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THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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INSIDE

RELIAS MEDIA

Employee Health Programs Stepping Up on Drug Diversion

If you look for drug diversion, you probably will find it

By Gary Evans, Medical Writer

Ten thousand pain pills. That's what authorities estimated were once contained in the stacks of blister packs found at the residence of a 33-year-old nurse recently arrested in Spring Hill, FL.

The nurse is charged with diverting opioids such as hydrocodone, morphine, and hydromorphone from a health and rehabilitation center where she worked. She reported "battling an extensive drug addiction for many years, after suffering an injury," the Hernando County Sheriff's office said in statement.[1]

It was not clear if the injury was occupational, but nurses in all types of healthcare settings certainly run that risk. Nurses face a confluence of risk factors for addiction, including long hours, risk of injury, and access to powerful medications, says **Indra Cidambi**, MD, an addiction specialist and medical director for Center for Network Therapy treatment centers in Middlesex, NJ.

> NURSES FACE A CONFLUENCE OF RISK FACTORS FOR ADDICTION, INCLUDING LONG HOURS, RISK OF INJURY, AND ACCESS TO POWERFUL MEDICATIONS.

"Nurses are hands-on, and it could be that lifting a patient could cause them to have a herniated disc or some kind of other injury," she says. Minor injuries can become aggravated, as nurses may not have time off due to lack of coverage by other staff, and must adhere to a schedule that requires long hours, she says.

"They may just pull a muscle, but

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they have to go back to work and deliver patient care," she says. "It becomes a chronic issue. They are working with slight pain, and eventually it becomes a chronic injury. They end up taking pain medication."

Eventually, if their primary care provider will no longer prescribe opioids — which is becoming more likely under more restrictive guidelines — nurses may be tempted to divert.

"There is an assumption that nurses wouldn't have drug problems and commit diversion, but the literature shows that their problems with addiction are the same as the general population — about 10%," says **Linda Good**, PhD, RN, COHN-S, manager of occupational health services at Scripps Health in La Jolla, CA. "Nurses have opportunities to self-medicate — they are in contact with pharmaceutical-grade drugs on a frequent basis."

Once the downward spiral of addiction starts, nurses and other healthcare workers may become overconfident in their ability to self-medicate with opioids, notes **Kimberly New**, JD, BSN, RN, executive director of the International Health Facility Diversion Association.

Nurses and other clinicians can become "desensitized" to the danger of the drugs, she said recently in Minneapolis at the annual conference of the Association for Professionals in Infection Control and Epidemiology.

"I see a lot of nurses who are actually diverting an opioid and something like naloxone — a rescue drug," she said. "They feel they are so in control that they can inject themselves with the opioid and then rescue themselves."

They are not always successful, as some diversion investigations begin with the overdose death of a healthcare worker, she added. Another impact beyond patients is that addicted healthcare workers are driving.

"These people come to work impaired and leave impaired," New said. "I'm aware of one case in Florida where an entire family was killed by an impaired provider driving home."

Threat to Patients

Of course, patients are the primary risk group. Drug diversion by addicted healthcare workers has resulted in recurrent outbreaks of hepatitis and resulted in tens of thousands of patients being advised to seek testing for bloodborne pathogens. For example, a hospital in Puyallup, WA, recently contacted some 2,800 patients and advised them to be tested for hepatitis C virus (HCV).

"We believe that a healthcare worker was taking part of doses of pain medications that were meant to be given to patients," the hospital said in a statement on its website.[2]

The hospital said that six patients tested positive for HCV that was genetically matched to two initial cases that triggered the investigation. A nurse was initially arrested but was released, and the case remains under investigation.

Too often in these cases a fired healthcare worker may end up in another facility, as healthcare employers fearing negative publicity may simply terminate the worker rather than reporting him or her to health officials.

As a result of these continuing incidents and outbreaks, many hospitals are setting up drug

diversion programs to detect and prevent theft of narcotics. "You need to make sure employees are not under the influence of anything that could jeopardize themselves and the patients," Cidambi says.

It is critical to develop a proactive diversion prevention program, and many employee health professionals are playing key roles in these efforts.

Seek and Find

As experts have emphasized, if you look for drug diversion, you probably will find it.

