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In a flash, Congress kills ergo legislation, ending decade of OSHA action

Rules are gone along with ergonomics imperative

In the first-ever use of a law that allows congressional review of new federal regulations, Congress rescinded the far-reaching ergonomics standard released late last year by the U.S. Occupational Safety and Health Administration (OSHA).

The resolution to repeal the Clinton administration workplace rules was quickly signed by President Bush, who said the rule "would have cost both large and small employers billions of dollars and presented employers with overwhelming compliance challenges."

Gone are controversial provisions that would have given workers with musculoskeletal disorders (MSDs) a different workers' compensation protection and provided for second and third medical opinions on work restrictions. Yet employee health professionals also lost a significant tool to make ergonomics a priority for injury prevention in hospitals.

"I don't know what it means for the future of ergonomics and the safety of the employee in the workplace," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, AOHP, executive president and employee health nurse practitioner at Sewickley (PA) Valley Hospital. "There were some good portions of the standard, yet there were areas of significant concern."

Advocates for health care workers decried the congressional action. "What the Congress did . . . is really a tragedy for health care workers," says **Bill Borwegen**, MPH, occupational health and safety

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COMING IN FUTURE ISSUES

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- Environmental hazards: Another side of employee health
- Do lift teams really work to prevent injury?
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- Another report cautions against artificial nails

director of the Service Employees International Union in Washington, DC. "It's really shameful that a 10-year effort can be eliminated in a 10-hour congressional debate."

Meanwhile, the Bush administration is reviewing the record-keeping and bloodborne pathogens standards, along with other regulations promulgated during former President Clinton's last days in office. Since the bloodborne pathogens standard stems from a law passed unanimously by Congress, employee health experts don't expect it to be impacted. However, revisions could be made to the record-keeping rule, which is due to become effective Jan. 1, 2002.

Opposition nearly constant to OSHA rule

The final blow to OSHA's ergonomics regulation ended a decade-long effort to address musculoskeletal injuries, the most common injury in health care. Workers report about 1.8 million work-related MSDs each year, 600,000 of which involve lost work. More than 18,000 hospital workers suffered an injury from overexertion due to lifting in 1998, according to the Bureau of Labor Statistics.

Yet industry opposition to ergonomics regulation had been almost constant since rulemaking began, including several congressional efforts to quash it. **(See timetable, p. 51.)** After issuing its proposed standard in 1999, OSHA received more than 7,000 written comments and heard from nearly 700 witnesses at four public hearings. But rather than resolve some of the concerns raised in hearings, the final rule drew fresh criticism.

As soon as OSHA issued the standard in November, opponents filed lawsuits seeking to overturn it. The American Hospital Association (AHA) was among the organizations asserting that the rule wasn't scientifically based and OSHA had greatly underestimated the expense of complying.

In January, a National Academy of Sciences panel released a report stating that certain workplace factors clearly had been linked to MSDs and ergonomic interventions would lessen the risk of injury. But that support of the ergonomics standard paled in comparison to the brewing political opposition.

The National Association of Manufacturers, the U.S. Chamber of Commerce, and major employers such as UPS branded the ergonomics standard as a danger to U.S. business and heavily lobbied Congress to intervene.

Calling the standard "overly prescriptive," **Rick Pollack**, AHA executive vice president, wrote the Senate sponsor of the Joint Resolution of Disapproval, Sen. Don Nickles (R-OK). "This new onerous, unreasonable, and unnecessary regulation will do little to further protect America's hospital caregivers. Only a mutual commitment between organizations and workers will achieve that goal," Pollack stated.

Meanwhile, the Bush administration issued a statement through the Office of Management and Budget supporting the congressional resolution to overturn the standard. "If implemented, [the ergonomics rules] would require employers to establish burdensome and costly new systems intended to track, prevent, and provide compensation for an extremely broad class of injuries whose cause is subject to considerable debate," the statement said.

The joint resolution passed the House by a 223-206 vote and the Senate in a 56-44 vote.

Injury prevention still requires ergonomics

So what happens now with ergonomics? The incentive to provide lift equipment and preventive programs remains the same as it has for years: reducing the cost and disability that results from back injuries and other MSDs.

