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Hospital Employee Health

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

AHC Media LLC

IN THIS ISSUE

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Editor Michele Marill, Associate Publisher Coles McKagen, Consulting Editor MaryAnn Gruden, and Managing Editor Gary Evans report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

DECEMBER 2008
VOL. 27, NO. 12 • (pages 133-144)

A 96-hour wait: The Joint Commission's new emergency plan for hospitals

'Employee health should definitely be at the table for disaster planning'

It was an eerily familiar scenario: A huge storm barreled through the Gulf of Mexico with New Orleans in its sights. Hospitals began implementing their disaster plans, calling in employees who would remain on duty throughout the storm. Days later, yet another huge storm entered the Gulf, again threatening the region and straining health care resources.

The emergence this year of those two storms (Gustav and Ike) — just three years after Hurrican Katrina — reminded those involved in emergency management just how sudden and unpredictable disasters can be. **(See related story, p. 135.)** That is why The Joint Commission revised its emergency management standard for 2008 to emphasize the need for hospitals to have a response plan that assumes no outside support for up to 96 hours — and to conduct at least one exercise a year that addresses that predicament. (The Joint Commission delayed the scoring of eight Elements of Performance until 2009 to give hospitals more time to collaborate within their communities.)

The U.S. Occupational Safety and Health Administration also announced that it is considering changes to standards to address emergency response and preparedness.

More is being expected of hospitals than ever before. "We now have

Special Report: Are you ready for disaster?

No one knows when disaster will strike. Each event has an element of the unpredictable. But hospitals should expect such emergencies to occur — and The Joint Commission requires hospitals to plan for them. In this issue, *Hospital Employee Health* explains the employee health role in emergency preparedness and offers examples from two emergency situations, Hurricane Gustav, and a chemical exposure.

eight separate standards that are all related [to emergency management] in much more detail on all the topics we consider to be important, with 45 additional elements of performance," says **Jerry Gervais**, CHSP, CHFM, associate director-engineer with The Joint Commission's Standards Interpretation Group, based in Oak Brook Terrace, IL. "The scope of what we're looking at, and the depth of what we're looking at, is markedly different [compared to the prior standard]."

Occupational health professionals should be a key part of hospital preparedness planning as hospitals review their programs, says **Mark Russi**, MD, director of occupational health at Yale-New Haven (CT) Hospital and associate professor of medicine and public health at the Yale University School of Medicine. "Occupational medicine is an expertise area for preparedness because we're dealing with exposures," he says.

Yale maintains stockpiles that range from antidotes for chemical exposures in the pharmacy to 200,000 N95s, stored in a building on the hospital campus. Annual drills keep employees' skills fresh — and remind them that the hospital has planned for their safety. That helps counteract the fear of working through a disaster or infectious disease outbreak. "It's part of what they end up weighing in the backs of their minds. 'Can I walk into that hospital and be safe?'" says Russi.

Toxic events happen '7 or 8 times a day'

Hurricane Katrina revealed much about the vulnerabilities of hospitals, and not just of those in the path of a storm. Small disasters happen literally every day around the country. In 2006, there were more than 6,000 hazardous material accidents involving railroad or truck incidents reports Gervais, citing federal government data.

"These were transportation accidents that released liquids or vapors into the atmosphere," he says. "It's occurring across the country seven or eight times a day, every day."

Katrina was a disaster of historic proportions. A Joint Commission analysis concluded that it actually comprised four distinct disasters: the hurricane itself, the levee breach and flooding, lawlessness and civil disturbance, and the breakdown in local, state and federal response.

A post-Katrina analysis influenced the Joint Commission to ramp up its expectations for hospitals to coordinate their plans with other hospitals and community entities.

"They compete against each other in normal operations, yet an emergency has a way of turning that around 180 degrees," says Gervais. "Your competitor may be your lifeline. Yet there was little being done to coordinate among facilities. You really should be working together in a disaster scenario to a common goal, and that's to serve the citizens of the community."

Hospitals must network with other hospitals to share supplies including personal protective equipment, Gervais says. That may mean making an arrangement with a hospital outside the immediate

Hospital Employee Health® (ISSN 0744-6470), including **The Joint Commission Update for Infection Control**, is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Hospital Employee Health***®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $469. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

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area that might not be affected by the same disaster scenario, he says.

