

# Lessons Learned & Success Stories – December 2015 to February 2016 Report

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The NBACC Lessons Learned and Success Stories Summary serves to reinforce a strong culture of safety and accountability by promoting consistent reporting of mishaps, establishing strong lines of communication with the safety department, supporting a learning environment by allowing others to learn from reported events, and tangibly demonstrating NBACC Leadership's commitment to safety, accident prevention, and continuous improvement.

## **SUCCESS STORIES:**

1. An employee noticed a coworker about to enter a BSL-2 lab that they believed to require dedicated shoes, however the coworker was wearing personal shoes at the time. A discussion ensued and it was identified that the lab door sign did not identify dedicated shoes as a requirement for entry. The EH&S Department was consulted and it was determined that dedicated shoes were required for entry. The door sign was updated to reflect the correct entry requirements.
2. While completing a task at home that required the use of a safety harness, an employee noticed the safety lanyard was past its expiration date. The employee ordered a new lanyard and properly disposed of the expired one.
3. An employee began to sharpen their knives at home when they stopped to consider a safer way to perform the task. They put on a pair of heavy leather gloves and carefully sharpened their knives without incident.
4. A BNBI employee called a stop work when they noticed the waste container from a reagent pack was bubbling. On further inspection, it was found that the equipment failed to indicate to the user when the waste container was full, and the container is not clear allowing for it to be visually inspected. A team was assembled to develop a plan of action to change out the waste container which was completed without incident.
5. The last person leaving before the long holiday weekend noticed that there were Christmas lights left on in someone's cubicle. The staff member stopped and unplugged the lights so they wouldn't remain on through the long weekend and then decided to do a walkthrough of the rest of the floor and the other floors before leaving.
6. During a recent group staff meeting, several staff members worked as a team to gather/present information related to emergency exit procedures. The individuals had thoroughly prepared for the presentation by reviewing procedures as well as walking down different facility areas. As a result of this effort, two process improvements were identified/implemented:
  - a. Emergency egress supplies located in the BSL-3 airlocks were staged in an inconsistent manner. They brought this to the attention of the BSO and the RO, and the issue was resolved throughout the NBACC.
  - b. A risk of staff becoming trapped in various areas of the building if they left their office without their access card was identified. The issue was raised with the IO Director and changes were implemented to ensure staff could safely exit the building during an emergency.

7. An employee was concerned that opening a cardboard box presented a potential cut hazard, so they asked for a Klever Kutter™ from a Safety member. They were able to open the box using the Klever Kutter™ reducing the risk of cutting themselves.
8. An employee noticed a low duct vent in the 2i library and reported to Safety their concern that someone might hit their head on the vent. A member of safety assessed the area and put in a ticket with facilities to put rubber padding around the vent.

#### LESSONS LEARNED:

1. NBACC staff frequently hear reference to our “Safety Culture” but what does that really mean? The term “safety culture” is really referring to the manner in which the aspects of all activities conducted at NBACC come together to create the NBACC way of performing work in an environment that supports doing the right thing in the right way. Examples identified this month includes:
  - a. Lessons learned are not only for use while at NBACC. When a strong safety culture is created, staff start to consider safety aspects in all parts of their lives. Multiple success stories this month highlight how the approach to safety at the NBACC can extend into non-work activities to help staff and their families remain safe.
  - b. A strong safety culture fosters a questioning attitude and a belief that it’s important for everyone to have their coworker’s back. When you see something that doesn’t seem right, standing up and asking questions or getting clarification can save themselves or a coworker from having a bad day.
2. Empty coffee pots, full waste baskets, everyone’s seen them. How often do you come across a situation where the previous person didn’t take the time to correct a situation and now you have to deal with it? Well not at NBACC. In numerous situations this month, staff members recognized a potential issue and took positive actions to correct the situation. Staff should always assume that the next person may not recognize a hazard and taking the time to eliminate it could very well save someone else from having a very bad day. Remember to always look out for your coworkers (and yourself) by ensuring hazardous situations are remedied as soon as possible.
3. The term “ownership” is frequently used in the work place to signify taking an active participant role in completing a task or assignment and involves staff delivering a work product that they would want to have their name associated with. Two excellent examples during the past month involve Success Story #1 and the appearance of finger cut awareness posters around the NBACC. In the first example, staff received a task to brief their team on emergency procedures. Instead of simply reviewing SOP’s and parroting information, they actively walked through processes to ensure they fully understood them and were able to identify two important improvements. In the second example, the ISC recognized that finger cuts continue to be a common occurrence at NBACC. They engaged in a brainstorming process and identified the use of posters as a way to increase the level of awareness with staff. While this may be a coincidence, for over a month after the posters appeared, there was not a single hand injury at NBACC.

#### EVENT SUMMARIES:

1. **FIRST AID SUMMARY:** 11/04/2015; A BNBI employee fainted in the BSL-3 while walking down a hallway. After examination by the CMA, the staff member was allowed to return to work. No injury resulted from the event.

