HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

INSIDE

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Efforts to Prevent Healthcare Violence Gain Momentum

Proposed federal law follows Joint Commission action

By Gary Evans, Medical Writer

There are signs that the historical complacency and "part-of-the-job" acceptance of healthcare violence is ending.

The horrific accounts of attacks on healthcare workers have humanized the problem, the opioid epidemic has highlighted the dangers in EDs, and a recent study found that overall violence appears to be increasing in hospitals.[1]

The issue may be reaching a tipping point, translating to political momentum at the state and federal level. While more states are adopting laws on violence prevention in healthcare, long-sought federal action has been stalled out time and again. The latest proposal for a national law comes with the recently introduced "Workplace Violence Prevention for Health Care and Social Service Workers Act."[2]

> THE BILL WOULD REQUIRE HEALTHCARE EMPLOYERS TO DEVELOP, AT A MINIMUM, WORKPLACE VIOLENCE PREVENTION PLANS BASED ON 2016 GUIDELINES FROM OSHA.

Introduced by Rep. Joe Courtney, D-CT, and 20 congressional co-sponsors, the bill would require healthcare employers to develop, at a minimum, workplace violence prevention plans based on 2016 guidelines from the Occupational Safety and Health Administration (OSHA).[3]

"This [OSHA] guidance is not enforceable," according to the bill. "Absent an enforceable standard,

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employers lack mandatory requirements to implement a violence prevention program, and workers lack sufficient protection from workplace violence."

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.[4] However, the action was a nonstarter with a new administration coming in to power.

"OSHA's efforts to move forward with rulemaking have been halting and inconsistent," the proposed bill states. "Therefore, legislation is necessary to ensure the timely development of a standard to protect workers in healthcare and social service settings."

The OSHA guidelines that the bill would codify into law cover key aspects of a violence prevention program, including management commitment, worker involvement, training, reporting, and assessing the risk of violence to employees. The risk assessment poses such questions as:

- Do the employees work alone?
- Do they work late at night or during early morning hours?
- Is the workplace often understaffed?
- Is the workplace located in a high-crime area?

The Joint Commission May Cite

While the federal bill comes amid shifting political power that could favor its passage, some hospitals are moving ahead to establish comprehensive programs. In April 2018, The Joint Commission (TJC) issued a Sentinel Event Alert[5] on violence, reminding healthcare facilities that several current standards can be cited if hospitals refuse to act to protect workers. Key provisions in the alert include that accreditation surveyors will be looking at reported violent incidents, leadership response, and trends in violence and injuries. TJC also may survey workers to assess the effectiveness of interventions to prevent violence.

Although various iterations of these standards, guidelines, state laws, and proposed bills are similar in substance and recommendations, federal regulation has been seen by many as the best long-term solution. That said, there are familiar concerns that federal legislation may be counterproductive if it contains "unfunded mandates" and limited local flexibility once implemented.

"As with anything in government, it's hard to enact and it's hard to change," says **Scott Cormier**, CHEP, NRP, vice president of emergency management, environment of care, and safety at Medxcel, a healthcare facilities management company in Indianapolis. "Our workplace violence programs need to be very fluid, so as we gather more information and see better results from best practices, we can implement those."

There is a problem that must be addressed through federal and state regulations or a call to voluntary action at the local level, he says.

"According to OSHA, there is four times more workplace violence in healthcare than any other industry," Cormier adds. "Workplace violence can be as simple as somebody reaching to grab your arm, to people being assaulted with weapons."

Any federal regulation should recognize the difficulty of preventing violence, which can be unpredictable, an occupational health nurse says.

JoAnn Shea, ARNP, MS, COHN-S, director of employee health and wellness at Tampa General Hospital, says she could support a regulation if it recognized such caveats and did not penalize hospitals acting in good faith.

"Yes, as long as it is reasonable for healthcare organizations," Shea says. "With workplace violence, there are so many variables and unknowns. You don't want OSHA to come in and ding a hospital that is trying to put a good program together. Things happen, but I think a lot of hospitals are really trying hard to address this issue now."

