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INSIDE

RELIAS MEDIA

Mandated Nurse-Patient Ratios Protect Healthcare Workers

Do benefits outweigh the costs?

By Gary Evans, Medical Writer

While nurse-patient ratios are primarily seen as a patient safety issue, studies have found that better staffing levels can reduce occupational injuries and the emotional toll of burnout.

A measure that would have mandated nurse-patient staffing ratios in Massachusetts was recently voted down, leaving California as the only state with a law.

There are ongoing efforts in other states to pass such measures; for example, the New York State Nurses Association is lobbying for a staffing law to give all patients "access to quality care."[1]

Passed in 2004, the law in California requires nurse-patient ratios from 1:1 to 1:5 depending on the unit, level of patient acuity, and other factors.

"We have seen from nursing documentation nurses [caring for] up to eight or nine patients at one time," says **Donna Kelly-Williams**, RN, president of the Massachusetts Nurses Association. "The patient is not aware that they are sharing their nurse with that many other patients."

> "THEY DON'T WANT TO CONCERN THEIR PATIENTS WITH THE FACT THAT THEY MAY HAVE TOO MANY OTHER PATIENTS TO GIVE THEM THE BEST CARE."

The nursing union led the fight for the Massachusetts staff ratio law, which was solidly defeated in a referendum in November 2018.

However, the issue is now out in the public, and more patients are aware of the risks of low staffing levels, she says.

"Nurses do a really good job as they

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are caring for their patients not to frighten them," Kelly-Williams says. "They don't want to concern their patients with the fact that they may have too many other patients to give them the best care."

In a statement after the vote, Kelly-Williams urged patients to save the distributed educational materials about nurse-patient ratios and "not be afraid to speak up for your loved ones in the hospital."[2]

Nurse Safety in California

Although patient safety often is emphasized in such efforts, nurses in California appear to have greatly benefited from the law. This effect was quantified in a study that found nursing injuries were reduced by roughly one-third in comparing data before and after the law was enacted.

"The California law was associated with 55.5 fewer occupational injuries and illnesses per 10,000 RNs per year, a value 31.6% lower than the expected rate without the law," researchers reported.[3] "The most probable reduction for LPNs was 33.6%. Analyses of confidence intervals suggest that these reductions were unlikely to be due to chance."

Other studies support the premise that staffing ratios protect nurses, says **Gerard Brogan**, RN, director of nursing practice at the California Nurses Association.

Findings include a study that showed that nurses in poorly staffed units were more likely to suffer needlesticks.[4]

Also, the stress associated with an increased patient load has been linked to burnout in one analysis of the literature on the subject. "The nurse-patient ratio is a direct determinate of the effects of psychological, mental, [and] emotional health and nurse productivity in the workplace, which also determines the patients' overall health," researchers concluded.[5]

Nurses with higher patient care duties also are at greater risk for musculoskeletal disorders.[6] Ergonomic research overall shows a direct relationship between staffing levels and these injuries, which often occur in the neck, back, and shoulder.

"We can trace the causal chain of nurse-patient ratios to the amount of patient handling, to biomechanical-exposure intensity, to back injury," says **Laura Punnett**, ScD, co-director of the Center for the Promotion of Health in the New England Workplace at the University of Massachusetts in Lowell.

In addition, Brogan cites the anecdotal evidence gleaned from interacting with the thousands of nurses he teaches each year, particularly after he shares his personal story of injuries due to lifting patients.

"It was seen by nurses, like many things, as just part of the job," he says. "We have been challenging that paradigm for the last 20 years. The main effective measure to prevent injuries is to have an adequate amount of staff."

Inadequate staffing levels also may heighten the risk of violence, Brogan adds. "I have a lot of experience as a psych nurse, and the less staff you have, the more dangerous it is," he says.

Patient Safety Data

Although it is certainly intuitive to conclude that more nursing hands on deck increases patient safety, opponents of staff ratio

mandates have argued there is a lack of evidence for this assumption. For example, authors of the aforementioned study[3] that found reduced injury rates for nurses wrote, "the evidence that legally mandated ratios improve patient outcomes — the stated purpose of the law — is very limited."

