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CDC Drafts New Guidelines for Occupational Health

Conduct assessments of infectious risks to HCWs

By Gary Evans, Medical Writer

In draft guidelines¹ expected to be finalized later this year, the CDC will better define and empower occupational health programs in hospitals and outpatient settings for the first time in 20 years.

The new guidelines are focused on protecting healthcare workers from infectious diseases and outline leadership responsibilities and resource-support issues that should raise the profile of employee health programs generally.

“These CDC guidelines recognize the importance of protecting healthcare workers from infectious diseases,” says **Linda Good**, PhD, RN, manager of occupational health services for Scripps

Health in La Jolla, CA. “Occupational health personnel are the ones who provide hands-on care to the caregivers. These updated guidelines highlight the variety of diseases requiring our vigilance.”

“TRANSMISSION OF DISEASES BETWEEN PERSONNEL AND PATIENTS IS A TWO-WAY ROAD THAT REQUIRES SAFETY MEASURES FOR BOTH.”

As the next step in a long process of reviewing and updating its 1998 guidelines² on healthcare workers, the CDC recently published a draft on occupational health program infrastructure. The update is being performed in sections,

and the comment period on the program infrastructure guidelines was slated to close on Dec. 14, 2018.

“Transmission of diseases between personnel and patients is a two-way road that requires safety measures for

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MEDICAL WRITER: Gary Evans

EDITOR: Jill Drachenberg

EDITOR: Jesse Saffron

EDITORIAL GROUP MANAGER: Terrey L. Hatcher

SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

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EDITORIAL QUESTIONS:

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

both,” says **David Kuhar**, MD, of the CDC’s Division of Healthcare Quality Promotion. Kuhar has been the CDC point-person on the guidelines, which are under development by the agency’s Healthcare Infection Control Practices Advisory Committee (HICPAC).

The massive shift in the delivery of care over the last two decades requires an emphasis at the outset that employee health programs are critical across the continuum.

In addition, two new elements in the CDC infrastructure guidelines are “leadership and management” and “assessment of reductions of risk for infection” among healthcare workers, he explains.

The 1998 guidelines were aimed primarily at the leadership of occupational health programs, but the new draft also reaches out to hospital administration.

“We have recommendations that are aimed at senior leaders and management that [emphasize] providing administrative support as well as resource allocation,” Kuhar says. “These services can’t be provided unless they are appropriately funded.”

The CDC draft guidelines recommend that healthcare organization leaders:

- invest in a work culture that prioritizes safety and prevention of occupational infections;
- regularly review occupational infectious risks, exposures, and illnesses with occupational health services;
- dedicate one or more staff with appropriate authority and training to lead occupational infection prevention;
- provide sufficient resources, including expertise, funding, staff, supplies, and information technology.

For their part, employee health program leaders should develop both routine and emergency response policies, be accountable for the program, emphasize continuous quality improvement, and seek collaboration with other departments.

The CDC cites many benefits of establishing a high-functioning occupational health service, including cost savings, reduced risk to workers and patients, and less tangible gains like improved morale and work culture. Employee health can use existing regulatory and accreditation requirements to assess risk and serve as performance measures for improving quality. (*See related story, page 4.*)

“For example, The Joint Commission has requirements to establish annual influenza vaccination programs for HCP [healthcare professionals] and to set goals for improving influenza vaccination rates, and the Centers for Medicare & Medicaid Services [has] requirements that hospitals identify and track selected communicable diseases among HCP,” the CDC guidelines state.

Other examples of performance measures that could be used to assess program effectiveness include the number of healthcare workers who sustain needlesticks or other potentially infectious exposures. A corollary to that measure could be the proportion of these workers appropriately given post-exposure prophylaxis if indicated.

Additional performance measures cited in the CDC guidelines include the proportion of workers who complete serial screening for latent TB, or the percentage of workers using N-95 respirators who were fit-tested.

The use of risk assessments

and performance measures is not necessarily new but is emphasized in the guidelines in part to ensure occupational health beyond the hospital, Kuhar says.

“We wanted to call this out for those that are offsite as well,” he says. “They should be involved in workplace safety. Their opinions and perspectives matter.”

The performance measures in the guidelines are cited by way of example; facilities can use the metrics of their choice, he says.

“They are examples only because there is a lot of diversity in how these programs are delivered,” he says. “But these are some tangible ideas of measures they could use to track how well their program is doing.”

Discourage Presenteeism

One area where performance is lacking across healthcare is “presenteeism.”

Healthcare facilities should have specific criteria clarifying when infected healthcare workers should stay home, as gray areas and disincentives currently result in exposures to patients and colleagues, the CDC emphasizes.

