HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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Heal the Clinician, Protect the Patient

HCWs suffering depression commit more errors

By Gary Evans, Medical Writer

Nurses with physical and mental health issues were more likely to self-report medical errors, showing a clear link between clinician wellness and patient safety, a new study reports.

Workers suffering physical or mental ailments "are not going to be fully engaged in their work, and when people aren't fully engaged more medical errors are going to happen. Quality of care is really going to suffer," says lead author **Bernadette M. Melnyk**, PhD, RN, dean of the Ohio State University College of Nursing in Columbus.

The findings underscore the critical role of employee health programs, not just for occupational wellness, but also for patient safety. The paper adds to the accumulating evidence that patient safety — a prime directive of healthcare — is intrinsically linked to the health of the caregiver. That means providing resources and support for employee health translates to the bottom line and the ethical imperative of protecting patients.

> THE PAPER ADDS TO THE ACCUMULATING EVIDENCE THAT PATIENT SAFETY — A PRIME DIRECTIVE OF HEALTHCARE — IS INTRINSICALLY LINKED TO THE HEALTH OF THE CAREGIVER.

"A lot of studies have shown that for every dollar invested in wellness, you get a three- to four-dollar return," she says. "Certainly, here at Ohio State we have seen that. If you have a good wellness culture, you are focused on your employees'

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health and wellness. They are going to be healthier, happier, and more engaged. As a result, you are going to see higher quality and safety of healthcare."

Indeed, perception is reality in this regard, as the health of the individual worker is to some extent reflective of the institutional culture.

"The nurses who perceived a greater level of worksite wellness support had better physical and mental health," she says. "Hospitals need to create a healthy work culture where healthy behaviors are the default choice for people to make. Culture eats strategy for breakfast, lunch, and dinner. These wellness cultures are so important."

On the other hand, working long hours was associated with poorer worker health and more medical errors.

"Ours is another study that shows the longer the work hours, the poorer the mental and physical health, the more medical errors," she says. "These 12-hour shifts need to go. How much more data do we need? We know they are not good for our clinicians and they are not good for patients."

Melnyk and colleagues conducted a descriptive survey[1] in a nationwide sample of 1,790 nurses. More than half the nurses reported "suboptimal" physical and mental health. Similarly, approximately half of the nurses self-reported committing medical errors in the prior five years. Compared with nurses with better health, those with health issues had a statistically significant range of a 26% to 71% higher likelihood of medical errors, they reported.

"We measured depression, anxiety, stress, quality of life, and worksite wellness support," Melnyk tells *Hospital Employee Health*. "This was the first study to actually show that depression was the biggest predictor of medical errors. Again, if you are depressed, you're probably not going to be fully engaged. You're probably going to be sad and thinking about what is not right in your life."

That, in turn, increases the risk of medical errors, which in the paper included medication errors and lapses or "omissions" in care that led to patient falls and preventable conditions like pressure injuries and catheter-related infections. Prior research links stress with depression and an attendant drop in job satisfaction, the authors noted, again linking the decline in the caregiver's mental health to the increasing risk of patient harm.

"The mental health component of employee well-being is so critical," she says. "We are living in an era where one out of every four to five people has a mental health issue, but less than 25% get any treatment. This is a huge employee health issue for healthcare systems."

Employers typically understand that healthy, engaged nurses translate to greater productivity and less presenteeism and absenteeism — all factors that favorably affect the bottom line. This study demonstrates that there is much more at stake in terms of patient safety. Preventable medical errors are the third-highest cause of death in the U.S., resulting in more than 250,000 deaths per year, the researchers reported.

"A lot of studies show that self-reported medical errors may be even more accurate than data collected within healthcare systems," Melnyk says. "Nurses and physicians are sometimes fearful of reporting errors because of the consequences. We did this anonymously, so we believe that this is probably accurate reporting."

If the data are even close to what's happening nationally, the impact is huge. Extrapolating the findings over a national population of some 3 million nurses, about one-third of them would report some depression. More than half would report anxiety, and about 40% — more than 1 million nurses — would report "higher than optimal" stress levels.

"Nursing is the largest healthcare provider in the country," she says. "If you extrapolate what we found in our study, you're talking about a significant portion of the nursing population that could be suffering from core mental health [issues] and depression."

