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IN THIS ISSUE

Continued on next page

Don't let second highest occupational injuries fall off the radar screen

NIOSH project seeks to prevent slips and falls

Are you ignoring the second costliest occupational injuries in hospitals? If so, you're not alone. Hospitals are spending thousands of dollars to prevent ergonomic injuries, but devote little attention to the second most common and costly injuries: slips and falls.

Injuries from falls are about 40% more common in hospitals than in general industry, according to 2000 data from the Bureau of Labor Statistics. They cause more than 14,000 reported injuries per year, leading to back sprains, fractures, and lost workdays. And they are difficult to prevent.

Bringing the problem into focus

For all of those reasons, injuries from slips and falls in hospitals have become the focus of a comprehensive new study by the National Institute for Occupational Safety and Health (NIOSH) in the Morgantown, WV, research office.

"From the standpoint of nonfatal traumatic injuries, once you roll out your back injury program, this rises to the top [as a priority]," says **James Collins**, PhD, MSME, NIOSH epidemiologist/engineer and project officer for the Slips and Falls Prevention in Health Care Workers project. "That's your No. 1 injury problem right behind the ergonomics issue."

"[But] it's a little bit of a different situation because it's not really clear how it's to be controlled," he adds.

In This Issue **continued from cover**

Are your employees breathless?

Nonsmoking health care workers suffer from asthma at rates twice as high than for the general population. That fact has prompted the National Institute for Occupational Safety and Health to take a closer look at the respiratory hazards in hospitals. In one project, a researcher will develop an asthma questionnaire and determine the prevalence of occupationally related asthma in certain health care occupations 114

A proven way to prevent workplace violence

Past violence predicts future violence. That truism is equally valid for disruptive and difficult patients who become violent or verbally abusive. A program of flagging certain patients has allowed the Portland (OR) VA Medical Center to prevent problems while continuing to offer care to those difficult patients 115

E-mail helps boost TB compliance

Christine Pionk, MS, RN, CS, a nurse practitioner in employee health at the University of Michigan Health Systems in Ann Arbor, found that her reminders for TB screening weren't always reaching her target audience, so she used a more high-tech method. Now she e-mails everyone who needs the screening and allows them to fax back the result, which is read by other nurses or physicians. Such practical solutions to employee health problems will be highlighted at the upcoming conference of the Association of Occupational Health Professionals in Health Care, to be held Oct. 16-19 in St. Louis 117

News Briefs

Also in this issue

COMING IN FUTURE ISSUES

- Why the nursing shortage is leading to HCW injuries
- Should foreign workers be tested for HIV?
- How two hospitals improved HCW vaccination rates
- Update on surgical smoke investigation
- TB exposure: How one hospital was caught off-guard

Collins is working with BJC Health Care in St. Louis, a 13-hospital system that hopes to save $1 million or more through prevention activities.

"Every year, we analyze our injuries and look at which entity has the worst injury rates and what type of injuries they are," says **Laurie Wolf**, MS, CPE, ergonomist and manager of WellAware program at BJC Health Care.

"The reason we're so interested in slips and falls is that our workers' comp claims are about equal to our back injuries," she says.

In 1999, an icy winter contributed to an awful year for slips and falls for BJC's 22,000 employees. (The system includes five long-term care facilities and eight home health care units.)

That year, 55 outdoor injuries and 165 indoor injuries led to a peak of about $2 million in fall-related workers' compensation claims, a substantial portion of the system's $5 million total claims costs. Falls led to broken hips, shattered kneecaps, and broken legs, in addition to the usual bruises and sprains.

Wolf also realizes that her staff may become more vulnerable to serious injury as the work force ages. "If a fall happens when you're 20, you might get up and walk away. If that same fall happens when you're 45 or 50, you're going to break something," she says.

Modest goal of 20% improvement

Often, falls seem like isolated incidents. One day, someone slips on a bit of soapy water that sloshed from a bucket. Another day, someone steps on an icy patch on the steps and falls. Could the events have been prevented?

By the time Collins finishes his three-year project, he hopes the answer will be yes — at least, sometimes, he says.

Collins is working with researchers from the Liberty Mutual Research Center for Safety and Health in Hopkinton, MA, and the Finnish Institute for Occupational Safety and Health in Helsinki, Finland.

They will review six years of injury data and compare interventions at five hospitals — including two Veterans Affairs facilities — with seven control hospitals. They will conduct laboratory tests of flooring, slip-resistant shoes, and floor waxes.

Yet Collins has modest goals. He doesn't anticipate the dramatic gains that occur with patient-handling equipment or safer needle devices.