A study published before the vote in Massachusetts found that a previously adopted state staffing law requiring at least one nurse for two patients in ICUs has had "little impact" on patient outcomes.[7]

On the other hand, a study comparing California with two other states found lower staff ratios were associated with significantly lower patient mortality. "When nurses' workloads were in line with California-mandated ratios in all three states, nurses' burnout and job dissatisfaction were lower, and nurses reported consistently better quality of care," the authors concluded.[8]

Additionally, a study in the *New England Journal of Medicine* concluded that "staffing of RNs below target levels was associated with increased mortality, which reinforces the need to match staffing with patients' needs for nursing care."[9]

Proponents of the failed effort in Massachusetts made these arguments, saying more nurses mean more nursing care for hospitalized patients, Kelly-Williams says.

"The bottom line is when you are in the hospital, you are there because you need nursing care," she says. "If your nurse is not able to do all the things that they need to do, that's when we start to see problems for patients."

One of the arguments against the staffing law in Massachusetts was that there were not enough nurses in the state for hospitals to comply.

"We have the nurses, but we also have nurses who are not willing to work under the current conditions," Kelly-Williams says. "But, just as in California, if you build it, they will come. After their regulation, they had nurses flocking back to the bedside."

Gold Rush

Indeed, there has been something of a nursing gold rush in California after the staff ratio law was adopted.

> "IF YOUR NURSE IS NOT ABLE TO DO ALL THE THINGS THAT THEY NEED TO DO, THAT'S WHEN WE START TO SEE PROBLEMS FOR PATIENTS."

The law has resulted in better nurse retention and recruiting, Brogan says. There was an influx of 110,000 nurses in the first four years after the law was passed, he says.

"Those were primarily nurses within California coming back into the profession," he says. "Now nurses across the country are coming to work in California. Staff ratios are the Holy Grail for every nurse. And they always cite that as why they are coming to work here."

That enthusiasm translates to greater nurse retention as well. A 2016 report[10] on hospital turnover rates for RNs showed an annual rate of 3.2% in California. That compared favorably to the RN turnover rates in states without staff laws, such as New York (8.7%), Florida (16.2%), and Texas (21.9%). The cost of replacing a single RN is estimated at $50,000.[11]

"When you are losing nurses, that is a lot of wasted resources that could go to patient care," Kelly-Williams says. "Those like myself, who have been in nursing for more than 40 years, stay at one place for their entire career. A lot of nurses today have more flexibility, and a lot of them are 'chasing' safe staffing. We have lost nurses in Massachusetts to California because of the safe limits."

Some young nurses are leaving the profession entirely because of the stresses of working short-staffed, she says.

"After passing all those competencies and being licensed as a nurse — to be put on a unit where you are given too many patients," she says. "The response of administrators — who should be there to get you the resources you need — is 'Do the best you can.'"

This situation goes beyond stress and aggravation, as nurses may "feel quite guilty that some harm may come to a patient if they have a prolonged hospitalization," she says. "All because the nurse wasn't able get in there and do the things we know need to be done to ensure a safe recovery."

With other states considering similar laws, the defeat of the staffing initiative in Massachusetts should serve as a cautionary tale for what powers may align to defeat such measures.

Although proponents of the effort argued the cost of required staff ratios would be offset by better patient outcomes and nurse retention, the opposition successfully argued the law would hurt hospitals and possibly shutter some. Hospital groups and the state association primarily led the fight to defeat the staffing initiative, with one health

system arguing it would have to care for 21% fewer patients and hire 220 additional nurses to comply with the law.

"We would risk being fined $25,000 per violation, per day — forcing some units to close, and crippling our community hospitals," Baystate Health posted on its website.[12]

The Massachusetts Health Policy Commission released a report[13] before the vote that concluded mandated nurse staffing ratios would cost an additional $676 million to $949 million annually.

Surprisingly, even the state chapter of the American Nurses Association came out against the proposal, saying it would undermine "the flexibility and decision-making authority of nurses and [put] rigid mandates above patient safety, clinical nurse input, [and] nurse manager's discretion."[14] Moreover, the Massachusetts College of Emergency Physicians and Massachusetts Emergency Nurses Association issued a joint statement against the bill, saying mandated staffing ratios were unworkable in the ED.[15]

Given this level of opposition, the measure failed. But Kelly-Williams says the struggle in her state goes on.