In some states, health care professionals can risk losing their license if they fail to report to duty if summoned during a disaster. But whether or not your state has such a law on the books, your hospital still needs to consider how to accommodate employees' needs.

"You can't ask the nurse to leave the kids at home with no roof over their head, no running water, no food, and come to work," says Gervais. "It has nothing to do with your rank at all. It's a reality. If you're put into a horrible position of having to make the decision about taking care of your family or coming to work to take care of your employer's needs, there's no mystery about it. People simply don't show up."

The Joint Commission requires hospitals to survey their employees to find out what their employees' needs would be in case of disaster. For example, if schools are closed during a pandemic, will employees feel compelled to stay home to take care of their children?

You may or may not be able to take care of children, spouses, elderly parents, dogs, cats, and birds. In fact, agreeing to take in family members may have unintended consequences. For example, during Katrina, one hospital noted that one of its greatest challenges came from family members who had been cooped up for three days with no food, no water, no air conditioning, and no working bathroom facilities, says Gervais.

Explain the limits of what you can provide to employees' families during an emergency, and encourage employees to create personal plans to cover their gaps. "At least they'll know where they stand," says Gervais.

Drill baby drill

Annual drills, which are required by The Joint Commission, are an important way to continually educate employees so they'll feel comfortable with the measures they need to take during an emergency. It's a challenge to keep disaster planning on the front burner, says Russi.

The focus on possible disasters may rise or wane based on media reports. Amid news of new cases of avian influenza around the world, concerns grew about pandemic influenza. But when it recedes from public view, it also becomes less immediate for health care workers.

"Take advantage of times when there is greater public awareness, when the issue becomes active again," advises Russi. "That's a good time to provide lots of education to people because they're going to be receptive to it."

Meanwhile, assert the role of occupational health as critical to any planning effort. After all, a hospital's emergency response will be weak if there aren't enough health care providers to respond.

"Employee health should definitely be at the table for the disaster planning," says Russi. "None of these disaster plans work without the people. If employees are at risk [in a disaster scenario], it's critical to consider their health and safety in any of the planning that is done."

(Editor's note: A resource guide on emergency preparedness, "Disaster preparedness for Healthcare Facilities: Stories, Statistics, Solutions," is available from AHC Media, the parent company of HEH, *at www.ahcpub.com. Resources also are available from Joint Commission Resources, www.jcrinc.com, including a book that incorporates case studies, titled "Emergency Management in Health Care: An All-Hazards Approach.")* ■

Lessons learned: Prepare for the unpredictable

After Katrina, hospitals were ready for Gustav

Surviving Hurricane Katrina was a life-changing experience. It also was a transformational experience for hospitals, which revamped emergency plans and even changed building design.

They learned some important lessons about communicating with staff and preparing for the worst. Those lessons paid off as two major storms struck the Gulf Coast this year.

In fact, even the emergence of two storms (Gustav and Ike) just three years after Katrina reminded those involved in emergency management just how sudden and unpredictable disasters can be.

"I really did not think we were going to have another storm in which we were going to have to do evacuations [so soon after Katrina]," admits **Cynthia Davidson**, RN, JD, regional coordinator for hospital emergency management of the Metropolitan Hospital Council of New Orleans in Metairie. "I just wasn't expecting it. It was a good reorientation to the realities of life."

Hospitals in New Orleans had made significant

changes. For example, East Jefferson General Hospital in Metairie installed shutters on windows on the upper floors and a protective grid on lower windows to prevent them from shattering. The pebble roof was replaced and the pumping mechanism for the hospital's well was raised above flood level. The hospital now has satellite phones, and the land lines connect to three different central telecommunications offices in the region to reduce the chance of a total loss of phone service.

But more importantly, the hospital honed its ability to communicate with employees. For any type of [disaster] scenario, communication is key," says **Linda Daigle**, MT, ASCP, emergency manager and pathology laboratory administrative director at East Jefferson.

"Because you are very open with what's going on, it eliminates any apprehension that people might have and it makes them want to work more as a team," she explains. "If you take care of your team members, that helps, too. We tell them to bring bedding and food, but we find places for them to sleep if they can't be housed in their units."

