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INSIDE

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From Relias

Time for Change: Violence Is Not Part of the Job in Healthcare

'The healthcare as an industry is really taking a stand'

By Gary Evans, Medical Writer

"I had a patient break through the nurse's station window and attempt to harm staff. He threw a computer at me and put hands on my co-worker. He missed me, but it was terrifying. I had dreams about it for a few weeks."

This chilling description is from an emergency department nurse participating in a recently published study that collected subjective, firsthand comments about healthcare violence,[1] which has been going on so long that the cliché "it's part of the job" remains a prevalent mindset.

"We wanted to primarily take a qualitative approach," says lead author **Lauren Querin**, MD, MPH, an emergency physician at UNC Medical Center in Chapel Hill. "Showing the numbers is one thing, but describing the experiences and the emotions involved makes it more [real]. A lot of us have conversations about these things, and just showing the numbers doesn't really get to the experience that our team has on a daily basis."

> WILL THE ROUTINE ACCEPTANCE OF VIOLENCE IN HEALTHCARE — MOST OF IT INFLICTED BY PATIENTS AND VISITORS ON STAFF — FINALLY BE CALLED TO ACCOUNT?

Although the pandemic is being bitterly fought in some areas, the efficacy of the vaccines foretells an eventual ending and aftermath that could include many changes to the healthcare system. Will the routine acceptance of violence in healthcare —

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most of it inflicted by patients and visitors on staff — finally be called to account?

"I think there is a lot of room for growth and change," Querin says. "People are more receptive to these kinds of things. Now is the time to rethink the ways to prevent violence as we start rebuilding our systems."

Healthcare workers (HCWs) worked without sufficient personal protective equipment (PPE) during the pandemic. There also is no official count of how many HCWs died from the virus. Thus, it is hard to argue with the contention that HCWs are viewed as expendable. *(For more information, see the April 2021 issue of* Hospital Employee Health.*)* Failing to address violent attacks would only compound this view. That said, preventing violence in healthcare is a complicated problem that requires multifaceted programs. These programs should include clear definitions, education, and a user-friendly incident reporting system. These are some of the new "elements of performance" requirements for violence prevention by The Joint Commission (TJC), effective Jan. 1, 2022. *(For more information, see related story in this issue.)*

To address an inevitable question, anecdotal accounts indicate the pandemic reduced violence in healthcare in 2020, due in part to widespread reductions in elective procedures and bans or limitations on visitors and family. Visitors are the cause of about 10%-20% of violence in healthcare, says **Susan Scott**, PhD, RN, CPPS, FAAN, a nurse scientist and violence researcher at University of Missouri Health Care.

"We haven't looked at our data yet, so this is just gut instinct," she says. "During the pandemic, many times we had limited visitors or no visitation at all. Just the sheer decrease in volume of people coming to visit the patient I'm sure has some kind of impact. They can get aggressive with the staff if they don't like something that they see. They respond very emotionally, and many times physically, to the staff members."

78% Assaulted in One Year

Querin's research was based on a survey of ED personnel conducted during November and December 2019. They also solicited the aforementioned narratives from residents, attending physicians, and nurses about their experiences of abuse and violence. The researchers collected 123 responses, a rate of 46%.

Among all HCWs in the ED, 78% reported violent assault within the prior 12 months. In addition, 70% of respondents reported "multiple" incidents of verbal assault in the period. Verbal assault can quickly escalate into physical assault.

"A patient was verbally assaulting," an emergency nurse reported in the survey. "After many minutes of being yelled at, the patient hit me and swung at another nurse, demanding IV pain medicine, then proceeding to scream that this was our fault, and threatening to kill us and our families."[1]

Some residents expressed fear for personal safety while rounding in a poorly designed psychiatric triage unit. The unit was narrow, and the door locked behind them upon entry.

"Any time I go into the psych triage area, I feel unsafe," a resident noted on the survey. "Once I am in there, there is no easy way to escape if I need to. And no way for others to get in easily."

