waste. TBG-treated waste still counts towards a generator’s status (SQG or Regulated Generator).

Ecology’s new TBG guidance specifically doesn’t apply to small quantity generators who treat their own waste. However, an SQG who wishes to treat DW onsite should follow applicable requirements for regulated generators. By writing the TBG policy in this manner, Ecology has managed to thread a way past federal language that does not allow Conditionally Exempt Small Quantity Generators to treat hazardous waste onsite.

In addition to its new TBG guidance document, Ecology has a number of additional guidance documents for generators on:

- Carbon Adsorption, #96-415
- Elementary Neutralization, #96-417
- Evaporation, #96-414
- Filtration, #96-413
- Separation, #96-418
- Solidification, #96-416

If you filed a Dangerous Waste Annual Report that identified your facility as a Regulation Generator solely because you treat DW onsite, you should file your 2012 DWAR as an SQG.
Clean Teams—Housekeepers & Epidemiologists—Can Dramatically Lower the Incidence of Nosocomial Infections

Nosocomial infections—those derived from pathogens in hospitals—have plagued patients and caregivers alike for decades. The problem has become much more acute because some pathogen strains have become resistant to most of our best antibiotics. Witness VRE (vancomycin-resistant enterococci), E. coli, Clostridium difficile, and MRSA (methicillin-resistant Staphylococcus aureus). The Centers for Disease Control (CDC) refer to these collectively as healthcare acquired pathogens (HAPs). Spore-formers like C. difficile are the most difficult to clean, but the multi-drug resistant gram-negative enterococci (e.g., VRE and MSRA) are the most virulent of the HAPs.

Housekeepers, by themselves, have struggled under fire to keep hospital-based infection rates down. Although bleach (sodium hypochlorite solution) is effective against all these HAPs, contact time and concentration are both critical elements of effective surface cleaning.

The most widely-used tactic in reducing nosocomial infection rates has been diligent hand sanitizing. Hospitals across Washington sport hundreds of wall-mounted instant hand sanitizer dispensers with ethanol-based gels designed to be used whenever a caregiver enters or leaves a patient room. While this practice is clearly effective, it has not eliminated the problem.

Now an innovative pairing of skills has been shown to dramatically lower the incidence of this problem. As reported in Scientific American by Maryn McKenna (with permission):

At N.Y.U. Langone in 2010, [Michael] Phillips [N.Y.U. Langone Hospital Epidemiologist] and his co-workers launched a pilot project that redefined those formerly disposable workers as critical partners in patient protection. Janitors, they realized, know better than anyone else which rails are touched most frequently and which handles are hardest to clean. The Langone “clean team” paired janitors with infection control specialists and nurses in acute care units to ensure that all high-touch surfaces were thoroughly sanitized. In its first six months the project scored so high on key measures—reducing the occurrence of C. diff infections and the consumption of last-resort antibiotics—that the hospital’s administration agreed to make the experiment routine procedure throughout the facility. It now employs enough clean teams to assign them to every acute care bed in the hospital.  

The CDC and The Joint Commission now expect hospitals to pair up their infection control and prevention (ICP) professionals with environmental services (ES) staff to identify problem cleaning surfaces. Together, these two common healthcare resources are slowly changing the microbiological climate in hospitals. 

The CDC has prepared a toolkit for hospitals to use in pairing ICP and ES staff effectively. The guide describes two different levels—Level I that relies upon ES staff education to reduce infection rates and Level II that relies upon both ES staff education and objective measurement of cleaning efficacy.

High-contact, difficult-to-clean surfaces in patient rooms are the primary target of these efforts. Bed rails, sink faucet handles, privacy curtains, chair arms, call boxes, tray tables, IV poles, telephones, cabinet pulls, toilet handles and door knobs are some surfaces that harbor HAPs and resist sanitizing.

(Continued on page 3, Clean Teams)
More on Common HazWaste Inspection Violations …

Recently a northwestern Washington hospital was visited by Department of Ecology inspectors who came up with a depressingly common group of citations. The following was reported by the Facility Manager:

1) Pharmaceutical bins for RCRA waste, stored in soiled utility rooms on patient floors, were found with the sliding lids askew and the containers open;
2) Some hazardous waste containers didn’t have proper labeling; and
3) The primary hazardous waste accumulation area did not have a weekly inspection log.

Let’s take a look at these violations in more detail because they occur all too commonly.

**Hazardous Waste Containers**—All hazardous waste containers, whether pharmaceutical or otherwise, should be normally covered when waste is not actually being put into them. Funnels should be removed and bungs and lids put onto all containers. This requirement applies to both primary and all satellite accumulation area containers.

**Hazardous Waste Container Labels**—All hazwaste containers in a primary accumulations area should be labeled with four items:

1) The words “Hazardous Waste”
2) The name of the contents in the container
3) The hazard posed by the contents (e.g., flammable, toxic, corrosive)
4) The date the container was moved into the primary accumulation area.

Containers in satellite accumulation areas should not have a date listed until they are moved into the primary hazardous waste accumulation area. The only exception to this is for pharmaceutical waste containers. Pharmaceutical waste containers should be dated the day they enter service on the floor because they can be kept onsite for just 180 days, regardless of the waste generator status of the facility.

**Accumulation Area Inspection Logs**—All hazardous waste accumulation areas including primary and satellite must be inspected weekly for leaks, proper labels, odors, 30’ aisles between rows of containers (primary accumulation area only), and secondary containment. A log of these inspections should be kept beside or in the accumulation area. The log should note the date of the inspection, any anomalies, and the initials of the inspector. Anomalies, such as leaks, should be corrected within 24 hours.

Another common inspection citation is not capturing lab stain wastes being washed off slides in a slide rack over the sink. These wastes should be captured and hauled offsite for disposal by a licensed vendor.

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1 Maryn McKenna, “Clean Sweep: Hospitals bring janitors to the front lines of infection control,” *Scientific American*, (September 2012), 30-31
13 Months to Implementation: Hazardous Drug Advisory Committee Building Plans

By January 1, 2014 each retail pharmacy, veterinary office, physician office and hospital across Washington must have a written and implemented Hazardous Drug Control Plan. Although the Hazardous Drug Rule was finalized January 3, 2012, many details on how to prepare a written plan and how it would be enforced were left to an advisory committee to finish.

The Hazardous Drug Advisory Committee has been meeting monthly to build an algorithm and plan templates for use by all parties. The committee is comprised of stakeholders from pharmacies, healthcare labor, healthcare employers and Labor & Industries.

The committee is examining a tier system of cataloging drugs by their hazard (toxicity, mutagenicity, etc) and to exposure by their formulation (oral liquid, uncoated tablet, IV administration). The tier will include job actions, such as unpacking and stocking, compounding, administering, transporting waste, etc.

Before a written plan can be put to paper, however, each facility is required to develop job hazard assessments, which will form the core of the Hazardous Drug Control Plan. For each job—receiving clerk, nurse, compounding pharmacist, physician—where there is occupational exposure, hazard assessments must address:

- PPE;
- Engineering controls;
- The physical layout of the work area;
- Types of hazardous drugs being handled;
- Volume, frequency, packaging and form of hazardous drugs handled;
- Equipment maintenance;
- Decontamination and cleaning;
- Waste handling;
- Potential hazardous drug exposures during work; and
- Spill response.

Time is short, but facilities can begin by conducting hazard assessments. When the committee’s algorithm is ready, facilities will ready to prepare their plans and implement them by the beginning of 2014.