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Stop the violence: Assault risk high for health care workers

Hospitals assess threats, set 'zero tolerance'

"You killed my mother!" the man shouted as he began shooting in the corridors near where patients awaited surgery at West Anaheim (CA) Medical Center. Less than an hour before, his 72-year-old diabetic mother had died at the hospital. He returned with a .357 Magnum, apparently targeting those who had cared for her. By the time he was subdued, three employees had died — a nursing assistant, the pharmacy director, and the director of environmental services.

That is every hospital's nightmare, come to life last January. Such homicides are rare, but the incidents of verbal abuse or physical assault are shockingly commonplace. More nonfatal assaults occur in nursing homes and hospitals combined than in any other workplace.[1] Nurses and other health care workers report being punched, slapped, choked, and even thrown across the room. A survey of 475 surgical residents nationwide found that 60% had witnessed a physical attack and more than a third had been attacked.[2]

While overall the rate of occupational injuries has declined in the past five years, workplace violence has shown no consistently downward trend. Some 7,800 cases were reported in hospitals in 1998, and patients were the main source of injury. Hospitals in England have set "zero-tolerance" policies for assaultive behavior, but many U.S. hospitals are just beginning to recognize the problem of workplace violence.[3]

The potential for violence exists in every facility

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and in every community, notes an official with the U.S. Occupational Safety and Health Administration (OSHA) who specializes in workplace violence issues.

"If you haven't typically had a reporting mechanism in place [for assaultive incidents], you may not think you have a problem," she says. "Most of the time there is a problem, and people haven't been encouraged to report it."

Emotions are at their peak when the stakes are high. Emergency department (ED) staff are well aware of the potential for explosive situations, and many EDs have implemented security measures to limit access.

But a locked door, metal detector, and security guards aren't the ultimate answer to workplace violence, experts say. Hospitals need a comprehensive approach that includes a risk assessment, staff training, and supportive policies.

"It's our recommendation that everyone look at the issue of violence and have a program in place," says the OSHA official.

In 1998, OSHA published *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*, outlining components of a violence prevention program. **(See box, p. 111.)** While some elements were later incorporated in the security standard of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, OSHA's guidelines are voluntary and not regulatory.

States with their own occupational safety and health regulations may have additional requirements. For example, the hazard analysis conducted as a part of California's required injury and illness prevention program must include violent injury.

Last year, the Atlanta-based American Association of Occupational Health Nurses (AAOHN) in Atlanta issued a position statement urging occupational health nurses to take an active role in violence prevention activities. "Many times, occupational health nurses are the only health professionals dealing with worker behavior and worker health. We felt that was an untapped resource," says **Deborah V. DiBenedetto**, MBA, RN, COHN-S/CM, ABDA, an occupational health consultant based in Yonkers, NY, and president of AAOHN.

A violence prevention program may fit into a broader context of creating a workplace free of sexual or physical harassment, as it does for Allina Health System in Minnesota.

In a survey of about 3,300 Allina employees, 29% reported that they had witnessed violence in

the workplace in the past 12 months. While physical threats or actions are most likely to come from patients or their family members, incidents of emotional abuse often come from peers, physicians, or managers, says **Marlene Jezierski**, RN, Allina violence prevention educator. "I'm a nurse; I'm from the [ED]. I had a good idea what's out there. I wasn't surprised [by the survey results]. But some people were quite surprised."

That is why OSHA recommends that hospitals conduct a hazard analysis for violence prevention. Many incidents may go unreported, and therefore hospital management may not realize the extent of the problem.

"In the health care setting, people haven't tended to think of it as workplace violence until the government and others started describing it that way," says the OSHA official. "[For example,] for years, psychiatric workers and nurses have endured attacks from patients. They just looked at it as part of the job."

The first step toward stopping verbal and physical abuse is simply to refuse to accept it. At Allina, a brochure urges employees to "stand up against workplace violence." Managers are trained to "reflect a zero tolerance for any workplace violence such as disrespectful language; aggressive, threatening behaviors; or immediate threat to personal safety." Even job interviews include questions designed to gauge a propensity for violent or aggressive behavior.

"I think one of the things that helps is telling people that they have a right to not be treated [in an abusive] way," says Jezierski. "I think that's a very important message we give employees."

At the same time, Allina stresses that employees must respond to other people "respectfully, objectively, and without making assumptions — even when the other individuals are being offensive and disrespectful," she notes.

Mercy and Unity hospitals, members of the Allina system, post the following statement:

"The administration and employees of Mercy and Unity hospitals are committed to providing a therapeutic environment, free from violence in any form, to promote health within our community.

