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INSIDE

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Enough Is Enough: OSHA To Issue Regulation On Violence

HCWs at hearing recount disturbing accounts of patient attacks

By Gary Evans, Medical Writer

Taking the first step in what is likely to be a protracted political struggle, OSHA recently announced it will promulgate a federal regulation to protect healthcare workers from a shocking epidemic of violence.

The decision came at a Jan. 10, 2017, public meeting in Washington, DC at which the standard litany of assault rates and statistics was devastatingly humanized by first-person accounts of healthcare workers.

In the current political environment, any new regulation could face stiff resistance, but after hearing such stories it may be hard to argue pros and cons, as academic discussions give way to a growing sense of outrage.

"I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon," said **Lisa Tenney**, RN, of the Maryland Emergency Nurses Association. "I have been bullied and called very ugly names. I've had my life, the life of my unborn child, and of my other family members threatened, requiring security escort to my car."

> "IT IS CLEAR THAT WORKPLACE VIOLENCE IS A SERIOUS OCCUPATIONAL HAZARD THAT PRESENTS A SIGNIFICANT RISK FOR HEALTHCARE AND SOCIAL ASSISTANCE WORKERS."

Unfortunately, such stories are not uncommon. *(For more information, see related story on page 28.)*

"It is clear that workplace violence is a serious occupational hazard that presents a significant risk for healthcare

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and social assistance workers, and I believe that a standard protecting healthcare and social assistance workers against workplace violence is necessary," said **David Michaels**, PhD, MPH, the outgoing assistant secretary of labor for OSHA. "I am pleased to announce, as one of my last actions, that OSHA will grant [HCW/union] petitions and will commence rulemaking to address the hazards of workplace violence in the healthcare and social assistance industries."

OSHA issued a request for information[1] on Dec. 7, 2016, asking for comments and suggestions as to how to best proceed with violence prevention strategies in healthcare. The comment deadline is April 6, 2017.

OSHA was prompted to pursue rulemaking by a recent GAO watchdog report[2] that cited staggering levels of assaults in hospitals, with attacks resulting in lost work days "at least" five times higher than private sector industries overall. Efforts to use the OSHA General Duty Clause to enforce existing protections have been minimal and ineffective, the GAO found.

"The collapse of America's mental health system has resulted in emergency rooms and hospitals being filled with patients in need of scarce inpatient psychiatric facilities, outpatient psychiatric facilities, and especially medical psych beds and medical geriatric psych beds," Tenney said. "This has resulted in ER psych orders, frustrated patients and family members, and it has increased violence. We ask that the OSHA [regulations] be coordinated with and complimentary to any efforts being undertaken by other federal agencies who are addressing the mental health crisis. While it's important that workplaces internally mitigate violence, it's also important for us to get to the root cause of the violence. As a nation, we need to have zero tolerance for anyone who hurts a healthcare worker, a patient, or a visitor."

While that level of violence is disturbing in any context, it actually represents an undercount because many assaults go unreported by healthcare workers.[3] The attacks are primarily made by patients or their family members, and healthcare workers that do not report incidents may fear reprisals or think that no action will be taken by administration. However, the grim prevailing dogma that violence "is just part of the job" is starting to be roundly rejected.

"We know that workplace violence could be dramatically reduced if employers respond to our concerns and develop comprehensive prevention plans to protect workers," said **Jean Ross**, RN, co-president of National Nurses United, the largest union of registered nurses in the country. "OSHA cannot stand by and watch one more injury, one more threat of violence, or one more death to healthcare workers that serve patients across this country. The well-being of nurses, healthcare workers, and their patients must be safeguarded, and it's past time for OSHA to mandate these protections."

Mental Anguish

The psychological effect of an assault may linger beyond the physical pain, becoming a traumatic echo that remains with the worker long after the incident.

"Aside from sustaining a physical injury, being a victim of assault

from a patient is vastly different from any other type of healthcare-related injury," said **Erin Johnson**, RN, of the Massachusetts Nurses Association. "Workplace violence has a psychological component that vastly affects one's mental ability to feel safe and secure when returning to work, and it takes support from employers to regain these feelings."

An RN for seven years, Johnson was recently attacked while working on a child and adolescent inpatient psychiatric unit at Providence Behavioral Health Hospital.