Comprehensive Upgrade

Shea and colleagues responded to the Joint Commission alert by taking a hard look at their violence prevention program and implementing a comprehensive and ongoing upgrade. The hospital formed an antiviolence committee that incudes members from nursing, employee health, psychiatric nursing, security, management, and compliance.

"My work comp manager and I are both on the committee," Shea says. "We are taking a very proactive approach to this, and the goal is zero harm to patients and staff."

The program still is something of a work in progress, but data are emerging that will inform future violence prevention efforts.

"We've had 31 injuries related to patient violence in 2018," Shea says. "They actually came to employee health and reported an injury. Some are minor, sometimes they get hit in the nose or they fracture a finger as a patient pulls at them. Most of these patients are very confused."

Injured healthcare workers also are given psychiatric care and counseling as needed after a violent incident.

"This can be very emotionally difficult for the healthcare worker," Shea says. "People have really gotten hurt, and then they are afraid to come back to work, so we provide them a lot of counseling."

Even verbal abuse, which often is not reported, can be very difficult to deal with, she adds.

"When I was a [staff] nurse people verbally abused you, and you were supposed to just shake it off," she says. "I think nowadays patients are even less respectful to healthcare workers. It is difficult to come into a work environment where patients are verbally abusing you."

Being a large teaching hospital and a Level 1 trauma center with a psychiatric unit, Shea sees a steady inflow of patients at risk of committing violence.

Communication Breakdown

"We are really taking this seriously," she says. "The main thing is collecting all the data and looking at how many verbal assaults, physical assaults, and near-misses we are having. We want our staff to feel safe."

An initial finding was that reports of violent incidents were logged in unconnected databases, with employee health, security, risk management, and other departments collecting siloed information that was not necessarily shared.

"We realized with violence, that if someone is injured at work, they come to employee health [and] we are collecting that data," Shea says. "But one of the missing pieces we identified is a central repository. Nobody was really talking to each other."

Realizing the data from violent injuries and codes were not being pooled, Shea and fellow committee members are developing a central repository to collect and aggregate all incident data.

Hospital security collects data on codes called for a violent incident or an escalating situation. The hospital calls a Code Gray for patient violence and a Code Bert to summon security for a tense situation that threatens escalation. "Security tries to defuse the situation, and that has been very successful," Shea says.

Near-misses include patients attempting to hit healthcare workers, lashing out, or acting like they have the potential for violence. These incidents often are not reported, but Shea and colleagues are trying to raise awareness about all aspects of violence.

"We are centralizing all of this so we can do aggregate reports by department," Shea says. "We need to get a better feel for how common these situations are. It's all over the place right now, but we are moving in the right direction."

Risk assessments are an important part of the program and are conducted regularly.

"We have psychiatric nurses that make rounds," she says. "They assess all the psychiatric patients and identify risks and see if we need to intervene. We also have a lot of severely disabled patients, and they might kick a nurse or something."

In some cases, given the patient's condition, healthcare workers are reluctant to report these incidents.

"They feel bad, but we tell them they are not getting the patient in trouble — we just need to know," she says.

To overcome reluctance to report, Shea is setting up an anonymous reporting system so that workers can

report threats and violent incidents without identifying themselves.

"People don't always want to report patients — they feel like [violence] is part of their job," she says.

All violent incidents that result in an occupational injury are subject to root cause analysis, with the central question: How could this injury have been prevented?

Shea's committee meets once a month, but more frequent huddles are used to identify patients who are potentially violent. Education and training increase awareness of the problem and emphasize the need to report all incidents. This training begins with orientation sessions for new employees but also is available for those already on staff. A link on the employee computer portal prompts workers to take the training.

"We also have two or three off-duty police we hire, including one in the ER," Shea says. "We have armed some of our security guards, too. They have tasers, but we also armed them with weapons recently. They are trained."

The hospital also teaches self-defense classes for workers and conducts active shooter drills.