Elements of a Violence Prevention Program

The U.S. Occupational Safety and Health Administration (OSHA) in Washington, DC, advises health care facilities to maintain a violence prevention program with the following elements:

MANAGEMENT COMMITMENT AND EMPLOYEE INVOLVEMENT

This includes the visible involvement of top management, appropriate allocation of resources, and medical and psychological counseling and debriefing of employees witnessing or experiencing violent events. Employee involvement includes participation in committees or teams, prompt reporting, and education.

WORK SITE ANALYSIS

A "Threat Assessment Team" or similar task force should assess the potential for workplace violence and identify preventive actions. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal, and human resources staff. In addition to reviewing reported incidents, the team may conduct periodic employee surveys and may hire security experts or other professionals to identify risk factors.

HAZARD PREVENTION AND CONTROL

Engineering controls to reduce hazards include panic buttons and alarm systems, metal detectors, enclosed nurses' stations, patient care rooms with two exits, and bright lighting. The guidelines offer numerous suggestions about changes in work practices and administrative procedures. For example, OSHA suggests establishing a list of "restricted visitors" for patients with a history of violence and developing a contingency plan for treating patients who are making verbal or physician attacks or threats. OSHA notes that the areas of greatest risk are the admission units and crisis and acute care units. OSHA also emphasizes reporting of incidents and "a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior."

SAFETY AND HEALTH TRAINING

"Every employee should understand the concept of 'Universal Precautions for Violence,' i.e., that violence should be expected but can be avoided or mitigated through preparation," the guidelines state. OSHA recommends conducting "required training" of employees at least annually, and more frequently (monthly or quarterly) in large facilities. Training includes information on risk factors, early warning signs, methods to diffuse escalating behavior, and response plans for violent situations.

(Editor's note: A copy of the Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers *is available at www.osha-slc.gov/SLTC/workplaceviolence/guideline.html.)* ■

We believe that each person, including patients and visitors, has a responsibility to maintain respectful, safe behavior in all their interactions while at Mercy and Unity hospitals. We will hold all individuals responsible for the effect their behavior has on our community."

Perhaps the ultimate example of a zero-tolerance policy comes from Great Britain, where the health secretary announced that hospitals could refuse to treat patients who threatened or attacked health care workers. After a first incident, patients would receive a written warning. If violent or threatening behavior continued, the hospitals could refuse treatment.

The policy would not apply to patients suffering from severe mental illness or life-threatening conditions.

Another way hospitals can show that they do not tolerate violence is by prosecuting those who assault employees, notes **Gabor Lantos**, MD, PEng, MBA, president of Occupational Health Management Services in Toronto.

"The proper decorum hasn't traditionally been enforced [in hospitals] as it has in other parts of life," Lantos contends. "It's a place where they feel it's safe to let loose. Rarely are there repercussions. There's a tendency for the workplace to become more and more violent because it's tolerated."

While making employees aware of their right to a violence-free workplace, hospitals also need to educate them about how to identify and defuse aggressive behavior.

John Byrnes, DHum, president of the Center for Aggression Management in Winter Park, FL, identifies the stages of behavior that lead to aggression, which he calls "the trigger phase, the escalation phase, and the crisis phase."

The trigger phase can comprise a series of anxiety-producing events, such as when a person oversleeps, rushes to get to work, then encounters an unexpected traffic jam.

"When a person stops coping with their anxiety and stress, they enter into the escalation phase and they have mounting anxiety," says Byrnes. "It changes our behavior, our body language, and how we communicate. We can identify these changes.

"We teach people how to identify the emergence of aggression so they can foresee the possibility of conflict. That foreseeability is essential," he says. "Imbedded in that foreseeability is the imperative to do something now."

When health care workers encounter an agitated patient or family member, they should try to engage the person and connect with them, Byrnes advises.

As an example, he relates a story of a man in his mid-50s who went to a hospital to visit his sister, a woman in her 70s who was suffering from advanced dementia. He found her in a corner of the room completely naked, covered in feces. He exploded and strode to the nurses' station. The nurses pointed him to the head nurse's office, where he barged through the door. She immediately told him, "If I ever found myself in the circumstances your sister is in, I pray I have someone like you as an advocate." The man fell to his knees in tears.

"It's very difficult for an aggressor to become aggressive with someone they perceive as genuinely trying to help," Byrnes comments.

Spot trends to lower potential for violence

The triggers for aggression don't lie solely in individual circumstances. By examining trends, a hospital may be able to make changes to reduce the potential for violence, says **Steve Kaufer**, CPP, co-founder of the Workplace Violence Research Institute in Palm Springs, CA.

"If you're always having conflict in the waiting area in the emergency department, why is that?" he says. "Is it that there aren't enough staff people? We don't explain well enough how the process works? People are more reasonable if they know what's going to happen."