Gruden notes that some states require employers that are self-insured for workers' compensation to have an injury prevention program. Ergonomics would be a part of that, and the overturned standard still provides a framework for evaluating and addressing MSDs, she says.

"We can still use [some aspects of the standard] as guidelines in approaching the whole issue of ergonomics in the workplace," she says.

In fact, with the high cost of these disabling injuries and the tight labor market, hospitals have plenty of incentive to reduce MSDs, says **Geoff Kelafant**, MD, MSPH, FACOEM, medical director of the occupational health department at the Sarah Bush Lincoln Health Center in Mattoon, IL. He is also vice chairman and communications chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine (ACOEM) in Arlington Heights, IL.

The ACOEM had withdrawn support for the final rule, which did not require a medical diagnosis of work-related MSDs. Instead, the rule provided a checklist for employers to determine if an MSD was work-related.

Chronology of OSHA Ergonomics

1979: OSHA hires its first ergonomist.

1986: OSHA begins a pilot program on reducing back injuries through analyzing injury records, training, and job redesign. Six months later, OSHA requests information from general industry on reducing back injuries resulting from manual lifting.

1987: OSHA cites automobile plants for ergonomic hazards.

1990: Labor Secretary Elizabeth Dole promises action on ergonomics and stresses the need to eliminate musculoskletal disorder (MSD) hazards. OSHA creates an Office of Ergonomics Support. OSHA also publishes ergonomics guidelines for the meatpacking industry.

1992: OSHA issues an Advance Notice of Proposed Rulemaking and requests comments.

1995: OSHA begins drafting an ergonomics standard. Congress prohibits use of fiscal year 1995 and 1996 funds to issue a proposed or final ergonomics standard or guidelines.

1997: Congress allows OSHA to work on ergonomics in fiscal year 1998 but prohibits issuance of any proposed or final standard or guidelines. A House conference report says this will be the last time OSHA's work on an ergonomics standard is restricted.

1998: OSHA holds "stakeholder" meetings on ergonomics rulemaking.

1999: OSHA publishes its proposed ergonomics standard in the *Federal Register*.

2000: OSHA holds five sets of public hearings on the proposed standard. President Clinton vowed to veto an appropriations bill that contained language barring OSHA from spending funds to complete or implement an ergonomics standard. A final standard is released Nov. 14. Opponents of the standard immediately file lawsuits to overturn the standard.

2001: A National Academy of Sciences panel issues a report citing scientific evidence for certain types of work-related MSDs and positive outcomes from ergonomic interventions. The ergonomics standard becomes effective Jan. 16, two days before Clinton leaves office. In March, the House and the Senate approve a Joint Resolution of Disapproval that overturns the ergonomics standard. President Bush signs repeal March 20.

"I think it's a perfect example of how things that are very well-intentioned go awry," Kelafant says. "Somebody needed to step in and just stop the whole thing."

New provisions appeared in the final version that had never been released for comment, Kelafant notes. For example, the standard provided for as many as three different clinical opinions on temporary work restrictions. "This is an example of something that had very little to do with science or medicine or the health of individual workers," he says of the standard as a whole. "It had everything to do with politics."

Can ergo regulation be revived?

Workers and their advocates expressed little hope that efforts to mandate ergonomics could be revived. The Congressional Review Act prohibits agencies from promulgating the same or similar regulations once one has been rescinded.

Labor Secretary **Elaine Chao** sought to soften that stance by promising to "pursue a comprehensive approach to ergonomics, which may include new rulemaking, that addresses the concerns levied against the current standard."

"This approach will provide employers with achievable measures that protect their employees before injuries occur," she said in a letter to key senators before the vote. "Repetitive stress injuries in the workplace are an important problem. I recognize this critical challenge and want you to understand that the safety and health of our nation's work force will always be a priority during my tenure as secretary."

Borwegen dismissed those comments as "political cover" for Republicans who were hesitant to vote against worker protections.

