HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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AHC Media

Under the gun: Hospitals pressed to take action on violence

HHS warns of "active shooters," OSHA cites hospitals

Violence against health care workers — particularly nurse assistants and nurses — is increasing at an alarming rate that warrants immediate action. Accordingly, there has been a surge of recent activity by a variety of federal agencies and other organizations that reach consensus on one point: The level of violence in health care has become unacceptable.

"There's absolutely a lot of momentum on this issue," says **Jaime Dawson**, MPH, senior policy advisor with the American Nurses Association in Silver Spring, MD. "I think the culture is changing. Nurses are not accepting violence as a part of their job."

> "I THINK THE CULTURE IS CHANGING. NURSES ARE NOT ACCEPTING VIOLENCE AS A PART OF THEIR JOB."

The Occupational Health Safety Network (OHSN) — a Web-based portal that collects data about injury and incident reports in hospitals and other settings — reports that from Jan. 1, 2012 to Sept. 30, 2014, workplace violence injury rates increased for all non-physician job classifications and nearly doubled for nurse assistants and nurses.[1]

Given that level of increase, is it possible some kind of a surveillance artifact could be occurring through increased reporting or other factors? Unfortunately, that is not the case, explained **Ahmed Gomaa**, MD, ScD, MSPH, a medical officer in the surveillance hazard evaluation branch of the National Institute for Occupational Safety and Health (NIOSH).

"This finding is an actual increase representing the data collected from the

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112 participating facilities located in 19 states," he says. "A similar workplace violence increase is also documented by a Bureau of Labor Statistics report — a national survey which showed a 16% increase from 2012 to 2013."

The OHSN collected data on OSHA-reportable injuries related to violence for the period, finding that the hospitals reported a total of 2,034 incidents. OSHA reported violent injuries were defined as incidents that result in at least one of the following: loss of consciousness, days away from work, restricted work activity or job transfer, medical treatment beyond first aid, a diagnosis by a physician, and death. Incident reports that provided details suggests that virtually all of the injuries resulted from physical assaults by patients.

"Patients at risk for committing violent acts [include] those with mental illness, behavioral disorders, and cognitive dysfunction," Gomaa says.

Numb to violence?

Given the surge of incidents it is fair to ask whether health care is becoming numb to violence, as it seems much of the nation has after one mass casualty event after another. Consider the glaring contrast of the Ebola outbreak: Two nurses became infected with the Ebola virus last year and there were nursing protests in the streets and government officials saying they would protect health care workers at all costs. Two cases and both survived. Strange that so little is said about health care workers dying every year due to workplace homicide. For the last decade, an average of 15 health care workers a year have been the victims of workplace homicide, according to **Dan Hartley**, EdD, workplace violence prevention coordinator at NIOSH.

Though the murder rate has seemingly plateaued at that grim level, overall violent incidents in health care are on the rise and are disproportionate to the level occurring in other work sites. In 2013, health care workers reported an estimated 9,200 workplace violence incidents requiring time away from work to recover, with the majority of these perpetrated by patients or their family members, Harley noted in a recent NIOSH blog post.[2]

"That represents 67% of all nonfatal violence-related injuries from an industry that only represents 11.5% of all workers," he emphasized.

The situation is serious enough that the Department of Health and Human Services (HHS) is advising hospitals and other health care settings to incorporate "active shooter" scenarios into their emergency operations plans. (*See related story, page 66.*) In April, the Occupational Safety and Health Administration released updated workplace violence guidelines. "This is the first update in over a decade and it could not have come sooner," **Jordan Barab**, deputy assistant Secretary of Labor, said in an OSHA blog post accompanying the release of the guidelines.[3]

OSHA has issued 18 citations and 57 "hazard alert" letters to health care employers since October 2012 for failing to have an adequate program to prevent workplace violence. During this period, the agency has conducted 148 inspections in response to workplace violence complaints. Of those, 101 were in healthcare or social service settings.

In addition to the actions by

OSHA and the HHS, other groups are sounding the alarm on violence in health care. For example, a major patient safety organization — ECRI Institute of Plymouth Meeting, PA — named "managing patient violence" as a top patient safety concern. The American Nurses Association is drafting a position statement on "incivility, bullying and workplace violence," and nurses continue to rank "on the job assault" as one of their top workplace concerns. The California Occupational Safety & Health Standards Board is drafting a rule that would require health care employers to have a comprehensive workplace violence prevention program. Five other states require workplace violence prevention programs in hospitals.

