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Tales of JCAHO: Prepare your staff to be quizzed about employee health

Will your hospital be one that gets grilled?

If you have a Joint Commission survey coming up, be prepared for this: Surveyors asking employees (not you) about follow-up to needlesticks. Surveyors asking for compliance rates of TB screening. Surveyors looking at your injury logs.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has an overriding focus on patient safety, but employee health is increasingly being swept into that scope of questions.

Some employee health professionals are feeling the impact of the Joint Commission's partnership with the U.S. Occupational Safety and Health Administration (OSHA).

Taking a closer look at injuries, problems

"They're looking much more at actual injuries and actual problems," says **Steven Weiner**, FNP, MS, MPA, clinical manager of the employee health service at New York University Medical Center in New York City. "This alliance with OSHA is important."

At the same time, "it is extremely variable," says **Geoff Kelafant**, MD, MSPH, FACOEM, medical director of the occupational health department at the Sarah Bush Lincoln Health System in Mattoon, IL. He also is chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine in Arlington Heights, IL.

At one hospital, employee health professionals

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COMING IN FUTURE ISSUES

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may sit in on the infection control and environment of care meetings with scarcely a comment to make. At another, a surveyor may pour through injury records and send employee health staff scrambling for more data.

One trend affects all departments of the hospital, according to **Patrice Spath**, RHIT, a health care quality specialist with Brown-Spath & Associates in Forest Grove, OR: Surveyors are talking directly to employees.

"If the surveyors want to know about the process for handling needlesticks, the employee health nurse probably knows exactly what the process is," she says. "But does the staff person in the emergency department whom the surveyor asks know the answer?"

Based on their recent training or background, surveyors may have certain areas they emphasize. "There are ways of finding out what the interests of a particular surveyor are [from their prior surveys]," notes Kelafant.

But one caution in trying to deduce a "favorite" topic of a surveyor: That person may have focused on one area at a hospital because of a special circumstance there. The surveyor's next encounter may take a completely different direction, says Spath.

While surveyors may have a particular interest in certain areas, they all will be concerned about patient safety. Links between worker and patient safety, such as improving patient transfers, will resonate, says Spath.

"I encourage employees instead of saying, 'We're improving quality,' to say, 'We're improving safety,'" she says. "The word safety is a key word surveyors like to hear."

Several employee health professionals offered to share their experiences in recent surveys:

Surveyor sends EHP scrambling for data

Performance improvement became a focus of a surveyor's questions at New York University Medical Center, according to Weiner.

"We had a performance improvement team that focused on body fluid exposures, and we adopted two safer devices: a butterfly blood collection device and an IV catheter. She wanted to be sure there were people from different disciplines on the team. Once we were able to show in a couple of questions that we had what [the Joint Commission] wanted [for evaluating exposures and seeking safer devices], that was the end of it.

"We also had been working on improving data collection and compliance rates with tuberculosis skin testing. That effort had been mentioned in the infection control committee minutes. I was very happy with the improvement.

"She wanted to know if we were saying there is an improvement, what were the baseline rates? Also, she looked at the rates for every department. We have a pulmonary function lab that has four employees, and one hadn't received a skin test. The pulmonary function lab looked like it had 75% compliance, and [the surveyor] wanted to know why.

"It just caused a headache. I had to spend a fair amount of my time looking for statistics. We had a compliance rate of 81% in 1999 and 91% in 2000. Meanwhile, the person in the pulmonary function lab came in an hour early one day and had the skin test.

"For another reviewer, the information in the [meeting] minutes might have been fine, but she wanted that level of detail.

"The surveyor concluded the EHS part of the interview by asking what other issues we were concerned with. I did have the right answer — for the survey and for the hospital — musculoskeletal injuries and ergonomics. It was clear it was an issue we were addressing, and that's all she wanted to know," Weiner says.

Why one EHP kept hold of the files

Confidentiality is a major issue, says **Mary Shock**, RN, an employee health nurse at Kettering (OH) Medical Center who worked with four surveyors during reviews of the hospital, home health unit, home infusion, and associated home medical unit:

"If [the surveyors] would start to look through the charts, I would stop them and ask them what they were looking for. Each one was testing me to see if I would stop them.