Gary Orr, PE, CPE, an ergonomist who helped draft the standard, also says it is unlikely OSHA could draft a standard that would overcome the strong opposition.

"In the six years I was working on the standard, I found if we came up with some accommodations to meet the requests of the [U.S. Chamber of Commerce and other opponents], they just asked for additional accommodations," says Orr, who is now an ergonomic consultant based in Washington, DC. "I think the people who were in major opposition are in opposition in philosophy to regulation."

Smaller employers are the ones most likely to back off from ergonomics regulation, he predicts. And he says OSHA won't have much room under the "general duty" clause to require ergonomic interventions. The general duty clause of the Occupational Safety and Health Act requires employers to keep workplaces free from recognized hazards that cause or are likely to cause serious physical harm or death.

Last fall, the Occupational Safety and Health Review Commission ruled that Beverly Enterprises Inc., a nursing home corporation based in Fort Smith, AR, was properly cited for ergonomics hazards under the general duty clause. That overturned a decision by an administrative law judge, who had said OSHA had not identified a "recognized hazard" when inspectors issued citations against five nursing homes in Pennsylvania in the early 1990s due to injuries related to patient handling.

It took more than five years for the review commission to issue the finding that lifting represented a hazard that requires abatement under the general duty clause. The administrative law judge still must decide the case.

"OSHA [still] has to prove that the industry knew about the hazard and there were reasonable abatements the industry knew about," explains Orr. That lengthy case is an example of why OSHA uses the general duty clause sparingly, he says. "When [employers] choose to fight it, it's a long, expensive road for both parties." ■

Improving morale may be key to future recruitment

Safety programs become retention tools

As predictions of a pending nursing shortage grow direr, employee health professionals are finding themselves in a unique role of coping with the possible consequences.

Even now, employee health professionals may see physical symptoms that arise from stress, fatigue, and low morale. By 2010, those problems may get worse. That's when experts predict the demand for nurses will exceed the supply, and the average age of the existing population of nurses will be 45. More than 40% of nurses will be over 50.[1]

Work environment, including safety-related issues, will become an increasingly important aspect of recruiting and retaining quality workers, experts say.

Employee health professionals also are in a position to alert hospital administration to the signs and symptoms of what health care futurist **Jeff Goldsmith**, PhD, calls the "most acute problem" in health care today: low morale.

"Certainly, clinical care and clinical services are stressful in the best of circumstances," he says. "But in an environment like the current one, where there has been so much change so quickly, I think it's numbed a lot of people."

Workload concerns fuel turnover

Nursing leaders have begun sounding the alarm about the pending shortage and workload issues. A recent report by a coalition of nursing organizations detailed the surveys and studies that point to future shortages.

The number of people taking the licensure exam has declined consistently since 1994, according to the National Council of State Boards of Nursing in Chicago.

"The American Organization of Nurse Executives [AONE] reports that in areas where the most acute shortages seem to exist, some hospitals are closing units, diverting patients, and canceling surgeries because there are not adequate numbers of professional nursing personnel," according to the nursing shortage policy statement of the American Association of Colleges of Nursing, the American Nurses Association, AONE, and the National League for Nursing.

A William Mercer study found "workload and staffing" are the second most cited reasons for turnover in the nursing profession. "Unless issues related to the care environment are addressed, strategies to increase the overall supply of nurses will not be successful," the nursing organizations concluded.

The policy statement also includes a recommendation that hospitals "redesign work to enable an aging work force to remain active in direct care roles." That would include such issues as ergonomics programs to reduce patient handling injuries.

Addressing low morale is a more complex task, and one that would seem to have little to do with employee health. Yet employee health professionals may have valuable input as they see the effects of stress and the physical strain caused by staffing shortages, says Goldsmith.

"There are health-related manifestations of stress that are signals that the work environment needs to be re-engineered," he says.

Low morale can be both a cause and effect of the nursing shortage, as some nurses leave and others are left with more work demands. The ANA is pressing for language in contracts that limits mandatory overtime to "defined emergencies."

"Mandatory overtime is one of the things fueling that accumulation of stress among nurses, which exhibits itself in low morale, absenteeism, and errors," says **Karen Worthington**, MS, RN, COHN-S, occupational safety and health specialist with the ANA in Washington, DC.