The CDC draft calls for sick leave policies that encourage reporting of illness and discourage working while sick. To do this, the CDC recommends that workers have access to clinicians with expertise in exposure and illness management 24/7 to ensure prompt testing and treatment.

Policies for exposed or ill healthcare workers should specify both how work restrictions are imposed and under what conditions staff can return to duty.

“Specify methods of communication between occupational health

services, healthcare personnel, and others (e.g., human resources, managers) about work restrictions,” the CDC guidelines recommend.

Reporting for work ill has been a longstanding culture at many healthcare facilities, Kuhar says.

“Presenteeism is a problem,” he says. “Coming to work ill risks transmitting an infection to not only patients, but co-workers. Then they can also transmit it to their patients and others that they interact with.”

However, CDC recommendations can only go so far to change an ingrained culture in facilities where healthcare workers often work because, for example, they do not have paid sick leave.

“That can actually encourage people to come to work when ill,” Kuhar says. “There are many things that discourage people from staying home that go far beyond the scope that can be addressed in this guideline.”

The CDC hopes to get a message through to healthcare leaders and occupational health personnel that specific policies are needed to reduce presenteeism.

“It is really helpful for every healthcare provider to know, for example, if they have a temperature above a certain threshold or a fever, they shouldn’t be showing up at work,” he says. “Preferably, they would have paid sick leave so they can stay at home and not bring in a potential infectious disease.”

The CDC concedes that developing policies that discourage presenteeism can be challenging, as different categories of workers may have different criteria for missing work.

“Clearly defining the criteria for work restrictions is a key piece for people understanding when they can and when they shouldn’t be coming

to work,” Kuhar says. “The point is if an infection is suspected, you want to make sure that people are not bringing it into a healthcare facility.”

Policies and Pathogens

One challenge in creating the guidelines has been to address the multiple infectious threats workers face, avoiding overkill without sacrificing the necessary protections for a broad range of pathogens, Kuhar says. There are likely to be continuing points of contention and clarification on achieving this balance.

For example, a comment on the CDC draft guidelines submitted to the docket by **Kevin T. Kavanagh**, MD, MS, of Health Watch USA, said the document does not sufficiently address the risk of healthcare workers becoming carriers of MRSA and other drug-resistant pathogens.

“Some of the resistant organisms such as MRSA have become endemic, and different methodologies for prevention of spread need to be instituted, such as routine periodic screening for carriers,” Kavanagh noted in the comments.

To clarify, the CDC has not yet published the guideline section on specific pathogens with important implications for occupational health. That portion was expected to follow the recently published infrastructure section, and a draft likely will be issued later this year.

The pathogen section of the update should better speak to MRSA concerns, as HICPAC discussions included colonization and screening issues for healthcare personnel and patients. Other multidrug-resistant bacteria will be addressed in that section, as well as bloodborne pathogens, tuberculosis, and a broad array of respiratory viruses.

Assessing Risk for Worker Infections

In new draft guidelines for employee health, the CDC recommends periodic risk assessments to identify and reduce infectious hazards to healthcare workers.

The CDC recommendations for occupational health services leaders and staff include “conduct, or collaborate with other healthcare organization departments or individuals in, regular risk assessments and risk reduction activities related to occupational infection prevention and control. Notify healthcare organization leaders and departments about hazards identified and risk reduction plans, progress, and priorities for healthcare personnel.”¹

The CDC draft recommends that healthcare administrators “regularly meet with occupational health services leaders to review results of risk assessments related to occupational infection prevention and control, set performance goals, and charge relevant healthcare organization departments and individuals to reduce risks.”

Risk assessments also can yield data used for performance measurement, facility accreditation, service improvements, and other quality assurance activities.

“Risk assessments may be prompted by the desire to create a safer workplace, federal, state, or local requirements, and by incidents such as reports of exposures or illnesses among HCP [healthcare professionals], infectious disease outbreaks, and device failures resulting in HCP exposures or injuries,” the CDC states in the guidelines.

The agency recommends using a hierarchy of controls, in order of descending priority:

- **Elimination:** Physically remove the hazard;
- **Substitution:** Replace the hazard;
- **Engineering controls:** Isolate people from the hazard;
- **Administrative controls:** Change the way people work;
- **Personal protective equipment:** Protect the worker.