"When you put every conceivable effort going

Research takes steps toward slip prevention

Slips and falls at work aren't just random events. As part of a comprehensive study of fall prevention, the National Institute for Occupational Safety and Health in Washington, DC, is implementing these and other interventions:

- ✔ pop-up tents to cover spills until they are cleaned;
- ✔ caution tape, chains, and other devices to prevent access from wet or soiled areas;
- ✔ beepers to contact housekeeping managers immediately when spills occur;
- ✔ skid strips on stairs;
- ✔ icebreaker mats at entrances;
- ✔ ice cleats for home health nurses;
- ✔ slip-resistant shoe covers (booties) for operating room staff;
- ✔ re-routing shuttle buses away from areas that collect ice and water. ■

in, we're looking at achieving a 20% reduction [in falls]," he says. "We're trying to be realistic about it."

Still, a 20% reduction would amount to $400,000 in savings for BJC, based on the 1999 data. Wolf hopes the efforts might yield even more.

When Collins reviewed the results of 29 interviews on cases of falls, only one reported no injuries. There were four extremity sprains, three fractures, and 21 contusions and lacerations.

Let's step outside

While falls may seem to involve unique circumstances, they can be grouped in some broad categories. For example, about a quarter of BJC's falls occur outside.

Icy weather creates problems, but sometimes there's an unnoticeable hole in the grass. Home health workers may trip as they approach someone's house.

In one case, a shuttle bus let off employees at a spot where a downspout drained and left a puddle of ice. The hospital moved the shuttle stop. But most interventions are not so clear-cut.

"I can't say [the falls are] all at the front entry way because it's wet," Wolf says. "It's not that simple. We're trying to do a little bit of intervention everywhere."

In the winter, BJC now sends out e-mail alerts to staff when bad weather is expected, urging them to take precautions. Administrators ask employees to report slippery patches to safety contacts so the areas can be plowed or salted.

Researchers to test shoes, flooring

A shoe with no traction, a newly waxed floor, a little moisture: That's a disaster scenario that Collins will try to unravel in the laboratory.

He'll test unglazed ceramic tiles (with and without anti-skid particles), rubber, linoleum, vinyl tile, and sheet vinyl as well as new flooring materials for their friction measurements.

Collins says he will try to determine which types of shoes most commonly are worn, and will compare their slip resistance with that of special slip-resistant soles. NIOSH researchers will visit test hospitals and conduct friction measurements on site. Researchers also will compare the impact of various floor waxes.

Meanwhile, Collins is seeking interventions that reduce the hazards. For example, housekeeping managers will receive beepers so they can be notified immediately when there is a spill and act quickly to clean it up and mark the area as a fall hazard.

"I think our greatest hope is going to lie in aggressive housekeeping, keeping the floors clean and dry, and keeping wet floor signs down with chains on them so people can't just run through the area," he says.

Then there are problems specific to different parts of the hospital. In the cafeteria, spilled oil or sloshing dishwater can leave dangerous slip zones.

In the operating room, infection control booties that become wet from water, blood, or other fluids can be as slick as an ice skate. The marble in the hospital lobby becomes a fall hazard when people track in rainwater.

For every problem that's identified, Collins and his colleagues will look for a solution. In fact, he notes, there has never been such a comprehensive approach taken to occupational slips and falls in the hospital setting.

"Let's hope we can cut down some injuries," he says. ■

Needle safety is not among JCAHO's top goals

Surveyors still will ask about compliance

A *Sentinel Event Alert* that once promised to put needle safety under the accreditation spotlight will remain consultative, according to the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

Needle safety was not among the National Patient Safety Goals announced by the Joint Commission in July. Hospitals will be monitored for compliance with those goals, which include medication mix-ups and wrong-site surgery. However, surveyors will still ask about needle safety, says **Richard J. Croteau**, MD, executive director for strategic initiatives.

"The expectation is the same," he says. "The difference is what we'll actually survey and score. It shouldn't be interpreted that we've backed off from the expectation."

Five of the recommendations in the needle safety *Sentinel Event Alert* — which outlined the mandate to use safety-engineered devices, maintain a sharps injury log, and involve nonmanagerial workers in device selection — were included in a pool of recommendations that were judged to be "efficacious, practical, and cost-effective," Croteau says.

A complete list of the recommendations reviewed by the Joint Commission's advisory group will be published in a future issue of *Joint Commission Perspectives*, he says.

Needle safety didn't quite fit with the concept for the National Patient Safety Goals, which are geared toward reducing health care errors. "These [needle safety] recommendations are different from almost everything else that we've published in that they're aimed more at staff safety," Croteau says. "It's a little outside the defined purview of this initiative."

The Joint Commission has a standard relating to employee safety, and another that requires facilities to follow applicable laws and regulations. For several years, the Joint Commission has maintained a partnership with the U.S. Occupational Safety and Health Administration (OSHA), including cross-training of surveyors and OSHA inspectors.

Surveyors have been asked to inquire about all the alert recommendations and provide feedback on facility response. "Very often just the fact that the Joint Commission has an interest in something is a strong motivator, whether or not it's explicitly surveyed and scored," Croteau notes.

JCAHO still could exert influence

Although needle safety experts expressed disappointment that the Joint Commission didn't place a higher priority on needlestick prevention, they still noted that the agency could become a positive force for change.