Stress also comes from a sense of powerlessness. Giving employees input into the goals and strategic direction of the hospital makes them feel more connected, says Goldsmith.

"Shortages are a manifestation of a larger problem, and that is that people aren't made to feel valued," he says. "I think there's an irony now that we're going to have critical shortages of workers at the time when baby boomers are actually going to need them [most]."

Safer workplaces attract nurses

There's a silver lining in the pending labor shortage cloud: Safety, employee health, and other working conditions gain greater attention as hospitals seek an edge in recruitment and retention.

Hospitals actually are featuring their no-lift policies or needle-safety programs in recruitment ads, says Worthington. "To me that says that health care facilities are aware that safe workplaces are important in attracting and keeping nurses," she says.

Some hospitals also are experimenting with "self-scheduling," in which nurses work with nurse managers to determine shift coverage. That allows nurses to consider their own shift rotation and hours.

As researchers link worker safety to patient safety and medical errors, hospitals may have stronger reasons to address fatigue and stress, says Worthington.

Meanwhile, employee health programs are being strengthened by the growing interest of physicians in the field, says **Geoff Kelafant**, MD, MSPH, FACOEM, medical director of the occupational health department at the Sarah Bush Lincoln Health Center in Mattoon, IL. He is also vice chairman and communications chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine in Arlington Heights, IL.

"There's been an explosion of interest in medical center occupational health," says Kelafant. Physician involvement gives employee health programs additional clout and a strong champion, he says.

Reference

1. Buerhaus PI, Staiger DO, Auerbach DI. Implications of an aging registered nurse workforce. *JAMA* 2000; 283:2,948-2,954. ■

Hospitals cited for poor training, control plans

OSHA citations likely to increase with new regs

Insufficient training or inadequate exposure control plans are deficiencies that most frequently result in citations by the U.S. Occupational Safety and Health Administration (OSHA) under the bloodborne pathogens standard.

In the 16 months after OSHA issued a compliance directive on needle safety in 1999, only 48 hospitals received inspections. Of the resulting 144 citations, 20% involved training deficiencies, such as the failure of hospitals to include all the necessary elements specified by the standard. For example, three citations stemmed from training programs that didn't include an opportunity to ask questions, such as video-only instruction. **(See chart, below.)**

The numbers of such citations are likely to increase substantially in the coming year, in light of the revised bloodborne pathogens standard and the inclusion of hospitals in OSHA's targeted inspection program. The Joint Commission on Accreditation of Healthcare Organizations also looks for compliance with OSHA regulations in its survey process.

Employee concerns can lead to complaint-related inspections as well. "A number of these inspections were initiated due to employee complaints rather than as a scheduled inspection," notes **Craig Moulton**, an OSHA industrial hygienist who works with compliance.

OSHA Bloodborne Pathogens Citations

Inadequate training	29
Inadequate exposure control plan	19
Lack of engineering controls	18
Sharps containers overfilled or not easily accessible	12
Violations related to HBV vaccination	8
Failure to ensure employees use personal protection equipment	6

Source: Occupational Safety and Health Administration, Washington, DC.

Analysis reveals vast deficiencies

Deficient training programs and exposure-control plans are long-standing problems. Those issues emerged in the two years before the compliance directive, according to an analysis by **Katherine West**, MSEd, CIC, an infection control consultant with Infection Control/Emerging Concepts in Manassas, VA.

From Aug. 1, 1998, to July 30, 2000, OSHA issued 410 citations at health care facilities for having no exposure control plan and 273 citations for having no training programs. The data include hospitals as well as other types of health care facilities, such as clinics and long-term care centers.

West says she was shocked to discover how many facilities didn't even have an exposure control plan. "What some people think is an exposure control plan isn't," says West, noting that a collection of policy and procedure manuals doesn't constitute an exposure control plan. "Most of the plans are missing the specifics."

