HOSPITAL EMPLOYEE HEALTH

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RELIAS MEDIA

Nurse Suicides Finally Coming to Light

American Nurses Association forming task force to address issue

By Gary Evans, Medical Writer

Overcoming the historic dearth of data on a critical issue, the authors of a new study reported that nurses are at higher risk of suicide than the general population.

Researchers reported[1] that female nurse suicide rates in the United States were significantly higher than for women in general, with a rate of 11.9 per 100,000 nurses, compared to 7.5 suicides per 100,000 women in the population. Male nurse suicides are even higher, with a rate of 39.8 per 100,000, compared to 28.2 per 100,000 men in general, says lead author **Judy E. Davidson**, DNP, RN, FCCM, FAAN, nurse scientist at University of California, San Diego (UCSD).

> FEMALE NURSE SUICIDE RATES IN THE U.S. WERE SIGNIFICANTLY HIGHER THAN FOR WOMEN IN GENERAL, WITH A RATE OF 11.9 PER 100,000 NURSES, COMPARED TO 7.5 SUICIDES PER 100,000 WOMEN IN THE POPULATION.

"We had a series of [nurse] suicides here in San Diego that piqued my interest in the topic," she explains. "I went to the literature and found out there was nothing. The data I could find about nurses in the U.S. were over 20 years old. But all of that old data were speaking to the point that nurses were probably at higher risk. For some reason, we had just let this research question go silent."

The ongoing research is difficult due to the lack of a national data base that links cause of death by

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occupation and gender. Davidson is working with the National Council of State Boards of Nursing to collect as much detail as possible to continue her research.

"If I had my druthers and a magic wand, I would ask each state to report gender with their licensure workforce data at the end of every year," she says. "Every state reports how many actively licensed [nurses] they have every year. If we had the gender data to go with it, we could do a much better job."

The findings already have resulted in significant national action, with the American Nurses Association (ANA) forming a task force to specifically look at nurse suicide. Davidson was in discussions with ANA leadership on preventing nurse suicide when nurse members brought up that issue for discussion at the group's annual conference in April.

"They have asked us to collaborate with them on a task force that will start in the fall to look at suicide prevention in nursing," she says.

When asked for comment, the ANA sent *Hospital Employee Health* the following statement: "Whether it's due to demanding shift work or the stress associated with providing care on the frontlines of nearly every clinical setting, we know that depression and anxiety are common complaints among nurses," the ANA stated. "UCSD researchers' investigation of nurse suicide provides much needed and timely insights into this critical issue."

Physician suicide has been studied closer, and it is estimated that as many as 400 doctors commit suicide annually, she reports. However, the current incidence of nurse suicide in the United States has been largely undocumented, a situation Davidson first addressed in a pilot study.[2] In a recently published follow-up paper, the researchers drew data for 2014 nurse suicides from the CDC's National Violent Death Reporting System (NVDRS). The data set included all suicides reported by medical examiners from 18 states for that year. There were 14,774 suicides in the 18 states, including 205 nurses, the researchers found.

Davidson and colleagues confirmed that their pilot study data suggested nurses are at risk for suicide and experience higher rates than the general public. A larger NVDRS data analysis that will include 40 states is underway.

"We are fairly confident that what we are seeing is real," she says. "We are finishing up a longitudinal analysis. The data should be released soon — 12 years of CDC data from 2005 to 2016."

HEAR Suicide Prevention

Originally formed to address physician suicide risk, the UCSD Healer Education Assessment and Referral (HEAR) program has been expanded to include nurses.[3] The program should be considered nationally by other institutions, she says. The program includes proactive measures like reaching out to clinicians to offer voluntary mental health screening.

"They can remain completely anonymous through this encrypted system that is managed through the American Foundation for Suicide Prevention," Davidson says. "We found that usually only people who are moderate to high risk answer the survey. They know they have a problem and have been waiting for someone to reach out."

Counseling is available by phone without providing identification.

Referrals can be made to counseling outside the geographic area to avoid recognition by colleagues or friends.

"We have had no physician suicides since that program was put in place, and we have had hundreds of clinicians accept referrals for the mental health that they needed," she says. "Three years ago, we started this same program for nurses. We just extended the program and tested it, and lo and behold, we are having the same results."

The chief of nursing sends a letter asking nurses to undergo the screening as a matter of self-care. The healthcare system employs two full-time counselors in the HEAR program.