National Collaborative

Melnyck is a member of the Action Collaborative on Clinician Well-Being and Resilience, which was formed last year by the National Academy of Medicine (NAM) to bring a large group of stakeholders together to address healthcare worker health. The collaborative is implementing an ambitious agenda of research and action aimed at raising the visibility of a healthcare workplace at clear risk.

"Clinicians of all kinds, across all specialties and care settings, are experiencing alarming rates of burnout, depression, and suicide," said **Charlee Alexander**, NAM program director for the collaborative project. "Four hundred physicians die by suicide each year, a rate more than twice that of the general population."[2]

Speaking at a recent webinar held by the collaborative, Alexander cited other alarming statistics. That included a 21% to 31% prevalence of emotional exhaustion among primary care nurses[3] and high rates of depression among physicians.

But it takes more than cold clinical data to shed light on a problem with such emotional nuance. In that regard, the collaborative has invited artistic depictions of clinical anguish, compassion, and variations on this theme, announcing that 100 of the art pieces will be displayed in an online collection.

"We hope the art show will promote a better awareness and understanding to barriers to clinician well-being," Alexander said.

The NAM collaborative is comprised of participants representing medicine, nursing, pharmacy, dentistry, professional societies, government agencies, and patient and consumer representatives.

The collaboration is planning to eventually issue a comprehensive report like *To Err is Human*, the 1999 Institute of Medicine report that drew national attention to medical errors and effectively launched the patient safety movement. A recently published paper by some of the members of the collaborative, "To Care Is Human," may foreshadow the

Accentuate the Positive

An epidemic of burnout in healthcare workers has been widely reported — but, these researchers suggest, perhaps the glass is half full.

Researchers at the Institute for Healthcare Improvement suggest shifting the focus from "burnout" to "joy in work."

"The difference is not merely semantic," they argued.[1] "Just as health is more than the absence of disease, so too is joy more than the absence of burnout."

What does this joy look like? It's an intellectual and emotional commitment to meaningful and satisfying work, they noted.

"Ample evidence indicates that management practices that are concentrated on producing a joyful, engaged workforce result in lower burnout, fewer medical errors, and a better patient experience," they concluded.

The researchers identified four steps leaders can take to develop a more healthful workplace:

- **Ask staff what matters to them.** "This first step is about asking the right questions and really listening for the answers to identify what contributes to — or detracts from — joy in work."
- **Identify impediments.** Identify the processes, issues, or circumstances that impede professional, social, and psychological well-being.
- **Make joy in work a shared responsibility.** "From creating effective systems to building teams to bolstering one's own resilience and supporting a positive culture, everyone contributes."
- **Test approaches.** "By using principles of improvement science, organizations can determine if the changes they test are leading to improvement, are effective in different environments, are sustainable, and can be spread." ■

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title of that eventual national report. *(For more information, see related story on page 53.)*

One goal of the collaborative is to standardize the research approach to healthcare depression and burnout. The group is trying to establish metrics that can be used in studies of healthcare workers, said **Robert Harbaugh**, MD, past president of the Society of Neurological Surgeons.

"We would like for researchers to be able to use similar instruments that are valid and reliable," he said. "That will make it easier to compare interventions across various organizations and try to elevate the quality of the research."

The transition to electronic medical records and other data documentation changes have been stressful to many clinicians. As part of its research agenda, the collaborative is conducting research that "really focuses on clinical documentation and solutions to alleviate burnout," said **Daisy Smith**, MD, vice president of clinical programs at the American College of Physicians. This line of research is looking at the link between clinical document requirements and clinician burnout, she said.

"It highlights challenges and opportunities to improve the situation — how we might be able to reimagine health IT and clinical documentation in a way that it could really support the work that is central to all of us," Smith said in the webinar.

Another collaborative research target deals with creating "high-functioning teams to promote clinician well-being and reduce burnout and improve patient outcomes," she adds.

Neil Busis, MD, a NAM collaborative member representing the American Academy of Neurology, is looking at the messaging and communications needed to raise awareness about clinician burnout and depression. He said it is important to emphasize people over profits.

"Focus on fixing the system, not blaming clinicians," he added. "Emphasize that burnout is a serious problem, but at the same time, frame the issue positively — promoting well-being rather than combating burnout."