The CDC notes that commonly required regulations could be used to inform risk assessments. These requirements include:

- OSHA logs of work-related injuries and illnesses meeting certain criteria, including infectious diseases exposures;
- OSHA Respiratory Protection Standard requirements for evaluation and correction of identified problems in the respiratory protection program;
- CMS requirements for reporting healthcare worker influenza immunization rates. ■

REFERENCE

1. CDC HICPAC. *Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention Services*. Oct. 15, 2018. Available at: <https://bit.ly/2JsbUPF>.

In general, the guidelines will be geared toward routine infectious disease threats to workers, not emerging pathogens like Middle East Respiratory Syndrome (MERS) and Ebola, Kuhar explains.

Those outbreak situations are characterized by a lot of unknowns and can raise issues that could put worker and patient safety at apparent odds. This was seen to some extent with the mask-respirator debate during the 2003 SARS outbreak, as well as the many personal protective equipment issues during the 2014 Ebola outbreak. Both outbreaks resulted in infected healthcare workers. These emerging infection situations are an “additional challenge to the relationship” between employee health, infection preventionists, and other clinical colleagues, Kuhar notes.

“Sometimes, modes of transmission aren’t well established for these pathogens of high consequence,” he says.

Thus, a healthcare system might elect to handle exposures differently to facilitate access to occupational health services, he adds.

“Services and procedures different from the norm very well may be needed for those pathogens, so that’s where the boundary is drawn on this document,” Kuhar says.

Noninfectious adverse occupational events also are beyond the scope of the document, with the CDC deferring to the National Institute for Occupational Safety and Health to provide guidance on issues such as workplace violence, patient handling injuries, and slips, trips, and falls, he says.

In a related development, the Association of Occupational Health Professionals in Healthcare (AOHP) recently released a position statement³ on the critical role their members play. (*For more information, visit:*

www.aohp.org.) According to the AOHP, these duties include:

- evaluating individuals prior to and throughout employment;
- providing vaccinations, fitness for duty evaluations, and injury management and reporting;
- understanding evolving national and state regulatory standards and guidelines;

- overseeing respirator fit-testing, and safe patient handling and workplace violence prevention programs;

- management of bloodborne pathogen and ergonomics practices.

“I know members of AOHP well, and our guidelines should align with them — that is the expectation,” Kuhar says. ■

REFERENCES

1. CDC HICPAC. *Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention Services*. Oct. 15, 2018. Available at: <https://bit.ly/2JsbUPF>.
2. CDC HICPAC. *Guideline for infection control in health care personnel*, 1998.

Keep Your Eyes Peeled: Severe Forms of Conjunctivitis Spread Rapidly

Preventing outbreaks may require increased monitoring of infected HCWs

By Jesse Saffron, Relias Media Editor

Conjunctivitis — often called “pink eye” or “red eye” — is a common, relatively mild condition. But adenoviral conjunctivitis (AC) and its most severe presentation, epidemic keratoconjunctivitis (EKC), should be cause for concern for healthcare employees, experts say.

“This is a highly contagious infection. The worst form of it, EKC, almost crippled U.S. military operations in the Pacific Rim in World War II, and hence its nickname, ‘shipyard eye,’” says **Irene C. Kuo**, MD, associate professor of ophthalmology and chief of infection control at Johns Hopkins University School of Medicine’s Wilmer Eye Institute in White Marsh, MD.

That nickname references the 1941 outbreak in Navy shipyards at Pearl Harbor. Ten thousand people became infected with EKC, which quickly spread to the Western United States.¹

AC can cause eye inflammation, eyelid swelling, extreme light sensitivity, excessive tearing, and ocular pain. EKC can produce those symptoms but also can cause dry-

eye syndrome and affect the cornea, in severe cases distorting vision for months and even years.

Kuo says transmission occurs by contact with tears and ocular secretions. “Studies have shown that the desiccated virus is still viable on inanimate objects — metals, plastic, textiles, etc. — for up to 2-4 weeks,” she says.

EKC can be especially problematic in healthcare settings. High transmission rates can lead to worker furloughs, facility closures, and increased healthcare costs. And lack of proper infection control practices and employee training can exacerbate such problems.

In 2013, the CDC analyzed six EKC outbreaks that occurred in four states between 2008 and 2010, citing “significant morbidity and cost resulting from the number of persons affected, duration of the outbreaks, and the temporary closure of a neonatal intensive care unit and several clinics.”²

Numerous other facility outbreaks have been discussed in the literature, but the extent of the problem may

be underestimated. “EKC is not a reportable condition, so there is no record kept of all cases,” says **Marie Killerby**, VetMB, MPH, an epidemiologist in the division of viral diseases at the CDC’s National Center for Immunization and Respiratory Diseases.

“I think now we have passive reporting; if a state calls us and they want assistance on an EKC outbreak, then we publish these reports,” she adds.