Allina uses a "Threat Assessment Tool" to analyze incidents and determine what steps could be taken to prevent future problems. **(See sample copy, inserted in this issue.)**

Sometimes hospital policy needs to be flexible to allow staff to diffuse the anxiety of family members. For example, Jezierski recalls a time when, as an ED nurse, the brother of a critically ill patient grabbed her arm and demanded to know what was happening with his brother.

"Please let go of my arm," she said in even tones. "I can appreciate your fear about your brother. You must be very concerned about your brother." She explained that she needed to bring some supplies into the room, but would bring someone back to talk to him. She was able to bring him back into the ED to see his brother, then she escorted him back to the waiting area.

Jezierski says she is a proponent of the family presence, whenever possible. "What a difference it makes for someone to see family members," she says. "There's such a need for people to be

Program gives care to assaulted caregivers

When an episode of patient care turns into a frightening moment of violence, the caregiver suddenly becomes someone who needs care. Will he or she get it?

Increasingly, the answer is yes, as hospitals adopt the Assaulted Staff Action Program (ASAP). Developed by psychologist Raymond B. Flannery Jr., PhD, in response to assaults at a large state mental hospital, ASAP offers a peer-based system of crisis intervention and support for employees who have suffered a workplace assault.

Hospitals that implement ASAP have lower staff turnover due to assault-related issues and actually register a reduction in the facility assault rate. The staff learn not just how to respond to violence, but how to avoid it.[1]

In the ASAP model, staff members volunteer to be ASAP team leaders, team supervisors, or first-line responders. The responders carry a beeper and are on-call for 24-hour periods. When an incident occurs, the ASAP volunteer provides immediate crisis intervention. "We would make sure the physical needs are attended to first," explains **Margaret Corrigan**, RNC, nurse manager at Quincy (MA) Mental Health Center and an ASAP team leader. "Within the first eight hours, the person would be contacted to discuss what happened and to see if [he or she has] any symptoms [of psychological trauma].

"People usually say, 'I don't need anything,'" she says. "They're stunned, they're frightened, [and] they become angry. A lot of people go through physical symptoms. They may become hypervigilant; they're watching everything really closely. They have trouble sleeping, difficulty with memory and focus, intrusive thoughts and dreams."

Corrigan knows those symptoms and feelings personally. As a psychiatric nurse, she has been knocked down, kicked across a room, and had her jaw broken by a patient. "If you don't deal with your feelings and get some mastery over them, you're going to carry them with you. It's going to affect your interactions with your family or other patients."

The ASAP volunteer follows up with the employee within eight hours of the incident, then at three days and 10 days. The staff member may be referred to a staff victims' support group, led by the ASAP team leader and an ASAP supervisor, or for more extensive counseling.

"It usually takes a month or more to get over [the trauma]," says Corrigan.

In some circumstances, the ASAP team may hold staff meetings to allow employees to discuss their feelings about a violent incident.

The design of the ASAP team depends on the facility (such as the number of sites) and the frequency of violence. Corrigan suggests gathering baseline information on incidents for a month, including verbal threats and nonverbal intimidation. "You use that information to measure how many people you need on your team to handle the assaults that are happening," she says.

The ASAP members receive training in violence, psychological trauma, and crisis intervention. "Teams work best when members are drawn from all disciplines, including management, and reflect the cultural diversity of the work force to be served," writes Flannery.

When a hospital implements ASAP, employees are reassured that someone is concerned about their feelings and needs if they're hurt. "Because we're caregivers, we think we have to take care of our patients. We always put their needs before our own," says Corrigan. With ASAP, caregivers can get some caring, too.

[Editor's note: A complete description of ASAP can be found in The Assaulted Staff Action Program: Coping with the Psychological Aftermath of Violence *by Raymond B. Flannery, Jr. ($25 plus $5.50 shipping and handling) Chevron Publishing, 5018 Dorsey Hall Drive, Suite 104, Ellicott City, MD 21042.]*

Reference

1. Flannery RB. *The Assaulted Staff Action Program*. Ellicott City, MD: Chevron Publishing; 1998. ■

with their loved ones before they die."

While patients and their family members are often sources of violence-related injuries in health care facilities, they aren't the only ones. A comprehensive prevention program addresses violence that could come from co-workers, managers, physicians, or domestic violence.

Problems that exist in the community at large are likely to spill over into a diverse and large staff. In the Allina system, primary prevention involves creating policies and training for a respectful workplace.

In secondary prevention, staff and managers learn how to detect the signs that a co-worker may be suffering from domestic violence. They also learn to identify and respond to behaviors that may be escalating toward violence.

The emphasis on respect is also designed to address verbally or even physically abusive behavior that may come from an authority figure.