"One surveyor called the office, gave me a list of charts he wanted to see, and said he would send a runner to pick them up. I replied, 'I'm sorry. You cannot do that. I will bring the charts over, but I cannot give them to a runner.'

"He asked why I wouldn't let the runner take the charts. I said, 'You and I both know you were testing me. I cannot let someone else take the charts because they contain confidential medical information,'" she explains.

"Surveyors also want documentation in each chart that hepatitis B vaccination is offered upon

How to Ace a Joint Commission Survey

Many hospitals hire consultants and conduct mock surveys to prepare for a visit from the Joint Commission on Accreditation of Healthcare Organizations. Still, it's hard to know what a particular surveyor may target for more in-depth questions. Here is some advice from employee health professionals who went through surveys in the past year:

"Make sure you highlight the information you want them to have. I have a main page with our main accomplishments, and the supporting data further back in the presentation. We made sure we would have charts and graphs and reports, and I think that made a big difference." — **Steven Weiner**, FNP, MS, MPA, clinical manager, employee health service, New York University Medical Center, New York City.

"[Realize that] you're never going to be perfect, and you're never going to succeed in hiding stuff. Once you realize you're never going to be perfect ,it makes it a lot easier" — **Geoff Kelafant**, MD, MSPH, FACOEM, medical director, occupational health department, Sarah Bush Lincoln Health System, Mattoon, IL. He is also chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine in Arlington Heights, IL.

"Your employees should be prepared to answer questions. The biggest change for 2001 is that a lot of the survey process involves talking directly with employees. It's important for you to send out fact sheets to employees on key issues so they'll know the answers."— **Patrice Spath**, RHIT, health care quality specialist, Brown-Spath & Associates, Forest Grove, OR.

"Know your regulations. Also, you can read the Joint Commission suggestions as to what they're looking for on their web site (www.jcaho.org)."— **Mary Shock**, RN, an employee health nurse at Kettering (OH) Medical Center.

"Be able to identify a project or a problem and show how you resolved that problem. Show how you got down to the root cause and how you work with various departments. They want to look at quality improvement."— **Patricia Dalton**, RN, COHN-S, administrator of occupational health at Pitt County Memorial Hospital in Greenville, NC. ■

hire and that those taking the vaccine are being sent reminders to come for their scheduled vaccine. When the vaccine was first offered [in the mid-1980s], we were doing mass inservice training for everybody. At the end of the inservice [employees] signed a consent saying they wanted to get the vaccine and report to employee health at their convenience.

"There were a few people who never showed up. We had no follow-through for those people, and [the surveyors] faulted us for that. We should have made [staff] sign a declination [if they weren't vaccinated immediately]," Shock adds.

"I am going through 6,000 charts to see who may have signed the consent and never taken the vaccine.

"Last spring, we became aware that anyone who had the HBV vaccine needed to have a post-vaccine titer [to detect antibodies to the HBsAg antigen]. We already had begun working on that before the surveyors came. Out of 6,000 volunteers and employees, we've probably got 2,000 that need to be titered," she adds.

JCAHO wants to see your team approach

Joint Commission surveyors like to see a multidisciplinary, team-based approach to issues, says **Patricia Dalton**, RN, COHN-S, administrator of occupational health at Pitt County Memorial Hospital (PCMH) in Greenville, NC:

"The surveyors seemed to want to know how we work together across departmental lines. We are very interdisciplinary at PCMH. My department works very closely with safety, infection control, and quality.

"Let's say we're doing an ergonomics analysis in dietary services. We will try to involve the staff-level people in dietary as well as the management," she explains.

"We have an IV access team [looking into safer devices] that includes physicians, nurses, and purchasing staff. A subcommittee of nurses has been observing IV sites to see how many sticks it takes and how often the IVs are switched out," Dalton continues.

"We've got employees in every department, so we have to relate to those employees, rather than just going in and saying, 'This is your problem and this is how you have to fix it.'