That EKC appears to be a low reporting priority at the national level may reflect that it often is perceived as low-risk; indeed, for many infected individuals, symptoms subside after 1-3 weeks. Still, the infection and AC in general present unique challenges for healthcare workers (HCWs). AC is a reportable condition in Germany and a Category IV infectious disease in Japan.

“It certainly deserves attention; it is difficult to deal with. It spreads very easily — it is a hardy virus that is resistant to some common disinfectants,” says Killerby.

A Close Call Spurs Reform

EKC is receiving significant attention at Johns Hopkins Medicine (JHM). In a recent paper³, Kuo and a colleague discuss a program created in 2011 “to ensure swift triage, accurate diagnosis, and appropriate work furlough for employees with adenoviral conjunctivitis.” The broader goal is “to prevent transmission of this infection and EKC in particular.”

Kuo, who initiated the program, says it has origins in an EKC scare that occurred years ago at JHM. “In the 1990s, my predecessor at Wilmer, Johns Hopkins’ department of ophthalmology, set up a policy that featured a ‘red-eye room’ in our eye emergency department as well as coded alerts because of a near-outbreak that almost shut down the department,” she says.

“When my current chairman closed the red-eye room and the eye emergency department, I talked with occupational health, hospital epidemiology and infection control, and virology and developed a new policy,” Kuo explains.

Key to the new approach was developing a polymerase chain reaction (PCR) assay to detect AC and EKC in swabs taken from hospital employees suspected of infection. It was created because PCR assays tailored for that purpose currently are not available on the market.

PCR tests are described in the paper as the “gold standard” in terms of accurate AC and EKC diagnosis. In contrast, “diagnosis by ophthalmologists may be 50% accurate at best, and diagnosis by other professionals is probably even less accurate.”

Of course, accurate diagnosis is not an end in itself. “The point is not to remove every employee who has red eye but only those with adenoviral conjunctivitis,” Kuo says. “If you over-call AC [or EKC] ... you put patient care at risk by having employees out of work.”

According to the paper, of 8,768 JHM employees who visited the occupational health clinic there from November 2011 through October 2016, “1,498 (17%) had eye

“REGARDLESS OF WHETHER IT POPS UP IN THE COMMUNITY OR HOSPITAL FIRST, WE NEED TO HAVE A HIGH LEVEL OF SUSPICION BECAUSE INFECTION IS TRANSMITTED VERY EASILY.”

complaints ranging from eye injury to red eye.” Of those, 1,059 were swabbed for suspicion of adenoviral infection. Twenty-six people had EKC, 78 had AC, and 673 had nonadenoviral conjunctivitis.

Median furlough length was 10 days for non-EKC infections and 14 days for EKC infections. These JHM areas had the largest AC and EKC infection numbers: outpatient pharmacy (9), surgery (8), ophthalmology (8), and medicine (8).

“Probably, the hospital employees are getting [infection] from the community,” Kuo says. “Luckily, and perhaps because of my policy, they are

not spreading it at the hospital, but they certainly have potential to spread it to patients and other employees because it is so contagious.”

Kuo and her colleague note in the paper that the “proportion of red-eye employees having PCR-positive adenoviral conjunctivitis increased over five years ... as did the proportion of employees with EKC.” However, they emphasize that the new policy has been beneficial in that it allows for better AC and EKC surveillance, which they say may help to prevent future outbreaks.

Other Important Strategies

It is likely that protecting HCWs and thwarting outbreaks will require more than adenoviral surveillance like that at JHM. The good news is that some recommendations are simple.

“Making sure everyone uses proper hand hygiene, making sure you are not having healthy patients going into a room right after an EKC patient, making sure you are using disinfectants that are effective — [those are important],” Killerby says.

“We [the CDC] recommend using EPA-registered disinfectants. The other thing is refraining from using eye drop bottles on multiple patients,” she adds. The CDC also recommends using disposable gloves and “making sure you’re disinfecting equipment after each use,” she says.

Such standard precautions are critical given that there are no proven treatments for adenoviral eye infections. A 2017 paper⁴ on EKC prevention says there is some evidence that topical corticosteroids can help alleviate symptoms, but in some cases, they have made symptoms last longer. The report says use of provodone-iodine eye drops may hold promise.

No matter what, says Kuo, caution should be used when it comes to antibiotics, which she says are wildly overprescribed in conjunctivitis cases and largely ineffective against AC and EKC. One problem is that physicians handling these cases often lack necessary training.

“It really is best that hospital employee health departments refer employees to ophthalmologists and not have employees run to urgent care, internists, or emergency rooms,” Kuo says.