Nurses have tales to tell of physicians who spoke in a demeaning way or threw charts or instruments at them. But with the support of top administrators, hospitals can set clear boundaries that do not allow that behavior, says Jezierski.

"A lot of people say, 'What kind of support am I going to get if I say this is not OK? Who's going to support me?'" she says.

"You need a strong human resources component in this, as well as administrative support," she says. "We have very strong support for a respect-for-work environment. Getting there is not always easy, but [you can do it if] there's strong support from the top down."

(Editor's note: For more information on the Center for Aggression Management, see the web site: www.aggressionmanagement.com. For more information on the Workplace Violence Research Institute, see the web site: www.noworkviolence.com.)

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High-injury hospitals get warning from OSHA

Prevention program keeps VA off the list

Hospitals with higher-than-average injury rates once again are coming under the spotlight as the U.S. Occupational Safety and Health Administration (OSHA) launches its targeted inspection program.

Fifty-six hospitals have received letters advising them that they have rates above eight lost workday injuries or illnesses per 100 full-time workers. Those with rates of 14 or higher will receive unannounced, wall-to-wall inspections.

OSHA reviews the lost workday injury rates of about 1,000 hospitals each year, and keeps on its list those hospitals previously surveyed that had a rate of seven or higher. That means the pool of hospitals in the targeted inspection program will grow somewhat each year, a senior OSHA official says.

One group of hospitals has been notably missing from the list: The Veterans' Health Administration (VHA) maintains 163 hospitals nationwide, but not one has injury rates high enough to attract an OSHA warning.

In fact, in 1999, the VHA had just 2.3 lost time cases per 100 employees, the consequence of a Veterans Affairs (VA) focus on reducing accidents and spreading best practices from its low-injury hospitals. The VA has created "a cultural shift where occupational safety and health becomes the core value, where people think about safety and health as a part of their job rather than a program goal they have to meet," says **Arnold Bierenbaum**, MS, CCE, director of safety and technical services at the VHA in Washington, DC.

The payoff comes not just in healthier workers, but in lower costs, says Bierenbaum. Despite rising medical costs, the VA's workers' compensation dropped from $142 million in 1994 to $138 million in 1999.

"We've been able to show management we've been able to hold the line on costs by making investments in [safety]," he says.

Bierenbaum offers these areas as among the most important elements of an effective health and safety program:

- **Have an organizational structure that directly connects occupational safety and health with top management.** "The CEO of the hospital should have the occupational safety and health function directly accountable to him or her. That would be my recommendation," he says.

In a VA reorganization, Bierenbaum began reporting to the assistant deputy undersecretary for health, who is the direct supervisor of the VHA's 22 network directors. Each network director supervises the CEOs of hospitals and clinics in his or her region.

Previously, Bierenbaum had reported to the director of facilities. "[The network directors] were given specific performance measures in occupational safety and health, and they have to report on the progress they're making toward those goals quarterly," he says.

For example, the network directors have specific targets for lowering accident rates. They also select an occupational safety and health initiative to implement networkwide. Successful projects are shared with other networks.

- **Maintain a database to analyze injury trends.** The VHA is developing a national database to track accidents and injuries. While some VA hospitals had used databases to collect information on needlesticks, this system will be

much more extensive, says Bierenbaum.

"This database will be able to tell you where an accident occurred, the time of day, what shift, where the employee was working," he says. "If we have shift problems, we'll be able to see that. If we have a service or function within a hospital that has a high accident rate, we'll be able to look at that. We'll be able to search and sort and analyze these accidents at a number of different levels."

The goal is to find common elements and to use the information to prevent accidents.

"Anytime there's a lost-time accident or an accident with medical costs, once this is implemented, the accident review board will be required to do a cause analysis to find out what the cause of the accident was," says Bierenbaum. **(For more information on accident review, see *Hospital Employee Health*, June 2001, p. 66.)**

• **Work as a team with other safety professionals.** Bierenbaum says the VA is building a "community of practice," made up of the main "stakeholders" in the effort to improve worker safety. They include safety and occupational health professionals, workers' compensation, unions, and top management.

"They all share a common goal of wanting more money for patient care and lowering their costs," he says. "You've now formed a common cause for collaboration. That's been hard to come by, but we're getting there.

"If employee health tries to work alone, [it] won't succeed," he says. "If safety works alone, [it] won't succeed. If workers' comp works alone, [it] won't succeed. But together, they will succeed."

The teams help develop best practices and policies, he says. The VHA also has compiled guidebooks with sample policies that can be used by its hospitals; the CD-ROMs are available for purchase by private sector hospitals, as well. **(See editor's note at the end of this article for more information.)**

• **Involve the unions in planning and implementing the safety program.** "One way we ensure there's quality control is to train and empower the unions," says Bierenbaum. "In some management quarters, that sounds like heresy. But the truth of the matter is the unions are . . . out there in every workplace. They know what's going on."