In ramping up a prevention program and hiring a full-time diversion specialist, a monthly audit of the frequency of medication use on hospital units picked up suspicious activity, says **JoAnn Shea**, ARNP, MS, COHN-S, director of employee health and wellness at Tampa General Hospital. Shea also co-chairs the hospital's Controlled Substance Diversion Prevention Committee.

"We look at who is taking the most drugs out," she says. "When we see outliers, the diversion specialist does some chart audits. We saw some issues of [a nurse] giving drugs too close together, or she would sign them out and not administer them."

When the nurse declined testing, the health department was contacted, and somewhat surprisingly, public health officials asked to see the minutes of the hospital's diversion prevention committee meetings.

"We have never been asked that before," says Shea, who was told by the health department that "'the district attorney really wants us to make sure hospitals have these programs in place now.' That was interesting, because there are still a lot of healthcare organizations that don't have these committees."

While healthcare drug diversion is a longstanding problem, these latest incidents are occurring amid a national opioid epidemic. The CDC recently reported that synthetic opioids like fentanyl drove a record 72,000 overdose deaths estimated for 2017.[3]

The opioid epidemic has resulted in public health and regulatory actions that have reduced the availability of the drugs. For example, hydrocodone has been reclassified as a Schedule II opioid, and many states have tightened requirements for physician review of prescription drug monitoring programs. The crackdown has led to shortages of common opioids like morphine, hydromorphone, and fentanyl.

THE EFFORTS TO STEM THE FLOW OF THESE OPIOIDS IS IN SHARP CONTRAST TO YEARS PAST WHEN THE FOCUS WAS ON RELIEVING PATIENT PAIN.

The efforts to stem the flow of these opioids is in sharp contrast to years past when the focus was on relieving patient pain, Good says.

"In my opinion, it has swung far in the other direction," she says. "I think there are people with chronic pain problems who are having more difficulty accessing medication because their doctors are under pressure to prescribe less opiates."

Shea concurred, saying, "I think sometimes, yes, doctors overordered a long time ago, but that was because we were told we weren't relieving pain adequately," she says. "People were not being relieved. Now [the message] is people are getting addicted because of the pain meds."

Fewer Drugs, More Diversion?

Ironically, the shortage of drugs could contribute to drug diversion incidents by healthcare workers, as scarcity leads to hoarding of vials. Unfamiliar products also make tampering less detectable, New reports.

"Be aware that the opioid shortage may be changing the [diversion] landscape," she said. "Many facilities are having a lot of trouble now getting the opioids that they need. One facility I worked with in Florida said we will be out of hydromorphone in the next two months if something doesn't change. Many facilities have gone now from a 2 mm morphine syringe to a 10 mm."

That can raise the temptation to preserve drugs that would normally be wasted, creating pockets of opioids for drug diverters.

"Multidosing — we are seeing people holding on to stuff as they conserve," New said. "People delay drug wasting. They try to hold on to it just in case something comes up and they may need to use a little more. People are carrying around opioids for extended periods of time."

While this is being done to ensure pain medication is available for patients, these breaks in normal practice may create the temptation to divert drugs.

For example, if such hoarding and scavenging become accepted practice on a given unit, workers found with opioids could claim they were saving them for patients, Good says.

"I haven't experienced this, but I also could see healthcare workers who, in the past, have had legitimate prescriptions for opioids but are no longer getting them in the amount they feel they need and may be more desperate to meet their need in illegitimate ways, including diversion," Good says.

While another department performs pre-employment drug testing, employee health becomes involved if a healthcare worker is tested based on a for-cause incident at her facility, she says.

"Our process is that if someone's behavior indicated that they may be under the influence or diverting, the manager would contact HR," Good says. "HR contacts us to do the collection with the chain-of-custody form and send it out, and then the results go to HR."

Having researched drug diversion as part of her academic training, Good says some of the common warning signs of addicted healthcare workers include rapid mood swings, suspicious behavior around controlled substances, volunteering to give meds for others, a lot of wasted medications, and uneven fluid levels in vials or predrawn syringes.

