HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

JULY 2018 Vol. 37, No. 7; p. 73-84

INSIDE

RELIAS
Formerly AHC Media

Ex-OSHA Chief: With Violence Reg Stalled, Hospitals Should Act

Patient-worker safety link nearing tipping point

By Gary Evans, Medical Writer

In the current political climate, the Occupational Safety and Health Administration (OSHA) has no realistic way forward to achieve its goal of issuing a proposed standard to protect healthcare workers from violence, a former OSHA director tells *Hospital Employee Health*.

"I don't think that is going to happen," says **David Michaels**, PhD, who is now a professor of public health at George Washington University in Washington, DC.

In the interim, hospitals should step up efforts to protect workers from a threat of healthcare violence that is increasing amid a national opioid epidemic.

"Hospitals certainly don't need a standard or a regulation to make sure their workforce is protected," Michaels says. "The growing opioid epidemic has raised the level of concern in the hospital community — you have people looking for drugs. We have had this issue of workplace violence in health settings for a long time, but I believe it has gotten worse in many ways."

> "WE HAVE HAD THIS ISSUE OF WORKPLACE VIOLENCE IN HEALTH SETTINGS FOR A LONG TIME, BUT I BELIEVE IT HAS GOTTEN WORSE IN MANY WAYS."

Appointed by former President Obama, Michaels left OSHA last year after a seven-year term as assistant secretary of labor — the longest tenure of any director in the agency's history. As his term closed with the ascendancy of the Trump administration, Michaels directed

Financial Disclosure: Medical Writer **Gary Evans**, Editor **Jill Drachenberg**, Editor **Jesse Saffron**, Editorial Group Manager **Terrey L. Hatcher,** and Nurse Planner **Kay Ball** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL EMPLOYEE HEALTH

Hospital Employee Health®,
ISSN 0744-6470, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Cary, NC, and at additional mailing offices.

POSTMASTER: Send address changes to:
Hospital Employee Health®
Relias Learning
111 Corning Road, Suite 250
Cary, NC 27518

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
Customer.Service@AHCMedia.com.
AHCMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours, $499. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

ACCREDITATION: Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.25] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is in effect for 36 months from the date of publication.

TARGET AUDIENCE: This activity is intended for hospital employee health professionals.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

MEDICAL WRITER: Gary Evans
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EDITORIAL QUESTIONS:
For questions or comments, call **Gary Evans** at (706) 424-3915.

OSHA to pursue a regulation to prevent violence in healthcare. After opening a request for information in 2016, OSHA announced on Jan. 10, 2017, that it would promulgate a federal regulation to protect healthcare workers from violence.[1]

In a statement at the time, Michaels said, "I am pleased to announce, as one of my last actions, that OSHA will grant [healthcare union] petitions and will commence rulemaking to address the hazards of workplace violence."

OSHA was prompted to pursue rulemaking by a government watchdog report that found lost days due to violent injury in healthcare were five times higher than other industries overall. The report noted that the nation's mental health system is in disarray, as the dearth of psychiatric facilities drives patients into other healthcare settings.

"The number of nonfatal workplace violence cases in healthcare facilities ranged from an estimated 22,250 to 80,710 cases for 2011, the most recent year that data were available from all three federal data sets reviewed," the Government Accountability Office (GAO) reported.[2] "The most common types of reported assaults were hitting, kicking, and beating. The full extent of the problem and associated costs is unknown, however, because according to related studies GAO reviewed, healthcare workers may not always report such incidents."

In the accounts reported, there is no shortage of grim details by assaulted workers. Yet, as urgent as the problem is, even when the OSHA rulemaking process begins, it takes years to move through the bureaucracy of hearings and review necessary to enact regulation. Until the political winds change, the duty falls to healthcare facilities, a setting where Michaels once worked himself.

"The first 13 years of my career I worked at Montefiore Hospital in the Bronx," he says. "I wasn't directly involved in the employee health service, but I worked very closely with them. So, I have a particular focus on healthcare and hospital workers."

Insult to Injury

In that regard, as this issue went to press, Michaels was scheduled to appear among the keynote speakers at a national conference on patient and worker safety. While violence is a compelling occupational threat, the epidemic of worker injuries takes a grinding daily toll in healthcare.

"Many healthcare institutions haven't yet recognized the link between patient safety and worker safety," he says. "Many of them that have recognized the link have only made small steps toward the problem."

Still, as data accumulate, healthcare may finally reach a tipping point where the patient benefits of safe lifting and mobility will justify investment in programs to protect workers from injuries.

