



HOSPITAL EMPLOYEE HEALTH



THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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AHC Media

CMS Finalizing Disaster Reg; Includes Training, Assisting HCWs

HHS stresses need to preserve healthcare workforce

By Gary Evans, Senior Staff Writer

As dealing with natural disasters and emerging infections becomes the new normal for hospitals, CMS will soon issue “all-hazards” emergency regulations that include requirements for protecting and accommodating healthcare workers, *Hospital Employee Health* has learned.

“That rule is not yet final, but we anticipate that it will be coming out within a few months,” says **Melissa Harvey**, RN, MSPH, director of National Healthcare Preparedness Programs at the Department of Health and Human Services (HHS). “It would require drills and exercises. It would also require engagement with community partners in healthcare coalitions.”

The CMS regulation has been

shelved since it was issued as a proposed rule for review and comment in late 2013.¹ The rule, which would apply to hospitals, long-term care, ambulatory surgery centers, and many other settings,

allows some flexibility in meeting the following four core components of emergency preparedness:

- risk assessment and planning,
- policies and procedures,
- communication, and
- training and testing.

“IT WOULD REQUIRE ENGAGEMENT WITH COMMUNITY PARTNERS IN HEALTHCARE COALITIONS.”

Provisions on healthcare workers include providing basic sustenance, sheltering in place, establishing a communication list of all employees, and training “all new and existing staff, including any individuals providing services under arrangement, and

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volunteers, consistent with their expected roles, and maintain documentation of such training,” according to the rule. “We propose that the hospital ensure that staff can demonstrate knowledge of emergency procedures, and that the hospital provides this training at least annually.”

Disasters can undermine healthcare delivery while simultaneously increasing the demand for care by a stricken community. “This makes it essential that healthcare providers and suppliers ensure that emergency management is integrated into their daily functions and values,” the CMS states in the proposed rule.

All-hazards planning is defined as emergency preparedness planning for a “full spectrum” of disasters, with the common-sense caveat that hospitals would tailor their planning to the events most likely to occur in their vicinity. Thus, one obviously does not plan for hurricanes in the Midwest, but that still leaves multiple natural hazards from tornadoes to blizzards.

Fire and Rain

Indeed, this young century has already seen an almost biblical succession of flood, fire, hurricanes, tornadoes, terrorism, and bioterrorism — not to mention emerging infectious diseases from SARS to Zika virus. There are many factors involved, but one a broad consensus of scientists agrees on is that global climate change is contributing to more extreme weather events. Meanwhile, rapid global travel and movement of human populations into animal habitats favors the emergence of infectious diseases of zoonotic origin.

(For more information, see related story on page 114.)

The importance of assuring the safety of healthcare workers and their families has been a recurrent theme as emergency events hit communities. Many healthcare facilities are preparing for disasters, but there are competing priorities in healthcare that can undermine efforts in others.

“We think [the CMS regulation] will be helpful, but there have been for many years now — even if it hasn’t been a regulatory requirement — accreditation requirements for education and drills,” Harvey says. “But healthcare executives may have to decide are they going to pay their staff overtime to exercise and drill or purchase a critical piece of equipment that was needed for patient care yesterday. Those are some tough priorities and choices to make. I think [healthcare] staff certainly see the need to train and drill, especially after reading in the newspaper about other facilities dealing with emergencies, but it is tough in the current fiscal environment.”

That said, planning and foresight may translate to prevention of substantial expenditures and interruption of healthcare delivery during an emergency event. To highlight this aspect, the HHS issued an emergency planning guidance document² on Aug. 18, 2016, that includes examples of healthcare systems responding creatively and heroically in the face of disaster. The HHS guidance document is designed for healthcare facilities and other community institutions, like schools, that are still operational after an emergency event. In the aftermath, people throughout the community may be reeling from injuries, loss of loved ones, and the

need for shelter and food.

“Healthcare providers and staff who maintain facility operations are no exception, and yet they are a critical component of the response phase and expected to care not only for their own loved ones, but community members and the facility, too,” the HHS guidance states. “Leadership plays a vital role in ensuring staff feel cared for and safe. Remind your team that their jobs are important and secure. Provide regular and clear communication regarding how leadership is working to continue and restore operations.”