"As devastating as the [outcome was] the day of the vote, I have to tell you there has been a resurgence of nurses looking for all opportunities to keep this in the forefront," she says. ■

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Failure to Report, Press Charges 'Enabling' ED Violence

ED is ground zero of violence epidemic

Healthcare workers and their employers are to some extent "enabling" an epidemic of violence by not reporting attacks and pressing charges, the president of the American College of Emergency Physicians (ACEP) warns.

"Healthcare workers tend to underreport because we are there to take care of people," **Vidor Friedman**, MD, FACEP, said recently in San Diego at the annual ACEP meeting. "We don't want to create more of a problem than already exists, but we are enabling the issue to a certain extent. It's not just healthcare workers. It is also the institutions that we work at."

Friedman spoke at a press conference about an ACEP violence survey[1] that netted responses from 3,539 emergency physicians, which represents about 11% of the group's membership.

"Among those physically assaulted, 70% of emergency physicians said that their hospital administration or security responded to the assault," the survey authors found.

The responses by hospital and security included placing a behavioral flag in the patient's chart (28%), and arresting the patient (21%).

"Among those who gave 'other' responses (42%), many indicated that the hospital's reaction was simply to remove or restrain the individual," the report states. "In some cases, the hospital responded to the assault but did nothing at all."

Hospital security pressed charges in 3% of assaults. In only 6% of assaults, the hospital administration advised the emergency physician to press charges.

"I've been assaulted three times in 30 years," Friedman said. "I know that is not a lot, but every time it happened my hospital asked me not to press charges. I don't know anywhere else people work where the institution would ask you not to press charges if you were assaulted."

This suggests that only the more severe incidents make their way into the news and public awareness, with many physicians not reporting and hospitals advising them not to press charges if they do.

Vile Threats

Friedman described a harrowing encounter with an agitated, drunken man who came in for treatment after just being released from a 10-year stint in prison.

"He was a pretty intimidating-looking guy, and he threatened to stab me," he said. "We appropriately restrained him, which only increased his agitation. The fourth time he said he was going to kill me, he said he was going to put an ice pick through my heart."

After treatment, the patient was discharged and police escorted him to the city limits. Friedman had trouble sleeping for a week. In survey results, 83% of emergency physicians said a patient has threatened to return and harm them.

"This is the kind of thing that healthcare workers are unfortunately exposed to," he said.

Patients also are exposed to violence and may be injured themselves, and the incidents prolong wait times and distract clinicians from patients who need care.

"We're not saying that every ED in America needs to have a metal detector up front, but this needs to be something that your institution takes seriously," Friedman said.

In the survey results on needed interventions, 49% of respondents said increase security; 18% said establish, communicate, and enforce clear policies; 10% said report incidents to the police; 9% said reduce public areas in the ED; and 9% said increase ED staff.

Overall, 47% of respondents said they had been physically assaulted at work, with 60% of those saying they had been attacked in the past year. *(See survey highlights, page 30.)*

"Nearly half of emergency physicians report being assaulted at some point in their careers," he said. "Almost three-quarters have personally witnessed others being assaulted."

Nearly seven in 10 say violence has increased in the past five years, with 25% reporting it has increased greatly, he added. If there is a ground zero in the national epidemic of healthcare violence, it is the ED.

"The results are quite troubling," Friedman said.

"Emergency physicians are reporting that violence in emergency departments is increasing. It's harming not only physicians and nurses but also patients and the care that is being provided."

In results by gender, 96% of

female ED physicians said they had been subjected to inappropriate comments and unwanted advances. Perhaps more surprisingly, 80% of men reported similar incidents.

A variety of physical transgressions included being spit on, punched, or kicked, with 27% reporting they were injured in the attack. This is primarily patient-to-worker violence, with 97% reporting patient assaults. In addition, 28% of assaulted workers said they were attacked by patient family members or friends.

"If you think about it, in some states and jurisdictions it is more dangerous working in the ER than being a police officer," **Leigh Vinocur**, MD, an emergency medicine physician in Belcamp, MD, said at the ACEP press conference.

ED conditions are a recipe for violence, as caregivers try to minister to patients who may be emotional and volatile, she said.

"People come in hurt," Vinocur said. "They are at their worst — frightened and vulnerable. Family members are also frightened and vulnerable, and there is stress."