"We are able now to link safely mobilizing patients with protecting healthcare workers," says **Susan Gallagher**, PhD, RN, a bariatric nurse, safe patient-handling consultant, and speaker. "Our concern is how do we protect healthcare workers and still maintain patient safety? There is a link between the two; we are seeing it more and more in our research."

Patient mobility initiatives have really come to the fore in the last

few years, generating more data on improved health outcomes.

"A patient-handling program designed 10 years ago didn't even have provisions for this," she says. "Now we know there need to be special accommodations in critical care to get sicker patients up and out of bed early. It reduces the length of stay and readmissions. The patients just have better outcomes."

Employee health professionals are critical to these efforts, and have spearheaded some of the more effective programs, she adds.

"In my experience, it is employee health and occupational health that have brought on the most successful safe patient-handling programs," Gallagher says. "These are individuals who see what really happens in the workers' lives. They really want to make a difference."

Of course, reducing costs in the form of workers' comp claims are very much a part of the equation, but employee health most directly addresses the "humanistic aspect" of worker injuries, while getting the secondary gain of improving patient safety, she says.

The C-suite Message

While employee health is in a critical role, the ultimate success of any program to protect healthcare workers depends on the support of leadership.

"I think that the most important players in this are the CEOs, boards of trustees, and directors," Michaels says. "What we are talking about here is culture change, and that has to come from the top."

Healthcare can learn from the business models of other industries, where occupational safety is linked closely with productivity and profits.

"Workplace injuries are evidence of the absence of operational excellence," he says. "If workers are being injured, the work isn't being done correctly."

Reasons for that may include understaffing or the lack of proper equipment, but the result is that healthcare has "random injuries higher than most every other sector — it's higher than construction workers," Michaels says.

"That is often surprising to people, especially in the healthcare industry," he adds. "They don't realize it is such a dangerous industry for their workers."

In addition, in part because many hospitals are not-for-profit institutions, workers' compensation costs are "very high, particularly in nurse and nurses' aides who suffer debilitating back injuries," he notes.

This problem is likely to get worse before it gets better because hospitals are seeing an influx of heavier patients and many do not have the equipment in place to deal with them, Gallagher says.

"About 20% of nurses in any given day — one out of five — are having discomfort related to an occupational injury," she says. "It impacts not only their professional lives, but personal lives as well."

Much as with violence, a severe patient-handling injury is an event that goes beyond the bedside, affecting the immediate families and surrounding communities of injured nurses.

"That's what we find when we really sit down with nurses and ask them how their work impacts their lives," Gallagher says. "Last week a woman said to me, 'I can't even wear

Where's the Fire? Extend Safe Handling to EMTs

There is a prevailing misconception that firefighters, first responders, and EMTs are young and strong enough to physically lift patients without being injured.

"Even a 100-pound person is just too heavy for a person to lift up and down stairs and that sort of thing," says **Susan Gallagher**, PhD, RN, a bariatric nurse, safe patient-handling consultant, and speaker. "There is an opportunity for vendors to create tools specifically for EMS. But even more importantly, there has to be a change in the way we perceive firefighters and EMTs."

It turns out, as with nurses, not all of them are young and strong, and some of them are fighting chronic pain.

"You talk to a 60-year-old firefighter and they are pretty miserable physically — just like the nurses — because they have used their bodies excessively over time," she says. "We need to change that paradigm. EMTs are there to protect us, but they need to protect themselves as well."

Among the strategies under discussion is performing an initial assessment of the environment to look for potential hazards for trips and falls.

"We know the hazard assessment has to happen quickly, but it has to happen before the firefighters enter the facility, the home, or where they have been called to," she says. ■

the clothes I used to wear to work. I can't wear anything if I have to reach over my head to put a shirt on.'"

Hospitals should consider forming a bariatric task force or at least an ad hoc committee, as facilities may underestimate the level of obese patients under care.

"You have to do a point-prevalence [review]," she says. "How many patients are admitted on any one day that weigh 300 to 600 pounds? How many weigh 600 to 1,000 pounds? Shockingly, right now we are seeing a lot of patients in that 600- to 1,000-pound range."

In addition to information on patient population, assess the various lifts and equipment to make sure they are compatible with patient room installations, she adds.

"I have a photograph I just took in the last 10 days in a facility that has a ceiling lift that accommodates 500 pounds hanging over a toilet that accommodates 200 pounds," she says. "That is not compatible. We need to know all this information ahead of time and then in planning address the gaps."

If possible, set up a simulation room so healthcare workers can practice working together to lift and mobilize patients, Gallagher recommends. This can help workers prevent injuries when a real situation arises, while testing equipment and lifts to see what works best in a given scenario.

"You can look at scenarios like what happens if the patient falls in the bathroom — which is very different from an open space," she says. "It helps us understand how to learn the nuances of the tools before we are put in that very stressful situation."