Many of the NAM collaborative's efforts, papers, and plans for the future are available on the group's Clinician Well-Being Knowledge Hub, "a one-stop shop for those wanting to learn more about clinician burnout and looking for solutions on clinician well-being," Busis said. *(The knowledge hub can be found at: https://bit.ly/2uw8JlX.)*

Raising awareness is critical, particularly for clinicians who suffer in silence.

"One of the things we found out is that many clinicians that were burned out thought they were alone," he said. "They are not — this is very common."

Similarly, various approaches to reducing burnout and promoting worker well-being are being done on a widespread scale, he added.

"While there are only a small number of meta-analyses, there are a whole lot of things being done at the local level in terms of quality improvement projects that never get published," Busis said. "We hope that those kinds of best practices will find their way to the knowledge hub [website]."

Indeed, in much the same way the adage applies to politics, ultimately all burnout is local.

"You don't [so much] leave your organization as you leave your immediate supervisor," he said. "The idea is to teach people methods to focus on the drivers of burnout and the things that inhibit clinician wellness in their own institution."

Busis struck a balance in discussing the role of patients and public, saying the collaborative is trying to bring them into the process without raising fears about their doctors and nurses.

"We understand that the public plays a central role in this work," he said. "The patient is really at the center of everything we do. We want to inform the public, but we don't want to scare them. Because remember, this is about their caregivers."

Patients are very receptive to the issue and they want to be informed. Busis added that one of the goals of the collaborative is to improve baseline understanding of clinician burnout.

"We will include the public in this phase of testing and we are going to frame it as a patient safety issue," Busis said. "That is a common thread throughout all of our messaging. We have learned that we need to emphasize that patients are actually a part of team-based care." ■

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To Care Is Human: Collaborative Tackles Toll on Healthcare Workers

Healthcare is at a 'critical inflection point'

Healthcare workers are at increased risk of burnout and depression, as a confluence of factors have created a toxic brew of occupational stressors.

"The health professions are at a critical inflection point. The health system cannot sustain current rates of clinician burnout and continue to deliver safe, high-quality care," warned the authors of recent report[1] by a national collaboration.

Formed last year by the National Academy of Medicine (NAM), the Action Collaborative on Clinician Well-Being and Resilience is meeting the problem through a comprehensive plan of attack.

"There is reason to be optimistic that the tide is turning," the authors noted. "The strong commitment of more than 100 national organizations to the work of the collaborative has made clear that clinician well-being is a growing priority for healthcare leaders, policymakers, payers, and other decision-makers capable of bringing about system-level change."

The ethical principles that guide clinical care, including the bedrock commitment to help patients, are under siege by growing demands on clinicians. "Burdensome tasks and increasing stress experienced by many clinicians, alarmingly high rates of burnout, depression, and suicide threaten their well-being," the authors noted.

Thus, physicians, nurses, and other clinicians are at an increased risk if these factors are not mitigated and their resiliency bolstered.

"Clinicians are human, and it takes a personal toll on them when circumstances make it difficult to fulfill their ethical commitments and deliver the best possible care," they noted. "Not only are clinicians' lives at risk, so is patient safety. Some studies have revealed links between clinician burnout and increased rates of medical errors, malpractice suits, and healthcare-associated infections."

In addition, clinician burnout undermines the fiscal health of the delivery system due to lost jobs and reduced productivity.

"The annual productivity loss in the United States that is attributable to burnout may be equivalent to eliminating the graduating classes of seven medical schools," they emphasized. "These consequences are unacceptable by any standard. Therefore, we have an urgent, shared professional responsibility to respond and to develop solutions."

Conceptual Module

The collaborative, as described in a recent NAM webinar, includes a somewhat intricate but potentially highly useful conceptual model.[2] The group is trying to standardize an approach to the common problem of burnout by balancing various social and job pressures with personal skills of resilience.

"This is going to be a very dynamic model. It covers all points of careers, all different healthcare providers, and is very interactive," said collaborative member **Arthur Hengerer**, MD, in a recent webinar. "We're talking about developing stories and scenarios."