Town hall meetings spread info

As Gustav approached, the hospital held town hall meetings, which gave employees an opportunity to ask questions. Emergency planners reviewed the "code gray" plan for severe weather.

More information was posted on "Team Talk," the hospital's intranet. Health care workers received targeted e-mails, detailing their responsibilities. As the hurricane approached, the hospital's CEO even made announcements on the public address system so everyone in the facility would have the updated information, says Daigle.

Employees who evacuated also had several avenues of communication. The hospital used an external web site with a password-protected site and provided a toll-free number to call for information.

The emergency plans and the open communication were reassuring to employees, says Daigle. "Pretty much everybody who was on our "A list" to report to work came," she recalls.

In fact, many employees also brought family members. The hospital actually discouraged bringing their dependents, including children and elderly relatives, but made provisions for child care and elder care.

"For the staff, as well as any other dependents, we tell them you have to come prepared to sustain yourself for seven days. That includes food," she says. "A lot of people will bring canned goods or snacks. It's just difficult when you have that many people to keep track of them. We need to know who's in the building. It puts a drain on the facility as well."

Part 2: The aftermath

The most challenging period may come after the incident. As part of emergency management, hospitals should tell employees to expect to work without backup or outside help for several days, says Davidson.

"There is no way after an event that you can get resources in any quicker. They have to be prepared to stay in place for this period of time," she says.

"Obviously, this was not [explained] to the staff members [before Katrina], because you saw a lot of panic going on because they were there for more than one or two days. The [emergency] plan says you've got to stay in place for three to five days. It still says that. That has not changed," Davidson said.

Education about the emergency plan is critical, she says. "The real issue is that you only have a certain number of people at the hospital who know the plan. The plans for emergency management really need to be made part of the yearly orientation."

Katrina was an example of a prolonged disaster. Employees were due to return to relieve those who had been on duty for days — but they couldn't return to their damaged homes.

"As people would come back to the area, they couldn't live in their house but they wanted to work. People who were here were tired. We allowed people to stay here at the hospital," says Daigle.

The hospital arranged for housing at an apartment complex that wasn't affected by the storm and flooding, and even set up a couple of trailer parks. A few people even lived at the hospital for a while.

As bad as Katrina was, Daigle imagines scenarios of other types of disasters. She takes an all-hazards approach to planning. "If we had a pandemic, it would even be worse than a hurricane situation," she says.

As a huge hurricane approaches, people in the community view the hospital as a safe haven and may even drop off loved ones for "safekeeping," says Daigle. That's much like the "worried well"

that hospitals expect to see if there is a pandemic or bioterrorism event.

That is why some hospitals have made arrangements for alternative sites to handle triage and fewer needy patients.

Helping employees cope emotionally also is an important aspect of emergency planning. After Gustav (and Katrina), chaplains visited all the departments at East Jefferson General Hospital. The Team Member Counseling Department (similar to an employee assistance program) put together special programs and met individually with employees.

Post-disaster counseling helps employees cope with tragedies they may have witnessed, but also offers support for personal losses. "In Katrina, we had many, many employees who lost everything," says Daigle. ■

Chem exposure tests hospital's readiness

Key concerns: Communication, access to PPE

At 3 o'clock on a Saturday afternoon in August, an SUV pulled up to the emergency department at SSM DePaul Health Center in St. Louis. A security officer peered in and saw three men covered in a yellowish powder. It looked like anthrax. Their skin was literally blue — they were cyanotic and near death.

A security officer, thinking of the patients more than his own safety, put on some synthetic gloves and pulled them out of the car. He immediately took them into the decontamination room, just inside the hospital, removed their clothes and showered them. Drifting in and out of consciousness, one man was able to reveal that the powder was the highly toxic industrial chemical nitroaniline, which can be absorbed through inhalation and skin contact. It can cause headache, dizziness, difficulty breathing, vomiting, increased heart rate, and eventually unconsciousness.

Elsewhere in St. Louis, five other men traveled on their own to three other hospitals. Officials later learned that they had all been exposed in an accident at Ro-Corp, a chemical packaging facility.