The union participates on the local management teams for safety and health, Bierenbaum says. It is involved not just in accident evaluation and prevention, but in related areas, such as software development, he says.

That doesn't mean the union has the ultimate power. "We don't seek its approval for everything; we seek its input," says Bierenbaum. "If [it has] good ideas, we use them. If [it doesn't], we don't."

Involving the union pays off in better accident prevention. But it also means union negotiations are much smoother.

"It takes more time on the front end, but overall you save time," he says. "Plus you get a good program [that involves] the front-end workers."

[Editor's note: To obtain VA Occupational Safety and Health guidebooks, contact Nancy Adams, Center for Engineering, Occupational Safety & Health. Telephone: (314) 543-6711.] ■

Break myths about flu vaccine to boost rates

Hospital sees one-year rise from 11% to 60%

Delays in delivery of influenza vaccine have created new challenges for employee health professionals as they try to boost their vaccination rates of health care workers. But as one hospital found, misconceptions about the influenza vaccine create long-standing obstacles to vaccination.

Health care workers often harbor myths about the vaccine's effectiveness and possible side effects, says **Mary Lou Solliday**, RN, MPH, CIC, director of infection control at St. Francis Hospital — The Heart Center in Roslyn, NY.

Solliday identified the reasons health care workers fail to receive the vaccine through a survey of hospital staff, conducted with assistance from the Centers for Disease Control and Prevention in Atlanta. A significant number of employees believed they could contract influenza from the vaccine — even though it uses a dead virus, says Solliday. Others worried that the vaccine could be harmful. **(For list of reasons, see box, p. 116.)**

Through a campaign to debunk myths, launched with highly visible top management support, St. Francis Hospital improved its vaccination rate from 11% to 60% in just one year, says Solliday, who presented information on her hospital's vaccination program at the recent Association for Professionals in Infection Control and Epidemiology conference held in Seattle.

"It's an educational process that requires

Reasons for not Getting Vaccinated

Justification	Resolution
Avoid all medications whenever possible	People of any age can get influenza. Most people are ill with influenza for only a few days, but some get much sicker and may need to be hospitalized. Influenza causes thousands of deaths each year, mostly among the elderly. Influenza vaccine can prevent influenza.
Worried about side effects	Randomized trials in healthy adults have reported that the only side effects seen more commonly in those vaccinated with influenza vaccine vs. placebo is sore arm.
Concerned about getting the flu from vaccine	The viruses in the vaccine are killed, so you cannot get influenza from the vaccine.
Forgot, too busy, inconvenient	Employee health services will set up an area on each floor to make vaccinations convenient for all employees.
Pregnant, breast-feeding, or trying to get pregnant	Pregnancy tests are available in employee health services. Influenza vaccine is safe for nursing mothers and their infants and is recommended for women who will be in their second or third trimester of pregnancy during the influenza season.
Not recommended by their doctor	Vaccination of all health care workers has been recommended for many years.
Concerned about effectiveness of vaccine	Influenza vaccine is effective only against illness caused by influenza viruses, and not against other causes of fever and colds. Influenza viruses change often, and they may not be covered by the vaccine. But people who do get influenza despite vaccination often have a milder case than those who did not get the shot.
Vaccinated previous year	Viruses that cause influenza change often. Because of this, influenza vaccine is updated each year by replacing at least one of the vaccine viruses with a newer one. This is done to make sure the vaccine is as up-to-date as possible. Protection develops about two weeks after the shot and may last up to a year.

Source: St. Francis Hospital — The Heart Center, Roslyn, NY.

constant reinforcement," says Solliday.

Health care workers sometimes don't realize the possible consequences of failing to get vaccinated. That came into focus at St. Francis in 1999 when the hospital identified a nosocomial spread of influenza in one cluster of patients.

Despite expected delays in distribution of the flu vaccine this year, the CDC and the Advisory Committee on Immunization Practice place a high priority on vaccinating health care workers who work with patients at high risk of complications from influenza.

"During the winter, influenza can have a pretty substantial impact upon hospitals in terms of patient visits, hospitalized patients, absenteeism among health care workers, and unrecognized nosocomial transmission of influenza," says **Tim Uyeki**, MD, MPH, MPP, medical epidemiologist in CDC's influenza branch.

The year after the outbreak, the chief executive officer of St. Francis sent a letter to every employee explaining the importance of getting vaccinated and emphasizing that the vaccine is safe and effective. CDC reports that the influenza vaccine, which is formulated each year to match the prevalent strains, is 70% to 90% effective.