Once they have gone down this road, diverters rarely turn back until their activities are detected or unsafe use of needles and vials results in a patient outbreak. New is wary of moments of temptation created by the current drug shortage.

"At one facility I worked with, the nurses are required to walk down to the pharmacy to get a morphine syringe, and then they carry it back up," New said. "That is a lot of time to be unsupervised with an injectable. A lot of things could happen in that time."

As various manufacturers try to meet the opioid demand, new products are coming into clinical settings, she added. Healthcare workers may be unfamiliar with the tamper protections, which were removed by a nurse in one facility New investigated.

"A new syringe from a new manufacturer was given to a particular unit because they couldn't get them from their regular manufacturer," she said.

The new syringes had a tamper-evident feature, but nobody knew beforehand because they had not worked with the product. "A charge nurse made sure she was right there when they were stocking it, and she pulled the tamper-evident feature off every one of them," New said.

> "IF YOU HAVE CONTROLLED SUBSTANCES IN YOUR FACILITY — IT DOESN'T MATTER WHERE YOU ARE OR WHETHER IT IS AN OUTPATIENT OR INPATIENT SETTING — YOU WILL HAVE DRUG DIVERSION."

Diverters seem to favor tampering to outright theft, refilling syringes with water or saline after injecting the opioid. "Tampering is happening at an alarming rate," New said. "It continues to increase. I am seeing cases every single week — just right and left. Many times these cases are not handled appropriately."

For example, healthcare workers seeing something different about a syringe may assume it was a manufacturing defect and discard it without reporting suspected tampering. Although tampering can be done with sufficient skill to pass for the original medication, it is also a "desperate activity" where safeguards will often be bypassed, New said.

"Often they are doing this in a staff bathroom, trying to tamper quickly before anybody becomes suspicious," New said. "One nurse who confessed to tampering actually had open lesions on her arms from injecting."

The diverter may take the drugs home for use, filling empty syringes with water or saline and replacing them the following day.

Despite all the publicity drug diversion has received with high-profile arrests and outbreaks in recent years, it too often remains the unspoken "elephant in the room" at many facilities, she said. Having looked for diversion and consistently found it for years in all manner of settings, New still is often told that it is not a priority because the organization has never had any incidents.

"That couldn't be further from the truth," she said. "If you have controlled substances in your facility — it doesn't matter where you are or whether it is an outpatient or inpatient setting — you will have drug diversion. It is a fact." ■

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Key Components of a Drug Diversion Program

Diversion risk points include preparation, administration, and waste

Although drug diversion may be considered a rare event, investigations reveal that the practice could be going undetected in facilities that do not have a proactive prevention program, warns **Kimberly New**, JD, BSN, RN, executive director of the International Health Facility Diversion Association.

"Having a formal program is essential. If you are treating this as a one-off, you are going to be inconsistent and have an incomplete response," she said recently in Minneapolis at the annual conference of the Association for Professionals in Infection Control and Epidemiology.

In the most basic terms, the program should increase transparency and develop a culture of accountability. "If you are not open within the organization about drug diversion, then people are not going to believe it's a risk," she said. "Make sure you have a good auditing surveillance program in place. Risk rounding is essential to prevention."

Employee health professionals looking to establish or improve a drug diversion program at their facilities may want to consider some of the measures taken by **JoAnn Shea**, ARNP, MS, COHN-S, director of employee health and wellness at Tampa General Hospital.

Shea and colleagues are following Guidelines on Preventing Diversion of Controlled Substances, issued last year by the American Society of Health-System Pharmacists (ASHP).[1]

The ASHP recommends forming a drug diversion committee that should include members from employee health, pharmacy, nursing, risk management, security, and other departments. Another key step is hiring a diversion specialist who can dedicate his or her time to detecting and preventing drug theft and tampering.

All of the Tampa General specialist's time is devoted to identifying diversion, Shea says.

> "IF YOU ARE NOT OPEN WITHIN THE ORGANIZATION ABOUT DRUG DIVERSION, THEN PEOPLE ARE NOT GOING TO BELIEVE IT'S A RISK."

The ASHP recommends that the diversion officer should have a license and a college degree in pharmacy or nursing, with at least five years of healthcare experience. At Tampa General, a pharmacy nurse specialist has been hired as the drug diversion point person.