A single exposure control plan isn't adequate for a multisite facility, notes **Sandra Elias**, RN, occupational health consultant with St. Jude Heritage Occupational and Environmental Health Services in Fullerton, CA. For example, details such as the location of personal protective equipment would be different from site to site, she says.

After all, the exposure control plan is supposed to be a working tool, not just a document that sits on a shelf, says West. "I think people are missing the great things that this document can do for them," she says. "Once they've created it and it's a useful document, then the update on an annual basis is very simple."

Training is an area of frequent lapses — not only in content, but also in the scope of employees who receive the training.

"There is a misconception that unless you're in a medical field you don't need this," says Elias.

Clinical staff aren't the only ones who have the potential for bloodborne exposures, she notes. For example, housekeepers may be stuck by needles left in dirty linens, or security personnel may be at risk when helping to deal with a combative patient.

Yet nonclinical staff shouldn't have the exact same course as clinical employees, says Elias. "The training should be task-specific," she says.

OSHA regulations are very specific about what must be included in bloodborne pathogen training. But West notes, "Most facilities are not complying with what OSHA states about education and training and what has to be accomplished and what needs to be included. They're trying to short cut it every way they can."

After training, employees should have a full understanding of the bloodborne diseases that can be transmitted through needlesticks, the details of the facility's exposure control plan, and the steps to take for post-exposure treatment and follow-up.

"If [employees] understand the diseases and how they work, we can bring down the apprehension level," says West.

Meanwhile, the revised bloodborne pathogens standard contains new requirements for recordkeeping and the involvement of frontline health care workers in the evaluation of safety devices.

The new language requiring the use of safety devices also may lead to an increase in citations in that area. From November 1999 to February 2000, OSHA issued only 18 citations at hospitals for lack of engineering controls. ■

Training required by new bloodborne pathogens rule

Within 90 days of the effective date of the standard (April 18, 2001), the Occupational Safety and Health Administration (OSHA) requires hospitals and other employers to provide training to all employees with occupational exposure on the new standard, including a copy of the standard and an explanation of its provisions.

Training must be provided at no cost to the employee and during working hours. New employees must receive the training at the time they are assigned to tasks that could involve occupational exposure, and all employees must receive bloodborne pathogen training at least annually. (Employees who have received training within the past year just need additional training on the provisions of the standard within the 90-day period.)

Here's what OSHA says the training should minimally include:

- an accessible copy of the regulatory text of the standard and an explanation of its contents;
- a general explanation of the epidemiology and symptoms of bloodborne diseases;
- an explanation of the modes of transmission of bloodborne pathogens;
- an explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;
- an explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
- an explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;
- information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
- an explanation of the basis for selection of personal protective equipment;
- information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
- information on the appropriate actions to take and people to contact in an emergency involving blood or other potentially infectious materials;
- an explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
- information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
- an explanation of the [hazard] signs and labels and/or color coding;
- an opportunity for interactive questions and answers with the person conducting the training session;
- additional special training for laboratory workers. ■

Do GPOs' cost limit safe needle device choices?

New law requires workers to evaluate choices

Are cost pressures and group-purchasing contracts keeping the safest needle devices out of some hospitals? It may be up to employee health professionals to make sure that's not the case.

The influence of cost on the selection of needle devices may be more complex than presented in a recent segment of the television show *60 Minutes*, which portrayed giant needle manufacturer Becton-Dickinson as forcing smaller manufacturers out of the marketplace.

There is no clear best needle device, and health care workers should judge for themselves which devices they prefer, experts say. However, employee health professionals need to be sure their evaluations aren't limited by materials managers who seek to keep costs in check, they say.

"Certainly, there are some hospitals being told by their materials management, 'You can only look at these products, [due to price],'" says **Cindy Fine**, RN, MSN, CIC, infection control and employee health program consultant with Catholic Healthcare West in San Francisco.

"It's a matter of saving money," she says. "They are told, 'You have to standardize; contract with one company, and save money that way.' Materials managers haven't quite learned that this is different, that we have to have health care worker input."

In truth, group-purchasing organizations (GPOs) do not require hospitals to purchase only their products. However, a hospital may miss out on certain rebates or special prices for selecting off-contract devices.