"Working with children ranging from ages 5 to 12 years old, I am more likely to be hit or kicked than I would be if I were working with older adolescents or adults, due to the higher tendencies of their impulsive behaviors," she said. "Recently, I was a victim of workplace violence, and although my experience may not seem horrific, it is one of the many examples occurring across the country."

Two patients broke through a secure door and escaped the unit last Christmas Eve.

"As these patients were being safely returned, I was punched in the back twice and bit on the inner portion of my upper right arm," Johnson said. "After my shift ended, I cried for what felt like hours, because I was in such a state of shock. I felt hurt, frustrated, sad, and most of all, angry."

The frustration may be widely felt when healthcare worker advocates are faced with the long slog it will take to pass an OSHA regulation under an administration that is moving to deregulate federal government.

While the recent passage of a California law[4] to prevent violence in healthcare certainly adds momentum to enactment of a national standard, hospital ownership and healthcare administrators will certainly raise the issue of costs, staffing, and warn against stigmatizing patients by "criminalizing" them, said **Katherine Hughes**, RN, with the SEIU Nurse Alliance of California.

"I don't want to criminalize the patient," she said. "I'm a nurse. I've taken care of white supremacists. I've taken care of gang members. I've taken care of murderers. I've taken care of the homeless. I've taken care of the hospital CEO. I've taken care of someone's grandma. We were able to show [in California] that healthcare workers don't really care where people came from. We treat them all the same, most of us."

Hughes also takes exception to the common argument that violence is unpredictable and regulations cannot effectively prevent incidents.

"But you can predict it," she said. "You know patients coming out of anesthesia might act up. So, do some training for people in the recovery room on what those things might be, right? I think it's really important that we can show our employers that if we had a little bit more time and a little bit more staff, we might actually be able to prevent some of the stuff that they say is unpreventable."

Yet, as urgent as the problem is, the OSHA process to enact regulation takes years of hearings, stakeholder meetings, and various and sundry bureaucratic and political requirements.

"I think the GAO assessed that generally, it takes on average about seven years," said **Jordan Barab**, deputy assistant secretary of labor at OSHA. "But again, it is a process. It will require constant vigilance on your part to move the process forward, and if the crowd here is any indication, I'm sure constant vigilance will not be a problem. I think the evidence is clear in terms of the significant risk that workplace violence poses, in terms of the cost that workplace violence imposes upon employers, and particularly workers — not just in terms of money, but in terms of their physical and mental health."

Without Warning

While expressing disappointment at the projected timeline for OSHA regulation, **James Phillips**, MD, of the American College of Emergency Physicians, said there are some positive signs of progress and the medical community should not be discouraged.

"We can't just rely on our government representatives and our organizations in Washington to make those decisions for us," he said. "As not only victims and healthcare providers, but as the research experts and those of us who are affiliated with them, it's our job to develop consensus, expert guidelines to help guide hospitals and other facilities going forward."

Having published a recent review article[5] on violence in healthcare, Phillips said he was, in part, motivated by attacks by patients in his work in emergency medicine and surgery.

"I've had a patient convicted of felony assault against me," he says. "But even worse was the fact that during my surgical residency, I actually had an intoxicated patient intentionally spit hepatitis C-positive blood in my eyes. I had no idea it was a crime. It was witnessed by the police, who didn't make mention of it. My attending said nothing. I visited occupational health, getting tested for the next six months."

One reason healthcare workers are not prepared for occupational violence is that the threat is not emphasized in medical school, he added.

"There's no training in medical schools to tell you, 'Hey, you are about to enter into the most violent industry outside of law enforcement in the United States. Be prepared,'" Phillips said. "Never — not one time in four years of medical school, nine years of residency, and a year of fellowship. I'm not qualified to speak about nursing school, but I certainly can say that the vast majority, if not all, medical schools do not discuss workplace violence or what you're entering into." ■

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A History Of Violence: One Nurse's Story

'It changes who you are as a nurse'

OSHA has formally initiated rulemaking for a regulation to protect healthcare workers from rampant violence perpetuated by patients and visitors. As a result, healthcare workers are coming forth with horrific accounts of violent attacks.

Consider one story, that of **Gena Deck**, MSN, RN, assistant professor of nursing at the University of Alaska, who conducted the following interview with *Hospital Employee Health*.