"We actually created that position for her," says Shea, who co-chairs the hospital's Controlled Substance Diversion Prevention Committee. "She reports to me and to the pharmacy director. It's kind of a 'dotted-line' relationship."

Duties include education, diversion identification, audits, and conducting a gap analysis based on ASHP best practices. The diversion committee meets quarterly and is currently conducting a gap analysis of drug use and controls throughout the facility. The hospital IT team developed software that can show graphs and detailed drug use by unit.

"It is an internal database that we can look at to review diversion issues," Shea says.

The diversion specialist and members of the team also are creating a controlled substance workflow checklist to be used in unit audits. In reviewing drug use practices, Shea says she is seeing medication overrides granted too routinely.

"That is not really a best practice, but once it is accepted it becomes the norm," she says. "We have had some diversion issues with discrepancies. One of the nurses will go to the charge nurse and say, 'I miscounted — the count's off.' And instead of doing a look-back [investigation], the nurse signs off."

The committee decided to ramp up education and training on diversion and drug-wasting, which prior to that had been a 30-minute program for new hires.

"We realized there is a lot of training and education involved," she says. "We needed education on diversion, discrepancies, and waste."

During an audit, the diversion specialist may pull charts and documentation to see if, for example, any leftover drug was wasted within 30 minutes of administration.

"Did they administer the drug within 30 minutes or an hour of signing it out?" Shea adds. "Those are the kinds of things we are looking at."

The audit checklist is a work in progress, with Shea and colleagues still identifying components to be assessed. Those may include

establishing some benchmark for the number of discrepancies a given unit should have.

"Why does this unit have 100 discrepancies and every other one has 10?" she says. "We are still building that part of the program. We based our gap analysis on what the ASHP recommended — their [guidelines] are very well put together."

Given the diverse challenges of a large hospital system and a single diversion specialist, interventions will have to be prioritized.

"We can't do everything at once with one person," Shea says. "We have to look at our inpatient pharmacy and our flow of drugs between our ambulatory facilities and inpatients. We have a freestanding ER and a surgery center. We want to make sure the chain of custody is being followed when we are moving controlled substances to the hospital."

Risk Points

The ASHP warns that there are multiple risk points for drug diversion as controlled substances move through healthcare systems. These include the following at various phases:

- procurement;
- preparation and dispensing;
- prescribing;
- administration;
- waste and removal. ■

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A Roadblock to Return to Work

While highly publicized drug diversion incidents are frequently in the news, less is said about the healthcare worker's road to recovery.

Some involved in diversion-related outbreaks that harm multiple patients have been imprisoned. Others are barred from returning to healthcare by licensing and public health officials. However, some addicted nurses can recover and return to work, but there are obstacles to overcome, says **Indra Cidambi**, MD, an addiction specialist and medical director for Center for Network Therapy treatment centers in Middlesex, NJ.

"It's important to keep an open mind and treat addiction like any other brain disease," she says. "If a nurse has a bipolar disorder, they are not going to tell them they can't work as long as that person is stable and on medication."

The addiction recovery process can stall as a nurse begins medicated-assisted treatment (MAT), which can raise red flags from employers. On the contrary, MAT is an essential part of rehabilitation, staving off cravings and providing a safety net for the return to work, Cidambi emphasizes. These nurses should be able to use MAT as part of return-to-work plan that includes random drug tests and other oversight.

"Many nurses I have treated for opiate use disorder are not allowed to come back to work after successfully engaging in substance abuse treatment, simply because they are on maintenance treatment with buprenorphine," Cidambi says.

A partial opioid agonist, buprenorphine is widely used to address withdrawal symptoms and craving related to opioid abuse. However, some employers may see it as substituting one drug for another.

"It is a very sad thing, and I am being as open as I can be on this topic," Cidambi says. "Nobody is really paying attention to this issue. MAT allows someone who is addicted to substances to function as a normal human being."

Some nurses who have gone through her recovery program and been sober for more than one year have been told they cannot return to work if they are using an opioid agonist to reduce cravings, Cidambi says.

"That's just not right," she says. "If they are tested on a consistent basis and maintain sobriety, I don't think they think there should be any discrimination on this."