Another resident said "a patient became upset related to narcotics and threatened to kill staff. He was escorted out but only to the hospital front door. He was waiting in the ambulance bay when I got off work at 2 a.m. I had to quickly get back inside and call hospital police."

Overall, 63% of respondents reported feeling unsafe. Nearly half said they had been asked to do something that made them feel physically or emotionally uncomfortable, Querin reported.

"On a daily basis, I was going in to evaluate individuals who were making a lot of comments that were kind of scary, in small spaces without a lot backup and security," Querin said. "We have made some changes in our emergency department. EDs around the nation are also working on these kinds of things."

As part of the changes, the psychiatric triage unit was completely redesigned, a safety committee was formed, and a better incident reporting system was implemented. The latter action was because, as has been widely observed, HCWs often do not report a violent incident because they feel nothing will be done about it. Only 20% of survey respondents said they filed an incident report. There is a sense of futility that sets in, contributing to burnout.

"Workplace violence is, unfortunately, part of the job," a nurse indicated on the survey. "It's concerning that charges can be filed against a healthcare professional for too much force, but nothing can be done when a patient punches, kicks, bites, scratches, pulls hair, or generally assaults you. I'm not here to get beaten up. This culture needs to change before a nurse gets killed by a patient."

That comment was made before the improvements had begun. It looks like the new system will be needed to protect workers as patient volume rises again.

"The volumes more recently have picked up significantly," Querin says. "Our psych population is getting heavier. We are seeing a lot of sick patients who have been experiencing COVID. I don't know if the violence has increased, but we are definitely seeing a lot more volume and a lot more frustration."

Peer Support

A violent incident can have a ripple effect, going beyond the HCW who is attacked to affect those who bear witness to the event. These so-called "second victims," as well as the actual victim, can experience debilitating emotional systems that can be mitigated by peer support programs, a recent paper by Scott and colleagues at the University of Missouri showed.[2]

Originally, such programs were designed to aid HCWs after the death of a patient. But it became clear some time ago the same symptoms were seen in staff who suffered or witnessed violence against colleagues.

"The common element is that healthcare workers are emotionally traumatized by the experiences, often reacting with an acute stress reaction with physiologic responses and accompanying confusion, anxiety, grief, shame, guilt, and feelings of inadequacy," Scott and colleagues reported.[2]

Between 2009 and 2019, the UM program documented 834 peer support interventions, 75 (9%) related to workplace violence. These included 57 one-on-one encounters and 18 group support sessions. In 2018-2019, the Missouri team experienced an increase in workplace violence, doubling to 20% of peer support team activations.

"My colleagues and I had a sense that violence was increasing in 2018," Scott says. "The Joint Commission sent out a Sentinel Alert for healthcare facilities that April. That May, we really started full-fledged effort on what can we do to tackle this problem head-on. Peer support is not a [direct] antidote for workplace violence, but we have another group that is working on all kinds of mitigation factors to prevent violence."

The ability to pause and process the moment with a trusted peer or co-worker has been proven through many research projects as an effective tool in the hospital's arsenal for helping ensure their staff members' psychological safety, Scott explains. Peers usually are experienced workers who have dealt with many personality types and possess a natural sense of empathy.

"They are individuals who, when everything breaks loose in the unit, they're the steadfast, strong person," Scott says. "We take peers with these interpersonal skills and with experience in the healthcare environment and then train them on working with individuals in crisis as well as offering them appropriate resources throughout the institution and even the local community."

Sometimes, it is the victim of an attack who receives the peer support. Other times, a wider group of those involved and who witnessed the incident meet as a group.

"It could be four, five, six people from one emergency department who were all [involved in] the same case," she says. "[It] is actually fairly helpful for the group to get together and talk about that lived experience and gain insights from each other's

perspectives. It strengthens them for the next encounter."

In general, there are three outcomes for an HCW involved in a violent event, Scott explains.

"They could thrive, where they take the event and learn from it, and provide insights into how to make it better," she says. "All of that is kind of healing and cathartic in a way for the caregiver. [They don't want] the next patient or the next staff member to fall prey to the same issue that they suffered from."