Immediate needs for healthcare workers may include care for their families, transportation, counseling, and funding. Failing to adequately prepare and accommodate healthcare workers could undermine patient safety and even lead to temporary closures.

“Having worked in this field for many for many years and having visited a lot communities after emergencies, there are two things we have found,” Harvey says. “One is some really excellent examples [of emergency response]. The other is the exact flip side where executives of healthcare facilities have come to us and said, ‘We could stay open right now, but we don’t have enough staff.’ This is largely because, in an emergency, healthcare staff are very concerned about what is happening at home. And I think all of us would feel that way.”

To address this issue, the HHS recommends options like setting up onsite care for children and elderly family members of healthcare workers.

“No employer should ever forget the loved ones of those who are aiding most in worksite recoveries,” says **Cathy Floyd**, MS, BSN, RN, DPA, COHN-S, regional manager

of occupational health at Memorial Hermann Health System in Houston.

Employee health professionals should know their role in the emergency response plan and communicate it to their colleagues, she says.

“Make sure employees know what employee health will and will not provide in an emergency,” she says. “Think about ‘what if’ scenarios, like ‘what if public disaster services can’t get to us for 24 to 48 hours?’ Be prepared — don’t be part of the problem.”

Floyd cites the following key points as some of the critical issues for employee health, particularly for those new to the field:

- **Take ownership of your employee health role in worksite emergency preparations.** Public health and community agencies may initially be overwhelmed. Partner with your employer’s disaster preparedness team and external public agencies.

- **Know your responsibilities for worksite employee health before disasters occur.** If necessary, conduct a needs assessment to determine what is needed in a disaster. Maintain supplies specifically for responding to post-disaster employee health issues. Human resources can identify mental health benefits to help with specific or anticipated problems.

- **Know your worksite’s weaknesses and vulnerabilities and participate in all disaster drills.** Prepare post-drill debriefings and identify what worked and what didn’t to improve your program.

Forward Thinking

While employees are more likely to report for work if their immediate needs are met, employers can also

raise morale and motivate their workforce by assisting healthcare workers.

“The Meridian Health System in New Jersey — near the Jersey Shore area that was affected during Hurricane Sandy — did some really wonderful things, such as giving out gift cards to their staff to Home Depot [and other stores] so they could take care of their very immediate [housing] needs,” Harvey says. “We certainly know other examples where healthcare facilities have kept tarps and sandbags on hand — not for the facility itself, but to give to their staff to shore up their houses either before or after an emergency.”

For those who must evacuate their homes, make sure employees have a list of local shelters. “After Hurricane Sandy, one health system comprised of 16 hospitals placed 62 employees’ families into temporary housing,” HHS notes. In addition to setting up flexible scheduling, HHS recommends appointing a “concierge” employee who could meet with groups of healthcare workers and determine who needs what. One issue that has come up time again is a marked concern for stranded pets.

“Recent experience has shown that survivors may be reluctant to evacuate their homes because they do not want to leave their pets behind,” the HHS emergency guidance states. “Employees may volunteer to ‘foster’ their colleagues’ pets in the short term or make sure the pets have been let out and have an adequate supply of food and water. If practical, identify nearby shelters that accept pets and share this information with your team.”

Understandably, even staff willing to work may have a hard time getting to the facility following floods or

other disasters.

“Consider partnering with churches or schools to use buses and drivers to transport employees to and from work,” HHS recommends. “In South Carolina, fire personnel used boats to transport staff through floodwaters to the hospital. Consider setting up a regular shuttle service or volunteer carpool service. After storms, gas can be in short supply. Facilities in Florida have had a tanker come to the hospital, allowing staff to fill their tanks.”

Such concerns may seem mundane for employees who have suffered a deep personal loss, so plans should include having behavioral health professionals ready to counsel and assist the emotionally traumatized. As part of this, staff may need to gather and process the experience, grieve, and share

experiences. This could continue in the disaster recovery phase if workers want to meet and discuss continuing challenges they are facing.

“Planning is different by facility, but every healthcare plan should involve some sort of staff ‘resilience’ aspect,” Harvey says. “They need to [address] resilience among their staff, which [could include] encouraging them to create a plan for their family and have emergency supplies in their home.”