“Ophthalmology is a small specialty, and MDs do not have much exposure, if any, to it unless they do residency. Many non-ophthalmologists prescribe antibiotics when unnecessary.”

Kuo says overprescribing in this area can cause negative side effects for patients and increase risk of antibiotic resistance. Further, costs in the hundreds of millions are imposed each year because of unnecessary prescriptions, trips to urgent care facilities and EDs, and missed work. “Probably more than a million patients are misdiagnosed and overtreated each year,” she says.

Nevertheless, Kuo seems acutely aware that her institution, JHM, is not alone in confronting issues related to AC and EKC. “Epidemics have occurred in other hospitals and medical and ophthalmology clinics, whereby both patients and employees developed infection,” she says.

“Regardless of whether it pops

up in the community or hospital first, we need to have a high level of suspicion because infection is transmitted very easily.” ■

REFERENCES

1. Jawetz E. The story of shipyard eye. *Br Med J* 1959;1:873-876.
2. CDC. Adenovirus-Associated Epidemic Keratoconjunctivitis Outbreaks — Four States, 2008-2010. *MMWR* 2013;62(32);637-641.
3. Kuo IC, Espinosa C. Five-year trends in adenoviral conjunctivitis in employees of one medical center. *Infect Control Hosp Epidemiol* 2018;39:1080-1085.
4. Hein AM, Gupta PK. Epidemic Keratoconjunctivitis: Prevention Strategies in the Clinic. *EyeNet*, February 2017:33-34.

Eye Protection the Weak Link in PPE

Respiratory infections may begin with eye exposure

Emerging evidence shows that healthcare workers may contract occupational respiratory infections through eye exposures, a risk that is underappreciated and for which eye protection is rarely worn, a healthcare epidemiologist emphasizes.

“There’s a lot of new data [on] respiratory virus transmission that suggests ocular exposure is a vulnerability,” **Leonard Mermel**, DO, ScM, professor at Brown Medicine in Providence, RI, tells *Hospital Employee Health*.

In a recently published letter, Mermel warned that respiratory viruses can use the eye as a point of entry to begin replication and infection. Eye protection may be suboptimal unless there is a perceived potential for splash, and hand contamination during

personal protective equipment (PPE) removal has been shown to lead to introduction of infections into the eyes.

“Based on the evidence to date, it would be prudent to wear eye protection when caring for patients with suspected or proven respiratory viral infection,” Mermel notes in the letter.¹ “This protocol would err on the side of caution in an attempt to mitigate the risk of transmission to healthcare workers and others.”

Such an approach would be in addition to source control — such as requiring infected patients wear masks — as well as the recommendations for PPE use for patients in contact and droplet isolation precautions.

Given historic compliance problems, there is still the question of whether workers would don eye

protection even if the risks of infection are underscored.

“We can make this easy by use of masks that are a combination mask/ eye shield,” he tells *HEH*. “That’s what we’re trying to do here in my hospital system. That way, we make it easy to do the right thing, so healthcare workers don’t need to find separate masks and eye shields.”

Such an approach could not only prevent respiratory infections but lower the many blood and body fluid splashes that occur to the eyes.

According to data from the International Safety Center’s Exposure Prevention Information Network (EPINet), “nearly 50% of all occupational exposure incidents in healthcare occur to the eyes, and only 3% of employees indicate that they are wearing any kind of eye protection during

that exposure,” says **Amber Mitchell**, PhD, director of the center.

These exposures have resulted in a variety of disease transmissions, underscoring the need for making eye protection easily accessible, she says. This is particularly true for patient and examination rooms, where the majority of occupational eye exposures are occurring.

“The peer-reviewed literature is rich with data on transmission of pathogens via eye exposures, including HIV, HCV, SARS, rabies, plague, influenza,” Mitchell says. “Since healthcare facilities do not do surveillance testing of healthcare workers, the real risk is unknown. That said, from what we do know, the risk cannot be emphasized enough.” ■

REFERENCES

1. Mermel, LA. Eye protection for preventing transmission of respiratory viral infections to healthcare workers. *Infect Control Hosp Epidemiol*. 2018;39(11):1387.
2. International Safety Center. *Report for Blood and Body Fluid Exposures*. May 8, 2018. Available at: <https://bit.ly/2SeiBlg>.

More Data on Moral Distress: It Harms Nurses, Physicians, Hospitals — and Patients

Ethics availability ‘vitaly important’

A group of researchers set out to learn the most effective ways to decrease moral distress in healthcare. In the process, they discovered the toll it was taking was greater than expected.