"I think JCAHO's going to look at [needle safety in surveys]," says **Katherine West**, MSEd, CIC, an infection control consultant based in Manassas, VA. "It's a federal mandate. I don't interpret it as completely backing off of the issue."

Increased scrutiny of needle safety efforts is needed, West emphasizes. "As I travel around the country, I find that a lot of hospitals have not yet complied [with OSHA's revised bloodborne pathogen standard]," she says. "I have run into a lot of places that have not complied at all, and some that have minimal compliance, like they changed one item."

That experience is shared by **June M. Fisher**, MD, a needle safety expert and director of the TDICT Project at the Trauma Foundation of San Francisco General Hospital. "At the present time, I'm hearing that a lot of hospitals don't have all the devices, or if they do, they don't really have health care worker input," she says.

Fisher notes that needle safety is, in fact, a patient safety issue. A needlestick exposure may impact the continuity of care of patients while the caregiver seeks treatment. Patients also are tested for bloodborne pathogens, a situation that may cause them some unnecessary anxiety, she adds. "I think it is simplistic to think this just happens to health care workers." ■

GPO contracts don't incite OSHA inspectors

But placing cost above HCW choice could

Buying needle safety devices based on group purchasing organization (GPO) contracts isn't likely to earn you an Occupational Safety and Health Administration (OSHA) citation, but making cost a priority over health care worker preference could.

GPOs have been under scrutiny in a series of articles in *The New York Times* that have questioned special fees and other contractual arrangements with manufacturers that could limit product choice. They allow hospitals to save money by pooling their buying power and negotiating contracts with suppliers.

Brand choice would not concern OSHA inspectors as long as health care workers favored the device selected and were able to evaluate various technologies, OSHA compliance officials told *Hospital Employee Health*.

"If they're buying good devices [through the GPO], that's OK," says **Melody Sands**, MS, director of OSHA's office of health compliance assistance. "If they're saying they can't buy safety devices, that's a problem. All we're looking at is: 'Is the employee protected?' We don't care [about the brand] as long as the device works for them."

There is no requirement for hospitals to consider a certain number of safety technologies, Sands notes. But each year, the exposure control plan must show that frontline health care workers were involved in the selection and that new technologies were considered.

The selection process should allow different hospital units to make their own choices, recognizing that the patient populations and procedures create different needs, notes **Amber Hogan**, MPH, an industrial hygienist in OSHA's office of compliance assistance.

OSHA has received phone calls from employees who say their employers chose a device based on cost that was not favored by the staff. However, none became a formal complaint, Hogan says. "It would worry us if an employer would only consider a device because of cost," she says.

Consider all choices in selection

Choice has become an integral aspect of device selection. With a fast-growing market of needle safety devices, hospitals now have an unprecedented number of options in various product categories. Needle safety experts say it's important to keep that breadth of choice available to health care workers.

June M. Fisher, MD, director of the TDICT Project at the Trauma Foundation of San Francisco General Hospital and an expert on device evaluation, advises hospitals to screen all available devices before selecting items for further consideration.

Device evaluation committees "shouldn't be restricted [in the initial screening] by their materials management," says Fisher. "You should know all the technology that's out there when you have your review."

Various product evaluation forms are available on-line, including at the TDICT site (www.tdict.org) and Premier, one of the nation's largest GPOs (www.premierinc.com/safety).

GPOs have made adjustments based on the federal Needlestick Safety and Prevention Act, which mandated the use of safety devices. Hospitals may purchase devices "off-contract." Some GPOs also have broadened their product base.

"The law requires frontline workers to choose the devices that are most appropriate for their particular work setting," says **Gina Pugliese**, RN, MS, vice president of the Premier Safety Institute in Chicago.

"The group purchasing contracts are only a place to start to look for cost-effective choices." she says. "The law says you have to pick what the frontline workers want."

Pugliese notes that Premier, one of the nation's largest GPOs, has contracts with 16 different sharps safety companies. "We have almost every IV catheter company on the market under contract," she says. "We think it's important that hospitals have the opportunity to try out all kinds of technology."

In 2001, Retractable Technologies Inc. of Little Elm, TX, filed an antitrust lawsuit against the GPO Novation, Becton Dickinson, Premier Inc., and Tyco International, another device maker, asserting that the large manufacturers and buying groups conspired to create monopolies in the safety device market. All have denied the claims. In July, an article in *The New York Times* revealed $1 million in "special marketing fees" paid by Becton Dickinson to Novation as part of its exclusive contract. In a release, BD said the fees were paid to "offset Novation's anticipated losses, resulting from the fact that Novation was switching suppliers." Novation called the fees "an element of the financial value that suppliers offer to members as part of their bids."