The bottom line that is that healthcare facilities that fail to address employee health needs in the wake of a disaster may take longer to get back up to speed, and may find that healthcare workers are less inclined to work there even when the recovery is complete.

“Ultimately, we know that those facilities that take care of their staff

very well after an emergency have an easier time retaining their staff and that leads to a much more efficient recovery for healthcare facility,” she says. “Given that healthcare is a competitive market, there is a need for healthcare executives to think about how to retain their staff and keep the knowledge base they have built up within their system.” ■

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Know What You Don't Know

Emergency preparedness in a nutshell

Emergency response and employee health ultimately boils down to a paradoxical paradigm: “Know what you don't know,” says **Cathy Floyd**, MS, BSN, RN, DPA, COHN-S, regional manager of occupational health at Memorial Hermann Health System in Houston.

“In all fairness, there is much more to it than that,” she says. “But, we do try to do just that.”

As this issue went to press, Floyd was slated for a talk on emergency preparedness at the annual meeting of the Association for Occupational Health Professionals in Healthcare (AOHP). She agreed to field a few questions on this important topic for *Hospital Employee Health*.

HEH: When a natural disaster strikes, what are some of the first important measures that should be taken to ensure staff safety and the well-being of healthcare workers and their families so they can continue to work or safely leave work?

Floyd: As natural disasters unfold, prepare to work your plan, and hopefully you will have one with plenty of supplies stocked up. Some of the first important measures include the following and should be included in your plan:

- If your employees are responding to a disaster, be supportive and ensure they have access to plenty of food; clean water; dry or protective clothing, depending on the disaster; shelter,

especially for rest and sleeping; ample supplies of hand sanitizer; and rubber or leather gloves (again, depending on the disaster and environment), dust respirators, goggles, hearing protection. You get the picture.

- **Double-check immunizations with Tdap or tetanus.** If employees have previously placed current prescription medications, inhalers, and/or other medical supplies in the clinic or worksite infirmary for safekeeping, ensure they have immediate access to their personal items. You will also need on hand several copies of injury reports in case workers are injured during event response and recovery.

- **Additionally, once you have**

taken care of physical needs, don't forget the mental and emotional aspects of working disaster scenes.

Make certain you have a good supply of mental health recommendations on hand in case referrals are needed.

HEH: In addition to the obvious moral duty, you note that there is a regulatory aspect to emergency planning as required under the OSHA General Duty Clause. Do some employee health professionals and their colleagues face resistance as they try to plan and drill for things that may not be seen as a high priority in the day-to-day operations of a hospital?

Floyd: Absolutely. In most organizations, employee health is not a profit center, or profit-generating department. But, we are still responsible for helping to maintain a safe and healthy work environment. So for the most part, we are an employee benefit. And although employees may very well be an employer's "greatest asset," we cannot escape the bare minimum fact that in the business world there are, as we often refer to it, "competing priorities." For some organizations, that means, "Do we meet payroll this week, or do we purchase equipment and bulk supplies for disaster preparations — hurricane, tornado, earthquake, flood, etc.?"

Yet, under those conditions the resourceful, resilient employee health professional will often network effectively with others tasked with disaster management responsibilities, either locally or in their communities. These individuals may include internal environmental health and safety teams or with disaster response neighbors in our communities such as public health, federal agencies, employee assistance programs (EAP), and mental health entities.

Law enforcement and community agencies can also help identify organizations in the community which supply disaster recovery resources and advisement for discounted prices, and even pro bono services and supplies. More often than not, all one needs to do is look.

HEH: Can you describe a couple of strategies in creating and testing response plans? Should they be "all-hazard," or tailored for different contingencies?

Floyd: Both are good. Remember, the key is to know what you don't know; that's how we learn. One strategy is to determine what risks, whether internal or external, your facility may be exposed to. Does the local fire department know where your most hazardous chemicals are stored in case they respond to a fire? There are laws requiring that they be aware. Or, do you have a team of highly trained professionals if "active shooters" or workplace violence may be a possibility? A lot depends on how you identify your risks in order to prepare a more complete and thorough plan. Another strategy is to test your response plans with local team players, corporate teams, and/or local responders. It's great fun, and you can learn so much from your peers in the community and throughout your organization.

HEH: What are some of the worksite departments employee health should partner with in developing a disaster response program?

