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THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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IN THIS ISSUE

■ **Changes in the air:** California drafts the nation's first aerosol transmissible diseases standard, which could serve as a model for other states . . . . . cover

■ **Slip resistance:** BJC Healthcare teams with NIOSH to prove that interventions can work to prevent slips and falls 124

■ **Flu shot challenge:** TJC offers accolades for hospitals that beat the HCW vaccination rate of 43%. 127

■ **Painful truths:** Updated guidelines from ACOEM provide advice on evidence-based management of back pain 128

■ **Stop the violence:** New Oregon law will shed light on workplace violence in health care 129

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Will CA lead the way? Airborne rule could lead to state, national standards

Novel provision: Fit-testing every two years for some HCWs

California may once again be setting a trend that could influence protection of health care workers who are exposed to infectious diseases — this time with a bold proposed standard to prevent aerosol transmissible diseases.

Like the bloodborne pathogen standard, which also originated in California, the proposed standard requires an exposure control plan and annual training — though the specific requirements differ based on the employees' potential for exposure. As opposed to annual fit testing the state rule would allow testing every two years for some health care workers. However, it would require the use of powered air-purifying respirators (PAPRs) with most high-hazard procedures. Those procedures include bronchoscopy and sputum induction, unless PAPR use would interfere with the accomplishment of the medical task. Respiratory protection would be required when dealing with "novel or unknown pathogens," including pandemic influenza.

Groups that have typically been at odds over respiratory protection have expressed support of the California proposal. Representatives of the hospital association, labor unions, infection control, occupational health, and industrial hygiene worked together on an advisory panel as the standard was drafted.

"The standard is comprehensive and will close a lot of the gaps in the protection of health care workers with potential exposure," says **Mark Catlin**, an industrial hygienist with the Service Employees International Union (SEIU) in Washington, DC.

Roger Richter, senior vice president for professional services with the California Hospital Association in Sacramento, notes that the standard goes far beyond fit-testing in "addressing various risks for airborne transmissible disease. The whole standard is based on risk management, while the fit-testing, no pun intended, is one size fits all," he says.

The lengthening of the period between fit-tests (after an initial fit-test)

was a carefully crafted provision. It was designed to encourage hospitals and other health care employers to prepare for health care surge events, such as possible pandemic flu, by preparing additional employees for respirator use, says **Deborah Gold**, MPH, CIH, senior safety engineer in the research and standards health unit at Cal-OSHA in Oakland.

The biannual fit-testing provision automatically reverts to annual fit-testing in 2015. At that time, Cal-OSHA could revise the fit-test requirement based on new research from the National Institute for Occupational Safety and Health (NIOSH) on appropriate intervals of fit-testing. Hospitals and other employers are loath to spend a substantial amount of time and money on a provision that hasn't been scientifically validated, says Gold. "It's hard to enforce a regulation on a regulated public that doesn't understand the basis for it," she says. "We try to make our regulations scientifically sound."

However, in comments to the Cal-OSHA Standards Board, NIOSH stated that "[t]he study is not designed to establish a scientifically validated periodicity for fit-testing of respirators. The study is designed to track changes in test subjects' key facial dimensions and fit factors with designated respirator models and sizes for six-month intervals over three years."

While that will provide insight into the relationship between changes in facial dimensions over time and the impact on fit, it won't analyze the effectiveness of annual fit-testing, NIOSH said. In fact, NIOSH asked the standards board to correct or remove the information about the NIOSH study from the proposed standard.

However, the study protocol states that it will "provide a basis for quantifying the benefit of periodic fit-testing and determining the appropriate periodicity."

More effective than feds?

States with their own Occupational Safety and Health Administration (OSHA) plans must set standards that are at least as effective as federal OSHA regulations. Gold contends that California meets that requirement because its proposed standard is much more comprehensive than the federal respiratory protection standard.

OSHA issued a proposed tuberculosis standard in 1997 but rescinded it in late 2003, citing advances in controlling TB. The federal agency has never addressed the hazard of airborne infectious diseases as a broad category and has no standard related to pandemic influenza.

"We're already being considerably more protective and broader than federal OSHA is right now," Gold says.

Cal-OSHA has been in discussions with OSHA over the proposed standard and (not surprisingly) the two-year fit-testing provision has been the main area of concern. "We're working toward having a positive resolution with them," she says.