Run, Hide, Fight

Cormier co-chairs a federal committee that publishes guidance on preventing, responding to, and recovering from active shooter incidents in healthcare.

"We update that guidance every two years," he says. That means an update will be coming this year, with the most recent report issued in 2017.

The "run, hide, fight" approach is recommended, meaning evacuate the target area if possible, find a secure place to hide or deny access, and as a last resort, "make the personal decision to try to attack and incapacitate the shooter to survive."[6]

The report also addresses the complex ethical decisions that arise during an active shooter situation in a hospital.

"Some ethical decisions may need to be made to ensure the least loss of life possible," Cormier and colleagues report. "Every reasonable attempt to continue caring for patients must be made, but in the event this becomes impossible without putting others at risk for loss of life, certain decisions must be made."

ALL VIOLENT INCIDENTS THAT RESULT IN AN OCCUPATIONAL INJURY ARE SUBJECT TO ROOT CAUSE ANALYSIS, WITH THE CENTRAL QUESTION: HOW COULD THIS INJURY HAVE BEEN PREVENTED?

Open discussion and preparation before an incident occurs certainly is preferable to dealing with these questions in the moment. Cormier and the panel recommend allocating "resources fairly, with special consideration given to those most vulnerable." Although urging healthcare workers to "limit harm to the extent possible," the report acknowledges that "with limited resources, healthcare professionals may not be able to meet the needs of all involved."

Remove as many barriers as possible to reporting incidents, as healthcare workers concerned for their patients' welfare may be reluctant to be drawn into a prolonged process, he urges.

"In one of our inner-city hospitals, if a healthcare worker is assaulted but doesn't require hospitalization, the local police department refuses to come take a report," he says. "If they want to report it, they have to take time to drive down to the police department and stand in line. The employees don't want to be taken away from caring for their patients."

Reluctance to report violence is a deeply rooted problem, but basic improvements in the process may increase worker participation.

"Primarily, you have to have a reporting system that the employees are willing to use and is easy to access," Cormier says. "If your reporting process is filling out a form that takes 30 minutes, they are not going to do it. They want to spend that 30 minutes caring for their patients. That is how dedicated healthcare workers are."

In addition, the reporting process should be available at all hours on all shifts.

"If you are working nights on weekends, you should have the same accessibility to it as somebody that works daytime during the week," he says.

Be aware that employees will likely become skeptical of the benefits of reporting if they see no action is being taken to address violence problems, he adds. Cormier recommends forming a crisis management team much like the one Shea describes, which should open a line of communication with local

law enforcement before an incident occurs.

"They need to understand your processes because if they don't, they are going to come in to it blindly," he says.

The violence prevention committee should look at the big picture, including addressing the full continuum of care and educating nonclinical staff such as environmental service workers.

"We need to be inclusive with these partners so they are part of our threat assessment team," he says. "Counselors in hospitals need to be part of the team, especially when it comes to the point of response. We need to have the resources in place to support our employees both physically and emotionally." ■

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The Joint Commission Comments on CDC Healthcare Worker Guidelines

CDC draft designed to prevent occupational infections

The CDC's draft guidelines for protecting healthcare workers from occupational infections "may inadvertently reinforce siloing of safety issues, which is increasingly recognized as contradictory to promoting a safety culture," The Joint Commission (TJC) warned in comments on the document.

"The document could be strengthened, however, by greater emphasis on collaboration with infection prevention and control (IPC) staff and the interrelationship between worker safety and patient safety," according to TJC comments. "To strengthen the guideline, CDC might consider adding a new section devoted to the intersection of worker safety and patient safety."

The section could include infectious diseases and sharps injuries, as well as exposure reporting systems and example tools for communication, risk assessment, and incident analysis, the commission recommended.

While generally praising the effort to update guidelines that are two decades old, public comments on the CDC draft[1] range from recommendations for such broad additions to changes in terms and nomenclature. Other sections will be added to the CDC guidelines, including one on specific pathogens that pose occupational threats to workers. That section is expected to be published for comment this year.