"We're able to get a lot of different perspectives on the issues and get a better resolution," Dalton says. ■

OSHA gives more time to comply with safe needles

Enforcement of revised standard begins July 17

Hospitals have gained some extra time to comply with the U.S. Occupational Safety and Health Administration's (OSHA) revised bloodborne pathogens standard.

As OSHA geared up an education and outreach effort, the agency announced that enforcement of the rule would begin July 17, 2001. States and U.S. territories with OSHA-approved state programs are required to adopt the revisions or more stringent requirements by Oct. 18.

OSHA has provided its educational materials on the revisions on its web site: www.osha.gov. Packets that could be used in training seminars are available from OSHA education centers. **(See editor's note at the end of this article.)**

This is OSHA's summary of the new definitions and requirements in the rule:

• Two new definitions are included in the revision, while one existing term is amended:

— **Sharps with Engineered Sharps Injury Protections** include non-needle sharps or needle devices used for withdrawing fluids or administering medications or other fluids that contain built-in safety features, or mechanisms that effectively reduce the risk of an exposure incident.

— **Needleless Systems** are devices that do not use needles for the collection or withdrawal of body fluids, or for the administration of medication or fluids.

— **Engineering Controls** include all control measures that isolate or remove a bloodborne pathogen hazard from the workplace. The revision now specifies that "self-sheathing needles" and "safer medical devices, such as sharps with engineered sharps injury protections and needleless systems" are engineering controls.

• Employers must review their exposure control plans annually to reflect changes in technology that will help eliminate or reduce exposure to bloodborne pathogens.

That review must include documentation of the employer's consideration and implementation of appropriate commercially available and effective safer devices.

• Employers must solicit input from non-managerial health care workers regarding the identification, evaluation, and selection of effective engineering controls, including safer medical devices.

Examples of employees include those in different departments of the facility (e.g., geriatric, pediatric, nuclear medicine, etc.).

• Employers with 11 or more employees who are required to keep records by current record keeping standards, must maintain a sharps injury log. The log must be maintained in a way to ensure employee privacy and will contain, at the minimum, the following information:

— type and brand of device involved in the incident, if known;

— location of the incident;

— description of the incident.

[Editor's note: Educational materials on the revised bloodborne pathogens standard are available from the OSHA web site (www.osha.gov).

For more information about the revised standard, contact bloodborne pathogens coordinators in the OSHA regional offices.] ■

On the back burner: TB rule faces indefinite delay

Rulemaking agenda offers no date for final version

The U.S. Occupational Safety and Health Administration's (OSHA) tuberculosis regulation remains alive, barely, as the agency included it on its most recent regulatory agenda, but without a target date for a final rule.

Previously, OSHA had indicated that publication of a final TB rule was imminent. The rulemaking was delayed as the agency focused on completing the ergonomics standard by the end of 2000.

Now it's a long-term action

In the regulatory agenda that was published in the *Federal Register* on May 14, OSHA listed occupational exposure to tuberculosis as one of its "long-term actions." OSHA officials declined to comment on the change.

The proposed standard faced stiff opposition, including vigorous arguments from the Association for Professionals in Infection Control in Washington, DC, that the standard presented an unnecessary burden and a misdirection of resources.

In January, an Institute of Medicine panel issued a report that supported the need for a regulation but criticized key provisions of OSHA's proposed rule. The proposed standard on tuberculosis fails to provide enough flexibility to hospitals at low-risk and relies on outdated and flawed estimates of the tuberculosis threat, the panel concluded.

OSHA officials already had acknowledged that the final TB standard would differ from the version proposed in 1997 on issues such as the frequency of respiratory fit-testing and skin testing. The indefinite time line for a final rule may indicate more extensive changes.

When OSHA began working on a TB rule in 1994, tuberculosis cases were rising nationwide. Outbreaks occurred in several U.S. hospitals, including cases of the deadly multidrug-resistant strain. TB cases have declined by 35% since 1992.

The Centers for Disease Control and Prevention (CDC) issued guidelines for preventing TB spread in health care facilities in 1990, then updated them in 1994. The CDC now is reviewing those guidelines with another update expected in 2002. ■

Can ANSI succeed where OSHA failed?