For example, nonaddicted nurses may work while taking appropriately prescribed pain medications. However, the policies for addicted nurses in recovery may tempt them to go off their MAT to reduce craving, setting up a scenario for a relapse.

"That is dangerous," she says. "This is a brain disease, and relapse is part of the disease."

Workers diverting drugs may be reluctant to seek help if they know they cannot return to work while using the MAT drugs to reduce craving.

"There is so much stigma in substance abuse treatment," Cidambi says. "Nurses will try to hide it before they come to seek help because of problems like MAT." ■

EMTs Exposed to Opioids via Mucous Membranes

Minute particles from gloved hands can enter eyes, nose, mouth

There have been recurrent reports of first responders and EMTs treating opioid overdose cases and then falling ill due to an occupational exposure of an undefined nature. While aerosols or skin exposures have been the subject of speculation, it appears that in many cases EMTs treating overdose patients are contaminating themselves with the powerful opioids by inadvertently touching their own eyes, nose, and mouth, said **John Howard**, MD, MPH, JD, LLM, MBA, director of the National Institute for Occupational Safety and Health (NIOSH).

"I would say if I had one lesson from the seven or eight [investigations] we have looked at, mucous membrane contact is probably number one," Howard said recently in Philadelphia at a meeting of the American Industrial Hygiene Association (AIHA).

Avoiding touching gloved hands to the mucous membranes calls for "a lot of awareness" in an emergency, he says. "It is very hard to do."

Contamination of the EMS work environment also is leading to exposures, he said, citing a case where a police officer typed on a keyboard without removing gloves after he handled some opioids.

"These are little things that you notice," Howard said. "During the response, there is a very intense involvement of the responder with the patient — these things may not come to mind. It is matter of education and training."

In addition to the difficulty in determining routes of transmission, EMTs exposed to opioids may experience a variety of symptoms not typically seen in an overdose patient.

"If you look in the toxicology textbooks for opioid overdose, you will see that the patient has respiration of zero or two or three," he says. "They are blue and lying on the ground. They have pinpoint pupils — all of the classic toxicological signs. We have never seen any of that in any first responder."

> "I WOULD SAY IF I HAD ONE LESSON FROM THE SEVEN OR EIGHT [INVESTIGATIONS] WE HAVE LOOKED AT, MUCOUS MEMBRANE CONTACT IS PROBABLY NUMBER ONE."

Instead, first responders feeling ill after caring for a drug overdose patient may report a variety of symptoms. A NIOSH investigation[1] after an overdose incident in March of this year revealed that a total of nine first responders and public safety officers were taken to an ED complaining of a broad range of symptoms that included headache, double vision, numbness, lightheadedness, nausea, and palpitations.

"What we have seen is that they are just not feeling right — they could be lightheaded," Howard said. "These people are athletes, so to speak, and they notice when they are not 100%."

While there have been no reports of fatal occupational exposures while caring for an opioid overdose patient, another speaker at the AIHA meeting reminded attendees how powerful some of these synthetic drugs are.

"It is important to understand how little of the substance can cause fatalities — exposures of two to three milligrams," said **Donna S. Heidel**, CIH, FAIHA, a member of AIHA. "That is the equivalent of a couple of grains of salt. These opioids can enter the bodies of first responders when they are exposed to the drug aerosols, dust in the environment, or when they touch the victim's clothing that may be contaminated. [They can] put the material into their eyes or mouth from contaminated hands."

The threat of occupational exposure to opioids goes beyond EMTs and hospital emergency staff to include crime lab analysts, funeral directors, customs and border protection, and package delivery workers, she said.

NIOSH Investigations

Hospital Employee Health asked NIOSH for clarification on two of its most recent EMS opioid exposure investigations, both of which highlighted unusual symptoms in responders that were not wearing respiratory protection.

"As noted in our interim reports, the responders' symptoms were not consistent with severe opioid toxicity," says **Sophia Chiu**, MD, a NIOSH medical officer. "Inhalation is a possible route of exposure in

both evaluations, although the routes of exposure were not definitively identified. The workers involved in both evaluations were not wearing respiratory protection."