The second outcome is "surviving," meaning the clinician continues to work but never returns to their pre-event baseline performance level.

"Many of them tell me that they do just enough to get the job done, but they don't want to be vulnerable," Scott says. "It's like presenteeism. You go to work with a cold or a headache and you're not quite there, but you're doing your job. That's what a survivor looks like."

The third outcome is the "dropouts," when workers leave their chosen medical field after a violent incident.

"That might be a nurse going from the emergency department to newborn nursery care, or it could be a clinical pharmacist who goes to pharmaceutical sales," Scott says. "It could be a surgeon who goes from being the top clinical performer at the institution to doing bench research. The dropouts are the ones that I worry about, because those are the ones that if they would get support, then maybe we could have saved them to work in the jobs that they truly had passion for."

The three classifications — thriving, surviving, and dropouts — do not necessarily predict the eventual success of that person's professional career, she adds.

A case study in the paper describes a nurse who was a victim of attempted strangulation in a post-anesthesia care unit. The nurse was performing an assessment when the patient grabbed a pulse oximeter cord and began choking her. A second nurse helped break the patient's grip, but the victim had marks around her neck and clearly was shaken. The peer intervention team counseled and assisted her. Initially, she seemed to recover from the attack.

"We're lucky she did so well, but she questioned just being a nurse in orthopedics. She had been in surgery for a long time, and that was kind of the tipping point for her," Scott says. "She actually left the facility and went to another hospital, though we had given her a lot of support in the aftermath of that event. However, within two years, the nurse returned, realizing she wasn't getting that kind of support at the other facility."

Historically, HCWs have performed their jobs and withstood the comments and physical attacks.

"For a long time, we've kind of accepted that kind of thing — the spitting, the violence that we've encountered," Scott says. "Now, healthcare as an industry is really taking a stand. We need to treat each individual with respect, and there's no room in healthcare for that kind of either verbal assault or physical aggression." ■

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The Joint Commission's New Violence Prevention Requirements

'I believe that change is inevitable'

The Joint Commission (TJC) has issued new hospital violence prevention requirements that call for an annual workplace risk assessment, formation of a safety committee, an incident reporting system, and staff education. The requirements will take effect in January 2022.

TJC has posted a compendium document of resources to help enact these new requirements, which were added as elements of performance under existing standards.[1]

"The Joint Commission is one of several organizations and associations who have made a commitment to safety in the workplace," says **Antigone Kokalias**, MBA, MSN, RN, TJC project director. "[We have] taken the position of formally defining workplace violence to lend guidance to hospitals in increasing the awareness and the understanding of what workplace violence is. The new and revised workplace violence prevention requirements provide guidance for developing, implementing, and sustaining effective workplace violence prevention systems that not only decrease workplace violence, but also promote a culture of safety."

Hospital Employee Health spoke to Kokalias about the new requirements in the following interview, which has been lightly edited for length and clarity.

HEH: Healthcare workers put their lives on the line during the pandemic, which also has spurred calls for changes in healthcare. Is this an opportunity to end the perception of violence as a part of the job?

Kokalias: I do not believe many could argue the commitment healthcare workers have to the care they give. This was [certainly] emphasized during the pandemic. With the challenges that the COVID-19 pandemic has brought to the field of healthcare, I believe that change is inevitable. What we want and hope to see is that the change is meaningful and sustainable. What better place to begin than by assessing your organization's commitment to staff safety?

The pandemic does present an opportunity to place a spotlight on violence in the workplace. What is important to remember is that we have an obligation to make this opportunity count. There are a few things we can do, new approaches we can take. A critical first step would be to concentrate efforts on understanding what workplace violence is and increasing awareness. This will help set a solid foundation for other important elements, one being staying informed of both the prevalence of workplace violence as well as the organizations' progress on their journey to a safe environment. Another important element is the utilization of tools and resources available to assist organizations in a workplace violence prevention program.

HEH: What are some of the first things accreditation surveyors might ask when assessing a facility's violence prevention program? For example, should a hospital show documentation of its annual worksite analysis "to identify and resolve workplace violence, safety, and security risks"?