The sudden chemical exposure tested the hospitals' readiness for a disaster and provided an important reminder about preparedness. Lessons learned: Personal protective equipment needs to be readily available in the emergency department. Communication is the antidote to panic and fear. And employees need more training to be prepared.

The hospital successfully contained the contamination because of the swift actions of the security officer. Within minutes, the fire department arrived and set up an external command center, and the hospital was locked down. No one could come in or out.

But communications channels weren't as effective as they could have been. "It was a huge communications issue," recalls **Joanie Riesmeyer**, RN, infection control coordinator. The hospital didn't call a "Code D," which would have established an internal command center and created a system to inform supervisors and staff. "That was a huge mistake," she says. "That put our patients ill at ease because they didn't know what was happening."

Battling misinformation in media

While the men were being given an antidote to the chemical, the local news media was broadcasting that the powder was anthrax. Even when hospital officials told ED staff that it was a chemical exposure, employees were skeptical. "People were hearing about it from the media and not trusting us," says Riesmeyer.

"It became mass pandemonium. The families [of patients] were upset and they kept calling the media, also," she says. "They would leave the patients' room and go out and call the media."

News reports said that two people had died from the exposure — which was not true. All the exposed victims recovered within two days and only one remained in the hospital longer.

Riesmeyer worked with the hospital's public relations department to create an informational statement: "You are not at risk. [The contaminant] is not being recirculated in our air system. You have nothing to worry about. There are no reports of anyone who has died [at any hospital]."

It was easy for false information to spread. Even the assistant battalion chief of the fire department initially thought there were 50-75 people contaminated. In fact, three patients and 14 employees were considered exposed. They were decontaminated and given scrubs to wear; their clothes were destroyed.

They then waited on buses that served as a temporary detainment area until it was clear that they had no symptoms of poisoning. Two pregnant ED workers were kept in the hospital overnight to

monitor them for symptoms. It's unlikely any of the employees except the initial security officer had actual exposure; air sampling and other tests in the ED failed to show even a trace of the contaminant.

Lessons lead to better preparedness

The hospital has already taken steps to improve training and preparedness, including fit-testing staff to use N95 respirators. Other personal protective equipment has been placed in the decontamination room, and staff are receiving training on donning and doffing PPE, says **Elaine Allrich**, MS, MT(ASCP), infection control specialist and co-chair of the hospital's Environment of Care Committee.

"We have a small decontamination team, but that's not to say they're going to be here when an incident occurs," she says.

In fact, in the recent chemical exposure, the appropriate PPE for chemical decontamination was stored in the basement. It has been moved to the Emergency Department. During the incident, employees wore N95 respirators with face shields, although the Material Safety Data Sheet (MSDS) for the chemical called for PAPRs, and they failed to wear foot coverings, Riesmeyer says.

The hospital also is creating a disaster-oriented Pyxis to store antidotes. Poisoning with nitroaniline can be treated with methylene blue, and ED physicians also wanted atropine, which is an antidote for organophosphate poisoning. With the existing system, "[employees] would have to come out of the pharmacy, which was clean, into what we determined was a hot zone, the ED," she says.

SSM DePaul has taken its lessons to heart. Everyone, from leadership to frontline employees, will receive additional training on emergency management, she says. ■

BJC: All HCWs must get seasonal flu shot

Policy a first for a multihospital system

BJC HealthCare, a highly respected 13-hospital system in St. Louis, has become the nation's first multihospital system to require influenza vaccinations as "as a condition of employment for all employees, clinical contract workers, and volunteers." In 2004, Virginia Mason Medical Center in Seattle was the first hospital to implement mandatory flu vaccines, although nurses were ultimately exempted from the policy due to union contract issues. For four years, other major hospitals and health systems had not followed suit. But this year, BJC decided to make a fundamental shift in strategy to achieve near 100% compliance.

The BJC policy applies to about 26,000 employees as well as contract physicians and agency nurses.

"Nobody likes being told they have to do something. But we have to remember that we're trying to save lives. It's about the patients," says **Nancy Gemeinhart**, RN, MHA, CIC, manager of occupational infection control.