Voluntary effort relies on consensus building

Another ergonomics standard may be on the horizon. Just months after the resounding political defeat of the U.S. Occupational Safety and Health Administration's (OSHA) ergonomics rule, a voluntary standard moved forward under the auspices of the American National Standards Institute (ANSI) in Washington, DC.

Labor Secretary **Elaine Chao** urged caution and asked for time to compile more data on ergonomics when she testified before Congress in April about the continued need for an ergonomics standard.

Yet at that moment, the National Safety Council, accredited by ANSI to coordinate the

development of national standards, was compiling comments to a second draft standard on controlling musculoskeletal disorders (MSDs). The ANSI standard focuses on work-related MSDs of the upper extremities and neck and outlines the basic elements of MSD management, reporting, employee involvement, training, and job analysis and intervention.

Voluntary, yet influential

While ANSI standards are voluntary, the organization is recognized as the standard-setting body for the United States in a myriad of areas, and its standards often form the basis for federal regulations.

The standards are developed through a process guided by strict procedures and consensus building. The 55-member ergonomics committee includes representatives from industry, labor unions, insurers, and ergonomics experts. Both the American College of Occupational and Environmental Medicine and the American Association of Occupational Health Nurses are represented.

Like OSHA, ANSI has been working on an ergonomics standard for about 10 years. The first draft generated numerous comments and led to significant changes, says **Terry Miller**, former secretary of the Accredited Standards Committee on Control of Cumulative Trauma Disorders at the National Safety Council, based in Itasca, IL.

"This issue is a very controversial one, whether it's with OSHA or a voluntary standard," says Miller. "You're going to get people with very strong opinions on both sides. A consensus standard doesn't mean everyone agrees and it's unanimous. ANSI is trying to see if there's enough agreement that they can propose the standard through the ANSI process."

ANSI standard shorter, more focused

Although its provisions could apply more broadly to MSDs, the ANSI standard addresses only work-related disorders of the upper extremities and neck.

It targets the most controversial aspect of MSD prevention and ergonomics: cumulative stress or repetitive motion disorders that could lead to carpal tunnel syndrome, tendinitis, or bursitis, among other diagnoses.

At a relatively short 20 pages, the standard is not nearly as detailed or prescriptive as OSHA's 600-page standard. For example, the draft ANSI standard calls for employers to use records of work-related MSDs, employee reports of MSD symptoms and job surveys to determine which jobs need further analysis and intervention. Job surveys are defined as a "cursory" review of jobs using questionnaires, checklists, or other methods.

"Each organization may want to establish criteria for when a job survey result or health surveillance data indicate the need for a job analysis," the standard states.

The OSHA standard required employers to use a "basic screening tool" to determine if a reported MSD was work-related. Work-related MSDs triggered other provisions that required employers to provide medical management, job hazard analysis and control, and training.

In its most controversial provision, the OSHA standard required employers to provide "work restriction protection," or 90% of pay and 100% of benefits for employees who are out of work due to their MSD injury. The ANSI standard does not address that issue or any other matter related to workers' compensation.

Finding strength in consensus

In the public arena, the views of those who oppose the OSHA ergonomics standard seem irreconcilable with those who support a standard. But in the ANSI process, those conflicting perspectives are represented on the panel drafting the document.

"We feel that makes for a stronger document," says **Stacy Leistner,** an ANSI spokesman. "It has been through multiple levels of review by diverse audiences."

Leistner stresses that the consensus process assures only consideration of all points of view. "The group may decide that not all comments would be incorporated," he says, adding, "There has to be a justification of why a comment would not be incorporated."

The background section of the draft standard reveals this give and take, offering various conclusions about MSDs.

For example, the draft standard says, "It is often possible to develop and implement control measures for suspected or established work-related risk factors for MSDs, although quantitative exposure disorder relationships may not be available in the technical or scientific literature for all work-related risk factors."

While employee health professionals welcome voluntary standards or guidelines that support ergonomics, they stress that the ANSI effort can't replace a new standard from OSHA.

"It could help move the standards-making process forward by presenting an approach to standards development," says **Guy Fragala**, PhD, PE, CSP, director of environmental health and safety at the University of Massachusetts Medical Center in Worcester, and a leading ergonomics expert.