At the same time, inspectors from the U.S. Occupational Health and Safety Administration (OSHA) usually would not cite a hospital for failing to buy the "cutting edge" in needle safety technology, says **Craig Moulton**, an OSHA industrial hygienist. Rather, the bloodborne pathogens standard and OSHA's compliance efforts focus on the involvement of frontline health care workers as they evaluate various safety products, adequate training, and proper use.

"The key to use of the device is acceptance by the people who are using it," says Moulton.

The nation's largest GPO, Novation, currently offers a sole source for blood collection devices from Becton-Dickinson. Yet the GPO is considering expanding its options to member hospitals in the wake of the recent Needlestick Safety and Prevention Act.

"Federal law and new states laws have definitely increased member demand for safety products and therefore increased demand for additional options, in light of capacity issues in the marketplace," says spokesman **Lynn Gentry**.

"Four or five years back, it was feasible for a single manufacturer to offer safety devices to the marketplace because the demand was not that significant," he says. "We recognize it's really not feasible for one company to provide the needs of an entire market at this point."

Gentry also notes that group purchasing contracts just offer a way for hospitals to reduce costs on supplies. Hospitals are free to spend more on a device they believe is more effective.

In the *60 Minutes* segment, Tom Shaw, founder of Retractable Technologies Inc. (RTI) of Little Elm, TX, asserted that his company's representatives have been unable even to show their safety needles to hospital staff due to group-purchasing contracts and have been excluded from some needle safety workshops.

The segment did not explore the experiences of numerous other small manufacturers, or the impact of the recent Needlestick Safety and Prevention Act and the revised bloodborne pathogens standard on the marketplace. RTI's web site indicates the company's products currently are offered through five group purchasing organizations, including Premier.

An ongoing challenge

For Bio-Plexus, a Vernon, CT-based maker of internal blunting devices, getting into hospitals with GPO contracts that don't include the product is an ongoing challenge.

"We were able to get into several university hospitals [which are members of Novation] because of their desire to protect their workers," says **John Metz**, president and CEO.

"Since there is overriding pressure in hospitals to reduce costs, it's harder to compete without being on contract," he says. "It is an extra hurdle for us. It takes extra resources to get over that hurdle."

Not long ago, needle safety devices were scarcely on the radar screen for most hospitals. But state and federal mandates have changed

that. Along with the greater attention to needle safety has come innovation in needle design.

The web site of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville lists more than 80 vendors of safety devices.

"The United States medical device market is the largest and most open medical device market in the entire world," says **Janine Jagger**, PhD, MPH, director of the worker safety center, who is credited with bringing the needle safety issue to the forefront of occupational health.

Jagger notes that no device can be considered the best, and that device choice depends on factors related to its specific use. "You can get very different product evaluation results with the same device in different hospitals," she says.

But **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union in Washington, DC, worries that innovation won't make it to the device selection committee due to group purchasing contracts.

"The people in purchasing in these health care facilities, regardless of what kind of exemption they have [from contracts], continue to buy the products where they get the [price] rebates," he says.

"Our members are not seeing the best safer products," asserts Borwegen. "This *60 Minutes* story is an accurate reflection of the types of obstacles our members are facing to get their hands on the best lifesaving technology."

Ultimately, it is up to employee health professionals to ensure that frontline health care workers have a variety of designs to consider, regardless of cost, says Fine.

"When we had our [evaluation] committee, we didn't allow our vendors to even talk about price," says Fine. The health system's individual hospitals and materials managers still brought price into their decisions, she says. "It's impossible to ignore it as an issue."

"We've purchased a lot of items that are off-contract because we think they're better," Fine adds. Meanwhile, the needle safety device market continues to evolve as demand picks up in the wake of the new federal law and revised standard, which mandate their use.

"Cost will continue to be a very significant pressure on this market," says Jagger. "The effect of that will be in the long run to bring prices down.

The rate of conversion to safety devices varies considerably, says Jagger. She estimates that 90% of hospitals use needleless IVs, but only 35% to 40% of IV catheters in use have safety devices. "We can see that there's a big surge in the conversion from conventional to safety devices. The companies in this field are reporting a surge in demand for those products. There is definitely a lot of movement.