BJC has the support of infectious disease experts. The Infectious Diseases Society of America, the Society for Healthcare Epidemiology of America, and the Association of Professionals in Infection Control and Epidemiology (APIC) advocate a comprehensive program that requires employees to either receive a vaccination or sign a declination statement.

Linda Greene, RN, MPS, CIC, director of infection prevention at the Rochester (NY) General Health System and lead author of the APIC position paper, predicts that more hospitals will follow BJC and Virginia Mason with a fitness-for-duty requirement of flu shots. However, APIC's recommendation does not address that issue. "We applaud those orgs that have done that, but we also realize that some orgs may not be able to," she says.

APIC endorses programs that use "informed declination" along with a comprehensive approach. Strong administrative support is key, and hospitals should include flu vaccination as a quality indicator, says Greene. "I definitely think we are going to see increases in immunization rates. Organizations will be much more assertive," she says.

The American College of Occupational and Environmental Medicine (ACOEM) has opposed mandatory flu vaccination and the use of declination statements as an unnecessarily coercive approach. The occupational health physicians note that influenza vaccination is just one measure needed to prevent the spread of flu in hospitals. "[P]atients will continue to be exposed to influenza through family members and friends regardless of the vaccination status of their health care workers," ACOEM position statement says.

Health care worker unions also decry the momentum toward mandatory flu vaccination. "Once you get [percentages] above the 70s and

80s, you have herd immunity. I don't understand the additional benefit of firing people for not getting vaccinated," says **Bill Borwegen**, MPH, occupational safety and health director for the Service Employees International Union (SEIU). "Comprehensive educational programs work without alienating your employees."

Despite education, myths persisted

BJC has worked hard to raise its annual influenza rates, using the strategies that have been touted as "best practices." Every year, they devised a catchy theme. Last year, posters around the hospital showed employees flexing their arms — which were adorned with a Snoopy Band-Aid. "Got my shot," the posters said.

Every year, BJC offered incentives, including one campaign with a raffle for a $1,000 bonus for three vaccinated employees. BJC had flu "liaisons" delivering vaccine on the floors and occupational health used a mobile cart to bring the vaccine to employees.

For two years, the health system also asked employees who didn't receive the vaccine to sign declination statements stating the reason. They got the usual responses: A mistaken belief that the vaccine could cause the flu. A concern about side effects. A fear of needles. A sense of invincibility — as in, "I never get the flu."

BJC tried to counter those attitudes and managed to attain an average 71% vaccination rate across the system, which includes long-term care and outpatient facilities. Some hospitals reached as high as 87%. Others, of course, were lower.

"Seventy-one percent is good; but in order to have optimal patient safety, we decided we wanted to do even better," says Gemeinhart.

Quality committee took first step

The Excellence in Patient Care Committee, which consists of all chief medical officers and chief nursing executives from all the hospitals, viewed flu vaccination as an important patient safety issue — as does The Joint Commission. A Joint Commission standard requires hospitals to track health care worker influenza immunizations and the reasons for nonparticipation and to take steps to improve vaccination rates.

The measles, mumps and rubella (MMR) vaccine is a condition of employment; why not the influenza vaccine, the committee said.

Gemeinhart drafted the policy with help from human resources, infection control and patient safety. It was ultimately approved by the health system's executive leadership.

Employees have two months from the beginning of the annual flu vaccine campaign to receive their vaccine. Because it is a condition of employment, they will not be able to work after that date if they are not vaccinated. Effectively, that means employees would face suspension and, if they still failed to comply, could be terminated.

BJC provides exemptions for documented medical contraindications and religious objections. Exempt employees who are involved in direct patient care are "strongly encouraged" to wear a mask during the influenza season.

The health system used a careful, coordinated approach to informing employees about the new policy. First, Gemeinhart and her colleagues met with leadership, human resources, infection control and occupational health professionals at each of the hospitals. Then managers throughout the system received information and instructions about how they would roll out the policy.

Meanwhile, organization newsletters contained educational information about the flu and flu vaccine. In September, managers held meetings with employees to allow face-to-face opportunities to ask questions.

"We wanted to ensure we had consistent timely communication to the employees," she says.

At press time for *Hospital Employee Health*, it was too early to know how many employees would fail to obtain the vaccine. (The hospitals record the information in a customized occupational health database, using bar codes on the back of employee ID badges.)