Floyd: A lot depends on what you currently have on hand. Is it a well-established disaster preparedness team, or are you just starting out? If you are joining a well-established team, ask a few questions to get started. What can you do to better support the

team and be a resource? Develop the employee health portion of the response. If you are truly just starting out, work with your human resources person, company legal resource, and security. Find out what their response plans are and what they have available, and who they network with in the community and build on that. From there you will want to know if they participate in community drills, or establish resources such as EAP, risk management, etc.

HEH: You mention the importance of having an Emergency Response Team (ERT). What kind of preparations should a healthcare facility's ERT have?

Floyd: A well-organized ERT will have local expertise in routine emergency first aid. I was on a team once where we contracted — for a minimal fee — with our local fire department paramedics to come out and train us on emergency procedures: bandaging, splinting, observation, evacuation, oxygen administration. It was an awesome team and our local fire department seemed to enjoy the opportunity to come to the worksite and familiarize themselves with our setup. An incredible partnership.

The ERT should also be up to date on their hepatitis B, tetanus, and seasonal flu immunizations. Beyond that, maintain current CPR and first aid certifications, and continuing education if employers are fortunate enough to have volunteer or moonlighting EMTs and firemen on their team. They often require continuing education units to recertify. So many people now work two jobs, so it's a real treat when an employer can score an ER team member who does double duty as after-hours EMT, fire responder, or law enforcement officer. ■

Contagion: A different type of disaster planning

Concern is that healthcare workers may not report for work

Though an upcoming CMS regulation¹ calls for an “all-hazards” approach to disasters, a pandemic or infectious disease outbreak brings some unique characteristics to the tabletop planning.

Though certainly unwelcome events, it may actually help that hospitals have had to prepare for a succession of infectious disease threats that include anthrax (2001), SARS (2003) pandemic flu (2009) MERS (2012) Ebola (2014) and currently Zika. That said, however, a recently issued emergency planning document by HHS focuses primarily on healthcare planning for natural disasters.²

“Every emergency event presents different sets of challenges, so in the planning process healthcare officials really need to think a little bit about all the different types of disasters,” says **Melissa Harvey**, RN, MSPH, director of National Healthcare Preparedness Programs at the HHS. “For example, this [HHS] document is more about natural disasters that affect the physical infrastructure of individual homes. Their houses may be flooded, or their children’s daycare may not be open and, therefore, they can’t come to work. That certainly is very different from something you would expect during a pandemic, where you are dealing with the staff or their families being ill and that’s why they can’t come to work. Planning for those two types of scenarios is going to be very different.”

While natural disasters raise important issues about accommodating healthcare workers’

needs and taking care of their families, the prospect of treating patients who have a contagion that is typically not well understood in the initial phases of an outbreak puts a whole different set of fears in play. It goes beyond the issue of “able” to work and raises questions

“THEY WANT TO KNOW THAT THEY ARE GOING TO BE SAFE, AND WHEN IT COMES TO INFECTIOUS DISEASES THEY WANT TO KNOW THAT THEY WILL NOT BRING IT HOME TO THEIR FAMILY. THEY NEED UTTER ASSURANCE AND REASSURANCE THAT THEY ARE GOING TO BE PROTECTED FROM INFECTION.”

about whether healthcare workers are “willing” to report for duty.

“We know what it takes to get people to report,” says **Robyn Gershon**, MHS, DrPH, a professor who researches and teaches disaster preparedness at the University of California, Berkeley. “They want to know that they are going to be safe,

and when it comes to infectious diseases they want to know that they will not bring it home to their family. They need utter assurance and reassurance that they are going to be protected from infection.”

Indeed, the desire to protect family is a more compelling emotion than self-preservation, according to a study published earlier this year.³ The researchers found that healthcare worker fears about potentially exposing their families and friends to Ebola (90%) was more than five-fold greater than their concern for personal safety (16.8%). The study also found that some 25% of healthcare workers may refuse to treat patients with the next novel pandemic pathogen that is perceived as life-threatening. (*For more information, see the article in the March 2016 issue of HEH.*)

Able but Unwilling?

Gershon’s research has revealed similar trends, in part because a novel pathogen often emerges in the absence of a vaccine, proven treatment, and certainty about the routes of transmission.