Indeed, the stress of working with bariatric patients can exacerbate toxic behaviors like bullying, she adds. For example, an experienced nurse may tell co-workers it is easier and faster to move the patient manually. Though these workers may have been trained to use safe handling equipment, they may feel pressure in the moment. It takes "moral courage" to defy a more experienced co-worker, she says.

"What if it they get the patient up off the side of the bed without the equipment, and then the patient falls?" she says. "Now we have a patient event and potentially an injured nurse. It's important for not only bariatric nurses to have moral courage in what they do, but for all safe patient-handling professionals."

Such scenarios should be discussed openly and the situations when equipment should be used clearly understood.

"It's a crucial conversation," she says. ■

REFERENCES

1. OSHA. Prevention of Workplace Violence in Healthcare and Social Assistance. *Fed Reg* 2016-29197, Dec. 7, 2016. Available at: http://bit.ly/2hB5gL5.
2. GAO. Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence. GAO-16-11: Published Mar. 17, 2016.

Lock Down Drugs to Prevent Diversion

Accreditation survey details citations

Although it is rarely detected, experts tell us that drug diversion by healthcare workers is a rampant and longstanding problem. There certainly is no reason to think it is less so today, with an opioid epidemic raging in the community.

As employee health professionals are increasingly involved in preventing drug diversion, it is well to remember that the addict can resist everything but temptation. Locking and securing crash carts and pharmacy supplies on a given unit is critical to prevent drug theft or some form of tampering and substitution.

The Healthcare Facilities Accreditation Program (HFAP) recently released an analysis of 88 HFAP accreditation surveys, finding that 16% of citations were related to the security of medications. HFAP pharmacy services standard 25.01.03 requires that all drugs and biologicals are stored so as to prevent unmonitored access by unauthorized individuals, explains **Donna Tiberi-Blaszczyk**, RN, BS, MHA, a member of the HFAP standards interpretation staff.

HFAP standards specify that units that provide 24-hour care are generally considered "secure" when hospital policies limit entry and exit to appropriate staff, patients, and visitors. A unit that is not currently in use is not considered secure. In that case, the hospital may choose to lock the entire suite, to lock non-mobile carts containing drugs and biologicals, or to move mobile carts to a locked room, according to HFAP. All Schedule II, III, IV, and V drugs must be kept locked within a secured area.

"For example, anesthesia carts should be locked at all times when there is no one in the room," Tiberi-

Blaszczyk says. "Because anyone could walk into the room and take out propofol or fentanyl. What we are looking for if you are going to have an anesthesia cart in the OR — and that cart isn't visible to the OR staff, or the OR is closed — then that cart has to be locked."

Similarly, carts that contain these medications should be maintained in a visible traffic area.

"For instance, make sure someone at the nursing station is always available to identify anyone who tries to access the cart," she says.

Medication cart locks are usually plastic with an identification number, which should be recorded so it is clear when the lock was changed.

"The crash cart should be checked each shift to make sure that the lock wasn't changed, that the lock number is the same," Tiberi-Blaszczyk says.

If the cart was accessed, the medication taken and the healthcare worker responsible must be documented.

Pyxis medication dispensing machines need to be monitored, with overrides the exception and not the rule, Tiberi-Blaszczyk says.

"You need to monitor Pyxis access," she says. "How many overrides do you have, and how are they validated? You need to know who is getting access to the medications and what they are taking out."

Bearing Witness

Surveyors also will ask what procedures are followed when it is determined that a narcotic is missing. Controlled medication counting should be completed by two people who sign off on the process.

"There is one that is counting and one is making sure the count is correct," she says. "When you do a controlled medication inventory check, you have to account for what was taken and if something is missing. If there is a missing vial of something, nobody should go home until you find out where it went."

THE HFAP REPORT FOUND THAT MOST DEFICIENCIES RESULT FROM INCONSISTENT ADHERENCE TO HOSPITAL POLICY FOR SECURING MEDICATIONS, INCREASING THE RISK OF ACCESS BY UNAUTHORIZED INDIVIDUALS.

Discarding opened but unused opioids also should be done in tandem.

"When medications have to be wasted, make sure there is a witness," Tiberi-Blaszczyk says. "We want to ensure morphine, fentanyl, and propofol are being wasted appropriately. There should be a double signature."

The use of witnesses would give pause to any momentary temptation while making diversion more logistically difficult.

"This way, no one can be in a position to divert," she says.

A common problem is that demands for space lead to placing medication carts in alcoves or blind spots.

"You have to be able to physically see your crash cart and Pyxis so you know it is not being tampered with," she says.

Employees can store the carts in a locked room, but that immediately raises the question of who has access to the key or key code where the cart is secured.