However, that appears to be in keeping with current guidelines, as respiratory protection is recommended when suspected fentanyl products or other illicit drugs are visible at the scene, she said.

"Respiratory protection is not recommended when the anticipated exposure level is minimal. [It is] suspected that fentanyl may be present, but no fentanyl products are visible," Chiu says.

In addition to the aforementioned NIOSH investigation, the agency recently filed an interim report on the EMS response to an opioid overdose in a hotel room. An EMS worker who later became symptomatic was providing "bag-valve-mask ventilation and intubating the victim," NIOSH reported.[2]

This required the first responder to get down on hands and knees on the floor, right over the patient, to administer care. The worker began to experience symptoms within 12 minutes of the victim being triaged by the ED. Symptoms included mild respiratory distress and pale skin.

The EMT was taken to an ED, where he received IV fluids and three doses of naloxone over a period of approximately 1.5 hours. "The first dose was given immediately upon triage and gaining intravenous access," NIOSH reported. "The second dose was given 15 minutes after the first dose, and the third dose was given 92 minutes after the first dose."

After the second dose of naloxone, the EMT's status improved. However, a third dose was needed when the worker reported feeling dizzy, facial numbness, and increase in heart rate. A respiratory rate of eight breaths per minute was noted just prior to the administration of the third dose of naloxone.

Although the EMT was working close to the victim's head, it is unlikely that exposure to opioids occurred through the victim's exhaled breath, NIOSH reported. Research has not identified fentanyl in the air from patients who have received the drug intravenously.

"However, these findings might not be directly applicable because the assessments did not involve fentanyl in a powder form that might have been 'snorted' or 'sniffed,' NIOSH reported.

"We cannot rule out several possible exposure scenarios," the report concluded. "First, a small amount of opioids might have been on the hotel room floor carpet or within the victim's respiratory tract and close to the responder's breathing zone when the victim was being intubated. Second, there was the possibility of cross-contamination of [the EMT's] gloves with small amounts of opioids and subsequent hand-to-face contact or aerosolization upon glove removal."

There has been some internal debate on this, but if the potential for opioid aerosols calls for a respirator at an overdose scene, NIOSH currently recommends a P100 as opposed to an N95, Howard said. A P100 rating is the highest for personal respiratory protection. ■

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Misconceptions Surround Mindfulness, but the Present Is a Gift

Helping healthcare workers fight anxiety, burnout, and depression

Though mindfulness is increasingly discussed as a tonic against stress and burnout in healthcare settings, there still is some confusion about the nature of the practice and how to set up a program.

"We know that the population in general is reporting higher levels of anxiety and depression, and even more so in the healthcare environment," says **Teri Pipe**, PhD, RN, chief well-being officer and founding director of the Center for Mindfulness, Compassion, and Resilience at Arizona State University in Phoenix. "The data from physicians, dentists, pharmacists, and nursing is becoming clearer about depression and suicide and, certainly, burnout."

Mindfulness, which often is practiced in the context of meditation, is a focus on the present moment with nonjudgment and a sense of compassion.

"It is not just zoning out. It's not just breathing, and it is not a religion," **Nika Gueci**, BA, MA, EdD, executive director of ASU's mindfulness center, said in a recent webinar. "It's evidence-based, and there is a lot of research behind it."

Mindfulness is a way to interrupt the stream of negative thoughts that typically dominate a person's ongoing scan of their emotions.

"We are our own worst critics, so those negative thoughts are mostly directed at ourselves," Gueci said. "Think about that on a cellular level — how do these negative thoughts impact day-to-day life? By focusing on the present moment, we free up that negative space in the brain that is spent worrying about the past or the future."

People under stress are more likely to overreact to situations, an "amygdala hijack" in the brain that stirs inappropriate fight-or-flight responses over some work interaction or critical email. The idea of mindfulness is not to stuff these emotions, but to calmly observe that anger, anxiety, or sadness are passing through you but do not define you. In these moments, the mindful person can remind him- or herself that everything is in flux, and these negative emotions will change — much like moments of happiness.

> "WE KNOW THAT THE POPULATION IN GENERAL IS REPORTING HIGHER LEVELS OF ANXIETY AND DEPRESSION, AND EVEN MORE SO IN THE HEALTHCARE ENVIRONMENT."