The hospital's medical director sent a similar letter to physicians, urging them to get the vaccine.

The annual vaccination campaign began on Employee Appreciation Day, when staff gathered for a barbecue. "Administrative staff served as role models by rolling up their sleeves and

getting vaccinated first," says Solliday.

Meanwhile, Solliday and her colleagues were armed with an information sheet explaining the myths and facts about the vaccine. For example, women who were pregnant, trying to get pregnant, or breast-feeding were concerned about getting the vaccine. Yet CDC actually recommends that women who will be in their second or third trimester during the flu season have the vaccine, and the vaccine is considered to be safe for those who are breast-feeding.

Health care workers also need to realize that the flu vaccine won't prevent them from all types of respiratory illnesses in the winter, notes Uyeki. "The common cold virus can cause a high fever, coughing, runny nose, and people will conclude, 'I have the flu. I got the flu shot in the fall, and I still have the flu,'" he says. "Most likely they didn't get the flu, they got other upper respiratory infections."

This year, the CDC has asked manufacturers to distribute some early vaccine to all providers. Hospitals will give priority doses to the highest-risk patients and those who care for them.

But education of health care workers should include information about the value of the vaccine even later in the fall or early winter, says Solliday. "It's still going to protect them, and it's still important."

The influenza vaccine takes one to two weeks to become fully effective. In an average year, the influenza season stretches from late December to early March, with peak activity in the early spring. Hospitals can improve influenza vaccination rates by extending the time period in which they offer the vaccine at employee health departments, says Uyeki. ■

Does your hospital's CEO promote hand hygiene?

No one ever enters the sterile field of the operating room without first scrubbing his or her hands. But how can you get other staff to place a similar importance on basic hand washing between patient encounters?

Researchers say two steps can lead to better hand hygiene: One step is complex, and one is simple. The organizational climate, led by hospital administration, needs to make hand hygiene a priority.[1] And the use of alcohol-based gels in convenient dispensers can reduce skin irritation and improve compliance.[2]

Trying to change behavior one unit at a time can be frustrating, or even futile, asserts **Elaine Larson**, RN, PhD, professor at the Columbia University School of Nursing in New York City and an expert on hand hygiene.

"I think the trick is taking a systems approach rather than trying to work on individual change," she says. "It takes the blame out of things. The whole organization expects this behavior from you, and it's the norm. Then I think people are much more likely to change. If they think their peers are going to be doing this, then they are as well."

The strongest way to emphasize hand hygiene would be to include it in employees' performance evaluation. But that is not the only way to impress upon staff that consistent hand washing is a vital part of their jobs, says Larson. "The difference isn't so much the specific strategies you use as it is the very strong administrative involvement."

In her study of organizational climate change, Larson began by meeting with the hospital's chief executive officer, vice president for nursing, hospital board, and medical staff board. A team of about 20 managers held brainstorming sessions and developed the interventions.

The team began with an open letter from the CEO to all employees, volunteers, and physicians emphasizing the commitment to hand washing and to the proposed intervention. It also sent out fact sheets on hand washing and conducted educational programs.

The strongest element, however, involved a new competency-based practice. All employees were required to demonstrate their competency in hand hygiene before they could provide patient care. That requirement remains for all new employees, as well.

"If you're trying to change a very inbred practice, you've got to make it look different than it did before," says Larson. "You can't just have an infection control nurse going around telling people to wash their hands. It's totally worthless, in and of itself."

Using counters hidden inside soap dispensers, Larson and her colleagues counted significantly more hand-washing episodes at the intervention hospital than the control hospital. At a six-month follow-up, hand washes per patient care day were double that of control. Meanwhile, nosocomial infections with vancomycin-resistant enterococci were significantly lower at the intervention hospital.[1] "Nothing's going to work unless there's this

climate change," says Larson. "Even with that, there have to be multiple interventions, even if they're small. The staff have to believe that their bosses really value this practice."

Even simple interventions work better from the top, down, says Larson. "The strategies [the managers] suggested, we have tried and they didn't work," she says. "They didn't work before because they weren't coming from the bosses."

To achieve sustained change, hospitals also must be prepared for long-term support of the interventions. At three Minnesota hospitals, a study found that a multidimensional intervention with education, reminders, and role modeling by unit heads resulted in short-lived improvements.[2]

"We did see a significant increase in adherence, up until about 50 to 60 days," says **Carol O'Boyle**, PhD, epidemiology supervisor at the Minneapolis Health Department. "At about two months, we began to see that it reverted to baseline. You need six months of support before [a task] is incorporated into their behavior."