“In the beginning, we sometimes don’t know all of the routes of transmission,” Gershon says. “Look at how much we are finding out about Zika: how long it survives in semen, maybe it’s in saliva, it’s definitely in blood. We have to act in the absence of complete information in the most proactive way that we can. In order to do that, healthcare facilities have to be on the top of these evolving and emerging trends so they are as ‘close’ to the

outbreak as they can be in terms of preparedness.”

A study by Gershon and colleagues found that only 65% of healthcare workers would be willing to report to duty during a pandemic.⁴ She also found in another study that workers are more willing to report during a natural disaster than a major infectious disease outbreak, going from 80% willingness during a snowstorm to 48% for SARS.⁵

One preparedness factor is that, given the unknowns of a novel pathogen, heavy use of personal protective equipment may be recommended until the routes of transmission are clear. That can immediately present PPE supply problems, which were widely reported during the Ebola scare in the U.S.

“It’s always hard because you don’t want too much [stock] of PPE,” Gershon says. “It’s very difficult, but on the other hand, in the absence of complete information about the risk of transmission you have to take an abundance of caution.”

Having worked in high-hazard biosafety labs, Gershon was surprised that, as Ebola emerged, the CDC initially took the position that any hospital could handle a case and airborne precautions were only recommended for aerosol-generating procedures. That changed rather dramatically with the death of a patient and transmission to two nurses in Dallas, as the CDC began advising respirator use and setting up response teams and designated Ebola hospitals.

“I knew it had to be treated at the utmost level of containment, and what they were proposing to do was simply not going to be enough,”

Gershon says. “Why that happened, I do not know. [Ebola] patients are incredibly infectious and they have a lot of body fluids. I was, frankly, a little amazed and I think a lot of people in the biosafety community were similarly amazed, but [the CDC] quickly changed that.”

Duty to Warn

Employee health professionals have a duty to keep abreast of the threats to staff, and this knowledge can make them a valuable asset to their communities as well, she says.

“They can do a great service by keeping their staff updated and informed about what’s happening and what do we know about this virus or agent,” she says. “They need to develop a plan — and then adjust it depending on the agent, of course — but you need to have a plan for surge capacity, what kind of PPE is needed, and if specialty training on certain respirators is needed. This is one thing healthcare facilities can do. We are lifelong learners in healthcare and that’s what I advocate.”

In terms of willingness and ability to work under such conditions, Gershon is researching a new set of emergency preparedness measures, including whether staff have the “capability” and knowledge needed to protect themselves and patients. Other research questions go beyond willingness to report and assess whether workers will be compliant with measures the hospital may put in place.

“During a public health emergency, we may have measures instituted like quarantine and social distancing,” she says. “Are you willing to not only abide by your

hospital’s recommendations, but by your local health department measures? What we have found in our research is a lot of people say, ‘I’m willing, but I’m not able because I have additional responsibilities like taking care of my children or elders.’ This was in answer to, ‘Could you be quarantined like they had to do for SARS in some hospitals?’”

The threat to healthcare workers will continue as pathogens of zoonotic origin emerge and pass between humans and animals.

“This Zika is not the same virus that was originally in Africa,” Gershon says. “This is a more virulent strain of Zika. It’s mutated.” ■

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Cancer Patients Urged to be Tested for TB in Seattle

Oncology worker goes from latent to active infection

Some 140 cancer patients at two healthcare facilities in Seattle have been advised to seek testing for tuberculosis after a healthcare worker with latent tuberculosis infection developed active disease that went undiagnosed for some time.

The University of Washington Medical Center and the Seattle Cancer Care Alliance announced that an oncology worker with TB cared for the patients from May to July 2016. In addition, 47 healthcare workers were exposed and all have thus far tested negative for TB, which is not thought to be a drug-resistant strain.

The worker, who was not identified by name or gender, acquired TB five years ago from a patient, but had been successfully treated with isoniazid (INH), **Steven Pergam**, MD, director of infection control at Cancer Care, said at a recent press conference.

“There are a lot of healthcare workers that have latent TB and it is really important to understand that latent TB is not infectious,” he said. “Cases where [a healthcare worker] with latent disease goes on to develop active TB are exceedingly rare.”

The cancer patients may be immune compromised due to chemotherapy and other treatments, making it more likely for TB to progress if the patients become infected.