"If we can become compassionate to ourselves and thereby more compassionate to others, we realize we are not our thoughts," Gueci said. "We are not that negative space that we hold over ourselves."

When practicing mindfulness and clearing the mind to the present, you can set an intention for future action. In such a moment, Gueci realized — when she just started her current job — that using her smartphone as an alarm clock was opening her day to stress.

"As soon as I woke up to hit the alarm I would check my work email," she said. "This set me up to have a stressful day because before I even had a cup of coffee, I was checking my email and worrying about what was coming up. Just by waiting until I got to work to check my email, I set myself up for a much more peaceful morning and set [the tone] for the rest of the day."

Mindfulness is a skill set that improves with practice, but anyone can access the present with this basic approach, Pipe says. *Hospital Employee Health* asked her to comment further on mindfulness in the following interview.

HEH: How can mindfulness help healthcare workers?

Pipe: Mindfulness has been shown in the scientific literature to decrease anxiety and depression. Anxiety is a focus on the future and the worry about things that may or may not happen. Depression is really looking back and maybe ruminating about things that you wish were different. Mindfulness brings us right into this moment.

The present is when we have the most decision [capability] about our situation and our behavior. The science is really showing a lot of promise in terms of anxiety and depression. In the healthcare arena, I

think the need has never been greater, but I don't want to overstate this. Mindfulness is not the only thing, but it is a pathway that people can look at in terms of reducing burnout and depression. Ultimately, suicide is a strong concern for us.

HEH: In mindfulness practice, what does it mean to be present without judgment?

Pipe: If I am dealing with anger or sadness, mindfulness teaches me that I need to experience these feelings in an appropriate way. These feelings aren't bad, and they don't define me. It doesn't mean I will always be sad or angry or hurt. It's like a weather pattern. My emotions come and go. So, mindfulness helps us see that in an appropriate time and place so that we are self-aware. We notice when we have those emotions. We don't just numb them.

A lot of people overeat or overconsume substances, shopping — whatever it is. We actually sit with our emotions, and we notice that as we do, they pass. If we don't, it sort of gets stuck and will come back even stronger than before. This is certainly a lifelong journey. Learning to sit with discomfort is not an easy thing.

Likewise, mindfulness helps us to be awake to things like joy, happiness, satisfaction, and contentment. We are not trying to hold onto anything. It teaches us that there is impermanence. Life is changing. It is more productive to go with the change rather than resist it.

HEH: There still seem to be misconceptions about mindfulness.

Pipe: A lot of people think mindfulness means to let go of goals or ambition — stop striving for anything. That's not true. Mindfulness just helps you understand what is your personal goal and ambition a little more clearly. It doesn't mean that you shouldn't go after something, or that you shouldn't strive for things you haven't achieved yet. It just means that you give yourself a little bit more compassion about the journey. A lot of people think it is a stagnant state of being and that could not be further from the truth. It is about being alive.

To be the observer of your own emotions helps you see that the emotion does not define you. A lot of patients get identified with their pain and their diagnosis. Healthcare providers get identified with the pain they are carrying. This helps us understand that no, that is not the definition of you. You are you. The pain and the depression and the joy may be there today or tomorrow. You may have it your whole life, but it changes your relationship with that to be more compassionate with yourself as you go through it.

HEH: While mindfulness can be practiced formally at a time set aside only for that purpose, like practicing a sport, you note that it also can be brought to bear in everyday life and work.

Pipe: Certainly, sometimes mindfulness has a strong formal practice component, where you may spend time in solitude and quiet to build up your skills, just like an athlete would do in the gym or a musician would practice. Certainly, that is one way, but athletes practice for the game, and life is our game. In healthcare, it is actually saving lives and making life better for people. A lot of times the most meaningful way to begin is to have some small ways that people can take it into their real life. It is a skill set, so it does require practice.

There are different ways that I and others have used it in their lives and in the healthcare arena. One is to really focus, learning to pay deep attention to what you are doing or how you are interacting with a patient. Whether that is preparing a medication, preparing for a procedure, or having a deep conversation with a patient, it is the skill of being totally present in that situation, and that is not easy. In healthcare, there are so many interruptions and distractions. You are often thinking about the next patient, the patient you just came from, or the meeting that you are going into.