Be alert to state laws

Hospitals may need to look beyond OSHA to determine how they select devices. Twenty-one states have passed laws regarding needle safety devices. Some of those laws contain requirements that are even tougher than federal OSHA and may

impact the issue of device selection. For example, in Georgia, hospitals with public employees must use "the most effective available needleless systems and sharps with engineered sharps injury protection." Minnesota's law requires hospitals to "document consideration and implementation of appropriate commercially available and effective engineering controls."

New Jersey, home of the BD corporate headquarters, requires licensed health care facilities to use only sharps and needle devices with integrated safety features that have been approved by the Food and Drug Administration. The law provides for a waiver if no appropriate device is available.

The involvement of licensing as a mechanism for ensuring compliance makes the New Jersey law one of the strictest in the nation.

[Editor's note: For more information on complying with OSHA mandates on needle safety devices, sign up for our upcoming audio conference, ***Sharps Safety Compliance: How to Avoid OSHA Citations and Costly Fines****, scheduled for Wednesday, Oct. 23 from 2:30 to 3:30 p.m., ET. To register, call (800) 688-2421 and mention effort code 62761. The facility fee is $299, which includes free CE and CME for your entire staff, program handouts and additional reading, a convenient 48-hour replay, and a conference CD.]* ■

Breathless? Respiratory hazards gain scrutiny

Why is asthma more common among HCWs?

The high rate of asthma among health care workers has prompted federal officials to take a closer look at respiratory hazards in health care facilities.

Among nonsmoking hospital workers, the prevalence of asthma is 14.4%, twice as high as the general population of nonsmokers.[1] Although surveillance of occupational asthma has been difficult, researchers are trying to determine the factors that may lead to higher risk in health care facilities. Meanwhile, asthma is a growing health problem nationally, with more than 17 million Americans now suffering from the disease.

This summer, the Occupational Safety and Health Administration issued fact sheets on ethylene oxide and formaldehyde. **(See editor's note for more information.)** The National Institute for Occupational Safety and Health (NIOSH) also launched several studies related to asthma in health care workers, ethylene oxide, and other respiratory hazards.

"NIOSH is responding to a variety of information sources that are suggesting that respiratory hazards are a possible increasing problem among health care workers," says **Lee Petsonk**, MD, senior medical officer in the division of respiratory disease studies at NIOSH in the Morgantown, WV, research office. "We're initiating a study looking at what exposures are occurring in the health care industry that might be hazardous."

While the study is a comprehensive one, respiratory hazards will receive scrutiny alongside needle safety and ergonomics, he says.

Asthma is a particularly difficult occupational injury to track because there are so many potential irritants in health care facilities as well as in the home and outdoor environment. "It's so difficult to tease out what is occupational and what is not occupational," says **Gabor Lantos**, MD, PEng, MBA, president of Occupational Health Management Services in Toronto and an occupational health consultant. In a training seminar on respiratory hazards in health care, Lantos outlines dozens of potential hazards ranging from aerosolized viral particles and anesthetic gases in the operating room to cleaning solutions used to strip wax on floors.

To get a better handle on asthma among health care workers, a NIOSH-sponsored researcher is developing a targeted asthma questionnaire and investigating links between occupational exposure and asthma. This link is important to establish because it's possible that people with asthma have a greater interest in health care professions — leading to a higher prevalence in that occupation, Petsonk says.

"The survey will also allow us to see if there were any specific associations with any chemical exposures in health care settings," says **George Delclos**, MD, MPH, associate professor and director of the Southwest Center for Occupational and Environmental Health at the University of Texas School of Public Health in Houston.

In previous studies, latex has been associated with occupational asthma in health care workers.[2] However, the reduction in the use of powdered latex gloves may have reduced that sensitivity, Petsonk says.

Glutaraldehyde, a sterilizing agent, also has been associated with respiratory symptoms.[3] **(See**

***Hospital Employee Health*, February 2001, p. 13.)** In fact, earlier this year, the United Kingdom's National Health Service withdrew Cidex, a Johnson & Johnson glutaraldehyde product, from its facilities in favor of Cidex OPA, an alternative that is glutaraldehyde-free. Complaints about skin and respiratory problems among health care workers prompted the change.

To validate the asthma questionnaire, Delclos, a pulmonologist and occupational medicine specialist, will administer it to a sample group along with interviews by an industrial hygienist and allergy and pulmonary function tests. He will then administer the asthma survey to a larger population of physicians, nurses, and respiratory therapists, as well as occupational therapists, which is considered a low-risk group.

Delclos says, "We're looking to answer three questions: What is the prevalence of asthma in selected groups of health care workers? How do the prevalence rates in these four groups compare to one another? What occupational exposures are associated with asthma in these populations?

Educate workers about symptoms

Education is the first step toward preventing occupational asthma, Petsonk and others emphasize. Employees must be able to recognize the early respiratory symptoms and minimize exposures to hazardous substances, he says. Employee health professionals should have a mechanism for referring the employees to a specialist for an assessment, he says.