The infrastructure draft acknowledges the massive shift in the delivery of care, emphasizing that occupational health must be extended across the continuum. The draft also includes a leadership and management section that emphasizes that employee health programs must receive adequate support and resources. It calls for periodic assessment of infection risks to workers and whether interventions are working.

"[We] suggest that you add a section for frontline staff," TJC comments stated. "Communication and collaboration with frontline healthcare workers, including medical staff and other licensed independent practitioners, are critical for effective interventions."

The accreditation group also recommended that consideration be given throughout the guideline to add "assessments of competence" in addition to training and education. "It is well known that training does not always result in proper implementation," TJC stated.

"Exposures will continue to

happen unless expectations related to engineering controls and use of PPE [personal protective equipment] are standardized," TJC warned. "It is imperative that healthcare workers follow the same practices to prevent exposure as they move through the continuum of care."

The CDC also should consider including process measures in addition to outcome measures as examples in the document, the commission added.

"Given the known problems with underreporting, it would be worthwhile to include an example measure related to needlestick injuries," TJC noted. "Organizations should be encouraged to submit standardized data to reporting systems to receive comparative reports and track trends over time."

There should be an expectation that leaders purchase and stock adequate supplies of PPE, particularly face and eye protection to address a common area of exposure.

"For example, EPINet data on splash exposures indicates that, in 2017, approximately 62% of exposures involved a splash to the eyes, nose, or mouth, but exposed [healthcare personnel] reported wearing face protection during less than 12% of exposures," TJC commented.

EPINet Comment

Also making that point was a principal involved in the cited exposure data, **Amber Hogan Mitchell**, DrPH, MPH, CPH, executive director of the International Safety Center for healthcare workers. A former Occupational Safety and Health Administration (OSHA) official, Mitchell oversees the center's EPINet surveillance, which has been gathering data on potentially infectious exposures to healthcare workers for many years.

"These updates are long overdue, and the care and effort that went into updating the guidance is a notable undertaking," she said in public comments to the CDC.

Safer healthcare workers have a direct impact on their ability to provide and maintain safer patient care, she noted.

"WHILE THE DOCUMENT IS QUITE COMPREHENSIVE, THERE ARE ELEMENTS THAT ARE MISSING AND OTHERS THAT NEED CLARIFICATION AND ADDITIONAL POINTS OF ACCURACY."

"While the document is quite comprehensive, there are elements that are missing and others that need clarification and additional points of accuracy," Mitchell stated in the comments.

For clarity, she recommended, the CDC should include the term "'occupational infection and illness' where appropriate and as frequently as possible together throughout the entire document." She added that "'infection' is often associated more with healthcare-associated infection, and 'illness' is consistent with OSHA terminology."

Mitchell also suggested that a greater distinction be drawn between occupational duties such as safety and respirator fit testing, compared to employee health functions like post-exposure prophylaxis and vaccinations. The CDC should drop the use of the term "safety-engineered sharps devices" in favor of the more widely used term "sharps with injury protection (SIP)," she advised. Developed by expert stakeholders, SIP "defines devices with integral features to prevent percutaneous injuries that may cause exposure to blood, body fluids, or other potentially infectious materials," Mitchell commented.

In other comments, the American Public Health Association (APHA) reiterated the point about drawing a more discernible line between occupational health/safety and employee health. The public health group also recommended including a section on environmental controls to prevent occupational infection.

"We recommend that the guidelines include information such as high efficiency particulate air (HEPA) filtration, other ventilation, UV systems, and anterooms," the APHA commented.

The labor union group AFL-CIO emphasized that the guidelines should protect all healthcare workers, not just those typically involved in clinical care. This includes "workers who clean and maintain facilities, such as cleaners, waste haulers, and other sanitation and maintenance workers. All of these workers and their associated exposures should be included in any exposure control model that aims to reduce occupational infection and illness."

Another commenter raised the issue that because some physicians are not legally considered hospital employees, there could be confusion about whether they are expected to comply with the recommendations.