HEH: To the degree you are comfortable, can you provide more detail on the patient attack you experienced?

Deck: The patient was known to the department and hospital, although I had never tended to him in terms of nursing care. I was new to the hospital within the previous few months. It was an emergency room environment. The patient was brought in by EMS for altered mental status secondary to diabetes. The patient has many medical and psychosocial issues — which I now know. He was placed in a trauma bay, in view of the healthcare provider's station. He was calm and cooperative while receiving services for about four hours.

Because he had a history of not wanting to leave the hospital at discharge, security was called to the bedside to assist. I did not know this information prior to this event. The patient presented many obstacles as to why he could not be discharged, including having no transportation, no place to go, and threatening to harm himself if we discharged him. A physician evaluated the patient and stated he was still to be discharged. He was offered a ride to the shelter, who had already agreed to accept him. The patient then stated he had no appropriate footwear. A security guard stated he would grab some temporary footwear from the storage closet.

In a flash, as soon as the guard was gone, the patient stood, grabbing the cording from the overhead Phillips monitor, wrapping all three cords around my neck, shouting, "Here, bitch, you try it" — in reference to his saying earlier he would hurt himself. In the next 10 seconds, hearing the screams and commotion, the guard and physician who had been assessing him returned to the room, freeing me from the situation.

HEH: Can you describe some the physical and emotional aftermath of this incident and a little more detail on the assaults you suffered previously?

Deck: During the previous two events of overt violence I've experienced, there were breakdowns in procedures, security, and an atmosphere of "it just happens." The first was an adult-sized autistic 15-year-old male who was in a guarded isolation room. I was asked to check on him to see if he needed anything. I was covering for a co-worker. The guard opened the door. The calm patient had his hand extended to me, showing me a penny in his hand. I reached for the penny, asking him about it. He closed his fist and punched me square in the face. There was no report filed. I was allowed to step into the break room "to calm down" and ice my face. I was then expected to return to work

the remaining nine hours of my shift. There was no offer of support, apologies, forensic assessment of the circumstances, or concern for the emotional toll the situation took.

The second event, at the same hospital, was a woman who had been brought to the psychiatric isolation area in response to her expressing her helplessness with a chronically ill child being cared for in the same hospital in the pediatric unit. Reportedly, she "was out of control" and threatened to hurt herself in desperation, not realizing she would be put in this position and separated from her sick child. While taking her vital signs to do a basic assessment, she lifted the equipment and threw it at me in anger. I had no physical injuries, other than bruising, but was again, not supported. The only question was, "Are you hurt?' To which I answered no, not wanting to appear weak.

In this situation, the police were called and a case made for assault. At the time, it was an automatic felony charge [for violence] against a healthcare worker in Pennsylvania. Alaska does not have the same law. At the very brief criminal hearing, it was ascertained that this person was a social service issue more than a violent criminal. I was asked what I wanted to have happen to her. I wanted for the woman to get the help she needed. I was never asked about how the hospital should have responded to the situation, nor did they offer any changes or discuss insight gained from the event.

This most recent issue has left me changed as a nurse and as a person. I believed that I would die. I physically had bruising, sore throat and scratches, all of which healed in a few days. The psychological impact was, and is, significant. I have sleeping difficulty, occasionally having nightmares that awaken my spouse, who then wakes me to calm me. I have anxiety when approaching some patients who are large, or loud. It changes who you are as a nurse. We are geared to go toward chaos and violence, not away from it. Professionally, I have had to become "that nurse" in the eyes of some co-workers. The one who was assaulted or is a victim, a title I bristle against. We have only one hospital in town, so sadly enough, the patient often frequents the same ER where I am employed. He now gets a security watch when he arrives and throughout his visit.

HEH: Many healthcare workers don't pursue prosecution. Why did you decide to do so and what was the outcome? Do you think this needs to be done more often?

Deck: Yes, prosecution needs to be pursued. Violence against healthcare workers is increasing in my personal experience and from the stories I have heard from co-workers and colleagues. I have since learned that this patient had been violent in the past, had a known history of becoming agitated, and had committed verbal assaults, physical assaults, and threats in the same hospital — many not officially reported. The system for conveying that information succinctly and expediently does not currently exist, short of reading each previous visit's nursing notes.