This model includes external factors in work cultures like the level of bureaucracy, organizational mission and values, leadership and staff engagement, data collection requirements, diversity, and inclusion in support of the healthcare team. While this mix will understandably vary by institution — and a lot will depend on the individual worker's defined role — each clinician brings his or her own individual factors to the job. Traits that will affect individual vulnerability and resilience include the following, cited by the collaborative:

Personal factors

- inclusion and connectivity;
- family dynamics;
- financial stressors/economic vitality;
- flexibility and ability to respond to change;
- level of engagement/connection to meaning and purpose in work.

Personality traits

- personal values, ethics, and morals;
- physical, mental, and spiritual well-being;
- relationships and social support;
- sense of meaning;
- work/life integration.

Skills and abilities

- clinical competency level/ experience;
- communication skills;
- coping skills;

- delegation;
- empathy management;
- leadership;
- mastering new technologies or proficient use of technology;
- mentorship;
- optimizing workflow;
- organizational skills;
- resilience;
- teamwork skills. ■

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Johns Hopkins Boosts Employee Health With CDC Scorecard

Make the easiest choice the healthiest choice

The CDC's Worksite Health ScoreCard effectively measures workplace wellness efforts and can highlight areas of needed improvement, researchers at Johns Hopkins Medicine (JHM) reported.

Using the CDC scorecard, 11 of the 12 JHM branches improved their overall score from year one to year two.

"The JHM enterprise surpassed national benchmarks in year two," the researchers reported.[1] "Organizations can use the scorecard as an effective measurement tool and as a method to improve the number of evidence-based health promotion strategies provided to their employees."

Healthy healthcare workers are more productive, contribute to greater patient satisfaction, and are less likely to make medical errors, the researchers emphasized.

"Despite this knowledge, only 46% of U.S. hospital workers agree that their organization promotes a healthy work environment, compared with 69% of U.S. workers overall," they reported. "In addition, about one-third (35%) of U.S. hospital workers report that current wellness programs encourage a healthier lifestyle, compared with nearly half (48%) of all U.S. workers."

The CDC scorecard was implemented to address these concerns. It provided an evidence-based employee health strategy that did not undermine the autonomy of local culture, but still drove Hopkins overall in a unified organizational direction. There were several benefits, but the area of nutrition emerged as a challenge.

"The nutrition section of the scorecard was the lowest-scoring topic area across JHM in both years one and two," the authors reported. "Implementing strategies that are proven to help employees make a healthy food choice may be onerous and cost prohibitive for many employers due to the multiple food access points often available, including vending machines, cafeterias, and retail outlets." *(The scorecard is available online at: https://bit.ly/2qguv6U.)*

To delve more into the findings, *Hospital Employee Health* interviewed one of the study authors, **Wendy Bowen**, MPH, health promotion specialist in the JHM department of employee health and wellness.

HEH: Can you comment more on the point that the CDC scorecard allowed individual JHM facilities autonomy while providing an overall measurable goal? Is it expected and encouraged that wellness and health cultures will vary somewhat by unit?

Bowen: Autonomy was provided through variation in how entities fulfilled elements contained in the CDC scorecard. Each entity had the leeway to determine which interventions were most appropriate for their local culture and how best to implement their selected strategies. Excluding the "organizational supports" section of the CDC scorecard in which leaders expected a year-over-year point improvement, each JHM entity managed their own strategic direction of topic area improvements. For instance, some entities chose to focus their improvement effort on high blood pressure, whereas others chose to focus on diabetes.

With regard to implementation methods, some entities determined it was best suited to offer in-person educational seminars, whereas others concluded live webinars would be most successful due to a large percentage of its employee population being offsite. Providing entities with implementation flexibility was fundamental in allowing their workplace wellness culture to flourish. There are many different cultures within

a large organization, and giving JHM entities flexibility in their CDC scorecard priorities and implementation strategy respects their culture.

HEH: Can you elaborate on why was it important to integrate the effort into the JHM business objectives? It is well known that prevention helps the bottom line, but historically this has been a difficult argument to secure resources.

Bowen: Integrating the CDC scorecard project into the JHM business objectives was one of the most important factors leading to score improvement. It provided accountability for our leadership teams. The year-end results of our business objectives are broadly shared, and this transparency fosters motivation for progress. Our philosophical approach of creating a healthy culture in our workplace is well supported by the socioecologic model of behavior that is the core of the CDC scorecard. Without a certain level of health culture in the workplace, it's difficult to expect employees to make healthy choices that would help the bottom line over time. When hospitals can utilize a measurement tool that is validated and based on scientific evidence, making the case to integrate it into an organization's business objectives becomes less difficult.