"When there's a potential exposure that's ongoing or predictable (such as in sterilization of equipment), then perhaps those individuals should be part of a formal health monitoring program," he says.

Health care workers also need to be educated about respiratory protective equipment, Lantos emphasizes. "Your typical surgical mask does not protect the wearer from anything — not from infectious materials, not from volatile substances, not from glutaraldehyde," Lantos says. "People have a false sense of security from wearing the surgical mask. It has absolutely no role to play in industrial hygiene."

Lantos tells employees, "If you think you've got a respiratory hazard, speak to someone who knows what the right kind of respirator is."

Ventilation is an important aspect of protection, he notes, as are work practices. For example, housekeeping staff should rotate their work so they are not continually using the harsh solvents.

"Just simply being aware [of the symptoms of occupational asthma] is the most important thing," Delclos says. Employee health professionals can play a role in identifying employees at risk for occupational asthma, he says.

(Editor's note: Facts sheets on ethylene oxide and formaldehyde are available at http://www.osha.gov/OshDoc/toc_fact.html.)

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'Flagging' disruptive patients reduces violence

Portland VA program cut incidents by 92%

A nurse reached into a car to help a man into the emergency department (ED) at the Portland (OR) Veterans Affairs (VA) Medical Center when suddenly, without warning or provocation, the man lashed out and punched her. As the nurse backed off, a colleague called the VA police.

Two police officers escorted the man into the ED, where he received a swift medical examination and was sent on his way.

For many hospitals, that scenario might end with no more than an injury report. But at the Portland VA, which has a system of tracking and responding to violent events, it triggered action by the Hospital Committee on Violence. This patient, suffering from withdrawal from prescribed narcotics he took for pain, was actually a regular at a VA clinic several hundred miles away.

Within days of the event, he received a letter by certified mail that informed him that such incidents in the future could result in the loss of health care privileges at the medical center.

"Those letters are very effective. We inform patients that we are looking at their behavior, and we aren't going to tolerate continued episodes," says **David Drummond**, PhD, director of the mental health clinics at the Portland VA Medical Center and chair of the Hospital Committee on Violence and the Behavioral Emergency Committee.

Despite that tough-sounding language, the Portland VA doesn't call its policy "zero tolerance." It is a part of the Coordinated Care Program that addresses patients with difficult, dangerous or drug-seeking behavior. The system flags and tracks violent incidents — and violent patients — and provides support and training to staff. Although the medical center rarely denies treatment, it alerts staff to high-risk patients.

A 1989 study of hospital violence before and after the program was introduced showed a 91.5% reduction in incidents.[1] The hospital has been able to sustain the system and maintain the reduction in incidents, Drummond says.

That is particularly impressive when compared with the track record of the hospital industry as a whole. In 1999, hospital workers suffered 2,637 nonfatal assaults, a rate of 8.3 assaults per 10,000 full-time employees — four times higher than the national average for all private-sector employers. This spring, the National Institute for Occupational Safety and Health issued an informational document on violence in hospitals. (The web site is www.cdc.gov/niosh/2002-101.html. **For an excerpt, see box on right.)**

When the Coordinated Care Program began, a survey showed that 23% of patients involved in dangerous incidents were responsible for 38% of the incidents. While violence may seem sudden and unpredictable, past abusive or violent behavior *is* one predictor.

That is why reporting is the cornerstone of the Portland VA's program. The medical center has worked hard to remove subtle barriers to the reporting of violent incidents in the workplace.

"[Employees] want to view the incident as isolated; it's really not a big deal," says **Shirley L. Toth**, RN, director of the Coordinated Care Program. "They have not had a problem [with the patient] in the past. But when we looked into it we found there is actually a pattern that emerged in the medical center over a period of time."

Even if the altercation is just verbal — involving threats, abusive language, or intimidation — staff fill out a "Dangerous Behavior Report." **(See sample form, inserted in this issue.)** This document isn't placed in the patient's medical record, but is reviewed by the Behavioral Emergency Committee.

"When a frontline worker takes the time to make a report, it is acted upon," Toth says. "That has done a lot to improve morale."

The committee interviews the staff involved in the altercation and determines what, if any, intervention is needed. For example, staff may receive additional training in handling difficult patients or situations. Staffing shortages or space constraints may be identified.

In the worst-case scenario, physical assault or repeated threatening or dangerous incidents,

Safety Tips for Hospital Workers

The National Institute for Occupational Safety and Health in Washington, DC, offers these safety tips for hospitals workers to prevent workplace violence:

Watch for signals that may be associated with impending violence

- ❒ Verbally expressed anger and frustration
- ❒ Body language such as threatening gestures
- ❒ Signs of drug or alcohol use
- ❒ Presence of a weapon

Maintain behavior that helps diffuse anger

- ❒ Present a calm, caring attitude.
- ❒ Don't match the threats.
- ❒ Don't give orders.
- ❒ Acknowledge the person's feelings (for example, "I know you are frustrated").
- ❒ Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly).