Active shooter incidents in hospitals are much less common than the day-to-day verbal and physical assaults. But they have focused national attention on the overall problem, says **Jane Lipscomb**, PhD, RN, FAAN, professor in the University of Maryland School of Nursing and Medicine in Baltimore and an expert on workplace violence.

"I think employers are waking up to this," says Lipscomb, co-author of *Not Part of the Job: How to Take a Stand Against Violence in the Work Setting* (ANA, 2015). "There are some hospitals that are really stepping forward and it's reassuring."

While most physical assaults never make the headlines, they are "none-the-less severe and life-changing," notes **Dee Tyler**, RN, COHN-S, FAAOHN, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP). The new OSHA guidelines provide strategies to help manage the situations that lead to violence, she says.

Violence a hazard OSHA 'takes seriously'

OSHA has been emboldened to use the "general duty clause" of the Occupational Safety and Health Act and will likely issue more citations for workplace violence in hospitals, says **Valerie Butera**, a partner with Epstein Becker Green in Washington, DC, who specializes in occupational safety and health law.

In its budget justification for Fiscal Year 2016, OSHA noted that it plans to hire more compliance officers and focus on more complex inspections. OSHA specifically highlighted its efforts related to workplace violence: "Novel hazards, such as workplace violence, are important to pursue to put the employer and employee communities on notice that these are hazards that OSHA takes seriously."

In August 2014, OSHA cited Brookdale University Hospital and Medical Center in Brooklyn, NY, for a "willful violation" — defined as one that the employer either knowingly commits or commits with indifference to the Occupational Safety and Health Act — related to about 40 incidents that occurred earlier in the year. Nurses had been kicked, hit, and punched, causing various injuries, OSHA said. In the most egregious incident, a patient attacked a nurse and stomped and kicked her repeatedly in the head, leading to severe brain damage.

"Brookdale management was aware of these incidents and did not take effective measures to prevent assaults against its employees. The facility's workplace violence program was ineffective, with many employees unaware of its purpose, specifics or existence," said **Kay Gee**, OSHA's area director for Brooklyn, Manhattan, and Queens.[4] As a result, OSHA cited Brookdale for one willful violation, with fines totaling $78,000 for failing to "develop and implement adequate measures to reduce or eliminate the likelihood of physical violence and assaults against employees by patients or visitors."

Brookdale contested the citations, issuing a statement that said: "The safety and security of our employees, patients and visitors is and has been our highest priority. Workplace violence is a challenge that all health care institutions around New York City and the country face, and it is completely unacceptable any time a staff member is assaulted while simply doing his or her job to help others. While we have fully cooperated with OSHA during its investigation and on our own have strengthened our already robust security procedures, we absolutely disagree with OSHA's finding that the Hospital willfully violated any regulatory requirement."[5]

Robert Kulick, OSHA's regional administrator in New York, said in a statement as the citations were issued, "The hazard of violence against employees is well-recognized in the health care industry and known to this employer. Brookdale must actively and effectively implement a Workplace Violence Prevention Program immediately to ensure the safety and well-being of its workers."

To Butera, such pronouncements indicate that OSHA's voluntary workplace violence guidelines are more than mere suggestions. In March, Wal-Mart withdrew its appeal of a general-duty clause citation related to the 2008 trampling death of a worker — which provides further encouragement for OSHA to use the tactic to address injuries for which there is no standard, she says.

"You should do all that you can to have a program that is similar to what they're setting out in the [workplace

OSHA outlines 'universal precautions' for violence

In recently issued guidelines on preventing violence, the Occupational Safety and Health Administration outlines key strategies to reduce hazards in high-risk health care environments.[1] Violent events are not completely predicable, but OSHA identified risk factors in patients and institutional cultures that can set the stage for an incident.

"While no specific diagnosis or type of patient predicts future violence, epidemiological studies consistently demonstrate that inpatient and acute psychiatric services, geriatric long term settings, high volume urban emergency departments and residential and day social services present the highest risks," OSHA reports. "Pain, devastating prognoses, unfamiliar surroundings, mind and mood altering medications and drugs, and disease progression can also cause agitation and violent behaviors."