“I was stunned to discover that a significant number of ICU nurses have considered leaving their positions because of moral distress,” says **Marianne C. Chiafery**, DNP, PNP-BC, a clinical ethicist at University of Rochester (NY) Medical Center and an assistant professor of clinical nursing at University of Rochester.

Over a two-month period, 32 nurses from three ICU settings in an 800-bed tertiary academic medical center participated in six ethics huddles.¹ A nurse ethicist led the discussions. Nurses appreciated the chance to analyze situations that troubled them deeply, says Chiafery, the study’s lead author. “The depth of moral distress ran deeper than I expected.”

The nursing ethics huddles were associated with higher quality of work life, improved patient care, and increased clinical ethics

knowledge. Many nurses reported improved communication skills as well. “This was not an intentional goal but a nice bonus for all involved,” says Chiafery.

Developing solutions to address ethical dilemmas was helpful in decreasing distress. Especially important, says Chiafery, is that someone with ethics expertise is available to:

- help nurses work through difficult situations;
- listen with an empathetic ear;
- facilitate conversation and discussion;
- provide ethics education.

“It is vitaly important that ethicists, or facilitators with a strong background in ethics and ethical reasoning, meet with staff on a routine basis,” says Chiafery.

Moral distress is nothing new, although there’s much greater awareness of it. “It has been around for a long time,” says **Lucia D. Wocial**, PhD, RN, FAAN, a nurse ethicist at Fairbanks Center for Medical Ethics at Indiana University Health in Indianapolis.

The fact that people are

recognizing that moral distress is a significant concern for all clinical care providers is a “hopeful sign,” says Wocial. “Individual providers as well as organizations are beginning to recognize that it is not just an issue for nurses.”

The National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience, launched in 2017, is one example. It is not enough, though, says Wocial: “Addressing moral distress also depends on a recognition that the culture of healthcare at the unit, organization, and industry level must change.”

Nurse-Physician Communication

As an ICU nurse, **Natalie S. McAndrew**, PhD, RN, ACNS-BC, CCRN, experienced moral distress many times. Mostly, it involved decisions made by family or providers about life-sustaining interventions at the end of a patient’s life. “Healthcare organizations have to start taking

this issue seriously. Otherwise, we will continue to keep losing nurses,” says McAndrew, an assistant professor in the College of Nursing at University of Wisconsin-Milwaukee.

McAndrew conducted several recent studies on moral distress. One explored the relationship between moral distress and the professional practice environment. That study identified communication between nurses and physicians as an important factor.² “The more we have a good relationship, the more moral distress is going to tend to go down,” says McAndrew.

For example, simply understanding why a provider wants to try one more intervention can decrease moral distress. “That is how you grow as a clinician and do the kind of self-reflective practice that can help you with the next moral distress and the next one after that,” says McAndrew.

Another study explored the differing perspectives of nurses and physicians on end-of-life decision-making in the ICU.³ “Nurses and physicians experience moral distress,” says McAndrew. “The ability to resolve the distress is closely tied to one’s ability to share their moral perspective.”

When team members feel their perspectives about care are not heard, says McAndrew, “it becomes difficult to provide support to patients and families.”

The overall impact of moral distress and effective interventions remained unclear. “We needed a good idea of, ‘What is the state of the science?’” says McAndrew. This led to an analysis of 42 studies from 2009 to 2015 that suggested that moral distress has negative effects on quality of care.⁴

“More data on how ethical conflicts and moral distress affects patients and families is needed,” says McAndrew. However, few effective approaches were identified in the literature. “We need to develop more effective interventions to improve patient, family, and provider outcomes,” says McAndrew. Putting metrics in place to assess the well-being of healthcare providers is an important step.

“THE BURNOUT THAT WE ARE EXPERIENCING IS A MANIFESTATION OF THE ETHICAL CONFLICT THAT WE FEEL, TYPICALLY WITH END-OF-LIFE DECISIONS.”

The growing focus on burnout among healthcare professionals has called attention to the problem of moral distress. “I think the burnout that we are experiencing is a manifestation of the ethical conflict that we feel, typically with end-of-life decisions,” says McAndrew.

Unresolved moral distress may be an antecedent to burnout. “Many health professionals will share that they get to a point where they have simply had enough and leave their clinical practice setting, or even the profession,” says McAndrew. Working with symptoms of burnout is a concern too, says McAndrew: “This can negatively impact patient and family care.”

While there is greater awareness of moral distress, hospital administrators tend to see it as something an individual nurse experiences. Too much emphasis on coping skills can obscure the fact that systemic problems are involved, says McAndrew.