"It is important and pertinent to explicitly state that providers and physicians must be involved in all healthcare personnel occupational health and infection prevention activities," said **Julie Babyar**, RN, MPH. "Providers and physicians must be required to submit and follow all vaccination, immunization, TB, and exposure documentation," she said.

In a point relevant to expanding occupational infection prevention beyond hospitals, she said safe injections must be treated like clinical practices. "The practice of providing injections continues to be performed in many sites as part of an office day, often with HCP walk-ins at random, [and without] clinic rooms."

The comment period on the CDC draft guidelines closed Dec. 14, 2018. ■

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Employee Health Perspective of a Pregnant Nurse

CDC encourages pregnant women to get flu shot

Employee health professionals can provide education and compassionate support for pregnant nurses so they can continue working safely as they approach their due date, notes **Laura Kinsella**, BSN, RN, CEN, an ED nurse in Washington, DC.

Kinsella recently wrote[1] about the occupational hazards to the pregnant nurse, citing risks that include sick patients, infectious agents, teratogenic chemicals, and radiation. There also are risks posed by the physical demands of patient lifting and handling. Kinsella worked as an ED nurse while pregnant. *Hospital Employee Health* asked her to share her experience and perspective in the following interview.

HEH: Can you describe how you felt as a pregnant nurse? Did you have any concern about vaccinations, exposure to medical chemicals, and other potential risks?

Kinsella: I was extremely vigilant as a pregnant ER nurse. I work triage often, and in that role I interact with many acutely ill patients per day. I had a lot of concern that I would become ill — especially last winter, which was a particularly bad year for influenza. Our emergency department saw hundreds of people with influenza, so I was always extra diligent about wearing a mask and performing hand hygiene. I always wore gloves when preparing or administering medications.

HEH: Were you able to continue work during your pregnancy with a feeling of safety for your and your baby's health?

Kinsella: My situation is a little different because I had a high-risk pregnancy, but I worked in the ER until two days before I went into labor. It was tough toward the end, but I had supportive co-workers who helped me avoid some physical strain such as lifting patients or pushing heavy stretchers or hospital beds. I felt that my colleagues and I tried our best to keep me and my baby safe.

HEH: Is there anything employee health professionals can do to better reassure, educate, and support pregnant nurses?

Kinsella: I was unaware of many of the risks for pregnant nurses before becoming pregnant. I researched what I should avoid exposing myself to, and I was very diligent about protecting myself and my baby. I was lucky to have extremely supportive management who were able to help me modify my schedule later in pregnancy to work more eight-hour shifts and fewer 12-hour shifts, since those were taxing on me physically.

I did not seek out resources from my occupational health department, but it would be useful if there were some articles or guidelines available about what to avoid to be a safer pregnant nurse. Many nurses are women in their childbearing years, so it is important to support this particular nurse population as best as possible so they are willing and able to return to the workforce. Compassion, understanding, and support for the physical demands of the nursing profession on a pregnant woman's body are crucial.

HEH: Just to clarify, did you receive the seasonal flu shot when you were pregnant?

Kinsella: I absolutely received the flu shot last year, and every year.

Getting a flu shot is one of the most important ways a pregnant woman can protect herself and her baby. Infants cannot receive the flu shot until they are six months old, so they rely on passive immunity from their mothers. It is completely safe for a woman to get a flu shot while she is pregnant.

Myths and Misinformation

That last point is important to emphasize, as the CDC says some misinformation may undermine its recommendation for pregnant women to get immunized against flu this season. The CDC recently emphasized it has not issued any recommendation for pregnant women to get written consent from their doctor "if they get vaccinated at a worksite clinic, pharmacy, or other location outside of their physician's office."[2]

Erring on the side of caution, the primary caveat is that pregnant women should get a regular flu shot and not the live attenuated influenza vaccine, also known as the nasal spray vaccine.

At the annual flu press conference in 2018 at the National Foundation for Infectious Diseases, the CDC and its clinical partners made immunization of pregnant women a high priority.