In addition, an individual hospital may have inherent risk factors for such incidents, including lack of facility policies and staff training for recognizing and managing escalating hostile behavior. According to OSHA, institutional risk factors include:

- Working when understaffed — especially during mealtimes and visiting hours
- High worker turnover
- Inadequate security and mental health personnel on site
- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms
- Unrestricted movement of the public in clinics and hospitals
- The perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges

If an incident occurs, make every effort to get to the root causes, OSHA urges: "Don't stop an investigation at 'worker error' or 'unpredictable event.' Ask 'why' the patient or client acted, 'why' the worker responded in a certain way, etc."

Investigate "near misses," as well, as these situations that could have escalated into violence may provide insights into prevention. "Near misses are caused by the same conditions that produce more serious outcomes, and signal that some hazards are not being adequately controlled, or that previously unidentified hazards exist," OSHA states.

Overall, OSHA recommends five elements as the building blocks of a violence prevention program.

Management commitment and worker participation: This includes articulating a policy and goals, allocating adequate resources, and holding managers, supervisors and workers accountable. A "comprehensive program of medical and psychological counseling" should be available to workers who witness or experience violent events. Frontline workers should be involved in the development and implementation of violence prevention programs.

Worksite analysis and hazard identification: A team that includes senior management, supervisors and workers should identify existing and potential hazards. This includes a records review, employee surveys and workplace security analysis. The team would then identify control measures and appropriate training.

Hazard prevention and control: Employers should take appropriate steps to prevent or control the identified hazards and periodically evaluate the effectiveness. This includes physical changes, such as barriers, panic buttons and better lighting, and work practice changes, such as adjusting staffing levels, identifying patients with a history of violence, and other safety measures.

Safety and health training: All workers, including contractors and temporary employees, should receive training on the workplace violence prevention program at least annually. Those in high-risk settings should receive training as often as monthly or quarterly with a focus on specific hazards. "Every worker should understand the concept of 'universal precautions for violence'— that is, that violence should be expected but can be avoided or mitigated through preparation," OSHA says.

Recordkeeping and program evaluation: Employers should track the effectiveness of the prevention program by using OSHA logs, medical reports of worker injury, information on patients with a history of violence, security reports and other documents and records. Monitoring should include surveys of employees regarding hostile situations they encounter on the job. "Responsible parties (including managers, supervisors and employees) should reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action," OSHA says.

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1. Occupational Health and Safety Administration. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. 2015: http://1.usa.gov/1al3BSr. ■

violence] guidelines," she advises.

Expect OSHA to scrutinize injury reports, especially those involving inpatient hospitalization, which must be reported to OSHA within 24 hours of an incident, she says. OSHA also has said it plans to focus on high-risk industries, which includes health care.

"I think it's a powerful time for OSHA," says Butera. "They're probably going to be extremely active for the rest of this administration."

Guide to keeping workers safe

The updated OSHA workplace violence guidelines are structured around the basic components of a comprehensive injury and illness prevention program: management commitment and employee participation, worksite analysis, hazard prevention and control, safety and health training, and recordkeeping and program evaluation.[6] (*See related story, page 64.*)

The guidelines provide charts with suggested safety measures and strategies for different types of health care settings, such as hospitals, residential treatment centers and community care. OSHA also provides checklists for issues such as security measures, staffing, training and work procedures.

"It helps employers understand how to fulfill their responsibility to keep workers safe," says Lipscomb.

OSHA notes that 50% of all reported workplace assaults involve health care workers. Assaults are the cause of about 10% of all health care worker injuries that require days away from work, compared with just 3% of such injuries among all private industry employees.

Changing that dynamic may require more than voluntary guidelines, says **Jonathan Rosen**, MS, CIH, of AJ Rosen & Associates LLC, who was instrumental in advocating for a New York law covering public employees when he was with the Public Employees Federation.

"In health care, there are all kinds of written programs that look impressive, but do they really reflect the practices day to day on the ward in terms of dealing with people before they become violent?" he says.

California is drafting a standard that will become the strongest in the nation, says **Mark Catlin**, health and safety director of Service Employees International Union in Washington, DC. It will require site-specific hazard analysis and monitoring of threats as well as injuries. It will cover non-clinical as well as clinical employees and the public and private sectors, he says.