Be alert

- ❒ Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- ❒ Be vigilant throughout the encounter.
- ❒ Don't isolate yourself with a potentially violent person.
- ❒ Always keep an open path for exiting; don't let the potentially violent person stand between you and the door.

Take these steps if you can't defuse the situation quickly

- ❒ Remove yourself from the situation.
- ❒ Call security for help.
- ❒ Report any violent incidents to management.

patients may be "flagged" using an electronic flagging system. Whenever a patient's name comes up in the registration process, an advisory appears on the computer screen and emits a soft tone.

Those flagged patients then receive kid-glove treatment. They may be moved ahead of other waiting patients in the ED so they can be discharged more swiftly. VA police may stand by outside the room during the medical examination. The patients may be checked for possession of weapons.

Flagged patients aren't restricted in their use of health care services. "It doesn't deter any kind of care that the patient needs and is entitled to," Toth says. But it gives nurses, physicians, and clerks some forewarning that they are dealing with a patient who has the potential for difficult or dangerous behavior.

The flagging works. In the second quarter of 2002, there were 76 ED visits by flagged patients. (EDs are the site of the highest rate of violent incidents in hospitals.) Only two incidents of disruptive behavior were reported during that time.

"We are virtually eliminating violence in those people we identify," Drummond says. "We know who the high-risk people are. We can handle them."

The flags are reviewed every two years. If there have been no further significant incidents, the flag may be lifted.

In some rare cases — particularly if the incidents involved weapons — a flagged patient may actually be banned from all but emergency care at the medical center. In those cases, the safety of the staff, other patients, and visitors takes precedence.

When Portland VA Medical Center began flagging repeatedly disruptive patients, Drummond and his colleagues worried that the action might be overly stigmatizing.

"This was unfamiliar territory," he says. "We were trying to weigh the rights and safety of other patients and employees with the right of patients to get care."

The emphasis has always been on providing appropriate care — not denying care. "This approach is not punitive," he says. "It is focused on safety and helping patients get health care. And helping employees not feel so helpless in a case where patients are literally terrorizing a whole institution."

Response to the program has been positive, and it has been implemented at VA medical centers around the country. Drummond and Toth also present the program to private hospitals.

The comprehensive nature of the program contrasts with piecemeal approaches to reducing violence. For example, metal detectors at the ED entrance of hospitals may filter out knives and guns. But a violent incident may involve a nontraditional weapon: a cup of steaming-hot coffee or a chair.

The Behavioral Emergency Committee also helps staff diffuse nonviolent but disturbing behavior. For example, when a patient with obsessive-compulsive disorder called the medical center's care line 156 times in 154 days, the staff became frustrated and the patient seemed increasingly upset.

"We gave him a plan that said you can call on Sundays and Thursdays. He thought that was great," says Drummond. "It decreased the number of calls, but he still felt connected."

Ironically, the flagged patients often revel in the negative attention. "I think some of them, if they could, would wear a T-shirt that says, 'I'm flagged at the VA,'" says Drummond. "They feel somehow special because they get this special attention when they come into the emergency room."

[Editor's note: For more information on the Coordinated Care Program, contact Shirley Toth at (503) 402-2962 or shirley.toth@med.va.gov or David Drummond at david.drummond@med.va.gov.]

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'Success stories': E-mail boosts TB compliance

AOHP conference highlights EHP experiences

Christine Pionk, MS, RN, CS, solved an age-old employee health problem with a high-tech tool. She sends e-mail to communicate directly with employees and remind them of their annual tuberculosis screening.

It's a simple change, but one that has made a big difference. TB screening rates have risen from about 60% to more than 80%.

"For years we've been trying to figure out how to increase our compliance rate with TB screening," says Pionk, a nurse practitioner in employee health at the University of Michigan Health Systems in Ann Arbor.

Pionk is one of several employee health professionals who will be sharing "success stories" at the upcoming conference of the Association of Occupational Health Professionals in Health Care (AOHP), to be held Oct. 16-19 in St. Louis. **(See editor's note, p. 119, for more information.)**

The "success stories" offer a way for employee health professionals to share in the educational program of the conference, says **Beverly Smith**, RN, COHN, employee health nurse manager at Hamot Medical Center in Erie, PA, and region four director and conference chair for AOHP. The personal experiences also fit into the conference theme of "Unlock the Gates to Success."

While AOHP will host leading experts in the fields of ergonomics, regulatory compliance, and bioterrorism preparedness, the "success stories" offer a new perspective, Smith says.

"It's nice to hear about how people actually made some things work for them," she says. "After hearing the theory [in conference sessions], sometimes you wonder, 'How can I put that into practice?'"

TB compliance is a common concern. Pionk typically sent paper reminders about TB screening to supervisors, who would then alert their staff. But the chain of communication didn't always work well and employees often failed to follow up.