"This year, we had 40 nurses accept referrals for mental health treatment that had expressed suicidality," Davidson said. "In the meantime, the therapists don't drop them in a hole — they don't say, 'Your appointment is in six weeks.' They continue counseling them until they go to their appointment, which is the beauty of the program."

It was the recognition and response to physician suicide risk that ultimately opened the door for nursing, she adds. "It's because of physician suicide [awareness] that here at UCSD we were able to develop the first nurse suicide prevention program in the country," Davidson said.

The suicide data reveal that nurses are more likely than the general public to have sought mental health treatment.

"They are seeking treatment, but it may be inadequate if their depression was so bad that it led to suicide," she says. "It may be undertreatment, intermittent treatment, or not the right treatment. In any case, they have had more mental health access than the general population and they still completed suicide. That is a problem that needs investigation before more nurses die."

The key difference in the HEAR program may be that someone is reaching out to the nurses and offering counseling, she adds. "We nurses are stoic as people. 'Buck up and take it; the work is hard,' is the way we have always been trained," she says. "[We are] getting past that, changing the culture and getting nurses to reach out and get the treatment that they need when they really need it. This proactive approach is working, and our culture here is shifting."

Crisis Debriefings

The hospital also offers "crisis debriefings" that may include group therapy with a clinical team that has been emotionally affected by a disturbing event. "It helps them process their feelings and emotions on what it was like to have a patient die, hit us, or throw things at us," she says.

Such interventions are common in some other professions, but nurses traditionally have been expected to weather a crisis in the name of patient safety. "Why haven't we done this all along? We are exposed to negativity all the time," Davidson says. "The horrific things you witness, the connections to people who die."

Even with a system designed to ensure anonymity, it is very difficult for some nurses feeling suicidal to come forward. To self-medicate, they may develop substance abuse disorders with alcohol or drugs.

"They felt the stigma against mental health treatment was too great, and they didn't get the help they needed psychologically," Davidson says. "They turned to drugs or alcohol for their existential pain and suffering. It may be work issues or home issues, and it gets out of hand. They never get the help they need. They try to hide it, but eventually it creeps into their work and they are found out, or they get a DUI."

Once these work or legal consequences arise, a nurse's license to practice may be in jeopardy. "My personal recommendation is that we need to do more about making the nursing response to nurse substance-use disorder nonpunitive," she says. "We need to develop systems like the physicians have in place to caringly refer affected nurses into treatment, without losing their license, so that they can come back into the workforce once they are rehabilitated. Substance use disorder is a disease, and needs to be treated like one."

Lethal Knowledge

In the 2014 CDC data, pharmacologic poisoning was the most common method of suicide among nurses. However, nurses were more likely to use drugs at home than divert them from work to commit suicide.

"That signals to me — and we won't know until we analyze the data from the longitudinal study — that the reason is usually not about access to drugs at work," she says. "Instead, it may be because of an understanding of how to kill yourself with drugs. It's the knowledge of how to use drugs in a lethal manner."

The suicide prevention project reveals that nurse-reported stressors are roughly equal between work and home. "But the stressors from work are all modifiable," she says. "Things like orienting your staff completely and thoroughly, making sure they

feel welcome in the environment, and not alone when they move from another state or another organization. Loneliness and feeling separated are big risks."

Nurse bullying, which has almost been viewed as a rite of passage in a culture that "eats its young," can inflict psychological harm. "That can lead to depression, and depression can lead to suicide," she says. "We need to actively address the bullying in our environment. Some of the bullying is from work compression. If people feel like rats in a cage, spinning the wheel and getting nowhere, they will act like rats in a cage."

Other modifiable factors in healthcare include reactionary rules and policies that were enacted in haste but become entrenched. Some practices that began with a single physician preference, warning from the health department, or a warning from an accreditation agency are never revisited, becoming sacred cows that add layers of unnecessary work.

"On any given day, we are overregulated as a profession, with policies and rules that don't have evidence behind them," she said. "Doing that hard work of stripping out these [unneeded] policies is a suicide prevention technique." ■

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Violence Prevention Begins With Culture of Respect

Security personnel incur more injuries

When a surgeon was shot and killed by a patient at a nearby hospital in 2015, clinicians at the University of Massachusetts Memorial Health Care in Worcester overhauled its comprehensive violence prevention program.