Meanwhile, employees performing high-hazard procedures who may use N95 or other tight-fitting

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At-a-glance: CA drafts rules against airborne diseases

California's proposed Aerosol Transmissible Diseases standard covers a range of issues, including the minimum air exchanges per hour in negative pressure rooms (12, although they can be six if HEPA filtration is used), vaccination and fit-testing. The standard would require employers to:

- implement "source control measures" such as a respiratory hygiene/cough etiquette program, as recommended by the Centers for Disease Control and Prevention.
- identify patients needing airborne infection isolation in a timely manner. If the facility doesn't treat patients with airborne infectious diseases, it must transfer the patient within five hours (or by 11 a.m., if the initial patient encounter occurs after 3:30 p.m.). Exceptions are provided when rooms are not available, and when a transfer is medically contraindicated.
- maintain an exposure control plan that outlines the job classifications that may involve aerosol transmissible disease exposure, high-hazard procedures, tasks requiring respiratory protection, and the control measures. The plan also must address medical surveillance, reporting of exposures, and evaluation of exposure incidents. It must be reviewed annually, and employees must be involved in that review.
- have a system of communicating the infectious disease status of patients to which employees may be exposed that complies with medical confidentiality requirements. Employees who the evaluating physician determines may be infectious, and therefore need to be removed from their normal assignment for infection control purposes, must be provided with an appropriate alternate assignment or be paid if they are furloughed. This "precautionary removal" period ends when either the person has passed the incubation period or if the employee gets sick or is otherwise unable to work.
- provide annual training to employees with potential exposure to patients with aerosol transmissible diseases.
- have adequate supplies of personal protective equipment.
- provide fit-tests every two years for employees who do not perform high-hazard procedures and at least annual fit-tests for those in areas where high hazard procedures are performed. Additional fit-tests would be required for employees who have a physical change, such as significant weight gain or loss, dental changes, or cosmetic surgery.
- provide powered air-purifying respirators (PAPRs) to employees performing high-hazard procedures "unless the employer determines that this use would interfere with the successful performance of the required task or tasks."
- provide vaccines for susceptible health care workers with the potential for exposure. Employees who decline a recommended vaccine must sign a declination statement.
- conduct TB tests at least annually for employees with occupational exposure (or perform annual symptoms screens for employees who are baseline positive for latent tuberculosis infection).

Employers would be able to use a streamlined version of the respirator medical evaluation questionnaire, which would potentially reduce the number of employees who are referred to a physician for further evaluation.

As with existing regulations, the proposed rule establishes a fit factor of 100 as the minimum acceptable fit factor for quantitative testing.

(Editor's note: You can view the proposed standard and explanatory information at www.dir.ca.gov/oshsb/atd0.html.) ■

facepiece respirators still must have annual fit-testing under this proposed standard. Employees conducting high-hazard procedures would need to use a PAPR, "unless the employer determines that this use would interfere with the successful performance of the required task or tasks."

While hospitals will save money with the longer period between fit-tests, other provisions will actually cost more, says Richter. "But we do know that some of the things that are being required are more effective than fit-testing, so you get a bigger bang for the buck," he says.

Conversely, the SEIU is asking Cal-OSHA to reconsider the extended fit-testing time frame. "We thought it was premature to weaken the protections first and then wait for the studies to see if that's appropriate," says Catlin.

However, that isn't enough to erode the union's support for the standard as a whole. "We see that as the weakest part of the proposal, but when we look at the whole proposal together, it looks really good," he says.

Catlin notes, for example, that the standard specifically applies to a variety of employers, including laboratories, home health and long-term care agencies, homeless shelters, and first responders such as firefighters and police.

The specter of pandemic influenza and severe acute respiratory syndrome (SARS) underlies the efforts to create an airborne transmissible

diseases standard.

During the SARS epidemic in Toronto in 2004, the effectiveness of N95 respirators was called into question when some health care workers contracted the infection despite their use. Many of the health care workers who wore respirators had not been fit-tested. Those performing aerosol-generating procedures were at the highest risk of contracting the virus.

SARS receded to the history books and medical journals, but pandemic influenza is a growing concern. As California emphasizes stockpiling of personal protective equipment and other preparedness measures for pandemic influenza, Cal-OSHA wants a broad number of health care workers to receive medical evaluation and training for respiratory protection and fit-testing, says Gold.

The burden of an annual fit-test rule actually leads many hospitals to limit the number of employees who are fit-tested and ready to wear a respirator, she says.