"We need to keep the momentum going," says Jagger. "We need to follow up the new law with compliance activities on the part of OSHA to make sure the law is fully implemented." ■

Mild flu season softens impact of vaccine delay

Flu peaked later this year for most of country

A milder-than-usual flu season helped lessen the impact of flu vaccine delays across the country, the Centers for Disease Control and Prevention in Atlanta reported.

Manufacturing problems with this year's influenza strain led to delays in the distribution of vaccine and an emphasis on the need to vaccinate high-risk patients and health care workers. The availability of vaccine varied widely across the country, as some hospitals received their usual flu vaccine orders nearly on time and others were told that most of their shipment would arrive in November and December — and that they should expect 10% to 15% less than they ordered.

The CDC had guaranteed an additional 9 million doses of vaccine, which became available in the fall. By January, about 6 million doses remained available.

Typically, hospitals conduct influenza vaccinations in October. Flu activity usually peaks between late December and March. As of late January, flu activity nationwide was below levels from winter 2000. "It certainly was fortuitous that [the activity] came later this year than we saw last year," says **Carolyn Buxton Bridges**, MD, a medical epidemiologist in the influenza branch of CDC. Even with a milder season, influenza could be a more serious problem in certain parts of the country. It may take a year or more for a full evaluation of the impact of the vaccine delay, she says.

"We know this has been a difficult year for a lot of health departments and hospitals," she says. "We're still gathering information to be able to gauge how much of a problem it was and what segments had a more difficult time than others." ■

Dermatitis culprit: Water for hand washing too hot

Fixing one water problem led to another

When cases of dermatitis suddenly spiked at Gundersen Lutheran Medical Center in La Crosse, WI, puzzled infection control and employee health professionals began to investigate. The culprit, they discovered, was hot water.

The problem began after the hospital resolved a seemingly unrelated concern. Legionella bacteria had been growing on rust surfaces in the hospital's galvanized pipes.

"We tried to isolate those areas from patient areas, but still legionella would rear its head in cultures of the water system," explains **Larry Lindesmith**, MD, FACOEM, FCCP, medical director of employee health and safety. "We increased our water temperature to 140 [degrees], and to a great extent, we got rid of legionella."

Some time after that, infection control specialists surveyed nurses about their incidence of dermatitis. About 60% of them complained of the problem, says **Marilyn Michels**, MSN, CIC, CRRN, nurse epidemiologist in infection control.

"We thought that was a bit excessive," says Michels. "We gathered a group of nurses together and asked them what they thought were some contributing causes. The water temperature was one issue."

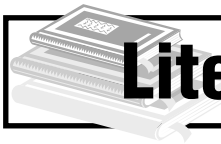
The problem was especially acute in units in which nurses and other staff must perform frequent hand washing. "It's the combination of the heat plus the trauma of scrubbing that irritates the skin and makes it more susceptible to developing irritative dermatitis," says Lindesmith.

The solution: Gundersen Lutheran replaced the older galvanized pipes and lowered the water temperature to 120 degrees. Cases of dermatitis went down. The hospitals also sent teaching carts into units to instruct on hand-washing technique to prevent dermatitis. Health care workers with symptoms of dermatitis were reminded to go to employee health.

Meanwhile, Lindesmith took other steps: The hospital switched from latex to vinyl exam gloves and reviewed its choice of soaps.

Michels has not repeated the survey, but she says, "Nurses tell me their hands are a little better."

Meanwhile, Lindesmith has a list of alternative soaps, including alcohol-based foam, for those who develop an irritation from the main product. "We're constantly finding somebody who develops a contact dermatitis related to the soap we use," he says. "We always have to have an alternate system for some people." ■



Literature Review

Beekman SE, Vaughn TE, McCoy KD, et al. **Hospital bloodborne pathogens programs: Program characteristics and blood and body fluid exposure rates.** *Infect Control Hosp Epidemiol* 2001; 22:73-81.