The HFAP report found that most deficiencies result from inconsistent adherence to hospital policy for securing medications, increasing the risk of access by unauthorized individuals. For example, often housekeeping and engineering staff have access to secure areas via master keys.

Other examples of surveyor citations included that drugs are delivered from the pharmacy to open bins in medication rooms that can be accessed by non-licensed personnel.

Somewhat surprisingly, the report also wrote up units for having no daily accounting system for what is removed by whom from the medication inventory.

"Usually in hospitals and ambulatory settings you are allocated an inventory so you know what you order in terms of medication," she says. "Those controlled substances are dictated by the needs and services you provide. We shouldn't survey and find controlled meds sitting out on a pharmacy counter or in a department counter. That should never happen, and if so, it should be immediately addressed." ■

REFERENCE

1. HFAP. Mastering the Standards for Survey Success: The 2018 HFAP Quality Review. Available at: https://bit.ly/2x5cNv3.

New Nurses May Struggle With Errors, Injuries

Employee health beyond the orientation checklist

New on the job, a recent nursing school graduate made a serious error involving patient medication. Distraught, she questioned herself — and a loss of confidence, and even career, could have very well followed.

The preceptor she reported to knew that such could be the consequence if she chose to focus on the error, unintentionally magnifying aspects of shame with which the nurse was already struggling.

"I remember how devastated she was," says **Amy Word-Allen**, BSN, RN, the preceptor in this case. "I was thinking I need to move beyond the teachable moment — the 'How can we do this better and how can we not make this mistake again?'"

That is important, of course, but as a mentor to the young nurse, Word-Allen chose to respond on an emotional level.

"The first thing I told her was that any nurse that walks into your life and says they have never made an error is a liar," she says. "We all do it. You are one of us. Even in your hard moments and mistakes, you are still one of us."

Word-Allen has co-authored a book[1] on nursing education that includes a chapter on the challenges faced by new nurses as well as their more experienced colleagues going through orientation in a new facility.

"I know in my nursing career we all assume responsibility for a lot, and errors are just part of the process," she says.

Sharing this kind of support with the young nurse allowed her to continue her practice with renewed vigilance, Word-Allen says. After dealing with the initial emotional toll, such errors are deconstructed for guidance in future encounters.

"Those [corrections] are basic and fundamental, but more than that it is creating a culture where we are allowed to be human beings," she says. "When we make mistakes, we own them, we learn, and we grow."

It's a difficult process that may affect a worker's mental state and have lingering effects depending on the severity of the error and subsequent patient harm.

"It's tough," she says. "Sometimes mistakes are black and white, and from an administrative perspective it can seem really easy to see where fault lies. Errors are not always about fault, but what happened that we could have done better."

A newly graduated nurse, or even one more experienced who is going through orientation in a new job, may have a higher risk of errors and accidents as they take on their new role in the high-pressure healthcare environment.

"You know the stakes, and when you do things wrong you are going to feel that," she says. "I can't take that away, but I told her that I remember the first mistake I made. It stuck with me, and I have never done that again. She opened up and was very emotional."

Errors are more likely when a clinician is exposed to a new environment that requires a new set of competencies, the authors noted in the book.

"If the error resulted in more severe harm to the patient, professional counseling may be required, and the organization should provide assistance in receiving this support," they wrote.

Accidents and Injuries

Given the increased likelihood of errors in the new orientation period, it seems intuitive that the nurse being bombarded with new information may be at more risk for an accidental injury like a needlestick.

"I remember my first needlestick," says book co-author **Alvin D. Jeffery**, PhD, MSN, RN, APN, FNP. "Fortunately, it was in a simulation lab. I was a new graduate nurse and I stuck a very large needle completely through my finger."

It was as painful as it sounds, but the traditional testing and follow-up was not necessary because the training did not involve a patient, he says.

"My [trainer] said, 'If you did this scenario over again, what would you do differently, if anything?'" he recalls. "It was a good opportunity in a safe space to reflect on the events leading up to that, the cause, and how I could change my behavior."

After joining the workforce, Jeffery suffered a true exposure, a splash incident that he reported to the employee health service.

"I got bloody gastric contents in my eyes from a patient who was hepatitis B-positive," he says. "I never seroconverted, but it was a big ordeal."

Drawing on his student experience, Jeffery says it may be a good idea for employee health professionals to ask exposed workers what they would do differently. The goal should be to shed light on

whether the incident reveals a systems problem, or whether the worker can identify a behavior he or she needs to change.

In this case, Jeffery says, "It was purely random and a system issue — maybe with the eye guards. It wasn't anything I did, but it was an opportunity to improve the system."