HEH: Do you think, with measures like the CDC scorecard and ongoing research, that the business case for employee health and wellness is getting easier to make?

Bowen: Historically, employee health and productivity management programs have focused on ROI [return on investment] as a means of proving success. There are many challenges with trying to build a plausible model to attribute programs to cost savings. As a research institution ourselves, we embrace the notion of applying an evidenced-based tool for health promotion programming. I can't say it is getting easier across the board to make the business case for employee health and wellness. Some employers are stuck in the mindset that a successful program is measured by program sign-ups. We believe in a program whereby employees do not need to sign up to be engaged in their health.

> "WHEN YOU PUT AN EMPLOYEE IN AN ENVIRONMENT WHERE THE EASIEST CHOICE IS THE HEALTHIEST CHOICE, THAT'S AN EASY CASE TO MAKE."

When you put an employee in an environment where the easiest choice is the healthiest choice, that's an easy case to make.

HEH: Do you plan to continue your program, and if so, are there any changes you are planning to make?

Bowen: We plan to continue using the CDC scorecard as a way to quantitatively measure our workplace health promotion efforts and ensure we are improving the number of evidence-based strategies from one year to the next. We also enhance the quality of our strategies each year as we learn from the previous years' effort. Finally, the CDC will be releasing a new version of their scorecard, so we'll be adjusting our efforts accordingly.

HEH: Would you recommend this approach to other large hospital systems?

Bowen: I would. Healthcare workers provide services to an ailing population. Ensuring the health of these workers in order to deliver optimal care is imperative. Hospitals have an opportunity to create a healthy workplace for their workers by providing environmental support that encourages healthy choices. The approach we utilized provides large hospital systems with a method of measuring and monitoring interventions over time while also giving multiple entities the ability to create a culture centered around their individual employees.

HEH: What about using the CDC scorecard in small community hospitals?

Bowen: Yes, I would also recommend this approach in small community hospitals. Large systems are not unique in that they face the same challenges as small hospitals in providing evidence-based opportunities for their employees to make healthy choices throughout the workday. Perhaps a small hospital system does not need the same level of implementation autonomy due to a lack of geographic dispersion. However, the CDC scorecard tool is valuable in providing a baseline measure of workplace wellness programs, identifying gaps, and creating a plan of improvement, independent of hospital size. ■

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The Long and Winding Road

Travel nurses experience employee health issues of their own

Travel nurses who routinely relocate and work at new facilities on an interim basis face some employee health problems unique to their situation. Others are slightly different manifestations of common issues in nursing, explains **Cheryl J. Roby**, RN.

Roby traveled extensively during her 30-year nursing career, taking on a variety of roles that included occupational health. Roby has set up a website for travel nurses where she regularly blogs and post other information and resources. *(Her website is available at: https://www.wanderingnurses.com.)*

"There are many thousands of travel nurses," she says. "It's a fluctuating business. There are nurses that try traveling for a year or so, and they don't like it and get out. There are nurses that get into it and do it until they retire. We cover all 50 states, and there are those who travel outside the U.S. to other countries as well."

Travel nurses usually are referred for jobs by recruiting agencies, signing for a typical contract of 13 weeks. "Sometimes they will get onsite and really like the hospital and they will extend their contract there if there is a need for them," Roby says. "They are in every nursing specialty you can think of. All kinds of nurses went down to Texas when they had the floods there, so they travel and do things like that."

All nursing jobs seem to be stressful to some degree, but there are several aspects of travel nursing that increase the pressure.

"You are moving into a work environment where you don't know anyone and you don't know the hospital," she says. "It's like starting a new job every 13 weeks. You have to learn the new policies and the technology in every hospital, so stress is huge."

The ebb and flow of this work means nurses who like "constant change" thrive as travel nurses. Others find out rather quickly it is not for them, no doubt in part by the attendant aggravations that affect health.

"Sleep is an issue," Roby says. "You are traveling to a new location, most of which work 12-hour shifts. They may have to flip-flop shifts when they get there, depending on what the hospital needs. Fatigue is huge."