“Though they may not be more likely to acquire TB, the difference is that once they acquire it, they are more likely to develop active

disease in a faster time frame than a normal person would with an adequate immune system,” Pergam said.

An immunocompetent person may manifest TB symptoms after exposure within the first two years, but cancer patients may develop active disease in a matter of weeks and months. The patients treated by the infected worker were

“I THINK IT IS REALLY IMPORTANT THAT WE DON'T FORGET THE HEALTHCARE WORKER IN THIS AND THE CHALLENGES THEY HAVE BEEN THROUGH.”

contacted via letter offering free testing, and a hotline has been set up to field questions from the public. They will be tested initially and then again in two to three months.

“What made this challenging is that this [healthcare worker] has a health condition that led to a cough,” Pergam said. “They went to see a primary care doctor and were evaluated appropriately and received treatment for that.”

However, at some point the

cough raised suspicions about TB and the worker was correctly diagnosed.

“TB can be difficult to sort out in its early phases,” he said. “Oftentimes it can be very subtle, particularly in a situation where someone has another condition that leads to a cough.”

Officials at both facilities said all protocols were followed, but will review the case to see if there were opportunities for earlier intervention. The local media at the Seattle press conference questioned why a healthcare worker with latent TB would be treating cancer patients.

“Healthcare workers that have latent TB don't have active disease and are not infectious to anyone, so there really is no risk for them to work with cancer patients or any other immune compromised patients,” Pergam said. “We continue to screen them on a regular basis for the development of symptoms.”

The healthcare worker is being treated with INH and should be able to return to work in less than six months.

“I think it is really important that we don't forget the healthcare worker in this and the challenges they have been through,” he said.

To further complicate the case, a close community contact of the worker tested positive for latent TB, which may have been from recent transmission or from a history of travel to areas where TB is common. ■

Making the Business Case for Safe Patient Handling Equipment

Leading indicators and, perhaps, a personal testimony

Though every healthcare worker who handles patients is at risk of injury, it may be difficult to convince hospital administrators to purchase a sufficient inventory of safe patient lifting equipment.

As this issue went to press, **Sandy Swan**, MS, BSN, RN, COHN-S/CM, CEAS, CSPHP, program manager of Occupational Health and Ergonomics at BJC Health in St. Louis, was slated to address this issue in a talk at the annual conference for the Association of Occupational Health Professionals in Healthcare (AOHP) in September. She described the program she developed to generate the data needed to make the case for new lifting and handling equipment in an interview with *Hospital Employee Health*.

HEH: We know today's healthcare market is fiscally strapped, but there have also been some high-profile reports on nursing injuries related to moving patients. Are some hospital administrators still unconvinced that safe lifting equipment is needed, or is it more of an issue that many facilities do not have sufficient stock of the devices?

Swan: I think it may be a little of both. It is, of course, key to have senior leadership support, especially chief nurse executives. They can ensure that there is funding for patient handling devices, promote front-line managers embracing the technology and holding staff accountable for using it, and allow time off the unit to train on the devices. Hospitals are in varying stages of safe patient handling

program (SPH) implementation. Some have really embraced it and have strong leaders and ownership of their safe patient handling committees. Others have not made it as much a priority, or have had more difficulty with the leadership and ownership piece.

While safe patient handling equipment is obviously important, the actual policy, SPH committee, training and education, commitment to use the equipment, auditing equipment use, troubleshooting barriers to use, and evaluating effectiveness of the program are the basis for success. I would say that there still needs to be increased education not only for senior leaders, but all the way down to front-line managers and staff, on the importance to both employee and patient safety of a robust SPH program.

HEH: What are a few of the key measures and stats that employee health professionals need to show administration to justify equipment purchase?

Swan: There is a lot of talk about the use of leading and lagging indicators. Lagging indicators would be the staff injury rates and workers' compensation costs from patient handling. Those are obviously after the fact and not proactive.

Leading indicators would be the reporting and tracking of near misses, auditing equipment use, etc. If there is a grasp of what leads up to injury, it can be addressed to prevent injuries. Most healthcare organizations are still using lagging indicators, but working

toward the use of leading indicators. My [AOHP] presentation will share some data tools we use to get to an "executive summary."