Now, e-mail allows for swift notification. Even physicians are on the e-mail system. The employee health department also streamlined the process of screening follow-up. Employees can access a TB skin test form on the health system's web site and bring it to the screening. Physicians and nurses in the units can read the test within 48 to 72 hours, and the employees fax the documented form back to employee health.

"If there's any question, they contact us and we look at it," says Pionk. Concerns about confidentiality limit some other uses of e-mail, but Pionk says she uses it to remind employees about influenza vaccination and post-exposure follow-up testing.

Also at the conference, effective ergonomics interventions will be highlighted in sessions by leading ergonomics experts Audrey Nelson, PhD, RN, FAAN, director of the Patient Safety Center of Inquiry at the James A. Haley VA Medical

CE *questions*

13. According to **James Collins**, PhD, MSME, NIOSH epidemiologist/engineer and project officer for the Slips and Falls Prevention in Health Care Workers project, how do slips and falls compare to ergonomics-related injuries?
    A. Slips and falls occur twice as often as ergonomics injuries.
    B. Slips and falls are second to ergonomics in frequency.
    C. Slips and falls are included in ergonomic data.
    D. Slips and falls can be prevented through ergonomic interventions.

14. When the Joint Commission on Accreditation of Healthcare Organizations decided not to include needle safety among its National Patient Safety Goals, what impact does that have on the *Sentinel Event Alert* on needlestick prevention?
    A. Hospitals still will be scored on compliance with that *Sentinel Event Alert*.
    B. Hospitals are not expected to comply with that *Sentinel Event Alert*.
    C. The *Sentinel Event Alert* is still being reviewed for further consideration.
    D. Surveyors still will sk about the *Sentinel Event Alert* recommendations but will not score on it.

15. In light of concerns about group purchasing organizations and access to needle safety devices, which of the following best represents the position of OSHA officials?
    A. OSHA is concerned about health care worker preference but not about brand names.
    B. OSHA requires hospitals to consider all available brands of devices.
    C. OSHA allows hospitals to consider cost as a primary issue in selection.
    D. OSHA has cited hospitals for using choices offered by GPOs.

16. The Portland VA Medical Center flags troubled patients who have been involved in violent or abusive incidents. What does "flagging" mean?
    A. Patients are denied treatment when they show up at the hospital.
    B. Patients are limited to emergency treatment only.
    C. Patients have a period of restricted treatment and may regain full rights if there are no other incidents.
    D. Patients continue to have access to health care, but staff are notified that the patient has been "flagged" as at-risk of violence.

Answers: 13. B; 14. D; 15. A; 16. D

Center in Tampa, and Guy Fragala, director of environmental health and safety at the University of Massachusetts Medical Center in Worcester.

Geoff Kelafant, MD, MSPH, FACOEM, medical director of the occupational health department at the Sarah Bush Lincoln Health Center in Mattoon, IL and chairman of the medical center occupational health section of the American College of Occupational and Environmental Medicine in Arlington Heights, IL, will present an update on regulatory issues.

Nick Colovos, MD, FAAEM, assistant professor of emergency medicine at Allegheny General Hospital in Pittsburgh, PA, will address bioterrorism preparedness.

[Editor's note: For more information on the AOHP annual conference, contact AOHP at 500 Commonwealth Drive, Warrendale, PA 15086. Telephone: (800) 362-4347. Fax: (724) 772-8349. Web site: www.aohp.org/aohp/.] ■

NIOSH investigates antineoplastic agents

Health care workers exposed to antineoplastic agents are at risk for adverse effects that include miscarriage and leukemia. The National Institute for Occupational Safety and Health (NIOSH) is launching a study to determine how much exposure occurs and what work practices and other conditions impact exposure.

NIOSH also will look for "biomarkers," or evidence of early biological effects from chronic, low-level exposure to antineoplastics, according to the agency's July 25 *Federal Register* notice. NIOSH will conduct environmental sampling of the workplace and will track blood and urine samples of participants and the menstrual cycles of female workers. (Go to www.cdc.gov/niosh/02-18781.html.)

The project will recruit oncology nurses, pharmacists, and pharmacy technicians and will be conducted in collaboration with the University of Maryland, the University of North Carolina, and the M.D. Anderson Cancer Center.

"Using the results of the proposed study, exposures can be minimized or eliminated before adverse health effects occur. Ultimately, the study will contribute to the prevention of occupational disease from antineoplastic drug exposure," the agency reported in the notice. ▼

Senate bill would require new ergonomics standard

The Occupational Safety and Health Administration (OSHA) would be required to produce a new, more workable ergonomics standard within two years under legislation introduced by Sens. John Breaux (D-LA) and Arlen Specter (R-PA).

The bill specifies that the standard must cover

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only musculoskeletal disorders (MSD) that are related to work and requires OSHA to state clearly what actions employers must take to comply. It also emphasizes a preventive approach.

In the prior ergonomics standard, MSD injuries triggered the measures that employers were required to take to reduce hazards. Congress repealed the standard in March 2001 under the Congressional Review Act. Since the act specifically prohibits an agency from creating a new regulation "in substantially the same form," the Breaux/Spector bill gives OSHA the express authority to develop a standard.