Another issue common in travel nursing culture is bullying. This is a toxic work culture trait that has too often been reported by all types of nurses, but travel nurses face a distinct risk upon arrival at the new job.

"These nurses will come in and there is already a clique of nurses who work the routine shifts," she says. "They tend to dump on the new person in the hospital."

In a blog post on the issue, Roby gave travel nurses some straightforward advice that also applies to nurses of all stripes. "Be aware of what is going on, and remember you deserve respect," she noted.[1] "Do not just brush off bullying and do not chalk it up to being the new guy or gal. Document and take notes — including dates, names, and times — on how you're being bullied."

React appropriately, but defend yourself.

"It's a tricky balance to strike, but just be communicative, professional, and honest," Roby wrote. "Speak up and say, 'You are bullying me. Please stop.'" ■

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Occupational Threat to Dental Workers?

Cluster of dental workers with progressive lung disease reported

Looking over the medical records at a specialty clinic in Virginia, public health investigators have uncovered a cluster of dental workers with a progressive lung disease that appears to be occupationally acquired.

In 2016, a Virginia dentist seeking treatment at the clinic was diagnosed with idiopathic pulmonary fibrosis (IPF), a progressive lung disease of unknown etiology. The dentist contacted the CDC after becoming aware that other dental workers also were being treated for IPF at the clinic.

"The clinic where these dental personnel sought care specializes in the treatment of IPF," said **Randall**

Nett, MD, MPH, a medical officer in the CDC's Respiratory Health Division, and lead investigator. "The dentist who reported this cluster to CDC was told of several dentists who had been treated at the same clinic by his treating physician."

This is the first report of IPF, but dental workers are known to be at risk to infectious agents, chemicals, airborne particulates, ionizing radiation, and other potentially hazardous materials, the CDC reported.

"Inhalational exposures experienced by dentists likely increase their risk for certain work-related respiratory diseases," the CDC report noted.[1] "For example, cases of dental technicians with pneumoconiosis, a restrictive occupational lung disease resulting from inhalation of dust, have been identified after exposure to either silica or cobalt-chromium-molybdenum-based dental prostheses."

Grim Prognosis

Occupational exposures have been linked to other professions, but this is the first published report describing IPF in dental workers. The lung disease has a grim prognosis, with the estimated median survival time after diagnosis ranging from three to five years.

Investigators reviewed the medical records for all 894 patients treated for IPF at the Virginia clinic from 1996 to 2017. They were looking for patients who had worked as dentists, dental hygienists, or dental technicians. Among 894 patients treated for IPF, nine (1%) were identified as dental personnel, including eight dentists and one dental technician. At the time of pulmonary consultation, the median patient age was 64 years (range: 49-81 years). In addition to patients from Virginia, three were from Maryland, and one was from Georgia. Seven of the nine patients had died by the time of the investigation, with a median survival time from consultation of three years (range: 1-7 years). One patient underwent a lung transplant three years after diagnosis.

"SURGICAL MASKS WOULD BE PROTECTIVE AGAINST BLOOD SPLATTERING FROM THE PATIENT, BUT WOULD NOT BE PROTECTIVE AGAINST SILICA EXPOSURE CAUSED BY GRINDING OR POLISHING."

Risk '23-fold' Higher

The report stated that "during 2016, dentists accounted for an estimated 0.038% of U.S. residents, yet represented 0.893% of patients undergoing treatment for IPF at one tertiary care center, nearly a 23-fold difference." That certainly raises concern for these workers nationally, but Nett was hesitant to go beyond the cluster data.

"At this time, we do not have any information about additional clusters of IPF occurring among dentists," he said. "We are in the planning stages for conducting additional studies to determine if the dental community is at higher risk for developing IPF."

A phone interview was conducted with the patient who had contacted the CDC. The patient was a nonsmoker, and reported never wearing a NIOSH-approved respirator during 40 years of dentistry. However, he wore a surgical mask for the last 20 years of his dental practice.

"He reported performing polishing of dental appliances, preparing amalgams and impressions, and developing X-rays using film developing solutions," the CDC reported. "He also reported work-related exposure to dust while working as a street sweeper for three months before entering dental school, and environmental exposure to dust from coral beaches for approximately 15 years while intermittently visiting the Caribbean region as a practicing dentist."