In this sense, EDs face common societal problems of guns, gangs, and domestic violence, all pressurized by injuries and pain in a crowded environment.

"We have a shortage of beds, and sometimes, we are boarding psychiatric patients for days, waiting for them to get treated appropriately," she said. "It's leading to overcrowding in the emergency department."

The opioid crisis and other substance abuse issues mean that many incoming patients may be impaired and potentially violent. The survey found that 50% of respondents estimated that half of all assaults are committed by people who are seeking drugs and may be under the influence of drugs or alcohol.

ACEP VIOLENCE POLL HIGHLIGHTS ED VIOLENCE

The American College of Emergency Physicians (ACEP) recently conducted a survey[1] about workplace violence, compiling responses from more than 3,500 members. Some of the highlights of the survey findings are summarized as follows.

ACEP: Have you ever been physically assaulted or witnessed another assault while at work in the emergency department?

- Physically assaulted: 47%
- Witnessed another assault: 71%
- Neither: 10%

Note: These findings were essentially the same regardless of gender, with 48% of males and 44% of females saying that they had been assaulted.

ACEP: How many times have you been physically assaulted in the emergency department in the past year?

- None: 39%
- Once: 34%
- Two to 5 times: 24%
- Six to 10 times: 2%
- More than 10 times: 1%
- Prefer not to answer: 1%

ACEP: What was the nature of your most recent assault?

- Hit, slap: 44%
- Spit on: 30%
- Punch: 28%
- Kick: 27%
- Scratch: 17%
- Bite: 6%
- Assault with a weapon (knife, other): 2%
- Sexual assault: 1%
- Assault with a gun: 0%
- Other: 13%

ACEP: What do you think are the biggest contributing factors to violence in the emergency department?

- No adequate punitive consequence or response towards the attacker: 34%
- Behavioral health patients: 32%
- Absence of adequate protective mechanisms for physicians/staff: 15%
- Emergency department crowding: 8%
- People seeking prescription opioids: 5%
- Emergency department boarding: 2%
- Other: 4%

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"I know that firsthand," Vinocur said. She described an attack by an opioid overdose patient who flew into a rage after being administered an antidote.

Part of the problem was that a responding clinician incorrectly administered the antidote before the patient was secured, and as he quickly recovered, he became threatening and violent, she said.

"He shot up [in the bed], still a little groggy, but then started screaming and yelling that we ruined his high," she said.

The patient suddenly grabbed Vinocur by the throat and began choking her.

"I tried to grab his fingers around my throat and tried to pull them away," she said. "At one point, I couldn't talk or scream. I thought I was going to pass out. Then I felt his grip loosen. He ripped a necklace off my neck — cut my neck. That was the last time I wore jewelry on shift."

Other healthcare workers were able to assist her and restrain the patient.

"I had those strangulation marks on my neck and broken blood vessels in my eyes for a couple weeks after that," she said, comparing such situations to clinicians overseas working in war zones.

"ER physicians that are on the front lines and taking care of people are being caught in the crosshairs of violence," Vinocur said. ■

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A Sharp Rise in the 'Constantly Fearful' in the ED

A full 30% of emergency docs fear workplace violence

In a particularly disturbing finding, researchers conducting a follow-up study[1] of emergency physicians found a near sevenfold increase in those who felt "constantly fearful" at work.

In the original 2005 study[2] of emergency physicians in Michigan, only 1.2% said they were constantly fearful, said **Terry Kowalenko**, MD, FACEP, co-author of the study and an emergency physician in Rochester, MI. The 2018 study found matters had drastically worsened, with 8.1% reporting a constantly fearful state.

In addition, "21.9% reported they were 'frequently fearful,' up from 9.4% in 2005," Kowalenko said recently in San Diego at a press conference at the annual meeting of the American College of Emergency Physicians (ACEP).

Part of the nature of fear of violence is its unpredictable nature in healthcare.

"It is very difficult to predict who the perpetrator will be or who the victim will be," he said. "Every job title has violence perpetrated against them. We did find that the more time you spend with patients increases your chances of having violence perpetrated against you."

Designed as a follow-up to the 2005 research of physicians in Michigan, the study found that violence was increasing even though security measures improved.

"We know that this is an ever-growing problem, but we don't know if we are finding [the increase] because we are finally starting to report it or there really is increased incidence of these things," he said.