But at the first hospital to start vaccinating, turnout was brisk. About 1,000 employees were vaccinated in four days — or about half the staff of the hospital. "They were surprised at the overwhelming response," says Gemeinhart.

Gemeinhart acknowledges that the flu vaccine is far from perfect. Sometimes, it is a poor match with prevailing strains. Even with a good match, it is about 70%-90% effective, which means some employees still may develop the flu.

But vaccinating virtually all employees will reduce the risk of health care-associated transmission — and show that the hospital is doing all it can to protect patients, she says.

"More people die from influenza than any other vaccine-preventable communicable disease," she says. "We need to do what we can to prevent it." ■

Money talks: HCWs get 20 bucks for a flu shot

Incentive boosts hospital's flu vaccination

Every employee who gets a flu shot at McLeod Health in Florence, SC, walks away with a $20 bill. Yes, you heard that right. Twenty bucks for rolling up their sleeve and getting the vaccine that the Centers for Disease Control and Prevention, The Joint Commission, and others say will help prevent the spread of flu to vulnerable patients.

The monetary incentive has been a simple and effective way to boost influenza vaccination. About 80% of the hospital's 4,500 employees receive the shot. The hospital budgets about $62,000 for the annual incentive, but in the long run, it's cost-effective, says **Octavia Williams-Blake**, BA, JD, director of Employee & Occupational Health, Workers Compensation, and Employee Safety.

With a dramatic rise in flu vaccination, absenteeism, and the use of sick leave during flu season has dropped, she reports.

Mondays are the most popular day for flu shots during the vaccination campaign — a time when employees are low on cash after the weekend. "You would not believe the number of people who say, 'I want the $20 shot.' They don't even know what it is," says Williams-Blake. "Of course, we take that opportunity to educate them."

In fact, education remains an important part of McLeod's flu campaign, with educational information in annual health and safety training and articles in the hospital newsletter.

McLeod still encounters employees with the usual misconceptions about the flu vaccine, such as the belief that one can get the flu from the shot. This year, the hospital also will focus on making the flu shot more accessible by delivering the vaccine to individual departments.

Serious message with a dose of humor

Average Joe is pouring a cup of coffee when a hospital co-worker asks him if he got the flu shot. The flu shot? Isn't that responsible for pandemic influenza, global warming, and all kinds of bad things? "I'm just going to stay away from people who are sick," he replies with a straight face.

That's just the opening of a new video produced by Marshfield (WI) Clinic in an effort to inject a little humor amid the education of health care workers who decline the flu vaccine.

The story of Average Joe (who really is a Marshfield employee) is spliced throughout the computer-based training for those who sign a flu vaccine declination. But it also is headed for YouTube.

Average Joe, an IT professional, does his best to avoid the flu shot. But then a patient sneezes all over a laptop — which is handed over to him to clean it up. He gets sick and ends up hospitalized with complications of the flu. The next year, he's seen running down the hall to be first in line for the flu vaccine.

"It gets the message across," says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety. "We're trying a little different approach."

The humorous approach takes the edge off the exhortations to get the flu shot. Last year, employees who opted out were required to talk to managers one-on-one. Some felt the flu vaccine efforts were too coercive, he says.

Last year, Marshfield vaccinated about two-thirds of its employees, including 70% of its patient care personnel. Efforts to boost that number have been frustrating. "It's pretty clear from the three years we've been using declination forms, we're getting the exact same excuses, even though we've educated employees," Cunha says. "The people who don't want to get it aren't going to get it."

If humor and other incentives awards don't work, the Marshfield Clinic may shift to a condition-of-employment policy, he says. Most likely, employees who refused the vaccine would be required to wear a mask but would not be fired, Cunha adds. ■

CDC: Tell patients to ask HCWs to wash their hands

Video shown on admission promotes hand hygiene

"Hello. I'm Dr. John Jernigan from the Centers for Disease Control and Prevention. Your doctor has chosen to admit you to this facility because you need high-quality medical care. The health care providers here want to do everything they can to help you get well and to avoid complications.

"You came to the hospital to get well, but you should know that each year in the United States,

patients get more than a million infections in the hospital while they're being treated for something else.