The report recommended that "dental personnel who perform tasks that result in occupational exposures to known respiratory hazards should wear adequate respiratory protection if other controls (e.g., improved ventilation) are not practical or effective." The choice in appropriate respiratory protection (e.g., surgical mask vs. N95 respirator) depends on the particular inhalational hazard, Nett said.

"For example, surgical masks would be protective against blood splattering from the patient, but would not be protective against silica exposure caused by grinding or polishing," he said.

Nett referred further inquiries on this question to the OSHA webpage about potential occupational exposures in dentistry, at: https://bit.ly/2GlmN7C.

This resource does not address IPF, but cites the danger of silicosis, another lung disease that has been linked to inhaling silica when working with dental casting and grinding porcelain. Though this would not be routine dental care, the recommendations for preventing silica exposures are to "wear a respirator when other control methods are missing or do not work. The type of respirator recommended is, at a minimum, a half-mask air-purifying respirator with type N100 particulate filters."

Nine cases of silicosis were recognized among dental laboratory technicians exposed to crystalline silica in five states during 1994-2000, the CDC reported. Based on the Virginia dental cluster, NIOSH is not considering new recommendations for respiratory protection of dental healthcare workers at this time.

"This was an isolated cluster that involved nine cases of IPF at a single tertiary care clinic," Nett said. "We need to conduct further studies to determine if the dental community is at higher risk for developing IPF." ■

REFERENCE

1. CDC. Dental Personnel Treated for Idiopathic Pulmonary Fibrosis at a Tertiary Care Center — Virginia, 2000–2015. *MMWR* 2018;67:270–273.

Student March Lends Momentum to Healthcare Violence Regulation

Fed bill would greenlight OSHA standard

Antiviolence efforts to protect healthcare workers have been underway with limited success for years, so the latest federal bill in that regard would normally be seen as another well-intentioned, but ultimately futile, effort. However, things are not normal.

In the traumatic aftermath of a school shooting in Florida, students from the school protested and organized national marches. The movement has raised public awareness about gun violence in a way that resonates with advocates for action in healthcare.

"We're incredibly proud of their efforts, which I believe are heroic," says **Bonnie Castillo**, RN, executive director of National Nurses United in Oakland, CA. "The fact that the students themselves are out defending their right to be safe is remarkable. When we look at gun violence, we see it as a public health problem that puts all of us at risk."

Having successfully fought for a California Department of Occupational Safety and Health (Cal/OSHA) healthcare violence prevention standard in her state, Castillo is lobbying for passage of a recently filed federal bill that would enact similar requirements nationwide. Introduced in March by U.S. Rep. Ro Khanna, D-CA, the Health Care Workplace Violence Prevention Act was co-signed by 12 other members of Congress.

If passed, the law mandates that federal OSHA develop a national standard on workplace violence prevention. Although it has fallen largely silent in the current antiregulatory climate, OSHA issued a request for comment on Dec. 7, 2016, on a workplace violence prevention standard for healthcare settings.[1]

OSHA cited the passage of healthcare violence prevention regulations by its state-based program in California. The Cal/OSHA program adopted the new standards in 2016, with implementation beginning last year. In doing so, Cal/OSHA became the first state OSHA plan to adopt a healthcare violence prevention regulation.

At the time of this interview, Castillo says California hospitals were just readying to fully implement the state requirements by an April 1 deadline.

"They are supposed to be ready to operationalize their work plans," she says. "But we understand with every health and safety regulation that we have fought for and won, we have to have a vigorous enforcement plan as well. We are working with the nurses that we represent to ensure that the hospitals comply with the full intent of the law and all of the regulations."

Despite the success of the state law, the national regulation faces the same uphill battle that has mired down other efforts for change in healthcare.

"Even prior to the current administration, we have had to fight," she says. "Primarily because the healthcare industry itself vigorously opposes regulation. There has always been a kind of [political] sympathy for this unregulated model, even across the aisle. But it puts all of us that work in this

industry and the public at risk as well."

The public includes the patients who seek healthcare, and the emerging social justice movement on gun violence could put more pressure on the medical industry to protect caregivers.