Indeed, pregnant women are recommended for vaccination because they are at high risk of serious complications of flu infections, said **Laura Riley**, MD, chair of the Department of Obstetrics and Gynecology at Weill Cornell Medicine and obstetrician and gynecologist-in-chief at New York-Presbyterian/Weill Cornell Medical Center in New York City.

"Pregnant women who get the flu do very poorly," she said at the NFID press conference. "They do way worse than any other nonpregnant individual. It is absolutely critical that we prevent pregnant women from getting the flu."

Immunization can be given at any stage of pregnancy. If flu infection does occur, the later the pregnancy, the greater the danger of severe respiratory illness in the mother, said Riley, a member of the American College of Obstetricians and Gynecologists.

"In every flu epidemic, we know that as you get into the second and third trimester of pregnancy, you're more likely to die and more likely to be hospitalized," Riley said.

While the CDC is looking into outlier data that has been interpreted by some as linking repeated flu vaccination with increased miscarriage risk, the current recommendation is based on the consensus that vaccination protects the mother and fetus and confers immunity into the early months of life.

"When pregnant women get a high fever for an extended period of time, we know that fever actually causes birth defects," she said.

In addition, women who get the flu may deliver early, raising a host of issues associated with premature birth.

"Not only has ACOG and CDC been recommending it to pregnant women, we've also been trying very hard to convince providers — nurse practitioners and midwives and obstetricians, family practitioners, anyone who takes care of pregnant women — they have to be on board," Riley said.

"They have to remember to strongly recommend it to pregnant women."

Only about half of pregnant women were vaccinated in the 2017-18 flu season. The CDC and partners are pushing to achieve an "80-plus" percentage of vaccination in pregnant women this season. ■

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Don't Shoot the Messenger: HCWs Will Report Incidents in a Just Culture

The Joint Commission's alert on building a 'reporting culture'

A common theme across a variety of occupational and employee health issues is that healthcare workers may not report a given incident — leaving surveillance data underpowered and needed interventions less likely to be adopted.

To address this problem, The Joint Commission (TJC) recently issued a Sentinel Event Alert on developing a "reporting culture."[1] A key aspect of such a culture is that healthcare workers feel safe in reporting errors, incidents, injuries, and near misses. Organizations that set a more punitive tone may risk pushing these incidents underground.

"Every year, The Joint Commission receives reports from healthcare staff of unsafe conditions in their organizations," the alert states.

"The majority of these reports indicate that leadership had not been responsive to these and to other early warnings even though their response may have prevented harm events from occurring. Typically, the most serious of these reports lead to an on-site evaluation."

To improve reporting, healthcare leaders must establish a "just culture" that prioritizes system solutions over individual blame.

"Leadership must gradually change the culture so that the need to report and do something about a safety issue outweighs the fear of being punished," TJC reports. "Providing employees with the psychological safety to speak up and engage in process improvement can have a positive impact on these efforts."

The alert cites a 2018 report[2] that reveals that healthcare worker "psychological safety" is lacking in many hospitals, with 47% of respondents expressing concern that reporting unsafe conditions will be held against them.

"Fifty percent of respondents indicated that, after an event is reported, it feels like the person is being written up, not the problem," TJC notes.

"All staff must see that those making human errors will be consoled, those responsible for at-risk behaviors will be coached, and those committing reckless acts will be disciplined fairly and equitably."

Q&A

Hospital Employee Health reached out via email to TJC, which submitted the following answers to our questions.

HEH: In one example in the alert, a pharmacy tech makes a mistake with pediatric nutritional solutions and reports the error when she realizes patients are at risk. In reporting, she "trusts that her organization would fairly assess the causes of the close call and make just decisions without undue punitive action." Can you comment on how fear of retribution drives down reporting in some hospitals?

TJC: The work on patient safety began in the years following the Institute of Medicine's 1999 report *To Err is Human: Building a Safer Health System*. Prior to 1999, it was very common to punish people for committing errors. Unfortunately, our best efforts to transform into a culture of accountability vs. punishment have not resulted in the elimination of fear of reporting.