The incident that shook the Boston area medical community was the murder of a popular and highly skilled surgeon at Brigham and Women's Hospital by a relative of a deceased patient. *(For more information, see the January 2017 issue of* Hospital Employee Health*.)*

"When that happened, it really caused a lot of concern because it was just down the street from us. A violence prevention task force was created," said **Maria Michas**, MD, MPH, FACOEM, medical director of employee health at UMass. Michas chairs the task force, and updated the program recently in Anaheim, CA, at the annual meeting of the American College of Occupational and Environmental Medicine (ACOEM).

"There was a lot of work being done in silos, but this was an effort to really bring together the key stakeholders who had a direct interest or were already working on projects in violence prevention," she said.

In addition to reviewing and updating policies and procedures on workplace violence, UMass created an interdisciplinary rapid response team.

"If a situation is escalating, we can quickly call in this team to help with violent patients in the emergency department or on the [hospital] floors," she said.

It is no easy task to ensure rapid response to all units and shifts 24/7, she notes. The many challenges of violence prevention are reflected in the size of the task force, which includes representatives from numerous departments and several subgroups.

For example, a policy subgroup reviews and updates plans in such areas as patient visitation, restraint, searches of visitors and patients, and domestic violence leave of absence for employees. A subcommittee on procedures routinely monitors security measures; for example, assessing the metal detectors, which were added to the ED in 2017.

"We have close contact with the police if a handgun, drugs, or things like that are found," Michas said. "We also have panic buttons, and there is a procedure for asking for one in your department if you need another one."

The task force also is evaluating wearable devices that can be used to sound an alarm and send a GPS location signal. "We are looking at other technology," she said. "If a patient is standing between you and

the panic button, it is not going to do you any good."

Security staff conduct routine walkthroughs every shift, responding to loitering and suspicious behavior or situations. "They are looking for things like secured doors, any suspicious packages, or people in the areas," Michas said. "The managers of the units are really tasked with making sure all of the security equipment is working in their areas; making sure their card readers, cameras, and alarms are working."

In addition to training staff in recognizing and responding to violent threats, the task force created work-culture Standards of Respect with the input of employees.

"This came about because our caregivers and employees' recognition that a more respectful culture was needed based on incidents of disrespect they were experiencing or witnessing," she said. "If people are feeling disrespected, they are more likely to leave your organization. Increased stress could also lead to absenteeism and decreased productivity."

In a 2016 survey, employees identified behaviors that help them, patients, and families feel respected and supported, she said. The resulting standards have become an organizational priority, with required employee participation in a series of workshops. About half of the hospital employees have received the training. As described by Michas, the standards of respect adopted at UMass are summarized as follows.

- **Acknowledge:** Notice others and recognize their concerns;
- **Listen:** Give full attention;
- **Communicate:** Share appropriate information with those who need it;
- **Respond:** Respond in the expected time frame;
- **Team player:** Work in a way that helps colleagues;
- **Kindness:** Be kind, friendly, and patient — even when it is not easy.

"Unfortunately, people don't always behave this way," she said. "There is a lot of roleplaying in the classes so that you can learn and practice these behaviors. It is a little too early to tell if this is making a difference in our facility, but it is leading to more reports of bullying and other incidents. It is going to be interesting down the road when the entire organization gets trained."

> NATIONAL HOSPITAL WORKPLACE VIOLENCE REPORTS ARE APPROXIMATELY SIX INCIDENTS PER 1,000 EMPLOYEES ANNUALLY.

The violence prevention program at UMass encourages reporting of "near misses," Michas added. "If you see something, say something," she said. "Don't wait until there is an actual assault. If you see aggressive behavior going on with a patient or co-worker, you need to report it."

Incidents are tracked and updated at a daily safety briefing.

"That is not just the employee health service on these calls, but it is across the institution," she said.

Security Staff Injuries

Another study presented at the ACOEM meeting revealed a high rate of injuries in security personnel responding to violent incidents in the ED, reported **Khaula Khatlani**, MBBS, MSc, a resident in the Yale School of Medicine.

National hospital workplace violence reports are approximately six incidents per 1,000 employees annually, she tells *Hospital Employee Health*. "That rate was for the overall hospitals," Khatlani says. "As we looked at only the emergency department setting, we are expecting a higher rate. It turned out to be way higher. We were interested in looking at different job categories to see if the injury rates differed."