I did, in fact, pursue prosecution; however, I may not do it again in the future. It was far more abusive than the original circumstance. It took nearly a year to come to trial, with many delays. From start to finish, it took about nine days. Although I was compensated for my time, I received no support from our legal department or human resources while at the trial. In addition, the hospital management was warned not to appear, as it could look prejudicial against the assailant. Some co-workers defied the statement and came for parts of the trial for personal support. The man was charged with three felonies, and found guilty of two. Because of his history of felonies and misdemeanors, he was sentenced to three years in prison with no parole. While that sounds like a good ending, the patient is out on appeal, arguing that there was not enough evidence. He has 180 days to make the case. In the meantime, he has the ability to come to the ER.

The employee impact on me is that I don't want to be forced to interact with the person — therefore, I have asked to be notified if he is in the department or request to be moved to another role when possible. Although supportive, management has recently suggested that I may be more comfortable in another department. OB is the only option, given that this patient will be in the ED, CCU, MHU and medical/surgical units at any given time.

HEH: You mention the event did not really transform your healthcare environment. Is that why it is important that OSHA enact regulation to standardize requirements and make hospitals accountable for protecting healthcare workers?

Deck: Yes. The environment is typical of emergency units and hospitals in general. The culture is one of expecting to be verbally yelled at, threatened, and treated poorly on a regular basis. Standing up to that is not the norm for the medical provider culture. Patients and their families in the healthcare environment or on mental health units are often in extraordinary acute distress. They are lashing out at anyone who may be in a position to keep them from what they want or

need. For OSHA to enact regulation about work environments, reporting, supporting, and prevention would require healthcare employers to take the situations seriously.

Let us not forget the perpetrators themselves would also be protected when possible. I have witnessed patients being wrestled to the ground with multiple staff, and in one circumstance had a patient who was tasered by police in his hospital room when things escalated.

As a result of my personal situation, there were some internal meetings for the root cause analysis of what went wrong. There was question of the physician's choices, or security's decision to leave the bedside. A psychiatrist who had treated the patient in the past actually said, "You're a nurse. There is some expectation of danger and violence in your job by its very nature." The changes suggested, some of which never happened, included having a computerized in-house flagging system for known violent patients in order to protect caregivers before close interactions, increasing security personnel numbers, having a no-weapons policy, purchasing personnel emergency alarms, and metal detectors.

Perhaps most importantly would be creating an environment for nurses that includes open discussion of violence, threatening patients, and reinforcing a zero-tolerance policy in support of medical staff. Positively, the support from co-workers has been very good, applauding the effort of prosecuting the criminal behavior and sticking together as a group of people who could be victimized at any time.

HEH: The scale of the problem of violence in healthcare has reached staggering proportions, but the incoming presidential administration is not considered pro-regulation. OSHA has taken the first step — are you hopeful of eventual regulation to protect healthcare workers?

Deck: I am hopeful, but doubtful in the short term. I would wonder what the actual objections to the regulations are. I have read in the comments of others that employers feel that this is a situation that can't be regulated and that violence is often random and unpredictable. I disagree. That may be true in many locations in our country where violence is exploding, but in the hospital setting, there are many areas of possible or anticipated violence where early interventions would work if incorporated into a comprehensive plan.

If the cost of implementation of regulations is perceived to be too expensive, I would suggest the cost of injuries, loss of life, and inability to protect other patients is also a very expensive alternative. Interestingly enough, outside of my professional environment as a nurse and a professor, I have told few people the story of any of these incidents, including family. It's almost like battered wife syndrome: It happens more than we will admit to, but it's "easier" to just let it go. ■

New York Safe Lifting Law Could Be Model For Other States

Hospital contracts with embedded lifting coaches to comply

A New York state law now in effect requires healthcare facilities to establish safe patient lifting programs that include the formation of committees, risk assessments and purchase of devices. As it becomes increasingly unlikely that any federal action on the issue will be forthcoming, the New York law could serve as a template for other states as the push continues to reduce the chronic, potentially career-ending injuries caused by manual lifting of heavy patients with high acuity.

The CDC reports that patient-handling injuries accounted for 44% of OSHA-reportable injuries at 112 hospitals in 19 states from Jan. 1, 2012, to Sept. 30, 2014.[1] Of all patient handling injury reports, 62% included data on the use of lifting equipment. Of those, 82% occurred when patient lifting and handling equipment was not used.