Kokalias: It is important to acknowledge organizations are faced with different challenges. We hope to provide organizations with the flexibility to develop a program that reflects [their] needs. The new requirements will [necessitate] accompanying documentation for the accreditation survey. An example of this would be the annual worksite analysis. Documentation will assist in supporting the conversation on how the organization has utilized the results of their annual worksite analysis to identify and resolve any actual or potential incidents or security risks. Understanding the process from identification of incidents to mitigation, and through the follow-up is important, especially when evaluating the effectiveness of the program. In addition, a proactive worksite analysis can help ensure the organization is examining the entire process and not just individual incidents.

HEH: The elements of performance include "verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors." Why did TJC define violence so broadly?

Kokalias: Many organizations have identified workplace violence, but one nationally recognized definition does not exist. We hope to see this as a step forward in that direction. A great deal of thought went into developing both the

definition and the requirements. We conducted a literature review, consulted with key stakeholders and experts in workplace violence prevention, and examined legislation across the country to understand the challenges organizations are facing and identify best practices. The definition is not intended to be all-encompassing. Defining workplace violence is a starting point for understanding the breadth of incidents that organizations should consider when developing a workplace violence prevention program.

Another critical element in workplace violence prevention programs is training and education. Both are important in creating awareness, and in establishing, implementing, and evaluating processes, which include reporting. The program is expected to be led by a designated individual and developed by a multidisciplinary team who are responsible to report incidents to the governing body.

HEH: A recurrent problem is these incidents go unreported by healthcare workers. How can these requirements change that through education and requiring that "the hospital monitors, reports, and investigates safety and security incidents, including those related to workplace violence"?

Kokalias: There could be many reasons why incidents go unreported. We first have to go back to what I originally talked about, which is identifying what workplace violence is and the importance of increasing awareness. There may be instances when individuals may not realize the situation they are in, or the incidents that have occurred could be workplace violence-related, which would be missed opportunities for reporting. Easy and accessible reporting systems can have an impact on the number of incidents that are reported. If the reporting system is complicated, the individuals affected may determine that the effort involved in submitting a report is too cumbersome. Employees also might struggle with whether they should report an incident, weigh the chances that actions will be taken to mitigate or resolve the situation as well as concerns of possible retaliation. This all falls under the umbrella of an organization's safety culture and their commitment to zero harm.

Editor's Note: TJC welcomes comments and feedback sent to: workplaceviolence@jointcommission.org on the compendium referenced below. More violence prevention resources are available at: https://bit.ly/2VeXegD. ■

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Clinicians at Johns Hopkins Create Artful Collaboration

Poetry and music to mark a year of pandemic

Among many other things, music is a way to process pain. Such was the birth of the blues. In a similar vein, poetry has been seen as healing and therapeutic for ages. Music and poetry together can speak to the human spirit, even when it is beaten down by a relentless pandemic. At Johns Hopkins Hospital, two colleagues created a collaboration that forged the two arts into a message of resilience and hope.

First, meet the guitar player, **Brian Garibaldi**, MD, a pulmonologist who has cared for many COVID-19 patients as medical director of the Johns Hopkins Biocontainment Unit.

"For me personally, music has been my primary source of release over the last 15 months, other than the time I get to spend with my family," he says. "Particularly early on in the pandemic, our unit was the first to be activated by our hospital for COVID patients. We are one of 10 federally funded biocontainment units."

The Hopkins unit was activated for Ebola in 2014. With so little known about SARS-CoV-2, it was opened again for the early U.S. patients.

"When we first activated, I moved out of my house because of the uncertainty of taking care of these patients. Also, we were so busy I was basically living at the hospital anyway," he says. "I moved across the street to a hotel the hospital has a relationship with. I took my computer and my guitar."

Playing the guitar is a way for Garibaldi to decompress. "You can ask my wife," he says. "She'll know if I haven't played in a few days because I'm just a little bit more on edge."

Pre-pandemic, he kept the guitar in his office and would sometimes take it to visit patients, particularly if they were musicians. "I could not do that during COVID," he says.