Researchers reviewed 107 workplace violence injuries reported in the ED between Oct. 1, 2015, and May 18, 2017. They found a rate of 31 per 1,000 ED employees, she says, noting that studies of workplace violence traditionally do not include security personnel.

"Security personnel had a much higher rate," Khatlani says. "They actually [comprise] only 6% of the total work force in the emergency department. However, 20% of them reported workplace violence injuries."

That compares to 6% of the nurses and ED techs reporting workplace violence injuries for the period. A longitudinal follow-up study over a longer period is underway to assess injuries in the ED and the reporting of job categories.

"We looked at all the injuries that were being reported in an association with aggression," she says. "These data are based on physical violence that resulted in injuries. The other aspect is verbal abuse, which was not captured in this database because that is not being actively reported."

Injuries included in the report resulted from slaps, kicks, punches, spitting, and biting. "There was one injury where the employee had a fractured nose because he was hit in

the face by a patient who was about 10 years old," she says.

The inclusion of security personnel in violent injury data may make Yale a comparative outlier to studies of clinicians only, but it highlights an important area of occupational risk. "If we excluded them, we would expect the overall injury rate to go down," Khatlani says. "However, we feel that the ED is a setting where people are frequently combative and aggressive. They are coming in with substance abuse disorders and somebody needs to calm them down. Usually, it is the security personnel — the [healthcare workers] taking care of an aggressive patient call them for help."

To recognize and defuse potentially violent patients, Yale is using the Brøset Violence Checklist developed by researchers in Norway.[1] The tool is used in patient observation, noting patient signs and symptoms that include confused, irritable, verbal, and physical threats, and attacking objects. The more symptoms the patient manifests, the greater the likelihood of violence. Similarly, as they are reduced or not expressed, the patient is considered less potentially violent. ■

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Measles Woes Lead to Pushback Against Antivaxxers

A single case can lead to laborious follow-up

For employee health professionals, discovery of an undiagnosed measles case sitting in the ED typically sets off a mad scramble to track exposures and ensure healthcare worker immunity.

The antivaccine movement has greatly aggravated this situation, but the tide of public opinion may be turning.

As a record number of measles cases have spread to 30 states, science is starting to win the "vaccine wars," said **Paul Offit**, MD, director of the Vaccine Education Center and an infectious disease physician at Children's Hospital of Philadelphia.

"Frankly, it is hard to make a case that vaccines are evil in the midst of epidemics," he said recently in Philadelphia at the annual meeting of the Association for Professionals in Infection Control and Epidemiology (APIC).

As of Aug. 29, 2019, there have been 1,234 measles cases this year in the United States, the CDC reports.[1] That is the most cases since 1992, and makes a distant memory of the announcement in 2000 that measles had been eradicated in the United States — an accomplishment that was primarily due to childhood vaccinations.

Measles resurgence coincides with parents citing unsafe vaccines in declining to have their children immunized. However, there is a growing pushback against the antivaccine movement, with herd immunity threatened and the real risk of measles to immunocompromised patients and those who cannot receive immunizations.

"These outbreaks — as awful as they are, as children have once again suffered a disease that is completely preventable — we are reaping some good from this," Offit said. "Society is finally standing up for itself."

In addition to several states acting to remove exemptions to childhood vaccines, there has been an accumulation of studies thoroughly debunking the claim that the measles, mumps, rubella (MMR) vaccine causes autism. One of the most recent studies was published this year, with researchers who examined 650,000 children in Denmark concluding that there is no link between vaccination and autism.[2]

"When you isolate the effect of that one variable — receipt of the MMR vaccine — there was no greater risk of developing autism if you got the vaccine or if you did not," Offit said. "There are 18 studies now that have looked at that hypothesis. I would argue that this is one of the most tested hypotheses in the history of medicine. MMR vaccine does not cause autism."

Thimerosal Bungle

At times, public health attempts to accommodate and reassure those concerned about vaccines have been poorly handled, Offit said. For example, in the 1990s, attention turned to thimerosal, a preservative primarily used to prevent bacterial and fungal contamination of multidose vials of vaccine. To err on the side of caution, public health

officials urged manufacturers to remove thimerosal from vaccines, even though it posed no established threat, said Offit, who was on the CDC's Advisory Committee on Immunization Practices (ACIP) at the time.

"This was done the wrong way," he said. "We removed thimerosal in a precipitous and frightening manner."