"Because of the high number of injuries that are occurring in this area, OSHA has to address this in some way," he adds.

The ANSI standard will be very useful for some employers, says **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union (SEIU).

"It gives a blueprint to employers who want to do the right thing," he points out. "For all the other employers, that's why we need an OSHA standard." ■

Be patient on ergonomics, Chao urges Congress

Prevention, high-risk jobs will guide new efforts

Caution was the byword as Labor Secretary **Elaine Chao** testified before a Senate committee on what steps the U.S. Occupational Safety and Health Administration (OSHA) would take toward developing a new ergonomics standard.

Chao indicated that a new standard would focus on prevention, would target "high-risk" occupations, and wouldn't affect workers' compensation programs.

Why did the standard fail?

Chao asserted that the ergonomics standard failed because of "the rush to action, the lack of consensus, and the continual forward movement despite repeated congressional expressions of disapproval." She acknowledged that seeking consensus could be difficult.

"The stakeholders who have come to the Department of Labor to discuss ergonomics are coming from completely different positions — ranging from those who want no action to those who thought that the previous rule did not go far enough," she said in testimony before the Subcommittee on Labor, Health, and Human Services, and Education of the Senate Appropriations Committee.

"This diversity of opinion suggests that precipitous action is not the wisest course at this time. If we want to find more common ground on this issue, we will need to engage in more discussion and analysis, and we will need more data," Chao continued.

Advocates for health care workers questioned whether this emphasis on "consensus" would lead to a perpetual stalemate.

"This is a ploy to do nothing and to continue to allow health care workers and other workers to be crippled by ergonomic injuries," asserts **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union (SEIU).

> *"This is a ploy to do nothing and to continue to allow health care workers and other workers to be crippled by ergonomic injuries."*

"How can you have people who are ideologically opposed [to ergonomics regulation] at the table and develop consensus?" Borwegen asks.

Chao cited the voluntary Ergonomics Program Management Guidelines designed with the meatpacking industry in 1990 as a positive approach to reducing work-related musculoskeletal disorders (MSDs).

Yet, Borwegen notes, "They were bolstered by an aggressive OSHA inspection program citing people under the general duty clause."

However, some occupational health professionals remain optimistic that OSHA can come up with a better standard — one that omits the most contentious aspects of the prior version.

Deborah DiBenedetto, MBA, RN, COHN-S/CM, ABDA, president of the American Association of Occupational Health Nurses in Atlanta, called the failed standard "very overreaching and burdensome.

"[OSHA has] had some good performance-based standards where they're less dictatorial," she says. "I think there's room for negotiation of what's a fair standard and meets the needs of the public."

The American College of Occupational and Environmental Medicine (ACOEM) in Arlington

Heights, IL, withdrew its support from the final ergonomics rule, largely over the lack of a requirement for a medical diagnosis for work-related MSDs.

ACOEM still supporting standard

However, the college still supports a federal standard, says **Gregory Barranco**, ACOEM director of governmental relations.

While the college doesn't feel that voluntary guidelines are sufficient, the ANSI draft has been well received, says Barranco.

"The majority of pieces in the ANSI standard we do find appealing," he says.

Meanwhile, the political maneuvering continues. Sen. John Breaux (R-LA) introduced a bill calling for OSHA to develop a new ergonomics standard within two years, but directing the agency to exclude injuries that are pre-existing but aggravated by work or that occur outside of work.

It also would prohibit the agency from requiring an expansion of current state workers' compensation protection — a particularly contentious part of the rescinded standard.

The SEIU, under the auspices of the AFL-CIO, submitted a petition to the Department of Labor asking for OSHA to issue a new ergonomics standard.

"This sets the stage for them to either act or for us to proceed legally," says Borwegen. "Once the petition is delivered, the Department of Labor has an obligation to respond."

Reworking the standard

Chao insisted that she is committed to developing an ergonomics standard. The Congressional Review Act, which was used to rescind the ergonomics standard, prohibits OSHA from developing a standard that is "substantially the same."