Training in standard precautions is inadequate for new employees and physicians in more than one-quarter of hospitals, and exposure rates of health care workers remains "unacceptably high," conclude researchers at the University of Iowa in Iowa City.

In a survey of 153 hospitals in Iowa and Virginia, researchers found that 29% offered training in standard precautions only once or twice a year. The U.S. Occupational Safety and Health Administration (OSHA) requires employees to be trained when they are assigned to exposure-prone tasks. Only 27% of physicians receive the training because they are not employees of the hospitals, the study found.

Blood and fluid exposures are still a common occurrence, the researchers found. Overall, 106 hospitals reported a percutaneous exposure rate of 5.3 per 100 hospital employees per year.

The survey was conducted in 1996 and 1997, some five years after OSHA's bloodborne pathogens standard required health care facilities to take measures to reduce exposures but before the recent state laws, federal Needlestick Safety and Prevention Act, and revised OSHA standard added tougher mandates for safety devices. Most of the facilities included in the survey are community hospitals. The use of safety devices varied by type of device and size of facility, the survey showed. About half of the hospitals (75 of 140 reporting) used a needleless IV system, and 35% (49 of 140) used safety devices for phlebotomy or IV access. Larger facilities were more likely to use the safer systems.

The annual percutaneous injury rates per 100 workers ranged from 1.0 for housekeeping staff to 10.8 for operating room and emergency

department technicians, for a mean of 5.3. "Despite the apparent trend to slightly lower injury rates, these rates still are unacceptably high," the researchers stated. Even more troubling, 11% of hospitals surveyed did not have clinicians available to provide postexposure care during all working hours.

"Health care workers clearly remain at risk for [injury]," the researchers concluded. "More attention needs to be directed not only to effective approaches for employee training and behavioral modification but also to needlestick-prevention devices."

In an accompanying editorial, **David K. Henderson**, MD, deputy director for clinical care at the Warren G. Magnuson Clinical Center of the National Institutes of Health in Bethesda, MD, called several of the study's findings "disquieting. "That several of these institutions invest little or nothing in training for staff with respect to occupational risks and postexposure management is disturbing, perhaps even frightening," he wrote. "The fact that that one of every eight of the responding hospitals does not offer continuous occupational medicine support for employees sustaining occupational exposures is even more problematic."

Safer devices, coupled with systematic analysis of all exposures and broad efforts to improve adherence to standard precautions, can help reduce exposures, says Henderson. Some issues raised by the University of Iowa study lead to simple solutions. Henderson suggests linking physician credentialing with training and tapping into the National Postexposure Hotline — (888) 448-4911 — for expertise on postexposure prophylaxis. **(For more information on the hotline, see**

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Hospitals need to commit resources to reduce exposures, Henderson wrote. "Their article underscores the importance of having the institutional administration to be cognizant of, intimately involved with, and aggressively supportive of organizational programs designed to reduce occupational exposures," he stated. ■

Privacy rules delayed, reopened for comment

AHA calls them too costly, cumbersome

Controversial new federal privacy rules were reopened for public comment and the effective date was delayed until April 14. The rules, which stem from the Health Insurance Portability and Accountability Act of 1996, were issued in December but did not undergo the 60-day congressional review period as required by the Congressional Review Act.

The American Hospital Association and other critics of the new medical privacy rules have said the rules are prohibitively expensive and would require new information systems and personnel. Because they cover only "standard transactions" related to information that is transmitted for medical claims, some types of employee health information would not be covered.

The American Association of Occupational Health Nurses Inc. and the American College of Occupational and Environmental Medicine support the privacy regulations, but have asked for the rules to cover employee health information.

In a statement, Tommy G. Thompson, secretary of Health and Human Services, said the department will review comments to determine if changes are needed. "[It] creates an opportunity to ensure that the provisions of this final rule will indeed work as intended throughout the complex field of health care, without creating unanticipated consequences that might harm patients' access to care or the quality of that care." ■

CE objectives

After reading each issue of *Hospital Employee Health,* the nurse will be able to do the following:

• identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;

• describe how those issues affect health care workers, hospitals, or the health care industry in general;

• cite practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■