The CDC announcement of the move said there was no evidence the mercury levels in thimerosal in vaccines were harmful. Pharmaceutical companies were urged to remove it "to make safe vaccines even safer," he noted.

"If it is not unsafe, then taking it out doesn't make it safe," Offit said. "It only makes it perceived to be safe, which is a very different thing. We scared people the way that we did this. We somehow felt that a tenet of risk communication was the compulsion to describe all theoretical risk, and it was done wrongly. In any case, because that was done, it really gave birth to several antivaccine groups."

Hospital Employee Health asked another national vaccine expert and longtime member of ACIP to weigh in on the thimerosal decision. "It continues to be debated as to how wise or unwise that decision was," says **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University.

The antivaccine movement saw the move in part as some kind of a concession, saying "they wouldn't have done that unless there was a reason for it," Schaffner recalls.

"The reason for it was to provide some calm," he said. "[With the thinking being] we will henceforth make single doses without preservatives and that should keep everybody happy, even though it wasn't a problem before. I think that remains an unresolved conundrum."

While the science now is undisputed in the medical community regarding the MMR vaccine and autism, many in the antivaccine movement likely will hold to their beliefs and suspicions, he added.

"There has been a certain turnaround in public sentiment, but it's not as though this group of people involved has suddenly changed their minds and every parent is bringing in their unimmunized children," Schaffner said. "I think there will continue to be people who wish to exercise their 'freedom' or options and withhold their children from vaccination, science be darned."

After a widely publicized measles outbreak at Disneyland, California passed a law in 2015 eliminating personal or philosophical beliefs as an exemption to childhood vaccinations for school attendance. With West Virginia and Mississippi, that resulted in three states with medical exemptions only. Several other states are considering or in the process of taking similar action to close loopholes to childhood immunizations.

"This is really dramatically different from where we were in the early 1980s," Offit said. ■

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A Risk Management Look at Employee Trips and Falls

Teach the 10-foot circle of safety

Falls, slips, and trips were the second most common event leading to workplace injuries and illnesses in hospitals, according to a report[1] from the U.S. Bureau of Labor Statistics, accounting for 25% of all reported employee injuries. Overexertion and bodily reaction, including injuries from lifting or moving patients, was the most common type of injury.

Addressing fall prevention with employees is different than with patients, says **Bette McNee**, RN, NHA, clinical risk management consultant at insurance broker Graham Company in Philadelphia. With patients, fall prevention focuses mostly on transfers from beds and wheelchairs, as well as environmental factors, she says. Employee slips and falls tend to be the top workers' compensation claim in both frequency and severity, she says.

Addressing employee fall prevention starts with the low-hanging fruit, like flooring materials, mats, footwear policies, and snow and ice removal, she says. Employee health professionals also should look at what makes the hospital

environment dangerous for workers — including the potential blinders of an intense focus on their duties.

"Healthcare employees typically are so focused on their work — nurses walking around, reading a medication label or looking at a patient chart — that they can lack the safety mindfulness you might hope for. Their attention on the one task keeps them from seeing everything going on around them," McNee says. "When they are focused so intently on the patient, they don't tend to see the cords at the bedside or the wheelchair legs that have been removed and left on the floor."

Encourage employees to think of a 10-foot circle of safety around them, she says. They do not necessarily have to be aware of everything in the room, but they should keep an eye out for hazards within this circle surrounding them. This encourages a situational awareness with a limited scope, which can be more realistic for someone highly focused and multitasking than simply telling them to watch for hazards, she explains.

"They are constantly told that everything is a top priority and they have to pay such close attention, so it can be hard to tell them to watch out for hazards on the floor, too," she says. "But if you keep it to that 10-foot circle of safety around them, that can be more attainable. You also build interdependence when your circle of safety overlaps with your co-workers'."

An aging workforce also increases fall risk, McNee says, as well as health issues such as obesity. Hospitals have addressed these issues successfully with wellness programs, she says.

Even in an organization in which patient falls are treated with the utmost seriousness and no excuse is acceptable, employee falls may be seen sometimes as an isolated event, McNee says. For example, if a nurse is rushing to a code call and trips on a trash can, supervisors may dismiss it as an accident.

"They tend to treat it as a very unfortunate one-off accident, treat her, and get her back to work," she says. "They don't look at the situation as something that happens because of the laser focus they have on their duties, and how the environment should be tailored to accommodate that."