A culture of accountability is one in which organizations separate blameless errors for learning vs. blameworthy acts (such as purposely choosing to ignore policy or being reckless) for discipline. One element that persists in many environments is concern that the reporter will become the victim of retribution by those who may have been involved in the incident.

In fact, healthcare is working to reach the point where colleagues feel comfortable holding each other accountable "in the moment" rather than issuing reports into the system about unsafe or reckless acts. This fear of retribution is still a problem today, but one that is being impacted by efforts to transform cultures.

HEH: What are some of the key steps needed to build the type of culture where workers will not be afraid to report medical errors?

TJC: Leaders must pay attention to five areas that promote this culture:

- building trust;
- establishing an accountability structure;
- leveraging that trust by supporting the recognition and reporting of unsafe conditions;
- using the reporting data to build stronger systems that defend against human error;
- assessing the culture of the organization and taking action on weak areas.

Each of these areas interacts with the others, but a key element is transparency. By informing the organization about what the reports are telling them and what they are doing with that information, staff are encouraged to report.

Conversely, if leaders are close-mouthed or vague about actions taken in response to reports, staff see the information as going into a black hole, and they will stop reporting. Similarly, organizations that develop objective methods to distinguish whether human error or a reckless act caused an event or unsafe condition will demonstrate to staff that their focus is on improvement.

HEH: In addition to medical errors, there are problems with underreporting in other areas, such as needlestick injuries and acts of patient abuse or violence that too many nurses accept as "part of the job." How can the principles outlined in this alert be applied to these areas where lack of reporting is a problem?

TJC: Leadership's efforts to create a culture of trust and reporting will impact the underreporting of staff injuries as well. In becoming a "learning" organization, leadership teams now recognize that many situations are driven by system factors.

Many healthcare personnel accept and even expect that they will be injured through such things as patient violence, needlesticks, and back injuries. Sometimes staff do not report these events because they may not have been adhering to the recommended safety practices due to the pressures of the job.

For instance, if a nurse knows that it will take an additional 10 minutes to retrieve lift equipment to safely get a patient into a wheelchair but perceives a time pressure due to numerous duties, the nurse may choose to assist the patient alone rather than take the time to get the equipment. If a back injury then occurs, the nurse may fear getting in trouble.

Leadership needs to be attentive to "how the work is usually done." Staff feel forced to make unsafe choices because the systems are imperfect. One solution to this type of problem is installing lift equipment in all patient rooms.

Another example concerns needlesticks. Over the years, many companies have developed technology to reduce or eliminate the chance of a needlestick. Sometimes these devices work well, but sometimes they do not. Rather than blame staff for their own injuries, leaders must examine the equipment and determine whether something else would be more effective.

By encouraging reporting and developing trust by taking action on these reports, leaders can impact staff injuries and unsafe conditions that are caused by flawed systems. In fact, many organizations committed to zero harm include staff and visitors in that goal, not just patients. ■

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Sleep Deprivation Endangers Employee, Patient Safety

NIOSH training includes 'drowsy driving' after a long shift

Healthcare workers who work long hours and night shifts can be prone to sleep deprivation that endangers themselves and their patients, the National Institute for Occupational Safety and Health (NIOSH) reports.

To address this issue, NIOSH makes available a free online training program that can be used to educate nurses and other healthcare workers. The training takes about 3.5 hours to complete and covers the risks of sleep deprivation, providing strategies for nurses and managers, says **Claire C. Caruso**, PhD, RN, FAAN, a research health scientist at NIOSH.

"It is comprehensive and covers the issues associated with shift work, long work hours, and sleep," she says. "It talks about individual differences in people's ability to cope with these demands. It covers the theory of why this occurs in terms of sleep physiology, so people can understand why they are having these problems."

The NIOSH training explains circadian rhythms, the internal body clock that prompts sleep and awakening. The day/night cycle of

the sun is the strongest cue, meaning night shift workers are fighting against their own biologic forces to stay awake on the job.

Some hospitals are creating nap rooms to help restore exhausted workers, but they must be aware and plan for "a period of grogginess" as staff awake and prepare to return to work, she says.