No similar legislation has been introduced in the U.S. House of Representatives. In April, Labor Secretary Elaine Chao announced a "comprehensive plan" to address ergonomics that relies on voluntary, industry-specific guidelines and selected enforcement under OSHA's "general duty" clause that requires employers to maintain a workplace free of recognized, serious hazards. ▼

Nursing homes face greater OSHA scrutiny

Nursing and personal care facilities with high injury and illness rates will get increased scrutiny under the National Emphasis Program, the Occupational Safety and Health Administration (OSHA) announced.

It will conduct wall-to-wall inspections in about 1,000 nursing homes and personal care facilities that have rates of 14 or more injuries or illnesses involving lost time from work per 100 full-time workers. The agency is focusing specifically on patient-handling hazards; bloodborne pathogen and tuberculosis exposure; and slips, trips, and falls. Inspectors received intensive training in recognizing nursing home hazards, OSHA said.

OSHA also targeted nursing homes for the first set of voluntary guidelines developed under the ergonomics "comprehensive plan." Those guidelines are expected to be released later this year. ■

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. ■

DANGEROUS BEHAVIOR REPORT

Department of Veterans Affairs Medical Center
Portland, OR

Name of Disruptive Person:
_____

Employee? ❒ Veteran/Patient? ❒

Last four digits of SSN (if vet/pt): _____

Reporting Employee: _____

Routing Symbol: _____

Work Site Extension: _____

Pager Number: _____

INSTRUCTIONS: Every staff member with knowledge of a disruptive incident IS REQUIRED to submit, or assure that someone submits, a detailed report. Disruptive incidents include any act or threat of violence, weapons, intimidation, harassment, or serious disruptive behavior. Since the only good predictor of future violence is knowledge of past violence, it is essential that all such incidents are reported.

FOR INCIDENTS INVOLVING VETERANS/PATIENTS, COMPLETION OF THIS REPORT WILL NOT REPLACE APPROPRIATE DOCUMENTATION IN THE PATIENT'S MEDICAL RECORD NOR COMPLETION OF VA form 10-2633, "REPORT OF SPECIAL INCIDENT INVOLVING A BENEFICIARY."

1. DATE OF INCIDENT:_____ BEGAN: _____a.m./p.m. ENDED: _____a.m./p.m.

2. LOCATION OF INCIDENT (BE SPECIFIC, E.G. MICU-WARD 4C): _____

3. **TYPE OF INCIDENT** (check all that apply)

Loud voices	❒
Standby/search per flag	❒
Medically unstable patient attempting to elope	❒
THREATS (Describe below)	❒
Possession of a weapon	❒
Violence against property	❒
Violence against people	❒

INTERVENTIONS (check all that apply)

Situation resolved verbally	❒
Person voluntarily left Center	❒
Police removed person from Center	❒
Restraints applied	❒
Person sedated	❒
Person placed in secure room	❒
Involuntary hold initiated	❒
Person removed to another facility	❒

4. Briefly DESCRIBE the incident, any interventions, and especially how the incident was concluded. Be SPECIFIC about THREATS, intimidation, harassment, and abusive language, etc. Use quotes if possible.

_____

_____

_____

_____

_____

_____

(Staple additional sheet if necessary)

NOT TO BE FILED IN PATIENT'S MEDICAL RECORD

5. Was anyone INJURED? (Circle Number) Employee _____ Visitor _____ Patient _____

0	1	2	3
NO INJURY	MINOR NO MEDICAL INTERVENTION REQUIRED	MAJOR MEDICAL INTERVENTION REQUIRED	DEATH

Please describe injury & treatment obtained: _____

_____

_____

6. WEAPON? No _____ Knife _____ Gun _____ Other (Describe) _____

7. How satisfied were you with the response time of the VA Police in this incident? (Circle Number)

5	4	3	2	1	0
Very Satisfied	Satisfied	Neutral	Disappointed	Extremely Disappointed	Not Applicable

8. How satisfied were you with the verbal skills of the VA Police who responded?

5	4	3	2	1	0
Very Satisfied	Satisfied	Neutral	Disappointed	Extremely Disappointed	Not Applicable

9. If physical restraint was necessary in this incident, how satisfied were you with the VA Police performance in doing so?

5	4	3	2	1	0
Very Satisfied	Satisfied	Neutral	Disappointed	Extremely Disappointed	Not Applicable

PLEASE SEND THIS REPORT IN MEDICAL CENTER MAIL TO P3CCP.

MARK THE ENVELOPE "CONFIDENTIAL." DO NOT FILE IN MEDICAL RECORD.

(COMMITTEE USE ONLY)

DATE OF REVIEW: _____

BEC REVIEWER: _____

Recommended follow-up action:

_____

_____

_____

_____

DJD — Revised June 2000