Health care workers have flocked to hearings to tell their stories of workplace assaults, giving the rule-making grass-roots energy, he says. "Our ultimate goal would be an enforceable national standard along the lines of what we're seeing in California," Catlin says.

Violence also a patient safety concern

ECRI Institute, a leading patient safety organization, gave hospitals another reason to implement violence prevention: It threatens to erode patient care, as well as worker safety. ECRI named "managing patient violence" as No. 3 of the top 10 patient safety concerns in 2015.

Health care workers who don't have adequate training may try to minimize contact with patients who are known to be verbally abusive or to act out violently, says **Cindy Wallace**, CPHRM, an ECRI risk management analyst. "It becomes a patient safety issue if staff are hesitant to manage someone who has acute care needs," she says.

ECRI advises hospitals to require reporting of incidents, train staff in de-escalation strategies, and implement and monitor security measures, including having a rapid-response team to respond to emergencies, if appropriate. "The hospital should have a facility-wide safety plan that considers all levels of risk, from the single acute episode of threatening behavior to an active shooter situation anywhere in the facility or on campus," ECRI said.

Hospital leadership should address factors that could be precursors to aggression and violence, says **Ruth Ison**, MDiv, STM, ECRI Institute PSO patient safety analyst and consultant. For example, a delay in finding a bed for a psychiatric patient in the emergency room may create unnecessary stress. Problems with staffing levels, staffing mix and team coordination can raise the potential for patient aggression, and patients under the influence of drugs or alcohol are likely to be more emotionally volatile, she says.

"It's the underlying risks that are going unrecognized in the health care environment," she says. "That's where the problem lies."

Meanwhile, the ANA issued a draft position statement on "incivility, bullying and workplace violence." The association is addressing worker-on-worker and patient-on-worker aggression as part of a "larger complex phenomenon."

"They are not separate issues. They all relate to a work environment where these risks exist," says Dawson.

The ANA is recommending a zero tolerance policy for bullying and violence, mentors for new nurses, and

even a Code Pink or similar code to provide support for someone who is being bullied on the job. Linking the different forms of violence is important, says Dawson.

"Nurses want to work in healthy environments where they feel safe and in environments that support the best patient care," she says.

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The active shooter in health care: 'Gut' feelings may be the first sign, but what about patients?

If an incident erupts HHS mantra is 'run, hide, fight'

Who is the active shooter in a health care setting? No real profile exists, but research in other settings indicates there may be signs or indicators, according to a recent report by the Department of Health and Human Services (HHS).[1]

For example, a report on campus shooting incidents by the Federal Bureau of Investigation and other agencies made several key observations related to pre-attack behaviors. Concerning behaviors were observed by friends, family, associates, professors, or law enforcement, the HHS reports. These behaviors included paranoid ideas, delusional statements, changes in personality or performance, disciplinary problems on site, depressed mood, suicidal ideation, non-specific threats of violence, increased isolation, "odd" or "bizarre" behavior, and interest in or acquisition of weapons, the HHS notes. Other behaviors often include development of a "personal grievance," a major life event involving "real or perceived personal loss," such as a death, breakup, divorce or loss of a job.

Given these various and sundry manifestations, it may come down to trusting a gut feeling about a particular person or situation.

"Pilots and other people in high-stakes fields learn how not to ignore their gut feelings," says **Michael Dorn**, executive director of Macon, GA-based Safe Havens International, which provides training to prevent violence on campuses. "If you have a patient who is not acting like patients typically do in a situation, then key in on that. What we know is people can key on specific indicators of danger because the brain is picking up patterns of behavior that are not the norm."

For instance, a patient or family member might exhibit inappropriate anger when meeting with hospital providers or behave in a way that causes a nurse to feel something is off. It's these gut feelings that nurses and other staff should pay close attention to, Dorn says.

Three moments in time

The HHS document is aligned with the three time frames associated with an active shooter incident: pre-incident, incident, and post-incident response, observes **Dan Hartley**, EdD, workplace violence prevention coordinator at the National Institute for Occupational Safety and Health (NIOSH). While still a relatively rare event, hospital-based shootings nearly doubled in one study — going from nine active shooter incidents per year during 2000-2005 to almost 17 per year during 2006-2011, he notes in a NIOSH blog about the issue.[2] In the study, the emergency department was the most common incident site (29%), followed by the parking lot (23%) and patient rooms (19%). Most events involved a determined shooter with a strong

motive as defined by grudge (27%), suicide (21%), "euthanizing" an ill relative (14%), and prisoner escape (11%).[3]

"The active shooter incident is still an anomaly in the healthcare setting," Hartley observes. "However, training in how to prevent and respond to an active shooter incident is very important and should complement training in prevention and response to other more prevalent types of workplace violence."