Given the chronic problem with underreporting, *HEH* asked Jeffery whether new nurses may be hesitant to report an injury that they feel may somehow reflect poorly on them in their new job.

"Often we hear there is a problem with reporting, so we are going to teach that in orientation," he says. "I think that is going to fail because orientees will mimic learned behavior from their preceptors. Educators get a bigger bang for the buck by reinforcing content with preceptors, who are more influential in changing the culture."

Beyond the Checklist

Having been inundated with training, new policies, and procedures, it also is possible that an employee under new orientation may not know the system for reporting.

"Sure, we may have checked the box that they 'understand what an injury is' — like when you lift a patient and feel that initial strain," Word-Allen says. "But this is learned behavior, and they will be less likely to report it if their preceptor did not. It is an ongoing conversation, and if there is not an occupational health culture within the facility, [non-reporting] will continue."

The book also discusses work culture issues familiar to employee health, including personality conflicts and communication problems between new nurses and their trainers and co-workers. New nurses are under a considerable stress facing a towering learning curve, and interacting with patients may exhaust their reservoir of social skills.

"Nurses are really good at interacting with patients and families," he says. "I don't want to say a façade, but you are putting a lot of effort into accommodating the patients' personal preferences, needs, and beliefs. I think you exhaust so much of that capacity that when it comes to your co-workers, the raw side comes out."

In an approach that could be used with other work situations if applicable, the authors endorse trying to match trainers and new nurses with personality tests like the well-known Myers-Briggs.

"Even when they revert to their natural tendencies with the exhaustion and stress of delivering care, perhaps if they are similar they will be able to get along," Jeffery says. "We found that to be the case."

When different or even directly opposite personalities have to work together, the best approach is open communication.

"With personality and communication styles, there is no right or wrong way but there are differences," he says. "We found that bringing those out in the open is really helpful in interpersonal relationships."

Given the combination of risks and pressures new nurses face, there could be a supporting role for employee health beyond the initial inservice.

"Typically in the organizations I have been in, employee health gives about an hour or two talk about TB testing, fit-testing, and other things," Jeffery says. "Maybe [they could] touch base later on after a few months."

For example, a lot of hospitals offer residency programs and they continue to check in with new graduate nurses over their first year on the job.

"Maybe employee health should come back in to talk about psychological and mental health well-being, and ask about reporting [errors and injuries]," he says. "It could be a really good source of data for understanding how to improve the system, checking the pulse, and giving these new nurses an opportunity to reflect."

Like so many aspects of nursing, education may benefit from a broader view that links worker wellness with clinical outcomes.

"Caring for the caregiver is really one of the most underutilized concepts in our field," Word-Allen says. "I think there have been some great strides since I've become a nurse, but naturally caregivers don't think of self first. That is part of what makes our dynamic at the bedside so powerful."

Citing the benefits of bereavement programs for nurses when a patient dies, she emphasized the need for real-time tools and interventions to help employees in distress.

"We need to get out of the box and beyond the checklist, to the heart of what employee health really is," Word-Allen says. "There were many times I wished as a new nurse that I just had an outlet. I formed that interpersonal relationship with my co-workers, which is great, but there [may be] a piece that occupational health could play in that." ■

REFERENCE

1. Jeffery AD, Jarvis RL, Word-Allen A. Staff Educator's Guide to Clinical Orientation, Second Edition: Onboarding Solutions for Nurses. 2018: Sigma International.

Legal Matters: Religious Exemptions for Flu Shots

Err on the side of communication, accommodation, respect

Healthcare facilities enacting flu shot mandates without some effort to reasonably accommodate healthcare workers claiming religious exemption could be open to a lawsuit, explains **Douglas Opel**, MD, assistant professor of pediatrics at the University of Washington School of Medicine in Seattle.

In light of recent court cases, healthcare facilities should consider exemption policies when they begin a mandated flu shot program, getting legal advice at that time.

"We found that hospitals prevailed in lawsuits when they developed ways to accommodate their employees' religious views and still protect patients," Opel tells *Hospital Employee Health*. "Getting advice at the time of developing a mandatory influenza vaccination program on how to accommodate employees is a wise strategy."

Opel outlined case law and legal strategies in a recently published review article on the contentious issue.[1]

For example, six healthcare workers fired for refusing mandatory flu shots for religious reasons won back pay and offers of reinstatement from Saint Vincent Hospital in Erie, PA, according to the U.S. Equal Employment Opportunity Commission (EEOC).[2] The hospital agreed to compensate the workers some $300,000 for lost wages and compensatory damages after the EEOC filed suit in September 2016.