"I don't think my guitar would hold up to the industrial [cleaning] products we use when you come out of a COVID unit. I did have the opportunity to play for my incident command team back in the early days [of the pandemic]. They were working ridiculous hours and there was a lot of stress."

He played a combination of original music and some instrumental cover songs that included Pink Floyd and the Allman Brothers.

Sometime later, when vaccines were becoming available, **Robin Lewis-Cherry**, RN, a nurse manager at Johns Hopkins, wrote a poem about the pandemic that addressed both the great loss and the resilient rise to overcome it.

"Robin was a nurse on the unit where I first worked as a medical student, and then during my internship that was my home unit," Garibaldi says. "Robin and I have known each other for 20 years. When she shared her poem at a nursing leadership meeting, I think the hospital at that point was really looking for things to lift people's spirits. I loved her poem and they said, 'Wouldn't it be great if we could set this to music?' I had a few things I had been working on during the pandemic, and this was sort of the opportunity to finish one of those and use it as the background music to Robin's awesome poem. It was an honor to be asked to do that."

Lewis-Cherry's father was a published poet. She has been writing for years.

"I usually only write for special occasions and when inspiration hits," she says. "When the inspiration struck in March 2021, leadership was talking about how we could commemorate all that we had gone through in the past year. COVID, in my opinion, interfered with every level of your life — every part of your life. With the vaccine coming about, I thought about the pandemic possibly coming to an end. I thought about what we had lost over the past year."

That thought is encapsulated in the opening lines of the poem:

"When the dust settles/What will we see?/For many, just empty spaces/ Where loved ones used to be."[1]

The loss was profound for so many colleagues, but Lewis-Cherry shifted the tone of the poem to ask whether little things, gestures, and simple acts could be fully appreciated again.

"Will we appreciate being able to see someone smile? You can't do that though a mask," she says. "And to be with your loved ones, your family, your friends, having a meal together or having a simple hug. I think a lot of that we had taken for granted before the pandemic hit."

During the pandemic, Johns Hopkins has emphasized that leaders look out for their teams, point them to available resources, and encourage them to take time off.

"I read [the poem] to my staff because of everything they went through," Lewis-Cherry says. "I dedicated it to them because it was a very challenging year. They showed up and they did their best."

The poem's larger message addresses the striking divisions seen when an election year and a pandemic coincide. "I wanted to be hopeful that a lot of things that have driven us apart as a people and nation, maybe that could be put aside," she says. "We could realize that we are all human and we all have the same needs and feelings. We are more alike than not alike. To rally in that and to know that as a human race we can be resilient — we've proven that over the centuries. But we have to want that."

In concluding the poem, she invokes the image of the phoenix — a mythological bird that is consumed by flame but always rises from the ashes.

"The one thing this has shown us/ And this is without a doubt/How resilient, strong, and determined/ We have been throughout./And so as we see an ending to all this grief and pain/May we rise from the ashes like the Phoenix/And let humanity reign." ■

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Delta Variant a Game-Changer for COVID-19 Vaccine Mandates

Highly transmissible mutation causing more than 80% of infections

With the delta variant now causing 80% of COVID-19 cases in the United States, vaccine mandates for healthcare workers have become a foregone conclusion. At a recent press conference, the CDC recommended the vaccinated return to wearing masks indoors because of the variant.

First seen in India, delta represents several iterations of viral evolution and is much more transmissible and possibly more virulent than the original SARS-CoV-2. Some treatments are not as effective against the strain, but the vaccines generally are efficacious, with some expected breakthrough infections. The hospital and death numbers are astounding among the unvaccinated, who are causing another surge, even though more than half the nation is vaccinated.

As has been said of highly transmissible measles, an airborne infectious virus can hit a susceptible population like a lit match on a tinder box. "We're mandating vaccines for [Veterans Health Facility] employees because it's the best way to keep veterans safe, especially as the delta variant spreads across the country," **Denis McDonough**, secretary of the department of Veterans Affairs, said in a July 26 statement.[1]

Recently, four unvaccinated VA employees died from the delta variant. "There has also been an outbreak among unvaccinated employees and trainees at a VA Law Enforcement Training Center, the third such outbreak during the pandemic," McDonough noted.