"Examples of infections patients can get in the hospital include infections in their bloodstream, surgical wound, or urinary tract, as well as pneumonia.

"These infections can be serious and hard to treat, but there's one simple thing you and your family can do to help prevent these infections: Wash your hands and make sure that everyone who touches you — including your doctor — cleanses their hands, too . . ."

Think of this as the hospital version of the "safety talk" when passengers board an airplane. Hospitals around the country have begun to use a new, free five-minute video created by the CDC and cosponsored by the Association for Professionals in Infection Control and Epidemiology (APIC) and the CDC Foundation.

The main message: Patients should politely demand that their caregivers clean their hands before they touch them.

"What we're hoping to achieve is a culture change," says **Kristin Rainisch**, MPH, health communications specialist with CDC's Division of Healthcare Quality Promotion. "You should wash your hands when you're in a health care facility. It's as important as washing your hands before you eat or when you use the restroom."

Bill Borwegen, MPH, occupational safety and health director for the Service Employees International Union (SEIU), supports the concept of encouraging patients to remind health care workers to wash their hands. But he says that's just one component of an effort to fight hospital-acquired infections and improve hand hygiene compliance. "It's a systemic problem that's the result of a lack of a safety culture in the institution," Borwegen says.

Rainisch agrees that the video reminder should be part of a comprehensive approach. "It's just one tool in the toolkit to help prevent health care-associated infections," she says.

Infection tragedy leads to safety campaign

The inspiration for the instructional video actually came from the mother of a patient who died from a health-care associated infection. **Josh Nahum**, 27, a skydiving instructor in Colorado, fractured his leg and skull in a hard landing; but at first his recovery seemed assured. He fought off a staph infection in the intensive care unit and moved to a rehab unit, where he was making progress.

Then Josh developed an aggressive infection with *Enterobacter aerogenes* in his cerebrospinal fluid. The pressure of the infection pushed brain matter into his spinal column, causing paralysis. He died two weeks later — not from his injuries, but from his health care-acquired infection.

His parents were in shock. As they learned more about health care-acquired infections, they began to speak out and created an organization to spread awareness, the Safe Care Campaign (www.safecarecampaign.org).

"Once a patient gets an infection, that's a dark hole you don't want to be in," says **Victoria Nahum**, Josh's mother. "You would rather prevent one than control one because they're not easily controlled."

Nahum had a sudden epiphany when she was sitting aboard a plane, waiting to travel to a speaking engagement. Why do we hear repeated information about safety on airplanes but none in hospitals? Couldn't patients be engaged to participate in their own safety?

The CDC agreed to produce the video, and APIC and Kimberly-Clark Health Care in Roswell, GA, became sponsors. Thousands of videos have been provided to hospitals around the county.

In the video, a patient asks a physician to wash her hands. She responds that she washed them before she came into the room. The patient presses the point, telling her she wants to see her wash her hands.

It is designed to help patients overcome their timidity about confronting their health care providers. A survey of health care consumers found that only one in four (25.9%) were likely to ask providers to wash their hands.[1]

"I myself would feel uncomfortable asking a health care provider," says Rainisch. "That's one of the things we try to address in the video by showing scenarios. The people who watch the video can see the behavior being modeled. It's a way of almost scripting the information for them. They can also see the results it yields [when the doctor readily washes her hands]."

Hand hygiene is an important strategy in the battle against health care-acquired infections, says Nahum. "Our message to health caregivers is that every single thing they do matters," she says. "One time that you wash your hands when you weren't going to, these things matter with enormous consequences."

(Editor's note: A copy of the video is available at www.cdc.gov/handhygiene/Patient_Admission_Video.html. A eight-minute employee education video, "It's in

Your Hands," is available from BD of Franklin Lakes, NJ, at www.cdc.gov/handhygiene/Patient_Admission_Video.html.)

Reference

1. Marella WB, Finley E, Thomas A, et al. Health care consumers' inclination to engage in selected patient safety practices: A survey of adults in Pennsylvania. *J Patient Saf* 2007; 3:184-189. ■

Success story: Boosting annual health screens

Too many employees lost to follow-up

Sometimes the routine becomes routinely ignored. That is what had happened at North General Hospital in New York City with annual health assessments.