For instance, there may be a policy in place that prevents a family member from remaining at the bedside continuously. “We want to be careful that we don’t just say, ‘It’s just your problem as an individual, and you need to go fix yourself,’” says McAndrew.

Also largely unrecognized: that physicians and other disciplines are adversely affected by moral distress. Often, it is viewed as purely a nursing issue.

“Physicians’ voices are heard over the nurses’ voices, and the nurse gets caught up in the middle of the physician and family,” says McAndrew. “We need to work together in this.” ■

REFERENCES

1. Chiafery MC, Hopkins P, Norton SA, et al. Nursing ethics huddles to decrease moral distress among nurses in the intensive care unit. *J Clin Ethics* 2018; 29(3):217-226.
2. McAndrew NS, Leske JS, Garcia A. Influence of moral distress on the professional practice environment during prognostic conflict in critical care. *J Trauma Nurs* 2011; 18(4), 221-230.
3. McAndrew NS, Leske JS. A balancing act: Experiences of nurses and physicians when making end-of-life decisions in intensive care units. *Clin Nurs Res* 2015; 24(5), 357-374.
4. McAndrew NS. Nurses and physicians bring different perspectives to end-of-life decisions in intensive care units. *Evid Based Nurs* 2018; 21(3):85.

Physician Stress, Frustrations Can Lead to Depression and Burnout

About half of general surgeons report experiencing burnout. Their levels of stress and frustration have reached the point where their mental health is at risk. (Read more about the American Medical Association's research on burnout online at: <http://bit.ly/2MIxNKs>.)

"All of us, whether or not we have underlying tendencies toward depression, could stand a little less frustration in our lives," says **Sharmila Dissanaiké**, MD, FACS, FCCM, professor and Peter C. Canizaro chair, department of surgery at Texas Tech University Health Sciences Center in Lubbock.

"Learning to cope with daily frustrations is important ... one strategy is to learn to pick your battles; you need to know which areas to put your effort and energy and improve."

For example, if a surgeon is working in a surgery center that never opens the OR on time, the surgeon can choose to be frustrated each day when the 7:30 a.m. start time slides into 8 a.m. or 8:30 a.m. Or, the surgeon can push for a change to make OR staff more timely.

"But that takes a lot of effort and energy. You might decide that's not a battle worth fighting," Dissanaiké says. "Anticipate that the OR won't start on time, and maybe you catch up on your paperwork, read your journals, or take a walk. Find something useful to do so you won't sit in the lounge, frustrated."

Dissanaiké describes these additional ways stress can result in burnout and how to prevent them:

- **Dealing with stress from the procedure.** Experienced surgeons are

less likely affected by stress from the procedures they perform. But such stress can be common when surgeons are in training, she says.

"As surgeons become more experienced, the stress level begins to drop," she says.

Surgeons learn how to cope with stress from their work through practice and finding that they

"EITHER YOU TRY TO FIX THE PROBLEM, OR YOU FIND A DIFFERENT WAY TO USE YOUR TIME. THE WORST STRATEGY IS SITTING THERE AND FUMING EACH MORNING."

can cope with different surgical scenarios, including patients who bleed or experience complications during surgery. Knowing the surgical team also helps reduce this type of stress.

"Make sure you have a team you are familiar with. Know who everyone is," Dissanaiké suggests.

Surgeons can make surgical timeouts a standard practice. With these, they not only go over the patient and surgical site before beginning, but they also listen as team members introduce themselves, Dissanaiké explains. "The surgeon knows the scrub tech by name." This sets the tone for a convivial team and reminds everyone that they work

together. It creates a more positive environment and helps reduce individual stress.

"Before the operation, discuss the potential things that could go wrong and how they'll be handled," Dissanaiké suggests. "Go over the contingency plan at the beginning of the case. It helps to make sure everyone is prepared and there's not poor communication in the room. It helps to ameliorate the stress of an adverse event in an OR."

For new surgeons, another stress-reduction strategy is to ask an experienced colleague or mentor to assist when there is a high-risk case. Or, ASC physicians might not take cases for which the risk is very high, Dissanaiké says. "Know what types of cases are appropriate for that setting, and make sure you don't do anything beyond what can be handled in that setting."

- **Coping with daily annoyances.** "A lot of stress in a surgeon's life is accumulated slowly and is due to peripheral annoyances," Dissanaiké says. "If you are never able to start the OR on time or you believe everyone is wasting your time, then that is a daily stress that can build up and lead to burnout."