For example, the Unit Patient Handling Hazard Assessment is to be completed/updated annually on every unit where patient handling takes place. It describes the unit by type, number of beds, average daily census, number of staff, average number of dependent and partial assist patients, and number of patient handling injuries in the past year. In addition, it includes high-risk patient handling tasks performed on the unit, available equipment storage, and equipment inventory. We put pictures of all the devices on the document so staff can easily identify them. [The hazard assessment lists] reasons for not using the equipment — for example, room size, doorway width, thresholds, broken equipment, and lack of accessories.

This information is placed in a Unit Hazard Assessment spreadsheet so it is all captured/organized on one page. It is used to make equipment recommendations. We also have developed equipment recommendations charts and we use these to compare the current state of portable floor-based lifts and ceiling lifts with the recommendations. Our recommendations and charts are based on work done by Mary Matz in the Facilities Guideline Institute's white paper in 2010¹ and also on an internal point prevalence study we conducted to determine on a given day how many patients were eligible for a ceiling lift.

Finally, the executive summary is a template that our SPH committees can use to present their data to senior leadership when requesting additional SPH equipment. It is customizable so the graphs/information can be modified for the specific audience since they have awareness of how their senior leadership prefer to receive data. There is a place for a “personal testimony” if the hospital has someone who wants to share. It may be a staff member who can no longer work at the bedside due to a patient handling injury or a success story of using equipment and positive outcomes. These appeal not only to the head, but to the heart.

The next section is a series of graphs. Hospitals can choose to use as

many of the graphs as they feel would be effective at their site. The graphs are hospital-specific. For example, graph one is a comparison of the hospital injury rate to the Bureau of Labor Statistics rate, benchmarking both injury rate and the DART [days away, restricted, transfer] rate. Another graph shows injury costs from workers’ compensation over a four-year trend.

HEH: Can these tools can be modified to fit the culture in other healthcare organizations?

Swan: These tools can hopefully provide ideas to other healthcare organizations on effective ways to present data to senior leadership. We offer them as a starting point and encourage modifications because we

know what works in one healthcare organization, or even in the same organization in different hospitals, does not work for another.

Culture varies greatly by hospital and leadership. The documents were created internally and belong to BJC HealthCare. We offer them to other healthcare organizations with the understanding that they can modify them, but also credit BJC. They cannot publish or sell them. ■

REFERENCE

1. Cohen, MH, Nelson GG, Green DA, et al. Patient Handling and Movement Assessments: A White Paper. The Facility Guidelines Institute. 2010: <http://bit.ly/2bzxWNJ>.

Zika Update: FDA Says Test Blood Supply in All States

Local transmission occurring in Florida

Underscoring the threat of Zika virus transmission via the blood supply, the FDA is calling for all states to screen donations, with Florida to do so immediately.

“Test all donations collected in the U.S. and its territories with an investigational individual donor nucleic acid test for [Zika] under an investigational new drug application, or when available, a licensed test, or implement pathogen reduction technology for platelets and plasma,” the FDA stated. “Blood establishments that collect whole blood and blood components in U.S. states and territories with one or more reported locally acquired mosquito-borne cases of [Zika] should implement the recommendations immediately. You should cease blood

collection until testing or the use of pathogen reduction technology is implemented, consistent with the recommendations in this guidance.”

That translates to Florida and Puerto Rico, the latter of which has already been screening blood for the virus. However, 11 other states were told to implement blood testing as soon as feasible, and no later than four weeks from the issuance of the guidance.

Because of their proximity to areas with locally acquired mosquito-borne cases of Zika or the number of travel-associated cases, the following states must meet the four-week deadline for blood testing: Alabama, Arizona, California, Georgia, Hawaii, Louisiana, Mississippi, New Mexico, New York, South Carolina, and Texas.

Other U.S. states and territories should follow suit no later than 12 weeks after the guidance issue date of Aug. 26.

Meanwhile, mosquito-borne transmission of Zika was continuing in Florida, which reported 43 “non-travel-related” cases as of Aug. 29. The state had 545 cases related to travel to an area where Zika is spreading. Health officials reported 75 pregnant women in Florida have Zika, which has been linked to birth defects and other adverse outcomes.