"We don't want to discourage hospitals and other health care institutions from preparing to use respirators, should it be [preparedness for] pandemic flu, SARS or anything else," says Gold. "[Fit-testing] encourages them to more narrowly define respirator use. At this point, we feel it's important to broadly define respirator use.

"We think it's a much better approach to surge to have people at least initially fit-tested and trained. The fit-test won't be older than two years," she says. "We think it's a relatively good compromise."

EHPs play a large role

For employee health professionals, the proposed standard offers some subtler benefits. Occupational health plays a prominent role in many of the tasks that are required under the standard, such as immunization of health care workers, hazard assessment, medical evaluation for respirator use, and fit-testing.

Hospitals may recognize the importance of the role of employee health and may provide more resources to allow for compliance, says **Sandy Domeracki Prickitt**, RN, FNP, COHN-S, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP) and employee health services coordinator/nurse practitioner at Novato Community and Marin General hospitals in Greenbrae, CA. AOHP was involved with the advisory panel that provided feedback on the draft standard.

"[The roles of] occupational health and employee health are more clearly addressed than in other state and federal standards," she says. "This hopefully will make [employee health] a little more visible."

For example, the proposed standard outlines the duties of the "physician or other licensed health care professional" who will conduct medical evaluations of employees who have been exposed to an airborne transmissible disease. ■

NIOSH: Slips and falls are preventable injuries

BJC Healthcare uses comprehensive program

As health care workers age, their risk of serious injury from slips, trips, and falls rises. Yet while the cause of individual accidents may seem random — coffee spilled on the floor, an icy patch on the sidewalk — comprehensive efforts can reduce the incidence by as much as 59%, according to a 10-year study conducted by the National Institute for Occupational Safety and Health (NIOSH).[1]

"Most people have accepted falls on the same level as unpreventible acts of God," says **Jim Collins**, PhD, MSME, associate director for science in NIOSH's division of safety research, and co-principal investigator of the study. "This research has shown that it is in fact possible to reduce falls by applying a comprehensive slips, trips, and falls program. We really can do something about this."

It is an important problem to tackle. Patient handling, the No. 1 cause of injury in hospitals, gets the spotlight of injury prevention. But slips, trips and falls account for about 23% of lost workday injuries and illnesses among hospital workers — making it the second leading cause of serious injury, according to the U.S. Bureau of Labor Statistics.

About 8% of those injuries involve fractures, and 48% involve strains, sprains, dislocations, and tears, according to workers' compensation data analyzed by the NIOSH researchers. Older workers (over 45) have significantly more slip-and-fall-related workers' compensation claims, although experienced workers of any age have fewer claims than those who have worked on the job for less than a year. Collins presented the findings at the annual conference of the Association of Occupational Health Professionals in Healthcare (AOHP), held in Denver in September.

With patient handling, hospitals can hire consultants and purchase equipment. "With slips and falls, there are so many different ways they can happen, places they can happen, and things that can be done. It can be challenging," says **Jennifer Bell**, PhD, research epidemiologist in NIOSH's Division of Safety Research in Morgantown, WV, and principal investigator of the NIOSH study.

Hospitals need to think about it as one problem with multiple dimensions, she says. That is what BJC Healthcare in St. Louis has done, both as the site of the NIOSH interventions and even after the study ended. The study was conducted at three of BJC's 13 hospitals, but interventions have been used throughout the system.

"Injury prevention is just a process of continuous improvement. It's not a one-time campaign," says **Laurie Wolf**, MS, CPE, ASQ-CSSBB, management engineer in patient safety and quality at Barnes Jewish Hospital, who pioneered the slips and falls efforts. "You need to keep doing it and you need to keep it fresh."

Food service at highest risk

So if you want to keep people from falling, where do you start? Bell, Wolf, and other safety experts began by looking for trends in the injury data. A red flag: The largest number of injuries occurred in food service.

A closer look at the incidents revealed that greasy or wet floors caused a hazard in the food service area. One hospital in the Barnes Jewish system installed tiles that had grooves in them — but found the floors were then difficult to keep clean.

NIOSH studied different types of slip-resistant shoes and flooring. Using ergonomics funds, BJC also bought slip-resistant shoes for the at-risk employees and requires food and nutrition services workers to wear them on the job. Slip-resistant shoes are a promising intervention, but not all brands function equally well, says Bell. She advises hospitals to find what works best for them. "Try some out in a slippery situation and see how they work," she says.

Floor cleaning is another important area of focus. BJC discovered that a degreaser was bringing the grease to the surface of the flooring but then the grease wasn't being adequately removed, Wolf says. The health care system has experimented with other cleaners and techniques, she says.