A law professor at Georgetown University (who predicted lawsuits against hospitals mandating the COVID-19 vaccine would fail) says it is time to move ahead with healthcare worker immunizations as a condition of employment. "Vaccine mandates in hospitals and for other businesses are entirely lawful and ethical, even under an emergency use authorization," says **Lawrence Gostin**, JD.

> "VACCINE MANDATES IN HOSPITALS AND FOR OTHER BUSINESSES ARE ENTIRELY LAWFUL AND ETHICAL, EVEN UNDER AN EMERGENCY USE AUTHORIZATION."

Of course, hospitals have long required vaccines for many diseases because healthcare workers have a "special responsibility" to protect staff and patients, he notes. Mandates have shown to significantly increase vaccination coverage.

"As COVID is spiking again, it is time for most hospitals to require vaccinations," Gostin says. "Most infectious disease experts and organizations have called for mandates. They are urgent, and we shouldn't wait until full FDA licensure."

Indeed, it is becoming difficult to find a major medical group that is not calling for mandates, with the American College of Surgeons, the American Medical Association, American Nursing Association, and the American Academy of Pediatrics recently joining the chorus.

These prestigious organizations were among more than 50 signatories to a joint letter calling "for all healthcare and long-term care employers to require their employees to be vaccinated against COVID-19. We stand with the growing number of experts and institutions that support the requirement for universal vaccination of health workers."[2]

The nation's leading infectious disease groups issued a joint paper recommending COVID-19 vaccination as a condition of employment for healthcare workers, with limited exemptions.[3] The broad consensus adds considerable momentum to the mandate movement. It appears to be only a matter of time before universal COVID-19 immunization of employees will be the standard across healthcare, particularly if the FDA lifts the emergency use authorization on the vaccines, as expected.

This consensus statement was issued by the Society for Healthcare Epidemiology of America, the Society for Post-Acute and Long-Term Care Medicine, the Association for Professionals in Infection Control and Epidemiology, the HIV Medicine Association, the Infectious Diseases Society of America, the Pediatric Infectious Diseases Society, and the Society of Infectious Diseases Pharmacists.

"The bottom line is that we, as a group of societies, feel that this is the right thing to do for our

communities, patients, and healthcare providers," statement lead author **David Weber**, MD, said at a press conference. "We have a precedent for doing this for other [occupational] diseases. We believe the benefits of the vaccine for our healthcare providers far outweigh any possible harm, and we strongly endorse this statement."

Weber also said the rapidly emerging delta variant underscores the importance of vaccinating healthcare workers and the public.

"It is much more transmissible and has a higher risk of hospitalization," he said. "The most rapid spread is occurring in those states with the highest percentage of unvaccinated people. There [are] good data that the mRNA vaccines continue to provide protection against hospitalizations, but a little less protection against illness. This is the time to be pushing vaccination to the general public and our healthcare providers as well."

The group did not specify the methods of establishing mandatory programs, but said it is time to start outlining COVID-19 vaccination requirements while both talking and listening to healthcare workers.

On the legal questions of mandating a vaccine that is approved under emergency use, "an individual has a right to refuse vaccination, but has no right to a particular job," the statement authors noted. "We still are early in the process, but this 'condition of work' approach has been approved in at least one court ruling. A key is allowing for specific exemptions to vaccination for medical and religious reasons. ... A medical exemption is based on contraindications and precautions set forth by the manufacturer or CDC and usually requires review and signature by a medical professional. While not a contraindication, healthcare facilities may wish to allow pregnant [healthcare workers] to postpone receipt of the vaccine until post-delivery. … Pregnant and lactating HCP (healthcare personnel) should be allowed to receive a vaccine because, as noted by the CDC, 'pregnant and recently pregnant people are more likely to get severely ill from COVID-19 compared to non-pregnant people.'"[3]

For religious exemption requests, employers could use a form allowing objectors to detail their sincerely held beliefs and practices, the panel suggested. "While affiliation with a traditionally organized religion may be evidence to support a claim of a sincerely held religious belief, the lack of such an affiliation cannot be the basis for rejecting an exemption request." ■

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COVID-19 No Worse Than Flu? Tell It to the 600,000 Dead

Many might recall that early in the outbreak, pandemic denialists — who continue to this day — frequently said COVID-19 was no worse than seasonal influenza. More than 600,000 Americans would beg to differ, if they could speak.