Time-consuming note-taking or documentation also can be a stressor. The key is to not let time-wasting activities or long waits drain a person's energy. "Daily stress can build up and lead to depression," Dissanaiké says. "Either you try to fix the problem, or you find a different way to use your time. The worst strategy is sitting there and fuming each morning."

- **Handling difficult personalities.** It is stressful to argue

with people or to deal with a conflict, Dissanaiké laments. Surgeons might not be able to choose every person working with them in the OR, but there are ways to improve these relationships and reduce conflict.

“The fundamental understanding has to be that we cannot change other people’s personalities,” Dissanaiké says. “We can barely change our own. You have to decide whether this person brings value in other ways.” For example, the troubling co-worker might bring a varied skill set to the job and demonstrate a deep understanding of his or her job. If the person exhibits these positive attributes, then the conflict might be a personality

conflict. The onus is on the surgeon to accommodate and accept that they will never be best friends with the person, but they can work together on a daily basis, Dissanaiké explains. “You can learn to overlook the daily things that are irritating,” she adds.

An exception might be if the other person’s behavior is demeaning or disrespectful. For instance, perhaps one employee’s habit is to call everyone “sweetie.” The surgeon can wait for a calm moment to ask the person to stop this, saying, “I’d very much prefer you didn’t call me that. You can use my first name, instead.” Some things cannot change, such as a person who always speaks loudly. But if it is necessary to curb

the irritating behavior, then it is important to focus on the behavior and not the person when speaking with the employee about correcting the problem, Dissanaiké offers. Also, any attempt to change an employee’s behavior should occur in person.

“It’s very common now for people to send off angry emails when things don’t go well,” she says. “When you’re angry, you overstate the case and exaggerate it. Other people reading the email think you are not reliable because you overstated the case.”

Emails are an easy way to throw someone under the bus, and they cannot be taken back. Once an email is out there, it can be shared and live on forever. ■

Proposed Federal Bill to Stop Healthcare Violence

Political momentum shifting on issue

With shifting political winds favoring its passage, a resolution has been reintroduced in Congress that would require OSHA to issue a standard to protect healthcare workers against violence.

The Workplace Violence Prevention for Health Care and Social Service Workers Act¹ could pick up some political momentum coming into the House of Representatives this year. Previous versions of the bill, as well as other attempts to address the epidemic of violence in healthcare, have been rebuffed at the federal level. As with prior versions, the bill would require healthcare employers to create and implement workplace violence prevention plans that pass OSHA muster.

“This legislation compels OSHA to do what employees, safety experts, and members of Congress have been calling for years: Create an enforceable standard to ensure that

employers are taking these risks seriously and creating safe workplaces that their employees deserve,” Rep. **Joe Courtney**, D-CT, the resolution’s primary sponsor, said in a statement.

In addition to 20 congressional cosponsors, Courtney’s resolution has received support from the nation’s large labor organizations, including National Nurses United.

“It’s so important for nurses, doctors, and other healthcare and social service workers to be directly involved in the development and implementation of these plans, because employees know best the

risks we face on the job,” said **Jean Ross**, RN, co-president of the nursing union.

The federal action follows action from states such as Illinois, which recently passed a law to protect healthcare workers. (See *Hospital Employee Health*, December 2018, for more information.) ■

REFERENCE

1. U.S. Congress. *Workplace Violence Prevention for Health Care and Social Service Workers Act*. Nov. 14, 2018. Available at: <https://bit.ly/2DKYcqj>.

COMING IN FUTURE MONTHS

- Will Democrat-controlled House enact HCW legislation?
- More effective communication and cooperation with other departments
- Preparing workers to field questions from Joint Commission surveyors
- Why isn’t there more discussion about the suicide risk to nurses?



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CE QUESTIONS

- 1. As the next step in a long process of reviewing and updating its 1998 guidelines on healthcare workers, the CDC recently published a draft focusing on which aspect of occupational health?**
 - a. Emerging and epidemic pathogens
 - b. Program infrastructure
 - c. Colonization issues for healthcare workers
 - d. Mandatory vaccinations
- 2. The CDC guidelines cited a hierarchy of hazard controls. Which of the following was the lowest priority?**
 - a. Elimination of the hazard
 - b. Substitution of the hazard
 - c. Personal protective equipment
 - d. Administrative controls
- 3. Leonard Mermel, DO, ScM, cited emerging evidence in recommending that workers wear eye protection when caring for patients with suspected or proven respiratory viral infection.**
 - a. True
 - b. False
- 4. A resolution has been introduced in Congress that would require OSHA to issue a standard to protect healthcare workers from:**
 - a. ergonomic injuries.
 - b. violence.
 - c. surgical smoke.
 - d. burnout and depression.

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.