Chao outlined the principles that would guide a new ergonomics standard:

- prevention;
- sound science;
- incentives;
- flexibility;
- feasibility;
- clarity.

"We must recognize the unique nature of individual workplaces — avoiding an unworkable one-size-fits-all approach," said Chao. ■

Are your 'safer' solutions also green ones?

Environment linked to worker, patient safety

Vinyl exam gloves allow hospitals to avoid latex allergies among workers and patients, but when incinerated, they create a toxic by-product. Some new safety syringes provide a shield to cover the needle but fill disposal containers more quickly. When your employee health choices solve one problem, do they create another, environmental one?

That question is increasingly coming to the forefront as hospitals face pressures to improve not only patient safety, but also worker safety and environmental stewardship.

By considering the possible impact of product choices, hospitals can avoid unnecessary costs and risks, says **Kathy Gerwig**, HEM, CPEA, director of national resource conservation and national environmental, health and safety operations for Kaiser Permanente in Oakland, CA.

"There are clear linkages between worker safety, patient safety, and environmental safety," says Gerwig, who spoke at the recent American Occupational Health Conference in San Francisco. "As a good business practice, we ought to be pursuing the activities that have multiple benefits."

Kaiser Permanente, which has 31 hospitals and 360 medical clinics, made a commitment to environmental stewardship. It has linked that to patient and staff safety as well, says Gerwig.

So when a Kaiser team began to look into latex alternatives, it contacted Gerwig for input. Vinyl, she notes, involves a "release of dioxin pollution when it's manufactured and when it's incinerated."

That was one factor that influenced Kaiser to choose nitrile gloves, she says. In other cases, worker or patient safety may outweigh disposal issues. For example, although safer needle devices often involve more bulk, Kaiser placed its priority on the need to reduce needlesticks.

"What we ought to be doing is working with manufacturers to encourage them to build products that are safe for workers and don't increase the waste stream," she says.

There are 15 subject areas that have environmental, patient safety, and employee safety connections, says Gerwig. **(See list, p. 81.)** At Kaiser, "We have a process for ensuring that environmental

considerations are part of product decisions," she says. Every request for proposal related to new products includes language about Kaiser's environmental goals. For example, Kaiser seeks to reduce packaging and buy only mercury-free products.

Gerwig reviews that portion of proposals and evaluates opportunities to integrate the environmental and safety aspects. Because of that, "we make a better decision for the organization, for the patients and for the community," she says.

The Sustainable Hospitals Project at the University of Massachusetts in Lowell is developing an assessment tool that would help hospitals evaluate environmental and safety issues. "If you look at the process, you can make it a cleaner process as you go along. You use a safer chemical and use less of it," says research associate **Tom Fuller**, MSPH, MBA, describing the general concept. "There's less pollution and less environmental impact . . . and it saves money in the long run."

For example, some hospitals have changed disinfectants and cleaners to less toxic substances that are safer for the environment and for workers. **(For more on glutaraldehyde, see *Hospital Employee Health,* February 2001, pp. 13-18.)**

Yet while the changes are made, someone needs to evaluate how the product is used and what training the staff may need. The assessment form will include an exposure assessment based on observation.

"We watch the process before the change and watch the process after the change," he says. "We're reporting what the exposure-level difference is. One of the things I saw was a worker who thought that [because] the chemical is safer, he could stick his hands in it."

Fuller also looks for ergonomic issues that may occur with products that require twisting or lifting. The Sustainable Hospitals Project maintains a list of alternative products and also considers risk shifting in its evaluations.

"When we look at selecting alternatives, we look at the broader implications," says **Catherine Galligan**, MS, the project's clearinghouse manager. If you like a new product, such as a needle safety device, but are concerned about excessive packaging and waste, you should contact the manufacturer, she says.

"If they get the feedback, they're often willing to make improvements," she says. "They often don't change a product because they hear nothing from a customer and they're afraid a change would get negative feedback," Galligan adds.