At the University of Utah Hospitals and Clinics in Salt Lake City, continuous feedback based on observation of hand hygiene helped employees boost their compliance rates.[3] A monthly "Golden Hand" award created competition that inspired units to improve their hand hygiene, says **Adi Gundlapalli**, MD, PhD, a third-year fellow in infectious diseases at the University of Utah School of Medicine who coordinated the yearlong project.

The feedback also was very visible. For example, graphs showing how units fared on hand hygiene were placed in the employee bathroom of the medical intensive care unit — where everyone was sure to see it.

Perhaps the most effective intervention came from the unit that chose hand hygiene as a pay-for-performance project. Their goal was 70% compliance, a rate the unit exceeded, Gundlapalli says.

The challenge now will be to provide periodic observation and feedback on hand hygiene, even after the project is completed, says **Barbara Mooney**, RN, CIC, coordinator of hospital epidemiology at the University of Utah.

"As infection control people, we have to sustain the effort," says Mooney. "We can't say we've done this, and move on. This will be something that's too important to let go."

Meanwhile, studies continue to show the potential impact of using alcohol-based gels instead of soap and water. Both O'Boyle and Gundlapalli found a high level of acceptance of the gel product. The gel can eliminate or reduce skin irritation due to washing, which is one reason for diminished hand hygiene, experts say.

In fact, while Gundlapalli limited his project to four units, other hospital departments independently bought the gel and began using it, Mooney says. "It's very successful for them also, although they're not a part of the project," she says.

CE questions

13. According to **John Byrnes**, DHum, president of the Center for Aggression Management in Winter Park, FL, what is one way employees should be taught to diffuse an agitated and potentially aggressive patient or family member?
    A. engage and create a personal connection
    B. notify security to respond to that person
    C. seek assistance from the physician
    D. avoid all unnecessary contact

14. With low injury rates, Veterans Affairs hospitals have avoided being part of OSHA's targeted inspection program. According to **Arnold Bierenbaum**, MS, CCE, director of safety and technical services at the VHA in Washington, DC, one reason the VA hospitals have low injury rates is:
    A. The VA can afford more sophisticated safety equipment.
    B. The VA conducts more inservice training that any other hospital system.
    C. A VA reorganization gave health and safety a high-profile position.
    D. The VA has a large employee population, which means a lower rate per 100 workers.

15. Which of the following is a common misconception about the flu vaccine and a leading reason why health care workers don't get vaccinated?
    A. Influenza is not a very serious illness and the shot isn't important.
    B. Only patients need to get influenza vaccines.
    C. The influenza vaccine is too expensive and should just be used on select staff.
    D. You can get the flu from the influenza vaccine.

16. According to **Elaine Larson**, RN, PhD, professor at the Columbia University School of Nursing and an expert on hand hygiene, why do efforts to improve hand hygiene fail to produce lasting results?
    A. Health care workers forget to wash their hands.
    B. Hospitals don't have enough accessible sinks.
    C. Hand hygiene efforts must be led by top management.
    D. Not enough research has been conducted on hand hygiene.

Swiss researcher Didier Pittet found numerous factors that contribute to poor hand hygiene, including heavy workload, understaffing, lack of administrative leadership and support, and lack of adequate hand hygiene agents.[4]

Although it can't address all the problems that lead to poor hand hygiene, alcohol-based gel can improve compliance, Pittet found. "[E]asy and timely access to hand hygiene . . . and the availability, free of charge, of skin care lotion, both appear to be necessary prerequisites for appropriate hand hygiene behavior," he concluded.

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Industrial hygienist takes helm of OSHA

Seven months after President George W. Bush took office, the U.S. Occupational Safety and Health Administration (OSHA) received new leadership. John L. Henshaw, the assistant secretary of labor for occupational safety and health, will immediately become a player in the agency's most controversial topic: ergonomics.

Secretary of Labor **Elaine Chao** promised to announce a "comprehensive approach" to ergonomics in September. Henshaw, who was confirmed by the U.S. Senate on Aug. 3, will lead OSHA's implementation.

Henshaw has been lauded for his extensive background in industrial hygiene. A former president of the American Industrial Hygiene Association, he worked in the chemical industry for more than 26 years, where he directed environmental, safety and health programs. Most recently, he was director of environment, safety and health for Astaris LLC, a St. Louis-based joint venture between Solutia and FMC Corp. chemical firms.

Henshaw, who earned a master's of public health from the University of Michigan, has authored books on safety and health management.

"We're supportive of his confirmation. We think he brings a stature to the job that it deserves," says **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union in Washington, DC. "It's really an agency that needs some leadership. It also needs to motivate the staff and get them to move forward in positive directions, where it's possible in this political climate. I'm hopeful that John has that ability."