The Nurse and Health Care Worker Protection Act (H.R. 4266/S. 2408) is languishing in Congress, and prospects for passage are not favorable. In the absence of a federal law, the New York state model could be considered by other states. The New York law required hospitals to form safe lifting committees by January 2016 and implement programs in January 2017.

"Although we have had a safe patient handling committee here for 8 to 10 years and are very familiar with safe patient handling, it was a huge undertaking to roll out a program

according to the requirements of the law," says **Carol L. Cohan**, RN, BSN, MHA, director of the Employee Health Department at Winthrop University Hospital in Mineola, NY. "We had a committee and small program here and we really wanted to expand it, and the law has empowered us to do that. Fortunately, the administration here is very supportive, very safety culture-oriented, and we have safety infused throughout our facility."

To comply with the law, the hospital contracted the services of a safety consulting firm that embeds "lift coaches" into facilities to assess risks and train workers at the bedside.

"We looked at several companies that could help us to roll out our program and introduce the equipment, lifts, and the training into the facility," Cohan tells *HEH*. The company the hospital chose is "equipment [neutral], which means they don't recommend any specific company for equipment. We are allowed to choose the company that we would like to use for equipment. They will make recommendations on equipment type, and we can follow what they recommend or look at other companies for a similar device. We liked that we wouldn't be committed to one company."

Having the lift coaches available by pager 24/7 was also a key factor, as they are available to train workers at the bedside as questions arise.

"They train at the bedside at the point of care," Cohan says. "To backtrack, first they came in and did a full assessment of our facility and made recommendations to our administration on what equipment they think we would need, and their proposal for the cost of the program."

In accordance with the state law, Winthrop has a multidisciplinary committee that is comprised of 50% front-line staff and 50% management or administration.

"The law really doesn't define what the program is and it is up to interpretation, but you have to have the committee start assessing your needs and start purchasing equipment and educating workers," she says. "We are looking at the [consultant] assessments and recommendations and working on a prioritization system. And we have actually started bringing in equipment in some areas based on their assessments. As we are doing that, other areas are asking for equipment so we have the opportunity to send those coaches in to those areas to assess them. They evaluate all of your statistics when they come in and they assess front line staff in how they lift and move patients."

THE PRIMARY CAUSES OF WORKER INJURIES AND STRAINS AT WINTHROP ARE REPOSITIONING PATIENTS IN BED AND LATERAL TRANSFERS.

Part of the initial assessment includes whether the hospital's safe patient handling equipment was functioning properly, what needed to be repaired, and what was outdated, she adds.

"They looked at our patient fall data and our work injuries, and then came up with their proposal for us," she says.

The primary causes of worker injuries and strains at Winthrop are repositioning patients in bed, and lateral transfers, Cohan says.

"We have recommendations in certain areas for wall-mounted equipment, and we have ordered some portable lifts, transfer sheets and boards, and now we are looking at hover mats, which are air mattresses that inflate and lift the patient for easy repositioning in bed and lateral transfer," she says. "Our intensive care unit has a good amount of injuries due to the type of patients they take care of — they have a lot of challenges with patients that really are not ambulatory."

The hospital is looking at devices that can improve early mobility in patients, which can aid healing and prevent complications like bed sores.

"The entire program that is ongoing addresses the quality of care for the patients, and hopefully will improve the time that it takes to get them well and discharged," she says. "It will decrease length of stay and decrease complications for the patient, and it will provide a safer environment for both the patient and the staff."

The cost of consulting and equipment purchases should be weighed against improving the quality of care of patients and protecting workers from expensive, potentially debilitating, injuries.

"Injuries arising in connection with manual lifting are among the most frequent injuries in healthcare — and among the most expensive, with the most 'lost time' occurring as a result," the New York law states.[1] ■

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'All Hazards' Training Must Include All HCWs

PPE considerations a priority

After a succession of emerging infections from SARS to Ebola in this young century, healthcare epidemiologists are trying to shift the response from reacting to a single pathogen to a more all-hazards approach. As with natural disaster planning, preparing for infectious disease outbreaks must prioritize protection and accommodations for healthcare workers if facilities expect to remain open for business.