"The reason we have been able to overcome some of this in healthcare is that we have been able to get public support from the patients that we serve," Castillo says. "That's what we are seeing with these marchers and that is what it is going to take. What is really great is that these students have a collective political voice, and they took it to the streets." ■

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1. OSHA. Prevention of Workplace Violence in Healthcare and Social Assistance. *Fed Reg*. 2016-29197. Dec. 7, 2016. Available at: http://bit.ly/2hB5gL5.
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Employees Face Opioid Overflow in EDs

The CDC estimates 115 people die of opioid overdose every day. Those that make it to the entrance of the EDs may arrive in large numbers, creating occupational threats of drug exposure or violence to healthcare workers trying to deliver care.

In data reported from July 2016 through September 2017, the CDC found that ED visits in 45 states showed that opioid overdoses are increasing across all regions.

"Out of 91 million emergency department visits, there were 142,557 suspected overdoses involving opioids," **Anne Schuchat**, MD, CDC acting director, said at a recent news conference. "Opioid overdose emergency department visits increased about 30% overall in this national system. We saw increases in cities and towns of all types from the third quarter 2016 to the third quarter 2017."

The toll of the opioid epidemic has reached unprecedented levels, with an estimated 63,000 overdose deaths in 2016, the CDC recently reported.

"We're currently seeing the highest drug overdose death rates ever recorded in the United States, driven by prescription opioids and by illicit opioids such as heroin and illicitly manufactured fentanyl," the agency reported.

As previously reported in *Hospital Employee Health*, there have been hospital workers, first responders, and police officers overwhelmed by narcotic exposures in dealing with opioid users and overdosed patients. Some of this is thought to occur because street drugs are being cut with powerful synthetic opioids, some many times more potent than anything typically used in a hospital.

In addition, EDs crowded with people under the influence of opioids raises the concern about patient violence toward healthcare workers. There are threats for violence even in the absence of drugs, as evidenced by a recent report from an ED in Florida.

"I've seen a lot in my career as a field director [for The Joint Commission] but I won't soon forget the night when members of rival gangs presented in our ED trauma center," **Jim Kendig**, MS, CHSP, CHCM, CHEM, LHRM, wrote in a Joint Commission blog post.[1]

The situation resolved without incident, but there were several follow-up meetings and discussions about ED safety.

While the opioid epidemic contributes to violence, will it also be a siren call to addicted healthcare workers? The opioid epidemic overlaps with the longstanding problem of addicted healthcare workers diverting drugs such as fentanyl from patients.

"For every fatal case there are many more nonfatal cases, each one with its own emotional and economic toll," Schuchat said. "Research shows that people who have had at least one overdose are more likely to have another."

The CDC is working with hospital EDs to refer these surviving addicts for subsequent treatment. "Take steps toward preventing a repeat overdose, ideally [by] alerting community partners to opportunities to improve prevention in the surrounding areas," she said.

On a personal note, U.S. Surgeon General **Jerome Adams**, MD, MPH, said his brother has struggled with addiction for decades. "I often contemplate the fact that it could have been me," Adams said at the press conference. Getting the opioid antidote naloxone in the hands of first responders and community members is an immediate priority, followed by public education and destigmatization of addiction, he added. ■

REFERENCE

1. Kendig, J. Lessons Learned: Rival Gang Members in the Same Hospital. The Joint Commission blog, Jan. 4, 2018. Available at: http://bit.ly/2GlCfk4.

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

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

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CE QUESTIONS

1. **According to a nursing survey, which was the biggest predictor of medical errors?**

   a. Bullying environment
   b. Depression
   c. Stress
   d. Poor sleep

2. **An Action Collaborative on Clinician Well-Being and Resilience hopes to issue a report of its work that will have a similar effect as which book that sparked the patient safety movement?**

   a. *To Err is Human*
   b. *Failsafe*
   c. *Wounded Healers*
   d. *Do No Harm*

3. **Researchers looking at the toll of burnout on physicians found that the annual loss in productivity is equivalent to eliminating the graduating classes of how many medical schools?**

   a. One
   b. Three
   c. Five
   d. Seven

4. **John Hopkins researchers reported that almost half of workers in general said their current wellness programs encourage a healthier lifestyle. What percentage of healthcare workers said the same about their wellness programs?**

   a. 28%
   b. 35%
   c. 42%
   d. 60%

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.