Hospitals can begin addressing employee falls by assessing fall reports to identify trends, says **Meaghan Crawley**, MSN, RN, CEN, trauma injury prevention/outreach coordinator at Spectrum Health Butterworth Hospital in Grand Rapids, MI. Are there any common environmental factors such as wet floors or obstructions? Are the falls occurring on a particular hallway or in any one unit?

"It's a root-cause analysis to find out why you have falls on this one hallway and with this one job code. You're finding out what the risk is and why it is occurring," Crawley says. "You may find that there is a broken pipe leaking water on the floor, in which case you can not only get the pipe fixed but also provide the staff a card that has a number for them to call if they see the leak again."

Employee safety is a top priority at Butterworth Hospital. Falls and other safety incidents are included in the daily reports to hospital leaders.

"The data are where you can find out what kind of problems you're having at your own hospital, and how much those falls are costing your organization," she says. "It all affects the care you provide to patients as well. If employees are not healthy and don't feel safe when they come to work, they can't provide the best care possible."

A common mistake is to implement fall prevention tactics without first looking at the data, says **Farheen S. Khan**, PhD, director of the Human Factors Division for the Rimkus Consulting Group in Atlanta.

Also, remember that solutions might not have to be facilitywide, she says. It is possible that environmental changes, such as new flooring, or policy changes, such as required footwear, might apply only to particular units. That can make implementation easier and less costly, Khan says.

"Falls among employees don't get written up as much in the literature, but it is a problem recognized by OSHA and the Bureau of Labor Statistics," Khan says.

Hospitals can encourage the same kind of tailored fall prevention with nurses as with patients, suggests **Christine Ninchich**, clinical specialist with Medline in Northfield, IL.

Patient fall prevention techniques are designed for the patient's unique needs, and a similar approach can be used for nurses, Ninchich says. Nurses working in certain patient environments can be reminded that they face greater trip-and-fall hazards than in other areas and should exercise more care, she says.

"If I am working in a patient room that has dozens of cords and tubes, lots of equipment around, I need to be more aware of that and move more carefully," she says. "The nurse needs to be more deliberate about movement in that kind of environment, more so than might be necessary in a typical patient room or other area." ■

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Griefwork: The Experience of Loss in Healthcare

Encourage grief support resources as part of worker health

When a patient dies, healthcare workers may experience grief that they barely acknowledge because they know their role is to move on to the next patient. But over time, such grief can build up and contribute to stress and burnout.

There are different dimensions of burnout, including the state in which someone becomes "detached" and is no longer able to communicate in a normal, personable way. This is known as depersonalization, says **Jennifer Gray**, PhD, MPP, associate professor of public health in the School of Health Studies at Northern Illinois University.

Younger staff in particular might need mentorship opportunities that discuss grief and bereavement. Without support and some training, they might lack skills that help them cope with losing patients, Gray says.

A focus on handling grief and patients' deaths should be part of any healthcare organization, but it is especially important in nursing homes and other settings where staff will lose many patients to death, she adds.

Healthcare organizations can help their staff cope with grief and prevent workplace burnout by ensuring policies acknowledge the emotional needs of staff. This could include allowing staff time off to attend patient funerals or memorial services. "Give them time to attend a service so they do not have to use one of their vacation days," Gray says. Employees who spent a lot of time with the deceased patient and are having difficulty with their grief might need a few days off, she adds.

One simple change is to provide staff with as-needed resources, such as grief support and counseling. Sometimes, a healthcare professional grieving over a patient's death can be helped by co-worker support. Organizations can encourage this natural support network by teaching staff a few skills in communication and listening.

THERE ARE DIFFERENT DIMENSIONS OF BURNOUT, INCLUDING THE STATE IN WHICH SOMEONE BECOMES "DETACHED" AND IS NO LONGER ABLE TO COMMUNICATE IN A NORMAL, PERSONABLE WAY.

"Gauge whether that person needs more time, and be a good listener," suggests **Eboni Green**, RN, PhD, co-founder of Caregiver Support Services in Omaha. "Let that person express sadness."

Co-workers who show major changes in mood and attitude could be in pain and do not know how to tell anyone about it. Ask them what is going on, she suggests. "Ask, 'Why are you so angry?' And then it will start flooding out," Green says. "It's not that these are not loving and kind people; it's just that there is a compiling of these losses."