Public health officials reported a case of likely mosquito-borne transmission in Pinellas County, which is in the area of St. Petersburg and Tampa. Few details were being released as they investigated the case, saying the exact area will not

be reported unless there is more transmission. The department said it was also investigating possible

transmission in the Palm Beach area, but still believes ongoing transmission is only taking place

in the area of the Wynwood neighborhood in Miami Beach and Miami-Dade County. ■

OSHA Cites Home Health Group for Failure to Protect HCWs

Fine of \$98,000 for willful violation

With the aging population, home healthcare is rapidly expanding — but worker protections must expand as well to protect employees who may be vulnerable to violence. A recent citation by the Occupational Health and Safety Administration (OSHA) underscores this point, as a company that provides pediatric home health was issued a willful citation and fined \$98,000 following the sexual assault of a healthcare worker.

According to an OSHA press release, the agency received a complaint on Feb. 1, 2016, from an employee of Epic Health Services who was sexually assaulted by a home care client. Finding that the company had previously received complaints of verbal, physical, and sexual assaults, OSHA cited the company for a willful violation. OSHA defines a willful violation as one “in which the employer either knowingly failed to comply with a legal requirement (purposeful disregard) or acted with plain indifference to employee safety.”

In response to a request for comment by *Hospital Employee Health*, Epic Health Services issued the following statement: “We were disappointed to receive this citation from OSHA and we disagree with the allegations. Epic Health Services cares deeply about our employees and patients, and their safety is paramount to our operations. Epic will continue to cooperate with

OSHA regarding this matter and work toward full resolution.”

According to OSHA, the company had no reporting system established for workers subjected to threats and violence.

“Epic Health Services failed to protect its employees from life-threatening hazards of workplace violence and failed to provide an effective workplace violence prevention program,” **Richard Mendelson**, OSHA regional administrator in Philadelphia, said in the release. The OSHA citation includes a number of “suggested and feasible means of abatement” for Epic Health, including these paraphrased as follows:

- a written, comprehensive workplace violence prevention program and training program,
- workplace violence hazard assessment and security procedures for each new client,
- procedures to control workplace violence, including giving workers the right to refuse to provide care in a clearly hazardous situation, and
- establish a system for tracking

and investigating violence that allows employees to report an incident regardless of severity.

An OSHA spokesperson said guidelines to implement the recommendations can be found at: <http://bit.ly/1WSQbjj>.

“There are tools designed and provided to help employers in industries where workplace violence is a significant hazard,” **Joanna Hawkins** of the OSHA Philadelphia office tells *HEH*. “Healthcare, including hospitals, is one of these industries. In addition to the guidelines and other links on our page, there are many examples of programs, checklists, etc., available online. Employers with employees at risk for workplace violence need to design programs specific to their needs and their worksites.” ■

REFERENCE

1. OSHA. Federal inspectors cite national pediatric health care provider for failing to protect home care workers from physical, sexual assault. July 5, 2016: <http://bit.ly/2a0d3eq>.

COMING IN FUTURE MONTHS

- More from the AOHP conference in Myrtle Beach
- Hand hygiene blues means damaged skin
- Federal safe patient lifting law in political limbo, but OSHA may enforce
- Seasonal flu vaccination: options and obstacles



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CE QUESTIONS

- 1. The Center for Medicare & Medicaid Services is expected to soon finalize an emergency and disaster planning regulation for healthcare that will recommend preparedness for:**
 - A. infectious diseases.
 - B. natural disasters.
 - C. all hazards.
 - D. power grid failure.
- 2. According to Melissa Harvey, RN, MSPH, healthcare facilities that fail to address employee health needs in a disaster may take longer to recover and may have trouble retaining healthcare workers when the recovery is complete.**
 - A. True
 - B. False
- 3. Some 140 cancer patients at two healthcare facilities in Seattle have been advised to seek testing for tuberculosis after a healthcare worker with latent TB infected a severely immunocompromised patient.**
 - A. True
 - B. False
- 4. To justify purchase of patient safe lifting equipment, Sandy Swan, MS, BSN, RN, recommended using which of the following, if possible?**
 - A. Personal testimony of an injury or success story.
 - B. Leading indicators that may help prevent injuries.
 - C. Injury costs in workers' compensation payouts.
 - D. All of the above.

CE 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.