The HHS report says health care employees should learn the signs of a potentially volatile situation that could develop into an active shooter incident. Each employee should be empowered to proactively seek ways to prevent an incident with internal resources or additional external assistance, the report states.

"During an active shooter incident, the natural human reaction, even for those who are highly trained, is to be startled, feel fear and anxiety, and even experience initial disbelief and denial," the HHS says. "There may be noise from alarms, gunfire and explosions, and people shouting and screaming. Training provides the means to regain composure, recall at least some of what has been learned, and commit to action."

The HHS recommends health care workers be taught the easy-to-remember mantra: "Run, Hide, Fight." As health care facilities train and discuss these options, they should be viewed on a continuum. Everyone should be trained first to run away from the shooter, if possible, encouraging others to follow. If that is not possible, they should seek a secure place to hide and deny the shooter access.

"As a last resort, each person must consider whether he or she can and will fight to survive, incapacitate the shooter, and protect others from harm," the HHS notes. "Though this may seem extreme, in a study of 51 active shooter incidents that ended before law enforcement arrived, the potential victims stopped the attacker themselves in 17 instances. In 14 of those cases, they physically subdued the attacker."

That said, health care workers may have challenges unique to their field and feel conflicted about, for example, abandoning patients by running away. "Health care professionals may be faced with the decision about the safety of patients and visitors in their care who may not be able to evacuate due to age, injury, illness, disability or because of an ongoing medical procedure," the HHS report notes.

THE HHS RECOMMENDS HEALTH CARE WORKERS BE TAUGHT THE EASY-TO-REMEMBER MANTRA: "RUN, HIDE, FIGHT."

This "sensitive topic" could be discussed in an open conversation with employees. The HHS guide provides some points for discussion, saying that addressing the topic may be uncomfortable to some and reassuring to others in the sense that the facility is trying to address a very difficult scenario. "There is no single answer for what to do, but a survival mindset and open and honest discussion can help increase the odds of survival."

Spotting weapons, unusual patterns

According to Dorn, some other specific ways hospital employees can be trained in a violence and active shooter prevention program include visual weapon spotting and pattern recognition.

"People can be trained to identify specific cues that someone is carrying a weapon," Dorn says. "For example, a jacket sag: If you stick a gun in the pocket of a jacket, then the jacket will pull tight on that side of the body and the gun may bounce against your hip as you walk."

Hospital security and emergency room or reception staff can be trained to spot the outline of a gun in someone's pocket.

"The key is to train people to observe these cues and then to empower them so nurses and other health care workers feel free to act on what they observe," he says. "You need to have systems in place so they can see things, size up the situation, and act fast enough by pushing a distress button or calling someone to start a chain of events to prevent violence."

Pattern recognition may include a routine event playing out in an unusual way. Dorn offers the example of a police officer at a middle school who watched from a football field away a school bus in which the pattern of kids quickly climbing on board was different. Instead, the children were milling around the bus and not getting on. The officer went to the scene and saw that three men across the street ere waiting for the kids to get on the bus, apparently targeting a particular student. He approached the men, who ultimately were arrested.

An unexpected benefit to this

type of training is that the attention to detail often translates to better customer service, Dorn notes. "When a hospital trains staff on pattern visual recognition, it creates better connectivity to people, and it makes reception staff more attentive to someone coming into the lobby," he adds.

Workplace violence often is related to domestic violence, so hospitals should screen employees and provide background checks. Employee health directors also should encourage hospital managers to adopt a discrete, open door policy when it comes to employees discussing personal life issues that might impact their working lives, Dorn suggests.

"Emphasize that people have situations that come up and can cause risk, so if an employee is having problems with a girlfriend or boyfriend, a neighbor, spouse, ex-wife or ex-husband, then the worker needs to talk about it with a manager," he says.

Reporting personal conflicts can save lives, he adds. "We had a situation where a teacher met a guy at a bar, gave him her personal information and then regretted doing so because she became afraid of the guy," Dorn recalls. "The man was a stalker, and the employee came to her administrator and discussed what was going on."