After the confirmation, the American Association of Occupational Health Nurses in Atlanta moved quickly to establish a relationship with Henshaw. **Kae Livsey**, RN, MPH, public policy

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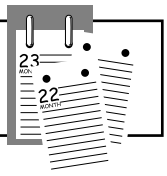
and advocacy manager, said she wants to emphasize the important role of occupational health nurses. "The office of occupational health nursing is a very valuable office within the agency," she says. "As they look at restructuring, which I'm sure they will, we have to be assured that [occupational health nursing is] going to be recognized for what they do." ■

CALENDAR



• **Association of Occupational Health Professionals** — Oct. 11-13, Pittsburgh. For information on the 20th annual conference, contact AOHP, (800) 362-4347. Fax: (703) 435-4390. Web site: www.aohp.org/aohp.

• **State-of-the-art Conference** — Oct. 28-Nov. 1, Seattle. Sponsored by the American College of Occupational and Environmental Medicine (ACOEM). Contact: ACOEM Education Dept., 1114 N. Arlington Heights Road, Arlington Heights, IL 60004. Telephone: (847) 818-1800. Fax: (847) 818-9286. Web site: www.acoem.org. ■

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. ■

Workplace Violence Threat Assessment Tool

Note: This tool would be utilized for data gathering and would not be kept as a part of medical records. Each business unit would determine who would maintain report files, how collective data are analyzed and who is accountable for findings and response to need for change.

Following are data points that may be helpful in evaluating safety. Information about the incident should be well documented. This tool is not all-inclusive, so additional information may be required depending on the circumstances.

CIRCUMSTANCES:

• Location of incident _____

• Time _____ Date _____ Length of time_____

• Threat? Yes or no. Violent act? Yes or no. Explanation of incident:

_____
_____
_____
_____

• Weapons? Description of any weapons or objects used to threaten:

_____
_____
_____
_____

• Victims and witnesses: Names, job titles, work location of all individuals involved:

_____
_____
_____
_____

• Perpetrator(s), Name(s), address(s), relationship to the hospital or intended victim:

_____
_____
_____
_____

• Perpetrator's status: At large? Yes or no. Under arrest? Yes or no. Current whereabouts are:

_____
_____

• Domestic violence: Is this a potential issue? Yes or no. If yes, explain issue(s):

_____
_____
_____
_____

HISTORICAL INFORMATION:

• Were there any precipitating factors which may have lead up to the threat?

_____

_____

• Has this threat occurred before and if so, under what circumstances?

_____

_____

• Is there any significant change in the alleged perpetrator's behavior?

_____

_____

• Is there anything that may be contributing to the behavior?

_____

_____

• Have others been threatened by this individual?

_____

• Other pertinent information

_____

_____

_____

_____

• Team recommendations:

Further Action	Responsible Person	Completion Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Follow-up meeting necessary? Yes or No. If Yes:

_____	_____	_____
Date	Time	Location

Source: Building a Respectful Workplace: A Toolkit for the Prevention and Management of Workplace Violence.

Documentation
FAX-BACK SURVEY

Supplement to: *Case Management Advisor, Complementary Therapies in Chronic Care, Contraceptive Technology Update, ED Management, ED Nursing, Hospital Access Management, Healthcare Benchmarks, Hospital Case Management, Hospital Employee Health, Hospital Home Health, Hospital Infection Control, Hospital Payment & Information Management, Hospital Peer Review, Healthcare Risk Management, Medical Ethics Advisor, Occupational Health Management, Patient Education Management, QI/TQM, Rehab Continuum Report, Same-Day Surgery*

Instructions: Please answer all questions completely and accurately.

Nearly every profession involves paperwork, but in health care, the need for thorough and accurate documentation is especially great. After all, poorly documented care can result in claims denials, lawsuits, and even criminal investigations. We'd like to hear your thoughts on why appropriate documentation is important in your work.

Do you think of documentation primarily as an issue of **(please circle only one item)**:

A. Coding
B. Outcomes measurement
C. JCAHO or other accreditation
D. Federal or state regulatory requirements
E. Other (please list) _____

On a scale of 1 to 5, please rate the following considerations by their relevance to you professionally:
(1 = extremely relevant to me; 5 = not relevant to me at all.)

__ Poor documentation could lead to legal or regulatory consequences.
__ Poor documentation could be an obstacle to accreditation for my department/facility.
__ Poor documentation could cost my facility money because of claims denials.
__ Accurate documentation is necessary to ensure proper care for patients along the continuum of care.
__ Accurate documentation is necessary to prove my/my department's effectiveness to administrators.
__ Accurate documentation helps me to identify critical needs in my department.
__ Accurate documentation is required to fulfill managed care contracts.

In your own words, why is documentation important in your work?

_____

_____

What sort of information or advice would help you better deal with your documentation responsibilities?

_____

_____

What is your title? _____

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Thank you for your assistance.

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