2. **FIRST AID SUMMARY:** 11/16/2015; A BNBI employee had their foot pinned to the bed of a pick-up truck by the hydraulic ramp on the loading dock. A steel plate had not seated correctly into its resting position allowing it to slip while not in use. The CMA examined the employee and applied first aid. A more global set of corrective actions to identify and eliminated future hazards is in effect.
4. **FIRST AID SUMMARY:** 12/10/2015; A BNBI employee cut their finger on the serrated edge of a roll of aluminum foil while in BSL-3. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.
5. **FIRST AID SUMMARY:** 12/30/2015; A BNBI employee cut their finger while moving a computer monitor in BSL-3. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.
6. **FIRST AID SUMMARY:** 01/04/2016; A BNBI employee twisted their knee while walking up a flight of stairs. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.
7. **FIRST AID SUMMARY:** 01/06/2016; A BNBI employee cut their finger while stacking and labeling plates in BSL-3. The CMA evaluated the employee, administered first aid, and ruled that this was not a potential exposure. The injury resulted in no work restrictions.
8. **OSHA RECORDABLE INJURY SUMMARY:** 01/06/2016; A BNBI employee reported that they observed a small amount of liquid splash out of the BSC and land on their lab coat while working with a RG3 agent at BSL-3. The employee followed all spill procedures and reported immediately to the CMA. The CMA ruled that this incident had a minimal potential for exposure and the employee was restricted from working in BSL-3 for seven days.
9. **FIRST AID SUMMARY:** 01/06/2016; A BNBI employee cut their finger while opening boxes in the BSL-3. The CMA evaluated the employee, administered first aid, and ruled that this was not a potential exposure. The injury resulted in no work restrictions.
10. **FIRST AID SUMMARY:** 01/11/2016; A BNBI employee experienced a cut on their face from the sharp edge of a re-sealable plastic bag while in an administrative area. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.
11. **FIRST AID SUMMARY:** 01/13/2016; A BNBI employee experienced a paper cut on their finger while in an administrative area. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.
12. **FIRST AID SUMMARY:** 01/14/2016; A BNBI employee working in an administrative area cut their finger when the lid to a lock box slipped. The CMA evaluated the employee and administered first aid. The injury resulted in no work restrictions.

#### **NEAR MISS SUMMARIES:**

1. **EQUIPMENT FAILURE SUMMARY:** 11/04/2015; A BNBI employee reported that an electrical outlet on a chemical fume hood overheated and tripped the ground fault circuit interrupter (GFCI) in a BSL-2 lab. The NBACC electrician replaced the outlet.
2. **LAB PROCESS FAILURE SUMMARY:** 11/05/2015; A BNBI employee reported that a gas permeable bag containing petri plates opened up while it was in a BSL-3 incubator. The bag opened due to tape coming undone.
3. **SECURITY FAILURE SUMMARY:** 11/05/2015; A BNBI employee reported a working stock form had not been correctly updated the previous day. The RO was notified and the form was corrected.

4. **SECURITY PROCESS FAILURE SUMMARY:** 11/10/2015; A BNBI employee was escorted into a laboratory prior to the escorted laboratorian form being completed. The proper paperwork was completed immediately thereafter.
5. **EQUIPMENT FAILURE SUMMARY:** 11/11/2015; A -80 freezer lock core became dislodged and disabled the lock during an external auditor inspection. The lock was repaired by FMO without additional consequences.
6. **SECURITY PROCESS FAILURE SUMMARY:** 11/15/2015; A NBACC staff member was escorted into a laboratory prior to the escorted laboratorian form being completed. The proper paperwork was completed immediately thereafter.
7. **FACILITY PROCESS FAILURE SUMMARY:** 11/19/2015; A BNBI employee reported that a valve on the EDS vent pipe dripped a small amount of material onto the floor of an industrial space. The spill was cleaned up with appropriate disinfectant. The valve connections were tightened to prevent to future occurrences.
8. **FACILITY PROCESS FAILURE SUMMARY:** 11/30/2015; A BNBI employee reported that a connection on a BSL-3 effluent pipe leaked a small amount of material onto the floor of an industrial space. The spill was cleaned up with appropriate disinfectant and the leak was repaired. A CAPA has been initiated to evaluate the BSL-3 drain system.
9. **FACILITY PROCESS FAILURE SUMMARY:** 12/01/2015; A BNBI employee found a small spill of unknown liquid underneath a BSL-3 autoclave. The material turned out to be non-contaminated water from a leaking door gasket pressure switch, which was repaired immediately.
10. **PPE FAILURE SUMMARY:** 12/7/2015; A BNBI employee reported that the outer layer of the hose supplying breathing air to another staff member's BSL-4 suit was torn. This was brought to the attention of the individual who then exited the lab using normal procedures. The internal air hose was not damaged and the CMA determined that it was not a potential exposure.
11. **PPE FAILURE SUMMARY:** 12/16/2015; When an employee in a BSL-3 lab went to put on a PAPR, they noticed that one of the prongs of the plug on the charging station had broken off in their PAPR motor. After further investigation they found that multiple plugs had damaged or missing prongs. The employee immediately notified a Safety staff member, placed the charging station and motor out of service, and hooked up the new station given to them by the Safety staff member.
12. **LAB PROCESS FAILURE SUMMARY:** 12/10/2015; A BNBI employee reported that they had accidentally broken a glass thermometer while working in a BSL-2 lab. The glass and the alcohol were cleaned up and no injuries resulted from the event.
13. **SECURITY FAILURE SUMMARY:** 12/30/2015; A BNBI employee was completing the daily pre-work checklist and discovered that an airlock door to the BSL-4 was not properly secured. The emergency release on the door had been pulled during a suite quadrant decontamination to allow for retrieval of biological indicators. The handle to the door was removed in order to maintain the BSAT exclusion area.
14. **PPE FAILURE SUMMARY:** 01/20/2016; A BNBI employee reported an outer glove tear (latex) while working with a Risk Group 3 agent in the BSL-3. The CMA ruled that this was not a potential exposure.