The administrator advised workers to be on the look-out for the man and his vehicle type. One day a custodian saw the car in the parking lot. Police arrived and found that the man had a gun and may have been intent on shooting the teacher.

"It's not easy for employees to talk about personal problems," Dorn says. "So you need to create an environment of trust where they feel comfortable doing that."

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Hospital uses team to defuse volatile situations

A 'Code Grey' call when events begin to escalate

As a hospital patient or visitor demonstrates escalating frustration or agitation, there may be a narrow, closing window to defuse the situation before violence ensues. At South Nassau Communities Hospital (SNCH) in Oceanside, NY, it's time to call "Code Grey."

Maureen McGovern, RN, CPHRM, director of risk management and patient safety officer at SNCH, also uses a specially trained team that responds to reports of a patient or other person exhibiting signs of potentially violent behavior. When healthcare workers recognize signs of agitation and a buildup toward violence, they call a "Code Grey" on the hospital intercom system. Employees with special training in de-escalating behavior and containment of violent subjects respond.

"All employees are trained in recognizing potential workplace violence and the availability of the Code Grey team," McGovern says. "The team is called out most often for situations that do not result in violence, but we're OK with that. There is no penalty for calling the Code Grey team."

"Speak in a calm, clear voice"

Also, the presence of the Code Grey team often defuses a person who otherwise might have become violent, McGovern explains. A nurse may call the team for a disruptive patient who refuses to take medications, for example, and seeing the team there and ready to intervene might make the patient think twice about lashing out.

All nurse managers are trained for the Code Grey team, along with nursing supervisors, and many are certified in crisis intervention through the Crisis Prevention Institute in Milwaukee. Some members of the hospital's security department also are certified in crisis intervention.

"They have been trained on what might trigger the situation to become violent and what techniques to utilize to calm the patient and avoid violence," McGovern says. "For instance, they are trained to always speak in a calm, clear voice, always be polite, be aware of their

own body language, listen to the person, and show confidence and compassion. They learn what the patient's complaint is and restate it to ensure they understand, apologize if appropriate, and give the person options for how to resolve the situation."

The team members also calmly but firmly outline the limits of what can be done to address the person's concerns. At SNCH, the Grey Team is usually called out between 20 and 30 times per month.

Understanding what typically prompts a patient to threaten violence or act violently is important, McGovern says. In healthcare, the motivation might be pain, alcohol or drug withdrawal; a reaction to a medication; disregard of the person's personal space; slow response to the patient's needs; delirium and dementia; or a number of other causes.

Every Code Grey call is debriefed to determine how the process worked in defusing or containing the violence, and any injuries are studied closely to see if improvements in the process would reduce them. Very few Code Grey calls result in injuries, McGovern says. ■

HCW injuries call for improved safety culture

'Every single injury is an opportunity to find the risk factor'

Injury prevention measures that reduce job risks to nurses and nurse assistants are urgently needed as part of a safety culture that emphasizes continuous improvement and resources such as patient lifting equipment and ongoing training, the Occupational Health Safety Network (OHSN) reports.

The OHSN is a Web-based portal that collects data about injuries among healthcare personnel at U.S. health care facilities to help target prevention efforts and measure their impact.

"OHSN does not collect culture of safety indicators, but in general we encourage a culture of safety and the attitude that every single injury is an opportunity to find the risk factor for the injury and put in place an unceasing effort to prevent similar future injuries," says **Ahmed Gomaa**, MD, ScD, MSPH, a medical officer in the surveillance hazard evaluation branch of the National Institute for Occupational Safety and Health (NIOSH).

OHSN collected data on OSHA-reportable injuries at 112 hospitals in 19 states from January 1, 2012–September 30, 2014. The report included 10,680 total injuries, including 4,674 caused by patient handling; 3,972 that resulted from slips, trips, and falls; and 2,034 due to workplace violence — primarily physical assaults by patients.[1]

Incidence rates for patient handling; slips, trips, and falls; and workplace violence were 11.3, 9.6, and 4.9 incidents per 10,000 worker-months, respectively. (A worker-month was defined as the number of full-time equivalent workers at a facility multiplied by the number of months worked within the reporting period. For example, a facility with a stable workforce of 1,000 full-time workers has 12,000 worker-months in a 12-month reporting period. If this same facility reported data for only eight months, then they would have 8,000 worker-months.)