"Some hospitals don't allow people to sleep on the job," Caruso says. "But as managers become more familiar with the usefulness of this, they may decide that it makes sense to allow short naps during the work shift."

Indeed, some hospitals have embraced the concept, setting up designated quiet rooms for workers to relax and nap.

"It can be like a meditation room," she says. "Some facilities have sleep coaches for night shift workers, who are associated with the most risk of sleep problems."

Make Sure Sleep Message Isn't Lost

Sleep deprivation plans also can be implemented during emergency events and natural disasters, she adds.

"A new shift, for example, can't come in because there is a snowstorm limiting the ability to drive," Caruso says. "In those cases, naps can be really helpful to restore people so they can continue working for a few hours."

The NIOSH training also includes a section on "drowsy driving," as getting home safely after a long shift is an underappreciated risk for nurses and other staff. NIOSH cites studies and surveys that found that 10% of nurses say they have been in a traffic accident related to work fatigue.

Sleep deprivation may get lost in the many issues and occupational threats of healthcare work, but it is important to keep it on the radar.

"Periodic messages from management are important, underscoring that they respect staff need to be off from work so they can sleep and recharge," Caruso says. "For example, during flu season it is really important to get enough sleep after you get the flu shot because [it boosts] antibody levels."

Daylight Saving Time changes do not faze many people, but employee health should be aware that some workers have difficulty adjusting.

"New employee orientation is a good time to communicate these messages," Caruso says. "Also, during vacation season, remind them that there is higher risk of drowsy driving because people tend to push themselves to drive longer to get to their destination."

Address Sleep Disorders, 'Healthy Sleep'

In addition to education, some healthcare programs are addressing sleep disorders in workers.

"Sleep disorders are pretty common, but they are often not treated and diagnosed," she says. "Some have a system in place to help people who seem to be having more trouble on night shift or falling asleep on the job. Try to get the assessment done by a certified sleep clinic."

In incident investigations, consider whether sleep deprivation could have played a role. For example, one study found that mandatory overtime for healthcare workers increased the risk for needlesticks and other work-related injuries, NIOSH notes.[1]

"The other thing [facilities] can do is set up an anonymous, no-blame self-reporting system for workers to report their near-misses and incidents," Caruso says.

Other contributing factors to healthy sleep include making healthy, nutritious food available on all shifts to decrease consumption of vending machine snacks. Onsite laundry and childcare also can really help night shift workers, she says.

"Build a culture of safety that, for example, shares messages on sleep wellness at every meeting," Caruso says. "There is a lot that can be done. Organizations that address this reap a lot of benefits in improving patient care, retention of nurses, and reduced stress and burnout."

The NIOSH training is available at: https://bit.ly/2A8BFkn.

REFERENCE

1. de Castro AB, Fujishiro K, Rue T, Tagalog EA, et al. Associations between work schedule characteristics and occupational injury and illness. *Int Nurs Rev* 2010;57(2):188-194.

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **In upgrading a violence prevention program, JoAnn Shea, ARNP, MS, COHN-S, found that incident reports were going into unconnected databases, with departments collecting information that was not always shared.**

   a. True
   b. False

2. **The Joint Commission suggested the CDC add a section to its draft infection prevention guidelines for healthcare workers focused on which of the following?**

   a. Hospital leadership
   b. Program management
   c. Frontline staff
   d. Volunteers

3. **Erring on the side of caution with regard to flu vaccine, the CDC said pregnant women should:**

   a. get an ultrasound before, and two weeks after, immunization.
   b. present a signed note from their physician stating that they can be vaccinated.
   c. be vaccinated as late term as possible to confer immunity to the fetus.
   d. not receive the live attenuated influenza vaccine.

4. **The Joint Commission said that to improve reporting of incidents and errors, healthcare leaders must establish an approach that prioritizes system solutions over individual blame. What term was used to describe this type of work environment?**

   a. Fail safe
   b. Just culture
   c. Root cause
   d. Trust teams

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.