Contaminants on the floor — such as spilled food or dripping water — cause almost one-quarter (23.6%) of slips and falls, according to the NIOSH study. So Barnes Jewish Hospital tries to provide a convenient way to keep them covered until housekeeping can clean them up.

Cones, tents, or nonslip mats or even the handy placement of paper towels can provide protection. "Use anything you can immediately have on hand to cover [the spill] — pop-up tents, spill pads. Quickly put something on a spill before someone has a chance to slip on it," says Bell.

For example, when housekeepers mop the bathroom at Barnes Jewish Hospital, they put up a barrier that looks like a makeshift shower curtain, along with a "wet floor" sign. Unfortunately, that can't completely prevent people from ignoring the barrier. In one case, a woman ducked under a barrier, fell, and suffered an injury.

It takes continuous education to keep people on guard for fall risks. BJC uses fliers, e-mail, closed-circuit television ads, and a presence at health and safety fairs. "It's just a [matter of] constant awareness," says **Sandy Swan**, RN, BSN, MS, COHN-S/CM, manager of occupational health and ergonomics.

In fact, employees must be partners in the effort to reduce slips and falls, says Swan. Every winter, BJC issues ice alerts when wintry weather is on the way and places salt bins by the walkways. "Any employee who sees an icy area can use the ice melt," she says.

The health system also bought Yaktrax for home health employees, ice traction devices that slip over shoes.

Meanwhile, BJC continues to explore new strategies for reducing slips and falls. "It's more than just a research project," says Wolf.

Reference

1. Bell JL, Collins JW, Wolf L, et al. Evaluation of a comprehensive slip, trip, and fall prevention programme for hospital employees. *Ergonomics* 2008; in press. ■

Strategies for reducing slips, trips and falls

The National Institute for Occupational Safety and Health (NIOSH) identified these strategies for reducing slips and falls in hospitals:

■ **Keep floors clean and dry**

- Encourage workers to clean up, cover and/or report floor contaminants promptly.
- Install wall-mounted spill pads or paper towel holders conveniently throughout the hospital to

provide easy access to cleaning materials.

• Advertise the phone/pager numbers to call for housekeeping through e-mails, posters, and general awareness campaigns.

• Install wall-mounted wet floor signs throughout the hospital to provide easy access to products to cover/identify a spill.

• Provide walk-off mats, paper towel holders, trash cans and umbrella bags near entrances to minimize wet floors.

• Provide cups, paper towel holders and trash cans (waste bins) near water fountains.

• Place water-absorbent walk-off mats with beveled edges at hospital entrances. The mats should be large enough for multiple steps to fall on the mat and wide enough to cover the entire doorway. Ideally, the soles of shoes should not be depositing ice or water on the floor when they step off the mat. Consider use of those mats in areas where employees may be continually exposed to wet conditions.

• Use appropriate methods for cleaning and degreasing kitchen floors; choose appropriate cleaning product for the conditions; mix cleaning products according to manufacturer's directions.

• Redirect drains away from walkways with high pedestrian traffic.

• Check that pipes are correctly aligned with the drain they are emptying into.

• Unclog drains, particularly in kitchens, regularly.

■ **Prevent entry into areas that are contaminated**

• Use barrier signs that block off areas (tension rod with hanging sign across doorways, tall cones with chains, hallway barriers).

• Install pop-up tent-style warning signs in wall-mounted tubes in easy accessible locations.

• Use taller, more noticeable STF signage (48-inch tall wet-floor signs, flashing lights on top of signs, pop-up tent style signs).

• Promptly remove wet floor signs after the floor is dry to avoid habituation.

• Completely block off area during floor waxing or stripping; place door-stopper barrier to prevent wax from overflowing into adjacent areas during waxing.

■ **Use slip-resistant shoes**

• A voluntary slip-resistant shoe program was implemented, primarily for food service workers and housekeeping staff, and included ice cleats for home health nurses.

■ **Keep walkways clear of objects and reduce clutter**

■ **Provide adequate lighting in all work areas including outdoor stairwells and parking garages**

■ **Secure loose cords, wires and tubing**

• Use cord bundlers and cord containers to secure cords under desks and computers and around medical and kitchen equipment.

• Cover cords on floor with a beveled protective cover.

• Organize operating rooms so that equipment cords are not stretched across walkways.

• Consider retractable cord holders on phones in patient rooms and nursing stations.