Physical Assaults on the Rise

Whether it is a surveillance artifact or not, the finding that 30% of emergency physicians are either frequently or constantly afraid at work adds to the accumulating evidence that there is a crisis in the ED.

"We also know that physicians are the least likely to be assaulted or threatened in the ED," he said. "Our nurse and tech colleagues are even at a higher rate than we are."

An electronic survey was sent to 1,102 emergency physicians in Michigan, and 268 (24.3%) were completed and analyzed. Respondents included 33.5% female physicians.

Comparing the results to a similar study in Michigan in 2005, the percent reporting any type of violence in the previous year (72.4%) was relatively unchanged over the 13-year period. However, those reporting a physical assault went from 28.1% to 38.1% in 2018.

Though the fear of workplace violence increased, other measures from the prior study declined. For example, those asking for a security escort to their vehicle fell from 31% in 2005 to 17.5% in 2018. Those who considered leaving the hospital after a threat of violence fell from 16% to 8.6%.

These findings may be explained

in part by increased security presence over the period.

"Between 2005 and 2018, more hospitals were reported to have security personnel that perform rounds throughout the entire hospital (53% versus 27%) and security personnel assigned to the ED (34.3% versus 24%;)," the authors noted.

In particular, the presence of armed security officers more than tripled over the period, going from 9% to 30.2% in 2018. A social media question in the most recent survey found that 6.3% of the physicians reported threats of violence online. That finding was linked to working in a large urban hospital, but the 17.9% reporting violent threats through patient satisfaction surveys represented all demographics.

"Workplace violence is still a common occurrence in the ED," Kowalenko and colleagues concluded. "Despite increased hospital security measures since 2005, emergency physicians across all demographics still experience various forms of violence, are increasingly concerned about becoming a victim of violence, and continue to take personal measures to ensure their safety."

Noting that he recently saw similar findings on ED violence in Turkey, he said, "This not just the United States — it is all over the world." ■

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'Futile' Care and a Desire to Leave Medicine

The emotional toll of end-of-life care

Providing potentially unnecessary or ineffective care for patients near the end of life can contribute to feelings of futility and burnout and a desire to leave the medical profession, researchers found.

The researchers broadly defined the condition, says **Jason Lambden**, MSPH, an MD candidate at Weill Cornell Medicine in New York City.

"We really wanted to get to the essence of the care that clinicians feel that they provide that might not be in the patient's best interest," he says. "The distinction in the literature is that 'futile care' is care that cannot possibly achieve the intended goals for a patient." Possible inappropriate care (PIC) is care that "might not" achieve the intended goals for a patient, he adds.

"Our hope in using both of these definitions was to encapsulate all the care that clinicians provide that they think might not be in the best interest of the patient," Lambden says.

To determine whether futile care/PIC is associated with measures of clinician well-being, researchers surveyed 1,794 healthcare workers at two NYC hospitals. The 349 respondents included attending physicians, residents, nurses working in intensive care, internal medicine, and a variety of specialties.

Overall, 91% of responding clinicians reported that they had provided or possibly provided futile care/PIC in the prior six months. The highest level of 95.3% was in physician trainees.

"These morally distressing experiences during the most formative years of training can lead to diminished professional identity and demoralization," the authors reported.[1]

In applying measures of wellness to those who thought they delivered futile care, the researchers found that overall, 43.4% of clinicians experienced burnout syndrome and 35.5% were thinking of leaving the profession.

Moreover, there seemed to a be a dose-effect response, with a higher perceived level of futile care/PIC linked to increased burnout and thoughts of quitting. One approach to alleviating these perceptions is improved communication between providers, patients, and family members.

"One in five Americans will receive intensive care at or near the end of life," the authors noted. "Although such care saves lives, it also has the potential to prolong the dying process and increase suffering of patients and families."

Communicate to Change Perception

Hospital Employee Health asked Lambden to provide further insight into this issue in the following

interview, which has been edited for length and clarity.

HEH: How does futile care\PIC contribute to burnout?

Lambden: It has been my experience as a medical student in the hospital that often when providers are providing care that they don't feel is appropriate for the patient's own goals and interests, it can be very distressing. Our hypothesis was that the stress that [clinicians] feel when they are providing care would be associated with measures of wellness, including burnout and having thoughts of quitting.