Patients notice. Patients can really tell if you are there with them or distracted and thinking about the next thing. They are much more likely to trust you and let you know what is really going on with them if they feel like you are very much with them. The opposite is there too. They may glaze over problems if they think that you are distracted. ■

Physician Burnout in the Emergency Department

'Canary in the coal mine'

As recently reported in *Hospital Employee Health*, researchers continue to quantify increasing physician burnout, tying well-being and work unit safety grades to major medical errors.[1] *(For more information, see the September 2018 issue.)*

Previous research has shown that among various specialties, emergency providers are particularly vulnerable to burnout, given the stress and time pressures they deal with daily. **Laura McPeake**, MD, FACEP, director of wellness for the department of emergency medicine in the Lifespan Health System in Providence, RI, notes the issue is multifactorial.

"I think the ED is kind of the canary in the coal mine for a lot of changes that are happening in medicine in general, with the EMRs [electronic medical records] and a lot more administrative requirements," she says. "We are seeing a lot of fallout from the opiate epidemic. A lot of that falls on the ED in terms of blame, but I don't think we are actually responsible for a lot of it. I don't think we have control over a lot of it."

The ED is the main door to the hospital, offering the biggest snapshot of what goes on in the hospital regarding boarding and crowding from the patient's point of view, she adds.

"Yet, we have very little control over the availability of inpatient beds, staffing models, and things like that," she says. "A lot of responsibility falls on us without a lot of the power to [make changes]. We know that is a big driver of burnout. The lack of ability to control and manipulate your environment leads to burnout."

What are the indications that burnout is an issue? A big warning sign is when clinicians become emotionally exhausted, McPeake advises.

"They may depersonalize and see patients as things rather than people," she says. "When they are just clicking boxes and trying to get through the day, and when they are more engaged with their computers than with interpersonal interactions, those are all signs that things are off balance."

When that happens, it is important to start engaging in conversations with people, McPeake explains. "That has two benefits. It has the personal benefit of venting and getting out what is on your plate, and also [the benefit of] reaching out to others and realizing there is a community connection," she says.

By communicating with colleagues and finding a way to express concerns and empower yourself, you can give voice to the issue at the administrative level, she says.

Of course, leadership teams can't address issues if they don't know about them, she adds.

"There is a tendency among physicians in general and emergency physicians in particular to just keep their heads down and go on to the next thing," she says. "We are good at advocating for others, but we are not used to advocating for ourselves. The only way we can really take care of patients is if we are really taking better care of ourselves." ■

REFERENCE

1. Tawfik DS, Profit J, Morgenthaler TI, et al. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. *Mayo Clin Proc* 2018 Jul 4. pii: S0025-6196(18)30372-0. doi: 10.1016/j.mayocp.2018.05.014. [Epub ahead of print].

CE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

- When healthcare workers become "conscientious objectors"
- In Ebola aftermath, self-contamination still a problem when removing PPE
- Safe patient handling program reduces musculoskeletal injuries
- Night of violence in the emergency department may lead to new law

HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **Linda Good, PhD, RN, COHN-S, said 20% of nurses have addiction problems, double that of the prevalence seen in the general community.**
   a. True
   b. False

2. **JoAnn Shea, ARNP, MS, COHN-S, said her hospital's drug diversion program includes which of the following?**
   a. Random drug testing of all employees
   b. Video cameras covering all medication areas
   c. Hiring a full-time drug diversion specialist
   d. All of the above

3. **Indra Cidambi, MD, says medicated-assisted treatment with which of the following opioid agonists is being red flagged and preventing recovering nurses from returning to work?**
   a. Buprenorphine
   b. Morphine
   c. Hydromorphone
   d. Fentanyl

4. **NIOSH investigations of EMS opioid exposures to overdose patients reveal that ingestion may be occurring in many cases because the workers are:**
   a. wearing surgical masks instead of respirators.
   b. having prolonged skin contact during resuscitation.
   c. touching their own eyes, nose, and mouth.
   d. inhaling the breath of drugged patients.