■ **Eliminate outdoor surface irregularities**

• Consider eliminating wheel-stops in parking areas.

• Patch, fill or slope cracks, holes or changes in level in walkways and parking areas that are greater than 0.5 inch.

• Create visual cues; highlight changes in curb or walkway elevation with yellow warning paint.

■ **Eliminate indoor surface irregularities**

• Replace or restretch loose or buckled carpeting.

• Replace mats that are curled or ripped; secure edges with carpet tape.

• Remove, patch underneath, and replace indented or blistered tile.

• Consider replacing smooth flooring materials with rougher surfaces with a higher coefficient of friction.

• Patch or fill cracks in walkways that are greater than 0.25 inch.

• Highlight changes in curb or walkway elevation with yellow warning paint.

■ **Check stairs**

• Ensure stairs and handrails are in compliance with safety codes and recommendations.

• Highlight the nosing of each step with contrasting paint or strips.

■ **Prepare for ice and snow**

• Provide ice cleats (or similar product) for home health and maintenance workers to put over regular shoes.

• Distribute winter weather e-mail warnings to all workers with e-mail access.

• Provide bins that anyone can use to spread ice melting chemicals on icy patches outside.

■ **General awareness campaign**

• Phone and pager numbers for maintenance and housekeeping departments prominently displayed and e-mailed intermittently to staff, to be used for reporting spills, slippery conditions, ice and other STF hazards.

• Slips, trips, and falls hazard awareness campaigns that are promoted through health fairs, posters, paycheck inserts, and e-mails. ■

Joint Comm awards flu vaccination push

Hospitals rewarded for rate of 43% or more

The Joint Commission requires hospitals to work toward better rates of health care worker influenza immunization. It's an infection control standard. But now, the accrediting body also is offering an incentive for success.

In this carrot-and-stick approach, hospitals with a vaccination rate above the national average will receive recognition from the Joint Commission Resources, an education and publishing affiliate. Vaccinating just 43% of your employees will earn the recognition.

Attention! Attention! All Health Care Workers! This is Not a Test This is an Important Notice about Common Misperceptions of the Flu

MYTH #1
You are not at risk for getting the flu because you're healthy, and as someone who works in a health care environment, you've been exposed to so many germs that you're immune to everything.

FACT
Health care workers can have an increased risk of exposure to the flu due to the nature of the job.

MYTH #2
You don't have any flu symptoms so you can't transmit the flu virus to your patients.

FACT
The flu is a contagious and potentially deadly infection. Even if you don't show symptoms of having the flu yet, the virus can still be transmitted to patients. Health care workers infected with the flu can transmit the virus to patients in their care, which is particularly troubling for the many patients at high-risk for flu-related complications that can lead to serious illness, and even death (mostly in adults 65 and older). Importantly, people who live with or care for persons at high-risk of complications should get vaccinated; vaccination can help caregivers stay healthy and avoid passing the infection to others. This group includes all health care workers.

MYTH #3
You work in a large facility and there are many staff members who don't get vaccinated against the flu. So, one flu vaccination won't make a difference.

FACT
You can demonstrate your leadership by getting vaccinated against the flu and show that quality of patient care is important to you. The CDC's Advisory Committee on Immunization Practices (ACIP) recommends an annual flu vaccination for a number of groups, including adults at high risk of complications from the flu and those persons who are in contact with them, including health care workers. In past years, flu infections have been documented in health care settings and health care workers have been implicated as the potential source of these infections. According to the CDC, annual flu vaccination is the most effective method for preventing the flu virus infection and its complications.

MYTH #4
The flu shot isn't safe.

FACT
The flu shot does not cause the flu. The flu shot contains inactivated viruses, which cannot cause infection. Many people will feel soreness in their arm after getting a flu shot, but, in general, flu shots are well tolerated. Other symptoms can include: mild fever, muscle pain, and feelings of discomfort or weakness, but these are generally less common. However, serious adverse events, including allergic reactions, may occur.

MYTH #5
The flu vaccine doesn't work.

FACT
The ability of the flu vaccine to protect a person depends on the age and health status of the person getting the vaccine, and the similarity or "match" between the virus strains in the vaccine and those in circulation.

MYTH #6
Antibiotics can work just as well as the flu vaccine.

FACT
The flu is a viral infection and cannot be treated by antibiotics. Antibiotics are **not** a substitute for the flu vaccine. However, antibiotics may be useful in treating infectious complications of the flu.

MYTH #7
By January, it's too late to get the flu vaccine.