In a similar case, Opel described a North Carolina health system that failed to provide religious exemptions from an influenza vaccination requirement. The resulting lawsuit, which alleged religious discrimination in violation of Title VII of the Civil Rights Act of 1964, was settled in January 2018. The healthcare system agreed to both compensate the employees and revise its policy on vaccination exemptions.

However, lawsuits related to religious exemptions to a flu shot mandate can be averted by making reasonable accommodations like stipulating that unvaccinated workers must wear a mask for patient care, he says.

"Title VII requires employers to reasonably accommodate an employee with a true religious belief unless doing so imposes an undue hardship on their business," Opel says. "In other words, reasonably accommodating a religious belief has limits. Employers are not expected to accommodate to the point that doing so would pose an undue hardship, such as by heightening the risk of spreading illness."

The EEOC's working definition of the word "religion" includes "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." Although the courts are not bound by the EEOC's definition, it is broad enough to create "uncertainty" about the line between religious and philosophical objections, he noted in the paper.

Objection to Other Vaccines?

HEH asked Opel if healthcare workers can successfully challenge flu shot mandates on the grounds of religious discrimination, does that open the door to their declining other required immunizations for healthcare employment?

"Title VII simply prohibits an employer from discriminating against an employee on the basis of religion," he says. "It is broadly applicable and not specific to any particular employer practice or policy."

The answer may be surprising, but established healthcare vaccination programs for childhood diseases and hepatitis B would certainly be more difficult to challenge than the flu shot, which changes every season and must be administered annually.

Some of this seems to be more about style than substance, as Opel found that hospitals that are arbitrary in evaluating religious objections and inconsistently enforce deadlines leave themselves open to lawsuits.

One hospital lawsuit arose in part because workers who missed the vaccination deadline had a grace period. In contrast, the exemption request deadline was strictly enforced. Given this, it may be best to avoid even the appearance of discrimination to head off legal challenges.

"We did find that litigation is often inspired by employees feeling that the processes used to weigh their opt-out requests weren't fair," he says. "Hospitals can avert problems by allowing employees adequate opportunities to explain their beliefs, not inserting unnecessary administrative requirements or being unduly rigid with filing deadlines."

Explain the reasons for denying exemption requests, and treat religious objectors with respect, he

advises. Be aware that there may be legal challenges by workers who have been accommodated by hospital policy.

In one case, an employer required masks only when unvaccinated employees were near a patient care area, but their employee ID badges listed an "unvaccinated" status. An accountant whose job involved little patient contact objected, claiming that the sticker was stigmatizing, Opel noted. The parties in that case settled out of court.

For employees without patient contact, it might be reasonable to simply require them to stay home if symptomatic, he adds.

Hospitals that have made reasonable efforts to accommodate workers — including polices based on where they work — have won subsequent challenges to their flu immunization policies.

While these approaches can help to prevent lawsuits, healthcare facilities also should stress the safety of the vaccine and the importance of immunization. It is important to emphasize that healthcare workers can spread influenza one day before symptoms begin, he says. ■

REFERENCES

1. Opel DJ, Sonne JA, Mello MM. Vaccination without Litigation — Addressing Religious Objections to Hospital Influenza-Vaccination Mandates. *N Engl J Med* (Perspective) 2018; 378:785-788. DOI: 10.1056/NEJMp1716147.
2. EEOC. Saint Vincent Health Center to Pay $300,000 To Settle EEOC Religious Accommodation Lawsuit. Available at: http://bit.ly/2ibTFSg.

Surgeons Prevail: Skull Caps Are Back

Push to use surgical caps that cover ears withdrawn

Healthcare workers can be reluctant to abandon their favored personal protetctive equipment [PPE] in the absence of science. A case in point is a recent victory by surgeons to continue wearing their traditional skull caps. A previous recommendation for surgeons to fully cover their hair and ears to prevent infections has been jettisoned for a lack of evidence.

"The surgeons felt there was not any data suggesting that abandoning tradition [skull caps] really prevented any infection transmission," says **Troy Markel**, MD, FACS, a member of the committee that issued the statement[1] and lead author of a recent study on the issue.[2]

Several medical groups, including the American College of Surgeons (ACS), the Association of periOperative Nurses (AORN), and The Joint Commission, agreed. They issued a collective statement that says, "Over the past two years, as recommendations were implemented, it became increasingly apparent that in practice, covering the ears is not practical for surgeons and anesthesiologists, and in many cases counterproductive to their ability to perform optimally in the OR. … The requirement for ear coverage is not supported by sufficient evidence."

The concern is that uncovered hair and ear particles may contaminate the sterile field during a procedure and lead to a surgical site infection (SSI). In reassessing the rationale for this "narrowly defined" recommendation, the groups concluded that "evidence-based recommendations on surgical attire developed for perioperative policies and procedures are best created collaboratively, with a multidisciplinary team representing surgery, anesthesia, nursing, and infection prevention."