The Society for Healthcare Epidemiology of America (SHEA) is partnering with the CDC to provide training and resources to infectious disease doctors to respond to hospital outbreaks and public health emergencies, says **Louise Dembry**, MD, MS, MBA, president of SHEA Board of Trustees.

"This type of training is really to focus on hospital epidemiologists and give them a breadth of background on emergency preparedness using the hospital incident command system, as well as how they interface with public health at their facility," she says. "It is applying an all-hazards approach to infectious disease, which has not been done a lot and certainly not on a big scale. It tends to be that we need to prepare, for example, a SARS response plan, and then prepare an Ebola response plan. Really, we should be looking at this more globally."

Common factors include the need for personal protective equipment (PPE), though that may vary to some degree with the emerging infection.

"There are key steps involved in preparing the facility for the next 'high-consequence pathogen,'" Dembry says. "The type of PPE might be slightly different, but you've got to be thinking ahead of time. What type of PPE do we need and what type of training to people need? How is that going to be done [with forethought] versus doing it on the fly? We learn with each one of these, and we certainly learned more about PPE with Ebola. And we were probably a little more prepared for Ebola after dealing with SARS. There are a lot of common themes that we need to always be thinking ahead."

> "WHEN IT COMES TO PROTECTING HEALTHCARE PERSONNEL, THIS IS WHERE WE CAN HELP OUR OCCUPATIONAL HEALTH COLLEAGUES UNDERSTAND THE RISKS OF TRANSMISSION."

For example, healthcare epidemiologists have been primarily in a reactive disease-specific mode. As part of a broader view, they need to be brought into disaster and emergency management training, she notes.

"Understanding how a hospital incident command systems works is very helpful," Dembry says. "We want to be careful to not be in silos with this. We need to work together and decide, where do we hand off the majority of [this particular] responsibility? We are trying to get all healthcare epidemiologists on the same basic level of understanding of how these things work — how they might unfold, and how to prepare and hopefully prevent [outbreaks]."

One issue that has been underscored time and again with natural disasters and emergency events is that hospitals will find it very difficult to stay open if planning does not include accommodations and reassurance for healthcare workers and their families. Thus, occupational health must be brought into the discussions very early on if an infectious threat is identified.

"There is a part of it that is occupational health and a part that is infection prevention — it is a team approach and collaboration," Dembry says. "And that's why understanding how a hospital incident command system works is very helpful. There will be somebody there who takes on the majority of occupational health [issues], but I think we as hospital epidemiologists and ID physicians are also the content experts about the infectious disease [threat]. When it comes to protecting healthcare personnel, this is where we can help our occupational health colleagues understand the risks of transmission depending on the person's job [and other factors]."

Similarly, the type of PPE and its proper use must be determined.

"They are going to come to us and say, 'Tell us more about this,'" she says. "What are the things we need to be concerned about for staff? Do we have the right things in our PPE stockpile? Should we be beefing up our PPE stockpile? So that takes

ongoing communication and working together."

Ultimately, the training program could create a standardized response across infection control and healthcare epidemiology, moving away from the reactive mode healthcare is typically in with an emerging infectious disease. ■

Employee Health Must Navigate Conflict Between State And Federal Marijuana Laws

Better marijuana testing could separate social, work use

Evolving state laws regarding the legal use of marijuana mean that healthcare providers' existing policies on drug use should be reviewed to ensure they do not violate labor laws or provide an opportunity for civil litigation, while still ensuring patient safety, experts say.

Healthcare employees may still be prohibited from using illegal substances or being impaired on the job, but legal experts say relaxed marijuana laws create gray areas that must be addressed.

Many states have relaxed marijuana laws in recent years, with some allowing medical use, others also allowing recreational use, and some decriminalizing possession. A total of 28 states, the District of Columbia, Guam, and Puerto Rico now allow medical marijuana, according to the National Conference of State Legislatures. Seven states and the District of Columbia have legalized marijuana for recreational use, including most recently California, Massachusetts, and Nevada, which all passed measures in November 2016 legalizing recreational marijuana.

Marijuana is still illegal at the federal level, so employers can prohibit its use at work and can still test employees for evidence of use, says **John A. DiNome**, JD, partner with the law firm of Reed Smith in Philadelphia.