As part of an argument for healthcare workers to take the vaccine, a physician noted in a recently published paper the mortality rate for influenza is estimated to be 1 in 1,000, whereas for SARS-CoV-2 is closer to 1 in 100 to 250.[1]

"We need merely review the large bump in national death rates and decrease in life expectancy last year compared to prior years to appreciate that SARS-CoV-2 is more deadly than influenza," says **Michael Klompas**, MD, a professor of population medicine at Harvard Medical School.

Trying to keep it simple, Klompas and authors listed eight reasons healthcare workers should be mandated to receive a COVID-19 vaccine as a condition of employment. The rapidly spreading delta variant was not one of them, but Klompas says such mutations make the other reasons for mandates that much more compelling.

"Variants sharpen all the issues associated with COVID and the rationale in favor of vaccination because they increase the likelihood that one will get infected and then pass on infection to patients and colleagues," Klompas says. "The vaccines, fortunately, appear to be protective against infection with variants and highly protective against severe disease."

Klompas and colleagues noted "up to two-thirds of cases of SARS-CoV-2 infection are attributable to asymptomatic and presymptomatic transmissions."[1]

"The high fraction of transmissions that are attributable to people without symptoms at the time means that you cannot rely on symptom screening to identify the patients or colleagues who might be infectious," Klompas says. "Vaccine provides protection against infection during all interactions, regardless of people's symptoms. Same applies to the healthcare worker as a potential source of infection. Just because I'm feeling fine, it doesn't mean that I may not be contagious and at risk of infecting my patients or colleagues. Vaccination helps diminish this risk."

Another reason healthcare workers should be required to take the vaccine is medical workers are critical for healthcare delivery, and the vaccines are safe and effective.

"Despite the enormous number of people who have now received SARS-CoV-2 vaccines, serious side effects have been exceedingly rare," Klompas and colleagues concluded. "We acknowledge that some life-threating adverse effects and deaths have occurred, but the incidence of these complications is vanishingly small, is substantially lower than the risk for complications of COVID-19, and is far outweighed, in our opinion, by the likelihood of benefit to both healthcare workers and their patients." ■

REFERENCE

1. Klompas M, Pearson M, Morris C. Ideas and Opinion. The case for mandating COVID-19 vaccines for health care workers. *Ann Intern Med* 2021 Jul 13;M21-2366. doi: 10.7326/M21-2366. [Online ahead of print].

OSHA Extends Comment Period, but Does Not Delay Emergency Temporary Standard

After receiving numerous comments requesting the action, the Occupational Safety and Health Administration (OSHA) extended the comment period for its COVID-19 healthcare emergency temporary standard (ETS) to Aug. 20.

"OSHA is extending the comment period by 30 days to allow stakeholders additional time to review the ETS and collect information and data necessary for comment," the agency announced.[1] However, as of press time, OSHA had not granted multiple requests to delay the ETS for six months.

Comments can be submitted electronically for Docket No. OSHA-2020-0004 via the Federal eRulemaking Portal at www.regulations.gov. Follow the online instructions

OSHA's ETS to protect healthcare workers from COVID-19 became effective upon publication in the

Federal Register on June 21.[2] Employers must comply with most provisions within 14 days, but can take up to 30 days for requirements involving physical barriers, ventilation, and training. The ETS is in effect for six months, and OSHA requested comments on whether it should become a final rule after that period.

The American Hospital Association (AHA), representing about 5,000 facilities, requested the six-month delay, saying "changes in hospital policies and procedures are not simply a matter of changing words on paper; they require careful analysis and planning, the acquisition of needed materials and tools, and the retraining of personnel. For organizations that are already busy caring for their communities' ill and injured, it will take time to accomplish all of these required changes."[2]

The AHA cited ETS requirements that could increase risk, including barrier requirements that could impede airflow.