HEH: Was this hypothesis borne out in the study?

Lambden: Yes, in the study we measured how often clinicians feel that they have personally provided care that they believe to be either futile or potentially inappropriate. We also included screening questions for measures of wellness, including burnout and thoughts of quitting. We found a strong association between the amount of futile and inappropriate care that they feel they are providing and measures of burnout and thoughts of quitting.

There are a lot of potential confounders, including the type of job and clinicians. For example, an attending physician vs. a nurse, the department that they work in, and also the number of dying patients that they care for overall.

HEH: The overall number of those who believe they were providing this type of care was something on the order of nine out of 10 respondents. Does that speak to the high acuity of patients now?

Lambden: One of the surprises to us in the study was how many clinicians believe that they provided futile or potentially inappropriate care for their patients. We expected it to be a relatively higher number, but 91% exceeded our expectations.

I certainly do think that high-acuity patients are more likely to experience this sort of care. But regardless of whether [providers] worked in an intensive care setting or in general internal medicine, the same association between providing futile care and measures of wellness existed.

HEH: Is there something specific to futile care regarding a desire for clinicians to quit, or is that a common manifestation of burnout in general?

Lambden: I think that both are probably true. Having a desire to quit is certainly a manifestation of burnout. My own speculation on this is that clinicians want to feel good about the work they do. We take pride in the work we do. I think when we start to feel uncomfortable about the care we are providing, it takes away a lot of the satisfaction of doing the job. My suspicion is that this is the ultimate source of this desire to quit, and it is certainly associated with burnout as well.

HEH: The suggested strategies in the paper included changing the "perception" of futile care. Can you elaborate on that point?

Lambden: One of the main ways we need to change is increased communication among all providers for patients at the end of life. This includes things like having all providers present for difficult family conversations to make sure everyone is on the same page, and that there are no misunderstandings among providers.

Also, I think having a formal debriefing session after difficult conversations can be really helpful in making sure that all clinicians understand the purpose and the intention of the care they are providing.

Another way we can help clinicians is to increase the support they have for these difficult, end-of-life care issues. This can be done by creating a culture where disagreements can be respectfully discussed and having ethics consults when they are needed. ■

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Two-Thirds of EMS Workers Have Been Attacked on Job

Weapons used in 10% of incidents

Almost two-thirds of emergency medical services (EMS) workers responding to an international survey said they had been physically attacked on the job, researchers report in a recently published study.[1]

"These EMS personnel have a rate of occupational fatality comparable to firefighters and police, and a rate of nonfatal injuries that is higher than the rates for police and firefighters and much higher than the national average for all workers," the authors reported.

Underscoring the international nature of the problem, the researchers are from Australia.

"In Australia, no occupational group has a higher injury or fatality rate than EMS personnel," they wrote.

In the United States, EMS workers' risk of violence is 22-times higher than the average risk faced by all workers.

The researchers used an online survey, netting 1,778 EMS respondents from 13 countries. Fifty-five percent described their work location as "urban."

"The majority of respondents were from the U.S.," the authors stated, making the findings relevant for employee health professionals stateside.

Overall, 65% of respondents said they had been physically attacked at work.

"In almost 10% of those incidents, the perpetrator used a weapon," the researchers reported. "Approximately 90% of the perpetrators were patients, and around 5% were patient family members."

In a related development, a group called the Paramedic Chiefs of Canada (PCC) recently released a position statement saying violence against EMS workers is unacceptable.

"The PCC supports a zero-tolerance position on all forms of violence experienced by paramedics and support staff," they reported.[2] "Each day, as they perform these tasks with compassion and dedication, these same individuals are at high risk of being victims of violence and abuse."

Workplace violence experienced by EMS has been "linked to psychological injuries in the form of stress, anxiety, and PTSD," the group stated. "Further, workplace violence has been linked to decreased job satisfaction in paramedics and an intent to leave the profession in healthcare professionals."

The Canadian group said interventions are needed on several levels including the following:

- the development of evidence-based training materials on dealing with violent patients and situations that threaten EMS staff;
- raising public awareness of the human toll and financial impact of the issue;
- changes in policy and laws to discourage such attacks and follow through with punitive measures against EMS attackers. ■

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2. PCC. Paramedic Chiefs of Canada Release Position Statement on Violence to Paramedics. *Journal of Emergency Medical Services* Sept. 18, 2018. Available at: https://bit.ly/2FZQQ3Q.