"That creates a conflict because employees say the state allows them to use it medically or recreationally, or both, and now you're drug-testing them for something that is legal in your state. They were using marijuana at home, at the same time you were home drinking your beer or bourbon," he says. "Then they come to work Monday perfectly sober, but the drug shows in their system when you test them. So they ask why you're terminating them for the use of a legal substance at home."

That conflict is especially difficult for employees to accept when they use medical marijuana as prescribed, he says.

A Colorado Supreme Court case addressed this issue when an employer fired an employee who had used medical marijuana legally. The employer argued that it was complying with federal law, and in particular it was obligated to comply with the Drug-Free Workplace Act because it was a federal contractor. The court ruled in favor of the company, saying that with an obvious conflict between state and federal laws, the employer can take the more conservative position of complying with federal law, DiNome says.

Some Hospitals Have a Choice

Federal contractors have no leeway on the issue, says **Danielle Urban**, JD, partner with the Fisher Phillips law firm in Denver.

"If you're a federal contractor, you can't allow any marijuana use, regardless of what state law says," Urban notes.

For employers with a choice, the question becomes whether you really want to take this hard-line stance on marijuana, DiNome says.

"You would have to consider that some educated, qualified people come to your state because that substance is legal, and whether you want to eliminate all of those people as potential employees," he adds.

One solution may be to use more advanced testing for the use of marijuana, DiNome suggests. Unlike a breath alcohol test that can determine how impaired a person is at the time of testing, the tests used to detect marijuana use only show that the person used the substance sometime in approximately the past 30 days. More specific tests are available, though they are likely to be more expensive and require a blood sample, DiNome notes.

"You still have to determine what is over the limit, and I don't know that there is any uniform answer to that," he says. "But if you want to prohibit impairment at work without telling people they can't do something legal on their own time, that would be the way to go about it."

If the organization does not

prohibit employees' use of legal marijuana, caution is still necessary the same as with many other legal substances, DiNome notes. Employees who use prescribed or over-the-counter medications that can impair their ability to operate machinery safely, for instance, must be required to report that condition and avoid compromising safety. The same would apply to the medical use of marijuana, if there is any effect on the employee during working hours, DiNome says.

Patient Safety Trumps All

Some states put employers in an even more difficult position by making it illegal to discriminate against employees who use marijuana legally, notes **Joshua Horn**, JD, partner with the Fox Rothschild law firm in Philadelphia. In those states, employers are forced to choose between complying with state law or federal law, and many may decide that it is more likely the state, rather than the federal government, that will take action against them for discrimination.

Federal funding, however, could shift that balance in favor of federal law.

"An institution that relies on federal funding may be at risk with that funding if they don't test people for Schedule I drugs as part of hiring and retention in employment," Horn says. "I suspect that is something that is going to be litigated at some point until we get more clarity on these conflicts."

Safety considerations almost always trump an employee's right to use any substance that could affect performance, notes **Bob Morgan**, JD, special counsel with the Much Shelist law firm in Chicago.

"Whether your employee is driving a truck cross-country or working in your ICU, there is almost always a protection that allows employers to enforce policies to protect those that they're serving," Morgan says. "That applies no matter what the cannabis laws are in your state. You're dealing with employees that are directly impacting the health and safety of individuals, so the obligation of protecting the people you are serving is paramount."

"YOU'RE DEALING WITH EMPLOYEES THAT ARE DIRECTLY IMPACTING THE HEALTH AND SAFETY OF INDIVIDUALS, SO THE OBLIGATION OF PROTECTING THE PEOPLE YOU ARE SERVING IS PARAMOUNT."

Unemployment compensation also could be disputed. An employee fired for marijuana use could argue that he or she did nothing illegal to prompt the dismissal and is due unemployment compensation. That question also is not yet settled, Horn says.

"When you're terminated for using a Schedule I drug, that could be heroin or LSD, and marijuana is still lumped together for that," Horn says.

Horn advises healthcare risk managers to review their drug policies and employee handbooks against what state law says about marijuana use.

Understand How Drug is Used

Medical marijuana has been legal in California for 21 years, so employers in that state are more familiar with how to work with employees using the substance legally, notes **John Malanca**, co-founder of United Patients Group in Greenbrae, CA, which supports education on the medical use of marijuana. Employers should first understand how marijuana is used medically and that it does not always impair judgment or physical activity, he says.