Patient handling and workplace violence injury rates were highest in inpatient adult wards, particularly in outpatient emergency departments, urgent care, and acute care centers and adult critical care departments. Rates of falls were highest in inpatient adult wards, non-patient care maintenance areas, and operating rooms. Of all patient handling injury reports, 62% included data on the use of lifting equipment. Of those, 82% of the injuries occurred when lifting equipment was not used.

"Similar to findings from other studies, OHSN data indicates that interventions [like] the use of lifting equipment could potentially reduce patient-handling injuries, particularly for activities involving positioning, transferring, or lifting a patient," Gomaa says.

Slips, trips, falls

Those activities can result in musculoskeletal injuries and disorders, which are increasing among health care workers, the OHSN report noted. Nursing staff are routinely exposed to several musculoskeletal disorder risk factors, including:

- caring for overweight/obese and acutely ill patients;
- high patient-to-nurse ratios;
- long shifts;

• efforts to mobilize patients almost immediately after medical interventions.

Of all slips, trips, and falls injury reports, 65% had data on fall type. Of those 89% were falls on the same level, 9% were falls to a lower level (e.g., down stairs, ramps, etc.) and 2% were slips and trips without falling. On the basis of OHSN findings, the major causes of slip, trip, and fall injuries are floor contaminants and contact with objects. However, the variability in types of these injuries indicates that each facility should use facility-specific data to guide prevention measures. The OHSN Web page provides links to helpful resources on safe patient handling methods and prevention of falls among health care personnel, including a comprehensive falls hazards checklist. (http://1.usa.gov/1Ow0A4r)

Nurse assistants were more likely to sustain injuries than workers in other job categories; this occupation had more than twice the injury rate of nurses for patient handling and workplace violence injuries. Injury rates for slips, trips, and falls were highest among nonpatient care staff (e.g., maintenance and security staff), nursing assistants, and nurses. Between 2012 and 2014, workplace violence injury rates increased for all job classifications and nearly doubled for nurse assistants and nurses.

Overall, the data indicate that interventions should first focus on prevention of injuries to nurse assistants and nurses from patient handling; slips, trips, and falls; and workplace violence. Patient handling and workplace violence injuries reported to OHSN were clustered in locations providing direct patient care, while slips, trips, and fall injuries occurred in both patient and non-patient areas. Analysis of detailed, facility-level data could identify the higher risk occupations and locations of each facility and assist in customizing prevention measures, the OHSN concluded.

"A culture of safety has been achieved if the healthcare facility — frontline workers up to top management — believe that their facility should offer the best hospital safety," Gomaa says. [They] have a daily huddle and strive to target prevention opportunities based on data-driven information. Hospital safety means patient safety, worker safety, and environmental safety — which are highly interrelated."

REFERENCE

1. Centers for Disease Control and Prevention. Occupational Traumatic Injuries Among Workers in Health Care Facilities — United States, 2012–2014. *MMWR* 2015:64(15);405-410 http://1.usa.gov/1JKjtd5. ■

Drug-diverting health care workers endanger themselves and patients, but are hard to spot

Usually 'high achievers,' behavior issues typically a late sign

Is an employee at your facility diverting opioids or other drugs for personal use? If so, not only are they risking their own life, they are putting patients at risk of suffering in the absence of pain medication and outbreaks due to contaminated medications.

Somewhat surprisingly, drug-diverting health care workers are not easy to spot by outward mannerisms, as most can appear perfectly collected and professional even under the influence of opioids, says **Kim New**, RN, JD, an independent drug diversion consultant in Knoxville, TN.

"When I work with institutions my first question is how many diversions have you uncovered in the last year and what method did you use," she says. "I feel very uncomfortable when I hear that hospitals are only picking up diversion through reports of behavioral issues. The reason for that is that behavioral manifestations are typically a late sign. Usually these folks are very high achievers. They are able to do a number of things and they are very well respected. They are top performers and continue to be that way even when they are diverting and using large amounts of opioids. So we need to be able to have a mechanism to pick up diversion before there are behavioral manifestations."