FACT
The beginning, severity and length of the flu season can vary widely from year to year. According to CDC data, the peak in flu activity between the years 1976 and 2008 frequently occurs after December, most commonly in February. In general, health care providers should begin offering vaccination soon after the vaccine becomes available and if possible by October.

Source: Joint Commission Resources, Oak Brook Terrace, IL.

The Flu Vaccination Challenge is a complement to the existing standard. The low rate required to receive recognition doesn't reflect low expectations, says **Louise Kuhny**, RN, MPH, MBA, CIC, senior associate director of the standards interpretation group at the Joint Commission, which is based in Oak Brook Terrace, IL.

"We are expecting organizations to continuously improve year to year in their vaccination rates," she says.

This is just another way for the Joint Commission to emphasize the importance of influenza immunization, says **William Schaffner**, MD, chair of the Department of Preventive Medicine at Vanderbilt University School of Medicine in Nashville and vice president of the board of directors of the National Foundation for Infectious Diseases. "It telegraphs that the Joint Commission is indeed very interested in health care worker immunization and is willing to promote these activities," he says.

Hospitals register for the program online, at www.fluvaccinationchallenge.com. They report their previous vaccination rate and set a goal to achieve by May 2009. So far, hospitals have signed up with vaccination rates ranging from 8% to 98%, says **Gina T. LaMantia**, MS, Med, manager of audio/web conferences for Joint Commission Resources.

"The campaign is meant to be a self-motivating program for hospitals," she says. "It's a way for them to reach an achievement, to be recognized, and to tell their customers this is something [they] value in terms of patient safety."

To help hospitals in their efforts, the Joint Commission Resources is sharing information on best practices and myths and facts about the flu vaccine. **(See box on p. 127.)** Hospitals also can improve their rates by continuing to vaccinate after the traditional fall campaign, says Schaffner. Every time an employee comes to employee health, nurses should make sure she has received the vaccine, he says.

"I'll bet you can add another 10% to your total if you keep vaccinating beyond the campaign and use every patient encounter as an opportunity to deliver influenza vaccine," he says. ■

Are you hot or cold on pain management?

ACOEM provides evidence-based guide

When employees complain of back pain, they often receive the conventional wisdom about how to get relief and hasten their recovery. *Rest. Ice the area. Take some pain meds.* Unfortunately, that conventional wisdom may be wrong.

The American College of Occupational and Environmental Medicine (ACOEM) has issued updated guidelines for chronic pain management to promote the use of evidence-based treatments for this very common ailment. The guidelines clearly state which treatments have been shown to be effective — and which are unproven or even potentially harmful.

"We want the injured workers in the United States to receive the most efficacious treatment for work-related injuries at the earliest possible date," says **Kurt Hegmann**, MD, MPH, associate professor and director of the Rocky Mountain Center for Occupational and Environmental Health at the University of Utah in Salt Lake City, who is editor-in-chief of the guidelines. "The guidelines have detailed advice on what does and doesn't work."

These guidelines are especially important because of the magnitude of the problem. About 46% of workers report having had low back pain in the past two months, according to Hegmann, who has conducted epidemiologic studies. That figure is even higher for health care workers, who face patient-handling hazards and are older than the general work force, he says.

Even health care providers often are mistaken about the best way to manage back pain, he says. "There are specific efficacious strategies and a lot of people don't know them, and there are also a lot of false beliefs about what is efficacious."

What works? Nonsteroidal anti-inflammatory medication. Muscle relaxants may be helpful, especially at night. A gradually progressive aerobic exercise program, such as walking. Heat applied to the area. Directional or slump stretch, or stretching in the direction that eases the pain.

Manipulation, as performed by chiropractors and others, has proven beneficial for some low back pain patients. "We don't recommend [ongoing] multiple treatments. If something doesn't get better in the first four, five, or six treatments, it should be stopped," Hegmann says.

Misconceptions about relief of back pain seem as commonplace as the condition itself. Many of the treatments are based on longtime assumptions rather than carefully controlled studies, he says.

"We've reviewed over 500 trials on low back

pain alone. Every single placebo treatment arm gets better. The natural course is to improve," says Hegmann. "In order to be efficacious, treatment has to improve [the condition] at a rate better than placebo."

Each person needs to be assessed, and their treatment should be based on the best available information about efficacy, he says. The ACOEM guidelines provide more than 500 pages of recommendations, defining the level of evidence for each.