An organization can help encourage staff grief support by providing an in-house memorial service for recently deceased patients. "It would be good if they offer it at least annually," Green says.

Self-care for healthcare workers might include taking breaks during the work day, practicing mindfulness or meditation, deep breathing, listening to relaxing music, exercising, eating well, and getting enough sleep.

"You have to learn how to establish good emotional boundaries so you're not taking so much of the emotional overload on yourself," Gray says. "You need to separate yourself emotionally from that patient's life and have your own life that you go back to at the end of the day."

One way to view this is to think of emotional well-being as a bank. Stress reduction activities increase the emotional bank funds. But when a patient dies or some other stressor occurs, the emotional bank dips, Gray explains.

"As a healthcare professional, you are drawing on those emotional resources to support people who might not be emotionally stable themselves," she says. "What kind of tools do you have in your toolkit that can help you put money into your own emotional bank?"

Healthcare leaders might view adding grief resources as yet another task that they do not have time to perform. They are focused on mandated training requirements and finding time for all of those, Gray notes.

"Trying to fit in grief and

bereavement as a training topic can be challenging," she says. "But it's also in some cases raising awareness that the emotional health of staff and families is really important. The organization needs to put resources into that if they want to do well as an organization and be successful on all fronts." ■

Employee Health and Emerging Infections

Ebola spreading in Africa, MERS simmers in Middle East

The CDC is stepping up efforts to fight Ebola in Africa, deploying more personnel and resources to stop an expanding yearlong outbreak in the Democratic Republic of Congo (DRC).

The World Health Organization (WHO) recently declared an international health emergency in the DRC after an Ebola case appeared July 14 in Goma, a city of 2 million people that has connecting flights to global air travel. As of Aug. 2, there were four cases in Goma, but the WHO vaccinated more than 1,300 contacts and had stopped transmission in the city as this report was filed.

"Right now, we have about 15 people on the ground in the DRC and in Goma responding to the outbreak," **Henry Walke**, MD, MPH, director of the CDC Division of Preparedness and Emerging Infections, said at a recent press conference. "We plan on doubling that number of responders in the next month and maintaining a presence in Goma, [DRC capital] Kinshasa, and perhaps in other large, urban areas to prepare for the spread of the outbreak."

As of Aug. 18, 2,888 Ebola cases were reported, including 1,938 deaths for a morality rate of 67%. Cases continue to be reported among health workers, with the number infected rising to 153 (5% of all confirmed and probable cases).[1] Of the healthcare workers infected, unverified reports indicate at least 40 have died of Ebola. No infections or deaths have been reported in deployed CDC personnel.

The CDC activated its emergency response in June, allowing the agency to provide more resources and fast-track its response. As of July 31, more than 200 CDC personnel have been deployed in the area, Walke said.

"There are no cases of Ebola in the United States," he emphasized. "At this time, we believe the risk to the U.S. from the current Ebola outbreak in DRC remains low, based on the travel volume."

There are no direct flights between the DRC and the United States. Fewer than 16,000 people a year travel to the United States from DRC, he said.

"However, risk of spread from DRC into neighboring countries is high," Walke said. "The CDC is coordinating with health officials in DRC, Uganda, Rwanda, and South Sudan."

Civil unrest and armed conflict in the DRC has made it difficult to contain the outbreak, which is spreading, even though an apparently effective experimental Ebola vaccine has been deployed. "Ongoing violence, community distrust, and other unprecedented problems have complicated the public health response," Walke said.

The Ebola response also has been undermined by people wary of the vaccine and the intensive questioning and follow-up after detection of a case. "In terms of trust from the community, it is not only related to vaccine," he said. "It is also related to basic public health measures, which include case identification, early isolation, and then monitoring the contacts of that case."

In the classic "ring" strategy used against smallpox, the idea is to vaccinate contacts of cases and go out another layer and vaccinate the contacts of those contacts. "As we try to implement contact tracing and identify people who need vaccination — it's a very mobile population," he said.

As previously reported, healthcare workers in the DRC are receiving the experimental Ebola vaccine, but the efficacy of immunization was unclear as this report was filed. The vaccine demonstrated high efficacy in one trial,[2] but is now being used on an unprecedented scale.

The vaccine appears to be effective at preventing Ebola deaths, **Anthony Fauci**, MD, director of the NIH National Institute of Allergy and Infectious Diseases, said at the CDC press conference.