Drug diversion typically involves theft of an injectable opioid drug intended for a patient. As addicted health care workers try to cover their tracks by replacing the targeted drug with saline, for example, medications can become contaminated and infect subsequent patients. In other cases, workers already infected with

hepatitis C virus pilfer drugs from vials and syringes, transmitting the virus to unsuspecting patients through contaminated equipment and solutions. It is particularly shocking to see how many patients can be endangered by a single health care worker. Over the past decade, outbreak investigations have documented more than 100 infections and nearly 30,000 potentially exposed patients stemming from drug diversion in U.S. health care facilities, a Centers for Disease Control and Prevention study reveals.[1]

As disturbing as those numbers are, it should be noted that while protecting patients is paramount, there is an employee health issue: the addicted health care worker. For example, nurses emphasize the ethical obligation to try to get their addicted colleagues into treatment: "Drug diversion is a symptom of the disease of addiction …a treatable disease."[2] Encouraging health care workers with an addiction problem to seek treatment may be one of the best ways to save a caregiver's career before the disaster of an outbreak — the event that typically reveals the diverter.

To catch a thief

Many facilities have automated dispensing cabinets with sophisticated data analytics programs, which will highlight suspicious transactions that occur and will also do statistical comparisons of individuals on a particular unit against each other based on dose per transaction day, New explains.

"That's where you really want to be finding signs of diversion and doing focused auditing based on those analytics," New says. "Because you will find diverters much more quickly using data analytics than you will just waiting for someone to report something unusual."

A case in point was a new graduate in nursing, beginning her first days of unsupervised care at the University of Tennessee in Knoxville, where New previously ran a drug diversion program.

"On that first night that she worked independently she started diverting," New said. "Three days after she started diverting, I was able to pick it up based on some statistical comparisons I was doing on a regular basis. She went from being totally normal among her peers to being an extreme outlier in a matter of days."

The nurse was simply taking out duplicate doses, giving one to the patient and taking one herself. In this case, the stress of taking on the responsibility of being a nurse likely triggered the drug seeking behavior, New says.

"I've caught a number of new grads and there are different things that may lead to this type of activity," she says. "Some of them have told me that they [previously] had legitimate prescriptions for opioids that they were simply not able to get off of — when the prescription ran out they started diverting. But of course working in nursing, particularly as a new graduate, can be extremely stressful. Diversion may occur at that point because they are trying to cope with the stresses of their job."

While hospital oversight is one issue, regulations and even the threat of criminal charges may not be enough to deter a health care worker who is already ready to risk their job and livelihood by stealing drugs, New says. Nor are diverters like recreational drug users who may only indulge themselves occasionally, she adds.

"In my experience in talking to a number of diverters — and I've spoken to many — what they say is once they cross the line and divert there is no going back," New says.

"I have yet to speak to anyone that told me it was just occasional," she says. "This is a situation where someone knows that they are risking the loss of their job, the loss of their license, potentially the loss of custody rights to children and the deterioration of their marriage. This is not something that folks engage in casually."

New finds that diverters are typically nurses, which is probably because "they are the number one health care provider and they have regular access to controlled medications," she says.

REFERENCES

1. Schaefer, M.K., Perz, J.F. Outbreaks of infections associated with drug diversion by US health care personnel. *Mayo Clin Proc* 2014;89: 878–887
2. Tanga HY. Nurse Drug Diversion and Nursing Leader's Responsibilities: Legal, Regulatory, Ethical, Humanistic, and Practical Considerations. *JONA's Healthcare Law, Ethics, and Regulation* 2011;13:13-16. ■

COMING IN FUTURE MONTHS

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HOSPITAL EMPLOYEE HEALTH

CNE INSTRUCTIONS

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CNE QUESTIONS

1. OSHA-reported violent injuries were defined as incidents that result in at least one of the following:

A. Loss of consciousness
B. Days away from work
C. Medical treatment beyond first aid
D. All of the above

2. For the last decade, an average of how many health care workers a year are victims of workplace homicide?

A. 11
B. 17
C. 9
D. 15

3. Maureen McGovern, RN, CPHRM, said when a hospital patient or other person begins demonstrating agitation that may build to violence, a Code Grey is called. Who responds?

A. Security personnel with stun weapons
B. All male employees who hear the call
C. Employees with special training in de-escalating behavior
D. None of the above

4. According to the Occupational Health Safety Network, 62% of patient handling injuries occurred despite the use of lifting equipment.

A. True
B. False

CNE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.