"An employee battling a disease as awful as cancer can do a non-psychoactive during the day, and at nighttime use the THC-dominant product to attack the disease at night," Malanca says.

The legal use of recreational marijuana also can be managed in the workplace, just as with any other legal substance that can impair performance, Malanca says.

"Cannabis is recreationally legal and alcohol is recreationally legal in this state. I'm not going to allow you to come to work smelling like liquor or intoxicated, and the same applies to cannabis," he says. "Like with opioids and other pharmaceutical substances, if the person comes to work and passes out from drug use, it's not OK just because he has a prescription and is using it legally. Employers can get the idea that legalizing cannabis means people will be under the influence at work, and that does not have to be allowed."

Consider Forms of Medical Use

Use of medical marijuana during the work day also is a concern for

healthcare providers, notes **Richard Kimball**, managing partner of HExL, a consulting company based in New York City. If the organization does not take a zero-tolerance stance and acknowledges that employees may use medical marijuana legally, it may be necessary to establish policies on how the substance can be used on the premises, he says. Most employees would be able to avoid using it at work, but some may find it necessary to take the drug during the day just as people take other prescribed medications at different times of day.

The same issue applies if patients need to use the substance while admitted.

"In that case, you're going to have to look at what's practical and safe in terms of the workplace," he says. "Smoking marijuana wouldn't make any sense in a hospital setting, vaporizing is questionable, and even edibles are probably questionable."

Kimball expects the acceptance of medical and recreational marijuana use to continue growing, so he says healthcare occupational health and risk managers should expect to confront these issues soon, even if they don't have to immediately.

One potential avenue of litigation is the Americans with Disabilities Act (ADA), in which the definition of disabilities is very broad, says **Amanda Wingfield Goldman**, JD, an attorney with the law firm of Coats Rose in New Orleans.

"If you take a medication to alleviate any sort of problem you have, a lot of people could argue that's medication for a disability," she says. "It is not farfetched to think of an employee bringing an ADA case against the employer for interfering with disability-related treatment and not making accommodations." ■

EH Urged To Take Annual AOHP Exposure Survey

Tracking trends in needlesticks and blood exposures

Employee health professionals are being urged to enter their 2016 exposure data into the annual Exposure Survey of Trends in Occupational Practice (EXPO-STOP) by the Association of Occupational Health Professionals in Healthcare (AOHP).

AOHP is hoping to get input from 200 hospitals, and is also targeting non-hospital settings. EXPO-STOP provides a timely nationwide database for sharps injuries and mucocutaneous exposures to healthcare workers.

"The past five surveys (2011-2015) show that AOHP has the membership, data, and geography to make a significant contribution to exposure knowledge both in the United States and internationally," the AOHP reports.

The 2015 survey confirmed that exposures have decreased since 2001, albeit slowly, but may now have reached a plateau, the association noted.

"A large number of participants in the 2016 EXPO-STOP survey will help to confirm the direction of this trend," the AOHP says.

The survey collects data on such areas as OSHA Log sharps injuries, the number occurring during surgical procedures, and mucocutaneous exposures (including bites).

Those who submit data by March 31, 2017, will be eligible to win free registration to the next AOHP national conference.

The survey can be found at: http://svy.mk/2jDatiT. ■

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.

COMING IN FUTURE MONTHS

- Training HCWs on the proper use of respirators
- The Joint Commission takes on healthcare bullies
- CDC finalizes new infection control guidelines for HCWs
- Will rising legal challenges undermine mandatory flu vaccine policies?

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE QUESTIONS

1. **According, to Jordan Barab, deputy assistant secretary of labor at OSHA, how long does it typically take to enact an OSHA regulation?**

   a. 18 months
   b. Three years
   c. Five years
   d. Seven years

2. **James Phillips, MD, pointed out which problem in addressing violence prevention in healthcare settings?**

   a. Laws preventing healthcare workers abandoning patients in need.
   b. Ingrained cultural expectation by nurses that doctors will protect them.
   c. Lack of violence awareness and training in medical schools.
   d. All of the above

3. **In accordance with a New York state law on safe patient handling, healthcare facilities must form a committee comprised entirely of front-line staff.**

   a. True
   b. False

4. **Which of the following infectious disease threats to healthcare workers have emerged in nature in this century?**

   a. HIV
   b. SARS
   c. Hepatitis B
   d. Smallpox