Serving on the panel representing the ACS, Markel said the push to use ear-covering "bouffant" surgical hats in recent years is not supported by the available evidence, including some simulation experiments in his study.

"This [committee] was one of the first times when we really had stakeholders come together about this topic," he says. "In 2015, basically the leaders of the ACS and the AORN came to a head over the use of the bouffant-style hats. The surgeons did not feel there was a lot of evidence out there mandating wearing it. Members of AORN thought it best to cover the forehead and ears."

Markel's study tested disposable bouffants, disposable skull caps, and newly laundered cloth skull caps. A mock surgical procedure was conducted and airborne particulate and microbial contaminants were sampled.

"No significant differences were observed between disposable bouffant and disposable skull caps with regard to particle or actively sampled microbial contamination," Markel and colleagues found. "However, when compared with disposable skull caps, disposable bouffant hats did have significantly higher microbial shed at the sterile field, as measured by passive settle plate analysis. When compared with cloth skull caps, disposable bouffants yielded higher

levels of particles and significantly higher microbial shed."

Thus, disposable bouffant hats should not be considered superior to skull caps in preventing airborne contamination in the operating room, they concluded.

"We showed that the bouffant caps that were mandated at that time really were not the best hat to be wearing," says Markel, a pediatric surgeon at Riley Hospital for Children in Indianapolis.

While the study supported the use of skull caps, the upshot for the immediate future is that either hat style should be acceptable.

"The Joint Commission was a part of this group," Markel says. "It is my understanding that they never formally cited centers for wearing one hat or the other, but they came out sort of informally and said they will not cite you if you are wearing a bouffant or a skull cap."

Surgeons have a strong tradition of wearing skull caps, raising intangible issues of psychological identity and patient impressions of their provider. Markel found this line of questioning a little too speculative, pointing out instead the practical issues.

"I don't know about psychological, but from a logistics standpoint people feel like they can't hear well when they have their ears covered with the bouffant," he said. "A lot of female nurses and doctors wear skull caps as opposed to bouffants because they feel that their hair is tighter inside those caps."

The bottom line is that there are no definitive data on surgical site infections linked to various surgical hat wear, a study that if attempted would have to overcome a host of variables to achieve significance. Thus, Markel and colleagues used simulation, which has been criticized for its limitations.

"There are some naysayers that might argue we haven't really shown a difference in SSIs, but I don't know that a trial could be done to really look at that," he says. ■

REFERENCE

1. American College of Surgeons. A Statement from the Meeting of ACS, AORN, ASA, APIC, AST, and TJC Concerning Recommendations for Operating Room Attire. Available at: https://bit.ly/2kmRDzi.
2. Markel TA, Gormley T, Greeley D, et al. Hats Off: A Study of Different Operating Room Headgear Assessed by Environmental Quality Indicators. *J Am Coll Surg* 2017;225(5):573-581.

A Healthy Nurse Means a Healthy Nation

The American Nurses Association is challenging those who wear the white to step up and take care of someone else: themselves.

The ANA's Healthy Nurse, Healthy Nation (HNHN) Grand Challenge is an ambitious outreach effort to engage nursing improvement in five key aspects of wellness: activity, sleep, nutrition, quality of life, and safety. The challenge features a wealth of information and networking opportunities on the web at: https://bit.ly/2GK1Ezh.

Hospital Employee Health reached out to a nurse involved in this work, whose successful Ironman Triathlon was featured on the website: **Charlene Moske-Weber**, PhD, RN, an assistant professor in the school of nursing at Salem State University in Massachusetts.

HEH: How do your efforts fit into the larger goals of the American Nurses Association's Healthy Nurse, Healthy Nation initiative?

Moske-Weber: One of the concerns that I have is the disconnect that we have on how we teach students to take care of others but we neglect to emphasize the importance of them taking care of themselves. In my mind, care of others begins with care of self. That is something in nursing education I feel we really need to emphasize, particularly in this era of extreme stress that students undergo. Nursing programs in general are quite rigorous. Nationally, we have concerns with mental health, so stress management, sleep, and the other things are very important.

HEH: This has been a longstanding problem. Are you noticing any generational change in attitudes as new nurses come into the field?

Moske-Weber: Well, it's interesting. I guess the answer to that is, sometimes. The demographics of our students here where I teach is anywhere from the traditional 22-year-old junior nursing student to the 60-year-old person who is coming back to school for a second career. I think with even the best of intentions students end up getting caught up in their studies, which they should. But I think nursing education has the responsibility to help them balance this a little more. It may be a little different than how we have been doing it for a very long time.