"Our members also are unsure how they will implement the provisions in the mini respiratory protection standard that permit employees who are not required to wear respirators to bring their own into the hospital," the AHA stated. "Moreover, this provision will allow employers to provide respirators to employees who are not required to wear them, and without the benefit of fit testing, medical evaluation, or a written program. Many of our members have noted that these requirements, which contradict OSHA's own PPE [personal protective equipment] and respiratory protection standards, raise huge liability exposures for the employer and put these employees at additional risk."[2]

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 14,500 nonprofit and proprietary skilled nursing facilities and skilled assisted living communities.

"Long-term care has been hit extremely hard by this pandemic and continues to confront substantial staffing challenges," the AHCA/NCAL said. "While many of these standards are already in place in our provider's communities, some of the new standards require a level of resources that many centers do not currently have available and will take extended time to fully implement. For example, designating a COVID-19 workplace safety coordinator is challenging for small or independent facilities with limited resources staffing-wise as well as financially due to census impacts from COVID-19."

> "FOR ORGANIZATIONS THAT ARE ALREADY BUSY CARING FOR THEIR COMMUNITIES' ILL AND INJURED, IT WILL TAKE TIME TO ACCOMPLISH ALL OF THESE REQUIRED CHANGES."

Designed to protect healthcare workers from COVID-19, the bulk of the ETS could be woefully out of date if mandated vaccination policies lead to immunizing virtually the entire hospital workforce against the virus.

"I hope there is an understanding that when you get people vaccinated some of these ETS requirements are not going to make sense," says **Connie Steed**, MSN, RN, CIC, director of infection prevention and control at Prisma Health in Greenville, SC.

OSHA requires hospitals and other facilities under the regulation to "provide reasonable time and paid leave for vaccinations and vaccine side effects." Beyond that, for the most part, those who are vaccinated must follow the OSHA regulations as if they were not immunized.

"I didn't see anywhere in the standard where they say it is OK not to mask if you are vaccinated in a hospital," Steed says. "I think people are asking the question, and what [OSHA] is saying is, 'If you have a controlled area in the hospital where you know there is not going to be anyone with COVID — and you know everybody is vaccinated — you can take off a mask."

Meeting those requirements without mandating staff vaccinations will be problematic. "It's going to be hard. I think this pushes employers to require the vaccine," Steed says, noting she is not in favor of the ETS being finalized as written currently.

While pointing out that approximately one-quarter of healthcare workers have not yet completed COVID-19 vaccination, OSHA left the door open for revisions as the pandemic continues and more people are vaccinated. ■

REFERENCES

1. Occupational Safety and Health Administration. OSHA extends comment period for COVID-19 healthcare emergency temporary standard. July 8, 2021. https://bit.ly/3ydZfZa
2. American Hospital Association. AHA requests more time for hospitals navigating OSHA's COVID-19 emergency temporary standards. June 29, 2021. https://bit.ly/3lbDbL0

HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **In a survey of emergency department workers, 70% of respondents reported multiple incidents of:**

   a. physical assaults.
   b. spitting patients.
   c. verbal assaults.
   d. patients blocking exits.

2. **The Occupational Safety and Health Administration decided to:**

   a. reopen rulemaking on violence prevention in healthcare.
   b. expand its COVID-19 Emergency Temporary Standard (ETS) to address respiratory pathogens in general.
   c. delay the ETS for six months.
   d. extend the comment period on the ETS by 30 days.

3. **Some treatments are not as effective against the COVID-19 delta variant, but the vaccines are generally efficacious with some expected:**

   a. deaths.
   b. blood clot cases.
   c. infections with live viral vaccines.
   d. breakthrough infections.

4. **According to Susan Scott, PhD, RN, which is not one of the three outcomes for a healthcare worker involved in a violent event?**

   a. Thriving
   b. Thoughts of revenge
   c. Surviving
   d. Dropout

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.