Here are some common but false beliefs about low back pain:

• **Early treatment of low back pain will prevent the condition from worsening.** Although this seems like common sense advice, there are no data to support it. While restrictions on heavy lifts or other job tasks that aggravate the problem, such as prolonged sitting, may be appropriate, employees do not necessarily need to be removed from their job, says Hegmann.

• **Bed rest will provide relief and hasten healing.** All quality studies fail to demonstrate any benefit from bed rest for acute low back pain, and in fact it can cause deconditioning and elevate the risk of blood clots, he says. It also is not recommended for subacute and chronic low back pain.

• **Opioids such as oxycodone are important tools to improve function through reduced pain.** Opioids should be reserved for patients with the most severe condition or for use before bedtime to reduce pain at night. Otherwise, anti-inflammatories have been shown to be as effective without the potential significant side effects. "It's recommended that they're not for routine use and they're reserved for more severely affected individuals," says Hegmann. "We also recommend that they are not generally prescribed for chronic pain patients unless there is evidence of functional improvement while using them and other treatment strategies have failed."

(Editor's note: Information about the chronic pain guidelines, which are a part of broader occupational medicine practice guidelines, is available from the American College of Occupational and Environmental Medicine at www.acoem.org/practiceguidelines.aspx.) ■

Awareness boosts prevention of assaults

Oregon law requires training, reporting

At every quarterly safety meeting at Providence Health and Services facilities in Portland, OR, employee health and safety professionals pay careful attention to reports of violent incidents. What they learn may help them prevent future assaults.

"It's important for us to make sure we provide an environment in which our employees feel safe to report and that they see the results of the reporting," explains **Rebbecca Maese**, RN, BSN, MA, director of the Oregon region employee health services/ergonomics for Providence Health and Services, a system that includes seven hospitals.

Violent events in health care often go unreported. But with a recent state law, all of Oregon's hospitals are now implementing tracking programs, as Providence has had for several years.

The Workplace Violence Prevention Law for Healthcare went into effect last year, requiring periodic security and safety assessments, regular training, and an assault prevention program.

By January 2009, hospitals must report their workplace violence data on all assaults, as defined by the law, for 2008.

"We want people to be very aware of safety issues in their facility," says **Yutonah Bowes**, MA, ergonomics outreach coordinator for Oregon OSHA in Salem. The Healthcare Workplace Violence Assault Log will enable hospitals "to really study where the incidents are happening and what types of assaults are happening," she says.

The Oregon legislature also will review the data to determine whether other measures need to be taken to address workplace violence in health care, she says.

Ultimately, hospitals will be able to identify best practices and share successful approaches, says **Lynda Enos**, RN, MS, COHN-S, CPE, ergonomist and nurse practice consultant for the Oregon Nurses Association in Tualatin.

"[Workplace violence] is an increasing problem in health care nationally," says Enos, noting that as behavioral health units close, those patients are more frequently seen in acute care settings. "You have to identify where your high-risk areas are. You have to anticipate where your problems may be and put a program in place to address them."

Log illustrates trends

Good reporting is a vital tool in the effort to reduce workplace assaults. At Providence, the reports doubled in the year that the health system began using a new tool to log events. They range

from the patient coming out of anesthesia who strikes a health care worker to a combative patient in the emergency department. **(See "Workplace Violence Checklist," on p. 130.)**

"As an organization, we begin to see where our challenging areas are, and we can focus what types of education we do to keep our employees and patients safe," says Maese. "We begin to understand more about what's going on."

Encouraging reporting also builds a "culture of safety," says Maese — a commitment to creating a safe environment for both patients and employees.

At Providence, every employee completes an annual module on workplace violence with their environment of care training. Employees who are in high-risk areas — behavioral health, security, the emergency department, and certain medical units — receive training on the escalation model and hands-on interventions in the prevention and management of violent behavior. The initial course lasts eight hours, and the annual refresher is a four-hour course.

Employees learn how to recognize warning signs and to calm agitated patients and de-escalate potentially violent behavior. If they are unable to diffuse the situation, employees learn how to protect themselves and the patient with physical intervention. They then work with the patient to respectfully diffuse the event, says Maese.

The Oregon law requires assault prevention and protection training "on a regular and ongoing basis," but doesn't specify that it must be annual. Safety assessment also must occur periodically.

The law allows employees to take actions to protect themselves from assault. They may refuse to treat a patient who has previously assaulted them. A home health worker also may refuse to treat a patient they believe to be potentially violent — based on past behavior or their physical or mental condition — unless they are accompanied by another employee. They also must be provided with a "communication device" that enables them to call for help. Employees also may use physical force in self-defense or to protect a third person, provided they used only the level of force that was necessary under the circumstances, the law states.