HEH: You describe more of a holistic approach to worker wellness. Is that a piece that has been missing?

Moske-Weber: It has, actually. We are working here in my nursing program on an introductory nursing course that would emphasize aspects

of self-care and a balanced, holistic approach to being a nursing student. That knowledge would then hopefully transfer over to being a nurse. My seniors that are graduating say to me, "Your class was the only class that taught me how important it was to take care of myself." Nursing school is rigorous. Students ought to be introduced to ways in which living well can assist them not only in their academic success, but as future nurses.

HEH: What are the next steps in this effort?

Moske-Weber: I am currently creating a wellness website for nursing students and faculty. In September, with the assistance of HNHN, I plan to work toward creation of an overall culture of health within the school of nursing. Like training for the Ironman, this process will require planning, effort, and perseverance. That is something that I am working on personally that I believe is so overdue. There just isn't an opportunity — curricula are pretty much established and we have to answer to accrediting agencies. We need to incorporate some of these self-care concepts into existing curricula. My idea is to have a website for the school of nursing that students could refer to for information about stress management, healthy eating, and a few exercise and yoga videos — things along those lines. And it's not just for the students, but also, dare I say, for faculty.

HEH: We have published many articles on nursing injuries, stress, and burnout. It sounds like what you are describing would address both physical and mental factors.

Moske-Weber: The students come in as one person and they leave as another. Hopefully when they leave they have both cognitive and practical knowledge in nursing on ways to prevent injuries and manage stress. We can't really sugarcoat healthcare today. It is demanding and stressful. ■

Researchers: Sharps Disposable Boxes Not Linked to *C. Diff*

Delay or reluctance to dispose of a used needle is never a good thing from an employee health perspective. Thus, the concern when a 2015 study[1] suggested a link between reusable sharps containers (RSCs) and the incidence of *Clostridium difficile* infections (CDIs) in patients.

A new study shows no such association, concluding that if processed and used properly, reusable sharps containers pose no risk of *C. diff* transmission.[2]

Comparing RSCs and disposable sharps containers (DSCs), the 2015 study found a decreased incidence of CDIs in patients in facilities that use DSCs. The authors of the new study revisited that premise, sampling 197 RSCs for *C. diff* at processing facilities. In addition, 50 RSCs and 50 DSCs were sampled in CDI patient rooms in seven hospitals.

"Results were coupled with epidemiologic studies, clinical requirements, and chain-of-infection principles, and tests of evidence of disease transmission were applied," they noted.

C. diff spores were found on nine of 197 (4.6%) RSCs prior to processing, which completely removed the spores. Detection of *C. diff* on room sharps boxes was minimal and not considered a transmission risk.

"With *C. difficile* bioburden being sub-infective on both DSCs and RSCs, sharps containers being no-touch, and glove removal required after sharps disposal, we found two links in the chain of infection to be broken and five of seven tests of evidence to be unmet," the authors noted. "We conclude that sharps containers pose no risk of *C. difficile* transmission." ■

REFERENCES

1. Pogorzelska-Maziarz, M. Relationship between sharps disposal containers and *Clostridium difficile* infections in acute care hospitals. *Am J Infect Control*. 2015; 43: 1081–1085.
2. Grimmond T, Neelakanta A, Miller B, et al. A microbiological study to investigate the carriage and transmission-potential of *Clostridium difficile* spores on single-use and reusable sharps containers. DOI: https://doi.org/10.1016/j.ajic.2018.04.206.

COMING IN FUTURE MONTHS

- Case study: TB exposures in a NICU
- Including laboratory workers in exposure reporting
- The industrial hygienist's role in protecting HCWs and patients
- When measles pays a call, where is your proof of HCW immunity?

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

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

1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select "My Account" to take a post-test.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CE QUESTIONS

1. **Susan Gallagher, PhD, RN, said patient mobility and lifting equipment clearly protects healthcare workers, but provides no improvement in clinical outcomes for patients.**

   a. True
   b. False

2. **On any given day, approximately what percentage of nurses experience discomfort related to an occupational injury?**

   a. 20%
   b. 30%
   c. 40%
   d. 50%

3. **Donna Tiberi-Blaszczyk, RN, BS, MHA, said which process requires two people, with one signing off as a witness?**

   a. Needle disposal in a sharps box
   b. Drug wasting
   c. Accessing drugs from a crash cart
   d. Administering pain medication

4. **Healthcare workers have successfully challenged flu shot mandates by citing which law?**

   a. Americans with Disabilities Act
   b. 4th Amendment Right to Privacy
   c. Public Health and Welfare Statute
   d. Title VII of the Civil Rights Act

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.