Connecting Worker and Environmental Safety

These items have linkages to patient safety, worker safety and environmental safety:

- ✔ Cleaning chemicals
- ✔ Energy conservation
- ✔ Green buildings
- ✔ Infectious waste
- ✔ Mercury devices
- ✔ Nonlatex exam gloves
- ✔ Paper (recycled content and source reduction)
- ✔ Pesticides
- ✔ Pharmaceutical waste
- ✔ PVC/DEHP plastics
- ✔ Reprocessing single-use devices
- ✔ Sharps generated from patient-administered treatment in the home
- ✔ Solid waste minimization
- ✔ Vernacare
- ✔ Electronic/dry imaging (radiology)

Source: Kathy Gerwig, Kaiser Permanente, Oakland, CA.

You'll have even more clout in that effort if you gain the support of your group purchasing organization, adds Gerwig. "That's where [hospitals] can have a tremendous amount of impact," she says.

(Editor's note: For more information on environmentally sound alternative products, see the Sustainable Hospitals Project web site: www.sustainablehospitals.org.) ■

Tracking helps stop hidden hazards in linen

Laundry task force reduces sharps risks

The risk of exposure to bloodborne pathogens can occur far from the hospital bed or operating room when needles and other sharps are carelessly left in the linens.

Lebanon (OR) Community Hospital was able to greatly reduce these hidden hazards with

tracking, education, and sharps elimination.

When laundry manager LaRee Noel raised concerns about the items found in laundry, **Deborah Fell-Carlson**, RN, COHN-S, employee health coordinator and safety officer, helped bring together a laundry hazard task force. The task force included safety, employee health, and housekeeping representatives from the health system's three hospitals and long-term care facility, as well as the laundry manager.

Sometimes, laundry workers would find syringes or suture needles wrapped in sheets. "Some of them are unused. We consider it a close call," says Fell-Carlson.

"It is a potential for an injury. When you're removing linen from a bag, you don't want to get any kind of injury," she explains.

One emphasis of the task force has been to track items. "We decided we needed to have accountability at the user level," says Fell-Carlson.

Color coding helps track origin of needles

Now, when a laundry worker finds a hazardous item, he or she fills out a reporting form that includes information on the facility it came from. The different color of scrubs in the bag often identifies the department, as well.

"They put that identifying information on the form. [Noel] gives that form to the point of contact at the site where the linen was generated," explains Fell-Carlson. "That person researches where the problem originated. The manager of that department has to tell us what corrective action [he or she has] taken."

Since one hospital may be much larger than another, comparisons are based on the pounds of laundry processed. In January and February, the health system processed 346,254 pounds of laundry and found four sharps. Fell-Carlson hopes to lower that to zero.

The hospital system has taken other measures beyond reporting. The hospitals seek to eliminate sharps, as much as possible, and are implementing safer devices. They also sterilize a magnetic strip with the suture tray so used sutures can be dropped on it.

"We haven't found any suture needles at all" since that change, says Fell-Carlson.

Managers also provided inservice training to staff about the new tracking of found sharps. "I think the reporting system has set up an air of competition," she says. "They don't want the dubious distinction of having the most." ■

CE questions

For your convenience, *HEH* will be printing CE questions in each issue, beginning this month. Subscribers will receive a complete test and Scantron sheet in the December 2001 issue.

1. According to Mary Shock, RN, an employee health nurse at Kettering (OH) Medical Center, what is the proper response if a Joint Commission surveyor asks to see employee health charts?
   A. Give them the charts as quickly as possible.
   B. Give them the charts but first black out the employee name.
   C. Keep possession of the charts and ask them what information they need.
   D. Refer them to the hospital attorney.

2. Vaccine-induced antibodies to HBV decline over time. According to CDC guidelines, what is the proper response to that?
   A. Provide HBV boosters if antibody becomes undetectable.
   B. Monitor antibody levels and provide prophylaxis if exposure occurs.
   C. Create a policy to reduce risk for employees who have a decline in antibodies.
   D. No HBV booster is necessary despite the decline in detectable antibody.

3. While OSHA's ergonomics standard sought to reduce all work-related musculoskeletal disorders, what is the limitation of the voluntary standard under development by the American National Standards Institute?
   A. It applies only to certain types of work activities.
   B. It addresses only work-related disorders of the upper extremities and neck.
   C. It addresses only lower back injuries related to lifting.
   D. It applies only to repetitive motion disorders.