"Certainly, there have been infections among individuals who have been vaccinated," Fauci said. "The potential benefit of the vaccine is that in those who were vaccinated and did get infected, the mortality rate is extremely low. In fact, I don't think any of them who have died were vaccinated."

The NIH is conducting a clinical trial[3] to vaccinate adult volunteers, including deploying healthcare workers and other responders, against Ebola. The study sites include the NIH and Emory University.

Another established threat to healthcare workers is Middle East Respiratory Syndrome (MERS) coronavirus. Although it has not been sustained in other countries following introductions and outbreaks, MERS has established an endemic presence in the Kingdom of Saudi Arabia since it emerged in 2012, the WHO reported.[4]

As of June 30, there have been 2,449 laboratory-confirmed cases of MERS reported, with 84% in Saudi Arabia and the rest in 27 other countries, including the United States. There have been 845 MERS deaths, a mortality rate of 35%. MERS is a zoonotic virus that has established a reservoir in camels on the Arabian Peninsula.

"Limited, nonsustained human-to-human transmission mainly in healthcare settings continues to occur, primarily in Saudi Arabia," the WHO reported. "The risk of exported cases to areas outside of the Middle East due to travel remains significant."

While there has been community transmission, MERS is a particular threat to spread in healthcare settings.

"[T]ransmission in healthcare settings is believed to have occurred before adequate infection prevention and control procedures were applied and cases were isolated," according to the WHO report. "Investigations at the time of the outbreaks indicate that aerosolizing procedures conducted in crowded emergency departments or medical wards with suboptimal infection prevention and control measures in place resulted in human-to-human transmission and environmental contamination."

Since the last WHO update of June 30, 2018, 52 of the 97 secondary cases reported were associated with transmission in healthcare facilities. These cases included 23 healthcare workers. Patient infections occurred in those sharing rooms or wards with MERS patients, and some visitors also were infected.

"Although not unexpected, these transmission events continue to be deeply concerning, given that MERS is still a relatively rare disease about which medical personnel in healthcare facilities have low awareness," the WHO concluded.

Globally, awareness of MERS is generally low and cases may be missed due to the nonspecific initial symptoms. "With improved compliance in infection prevention and control, namely adherence to the standard precautions at all times, human-to-human transmission in healthcare facilities can be reduced and possibly eliminated with additional use of transmission-based precautions," the WHO noted.

A recently published analysis[5] of a MERS cluster in a women's dormitory in Riyadh, Saudi Arabia, confirmed that 19 infections occurred there in 2015. "Our study highlights the potential role of healthcare workers not responsible for direct patient care (e.g., hospital cleaners) in the spread of MERS," the authors concluded. "Often, hospital cleaning staff may be from other countries, may speak several languages, and may be missed by efforts to increase infection prevention and control specific to MERS." ■

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COMING IN FUTURE MONTHS

- Why are needlesticks still occurring?
- Policies for employees colonized with a multidrug-resistant pathogen
- NIOSH update on the safe use of PAPR respirators
- Avoiding an employee vaccination lawsuit claiming religious discrimination

HOSPITAL EMPLOYEE HEALTH

CE INSTRUCTIONS

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CE QUESTIONS

1. **According to Judy E. Davidson, DNP, RN, MCCM FAAN, female nurse suicide rates:**

   a. exceed the suicide rate in male nurses.
   b. are driven primarily by nonwork factors.
   c. are significantly higher than suicide rates in women in general.
   d. are strongly linked to drug diversion in healthcare.

2. **Khaula Khatlani, MD, MSc, a resident in the Yale School of Medicine, said 20% of violent injuries in the ED were reported by:**

   a. physicians.
   b. security staff.
   c. EMTs.
   d. nurses.

3. **Paul Offit, MD, said which vaccine issue was handled by public health officials in a "frightening manner?"**

   a. The removal of thimerosal
   b. An initial concession that some cases of autism could be linked to immunizations
   c. Changes to the childhood immunization schedule
   d. A public relations campaign that depicted vaccinations as a "risk worth taking"

4. **Anthony Fauci, MD, said an experimental Ebola vaccine administered to healthcare workers is most effective:**

   a. at preventing infection.
   b. if followed by a booster shot at six months.
   c. at allowing clinicians to work without fear.
   d. at preventing mortality.

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 healthcare 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.