The law only covers home health workers who are employed by a hospital, not independent home health agencies.

(Editor's note: A sample workplace violence prevention plan is available from Oregon OSHA at www.orosha.org/educate/training/pages/120plan.html.) ■

CNE *questions*

17. According to Deborah Gold, MPH, CIH, why does the proposed aerosol transmissible diseases standard allow for fit-testing every two years?
A. It mirrors the requirements of the OSHA.
B. It reflects guidelines from the Centers for Disease Control and Prevention.
C. It would encourage hospitals and other health care employers to prepare for pandemic influenza by fit-testing more workers.
D. It involves new fit-testing protocols.

18. According to according to a 10-year study conducted by NIOSH, a comprehensive program of interventions can reduce workers' compensation claims due to slips, trips, and falls by:
A. 28%.
B. 35%.
C. 45%.
D. 59%.

19. According to Louise Kuhny, RN, MPH, MBA, CIC, the Flu Vaccination Challenge is designed to:
A. complement The Joint Commission standard on flu vaccination.
B. replace the current standard with an incentive system.
C. provide rewards to health care workers who are vaccinated.
D. expand influenza vaccination beyond employees.

20. What protection does Oregon's Workplace Violence Prevention Law for Healthcare specifically provide for home health workers employed by hospitals?
A. Home health workers must receive additional self-defense training.
B. Home health workers may refuse to treat a patient they believe to be potentially violent unless another worker accompanies them.
C. Home health patients must undergo a criminal background check.
D. Home health workers must never enter a patient's home alone.

Answer Key: 17. C; 18. D; 19. A; 20. B.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

Workplace Violence Checklist

(Editor's note: This checklist is part of U.S. OSHA's Guideline for Preventing Workplace Violence in Healthcare *can be found at www.osha.gov/SLTC/etools/hospital/hazards/workplace violence/checklist.html.)*

Designated competent and responsible observers can readily make periodic inspections to identify and evaluate workplace security hazards and threats of workplace violence. These inspections should be scheduled on a regular basis; when new, previously unidentified security hazards are recognized; when occupational deaths, injuries, or threats of injury occur; when a safety, health, and security program is established; and whenever workplace security conditions warrant an inspection.

Periodic inspections for security hazards include identifying and evaluating potential workplace security hazards and changes in employee work practices that may lead to compromising security. Please use the following checklist to identify and evaluate workplace security hazards. Every "true" answer indicates a potential risk for serious hazards:

True or False?

__ This industry frequently confronts violent behavior and assaults of staff.
__Violence has occurred on the premises or in conducting business.
__ Customers, clients, or co-workers assault, threaten, yell, push, or verbally abuse employees or use racial or sexual remarks.
__ Employees are NOT required to report incidents or threats of violence, regardless of injury or severity, to employer.
__ Employees have NOT been trained by the employer to recognize and handle threatening, aggressive, or violent behavior.
__ Violence is accepted as "part of the job" by some managers, supervisors, and/or employees.
__ Access and freedom of movement within the workplace are NOT restricted to those persons who have a legitimate reason for being there.
__ The workplace security system is inadequate — i.e., door locks malfunction, windows are not secure, and there are no physical barriers or containment systems.
__ Employees or staff members have been assaulted, threatened, or verbally abused by clients and patients.
__ Medical and counseling services have NOT been offered to employees who have been assaulted.
__ Alarm systems such as panic alarm buttons, silent alarms, or personal electronic alarm systems are NOT being used for prompt security assistance.
__ There is no regular training provided on correct response to alarm sounding.
__ Alarm systems are NOT tested on a monthly basis to assure correct function.
__ Security guards are NOT employed at the workplace.
__ Closed-circuit cameras and mirrors are NOT used to monitor dangerous areas.
__ Metal detectors are NOT available or NOT used in the facility.
__ Employees have NOT been trained to recognize and control hostile and escalating aggressive behaviors, and to manage assaultive behavior.
__ Employees CANNOT adjust work schedules to use the "Buddy System" for visits to clients in areas where they feel threatened.
__ Cellular phones or other communication devices are NOT made available to field staff to enable them to request aid.
__ Vehicles are NOT maintained on a regular basis to ensure reliability and safety.
__ Employees work where assistance is NOT quickly available. ■

CNE 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. ■

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