4. When hospitals consider switching from latex gloves, what environmental issue should they consider in choosing an alternative?
   A. The incineration of vinyl creates a toxic by-product.
   B. Vinyl and nitrile gloves do not decompose.
   C. Certain glove products involve the destruction of rain forests.
   D. There are no environmental differences among gloves.

Literature Review

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McNeil SA, Foster CL, Hedderwick SA, and Kauffman CA. **Effect of hand cleansing with antimicrobial soap or alcohol-based gel on microbial colonization of artificial fingernails worn by health care workers.** *Clinical Infectious Diseases* 2001; 32:367-372.

When health care workers clean their hands, how much potentially infectious bacteria remains? In these two articles, researchers address this question in a very different fashion.

Researchers in Brazil questioned whether the hand-cleansing agent could make a difference in the transmission of methicillin-resistant *Staphylococcus Aureus* (MRSA) via the hands of health care workers. In this study at the State University of Maringa, MRSA was artificially applied to the fingertips of five health care workers.

The first series involved light contamination (103 colony-forming units per fingertip), and the second test involved heavy contamination (106 colony-forming units per fingertip). As a control, one health care worker was contaminated but did not use hand-cleansing agents.

In both cases, the ethyl alcohol 70% and the 10% povidone-iodine detergent (which contained 1% active iodine) killed 99% to 100% of the MRSA. The chlorhexidine gluconate detergent and plain liquid soap were significantly less effective.

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Yet even when an effective agent is used, artificial fingernails may harbor pathogens and reduce the impact of hand cleansing, according to a study from the Ann Arbor Veterans Healthcare System and University of Michigan Medical School in Ann Arbor.

Researchers cultured the nails of 21 health care workers with salon-applied, permanent polished acrylic artificial nails and of 20 control subjects who did not wear artificial nails. The samples were taken at unscheduled times during regular work activities. The volunteers then cleaned their hands either with an antimicrobial soap containing para-chloro-meta-xylenol or an alcohol-based gel that contained 60% ethyl alcohol, and additional samples were taken.

Before cleaning with soap, a pathogen was isolated from 86% of health care workers wearing artificial nails, compared with 35% of control health care workers. The same pattern occurred among health care workers cleaning with gel, as 68% of those with artificial nails, and 28% without the nails had a pathogen isolated. The alcohol gel was more effective than the antimicrobial soap in removing pathogens. However, only one of five in the control group had pathogens after cleaning with gel, while more than 50% of those with artificial nails still had pathogens remaining.

The authors speculated that health care workers with artificial fingernails may wash less vigorously in order to protect their manicures. "However, it is also possible that organisms persist on artificial nails because of properties intrinsic to the acrylic material of the nail," they added.

Supporting the position of the Association of Operating Room Nurses, the authors suggest that artificial nails should not be worn in the operating room.

"Hospital infection control committees should seriously consider the development of policies to restrict the use of artificial nails by HCWs [health care workers] who work in other high-risk areas, such as intensive care units," they state. "In the absence of policies to restricting the use of artificial nails, HCWs who choose to wear them should be educated about the tendency of artificial nails to harbor harmful bacteria and the difficulty in eliminating these bacteria with hand cleansing. The importance of conscientious hand cleansing should be stressed and proper techniques emphasized."

The study also showed that routine hand washing with antimicrobial soap did not eliminate pathogens on health care workers' nails, whether they were artificial or natural. The authors noted that most health care workers in the study washed for a very brief amount of time. "Thus, we cannot exclude the possibility that the failure of antimicrobial soap to eliminate microorganisms was due to inadequate hand cleansing technique by our volunteers and not to ineffectiveness of the antimicrobial soap. ■

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. ■

American Health Consultants
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Post-exposure prophylaxis	1	2	3	4	5
Influenza update	1	2	3	4	5
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Drug interactions	1	2	3	4	5
Medication errors	1	2	3	4	5
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	No Interest		Some Interest		Much Interest
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Improving documentation for nurses and physicians	1	2	3	4	5
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