OSHA Surprise Inspections on Illness and Injury Reports

Targets include hospitals with 20 or more employees

The Occupational Safety and Health Administration (OSHA) will continue unannounced inspections this year to verify that worker illness and injury reports are valid and to deter underreporting of incidents.

Effective until mid-October 2019, the OSHA Site-Specific Targeting program may trigger inspections of injury and illness electronic data submitted by employers, an employee health expert noted in a recently published article.

"Federal OSHA will be conducting comprehensive, wall-to-wall inspections, either a safety or a health inspection — or both, based on certain employers' electronic filing in 2017 of their 2016 OSHA 300A Annual Summary forms," noted Stephen A. Burt, BS, MFA, president and CEO of Healthcare Compliance Resources, an affiliate of Woods Rogers Consulting in Roanoke, VA.

"These unannounced inspections apply to hospitals and long-term care facilities with at least 20 [employees]," he added.[1]

OSHA inspections are randomly determined from target groups the agency terms "High-Rate" and "Low-Rate." According to OSHA, the random inspections are performed in part "to deter employers from failing to report their injury and illness information to avoid inspection."

State OSHA programs have until April 16, 2019, to either adopt the federal OSHA inspection plan or develop similar state policies. Employers are advised to be proactive and make sure they are submitting accurate reports to OSHA.

"As a practical matter, you should probably just do the right thing and get in compliance now so that you do not have to worry about whether your workplace is on a targeted list," Burt wrote. ■

REFERENCE

1. Burt SA. *OSHA Announces New Site-Specific Targeting Inspection Plan Based on Electronic Recordkeeping Rule Data*. AOHP E-newsletter, October 2018:8-9.

American Healthcare Worker Exposed to Ebola Discharged

At least 54 healthcare workers infected in the Congo

An American healthcare worker exposed to the Ebola virus during the ongoing outbreak in Africa was recently released from Nebraska Medical Center in Omaha.

The unidentified worker never developed Ebola but was exposed while delivering care in the ongoing outbreak in the Democratic Republic of Congo.

The patient "completed the required 21-day monitoring period and did not develop symptoms of the disease," **Ted Cieslak**, MD, infectious diseases specialist with Nebraska Medicine, said in a statement. "Because this individual was symptom-free throughout the monitoring period, it was determined they did not have Ebola and therefore were free to depart our facility and return home."

This healthcare worker arrived for monitoring at the medical center on Dec. 29, 2018. The patient was carefully isolated and monitored in an area of the facility not accessible to the public or other patients. If the patient developed Ebola, the plan was to transfer care to the Nebraska Biocontainment Unit, where three healthcare workers were treated during the 2014 outbreak in West Africa.

The current Ebola outbreak in the Congo reached 591 cases by Dec. 26, 2018. That included 543 confirmed and 48 probable cases, the World Health Organization (WHO) reports.[1]

"Of these cases, 54 were healthcare workers, of which 18 died," the WHO stated. Overall, 357 cases have died, resulting in a case fatality rate of 60%. More than 200 Ebola patients have recovered to date in the Congo outbreak. ■

REFERENCE

1. WHO. Ebola virus disease – Democratic Republic of the Congo Disease: Dec. 28, 2018. Available at: https://bit.ly/2CGWR1q.

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

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

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CE QUESTIONS

1. **A study found registered nurse injuries were reduced by how much after the California nurse-patient ratio was enacted?**

   a. 55.5%
   b. 31.6%
   c. 20.2%
   d. 13.7%

2. **Research in the *New England Journal of Medicine* concluded that staffing of RNs below target levels was associated with increased:**

   a. patient mortality.
   b. hospital infections.
   c. nursing burnout.
   d. staff turnover.

3. **In an ACEP poll of emergency physicians, 80% of male respondents said they had been subjected to inappropriate comments and unwanted advances at work.**

   a. True
   b. False

4. **An OSHA inspection program on occupational injuries and illnesses includes hospitals with how many employees?**

   a. Less than 20
   b. At least 10
   c. 20 or more
   d. At least 50

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.