The hospital viewed them as an important encounter for immunizations, TB screening, fit-testing, and other fitness-for-duty issues, and Joint Commission surveyors asked about employee health records. But too often, the employees themselves let the appointments slide.

"It was easy for them to get lost to follow-up for some particular reason," says **Linda Primus**, MS, PA-C, employee health services manager. "It makes it quite difficult to monitor the employees for their own safety."

Employees received a letter reminding them to come for their health assessment during the month of their birth date. It was difficult for supervisors to know which employees had complied. By midyear in 2006, when Primus arrived at North General, only about 20% of the employees had completed their annual health assessment. Annual assessments had previously been as low as 47%.

"If we keep on going at this rate, we're not going to make it [to 100%]," Primus realized. As tedious as it was, she began a review of employee charts to identify the employees who had missed their assessment.

Then, working with human resources, she changed the system. Instead of coming to Employee Health during their birth month, employees would receive their assessments with their departments during a designated month. For example, nursing received their assessments during January and February.

With the new system, managers could help

CNE *questions*

21. In revising its 2008 Emergency Management standards, The Joint Commission wanted to emphasize that hospitals should:
A. take an all-hazards approach.
B. stockpile supplies.
C. incorporate vaccination programs with emergency management programs.
D. coordinate with other hospitals and community organizations.

22. In Hurricane Gustav, what methods did East Jefferson General Hospital use to communicate with employees about emergency plans?
A. Direct email
B. Town hall meetings
C. Intranet
D. All of the above

23. The new fitness-for-duty policy at BJC HealthCare provides that:
A. employees must sign a declination statement if they don't receive the flu vaccine.
B. employees may be exempt from the flu vaccine if they have medical contraindications or a religious objection.
C. employees may decline the seasonal vaccine but must take a pandemic influenza vaccine if one becomes available.
D. no employee is exempt from the flu vaccine.

24. By giving $20 to each employee who receives the flu vaccine, what vaccination rate does McLeod Health achieve?
A. 73%
B. 80%
C. 92%
D. 100%

Answer Key: 21. D; 22. D; 23. B; 24. 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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

keep track of which employees had completed the assessment, and it was easier for employees to remember when to come. Employee Health often lacks manpower, but now managers were able to assist, says Primus. "We have to learn how to collaborate with the other departments," she says. "They were very helpful in bringing up our numbers."

The new method also allowed for better health and safety education of employees by department. For example, Primus discovered that only about 50% of employees with bloodborne pathogen exposure had received their hepatitis B vaccine. With focused education, more employees agreed to the vaccine and the coverage now is about 85%.

As cases of mumps appeared in New York state, North General took a new policy on mumps immunity. All employees must either have documentation of the MMR vaccine or previous mumps infection or must have a titer. If a mumps outbreak occurs, "we're at ease because the proof of immunity is already there," she says.

One more fundamental policy change made it clear that the hospital placed a high priority on the annual health assessments: They became a condition of employment. Employees who neglect their annual assessment first receive a reminder from Employee Health that noncompliance could lead to suspension without pay. Then human resources and the department manager are notified. If the employee still doesn't comply, she or he faces disciplinary action.

All departments have had 100% compliance — and no one required disciplinary action, Primus says. ■

OSHA updates hospital eTool

Hazards faced by sonographers now are addressed in the online safety module, eTool, of the U.S. Occupational Safety and Health Administration. The segment provides possible solutions to musculoskeletal disorder (MSD) risks and suggests equipment that could reduce the hazards.

OSHA updated other segments, including the hazards and possible solutions in the surgical suite. For example, it addresses enflurane, isoflurane, sevoflurane, and desflurane as the waste anesthetic gases that may present an exposure hazard. Trichloroethylene, methoxyflurane, and chloroform have been removed from the list.

The Hospital eTool is available at www.osha.gov/SLTC/etools/hospital/index.html. ■

Special issue in January: A sharper look at safety

Zero needlesticks. That is the goal set by the Centers for Disease Control and Prevention in Atlanta as one of the Seven Healthcare Safety Challenges. So why did CDC contract with Novartis for prefilled, thimerosal-free syringes that had conventional needles attached? Federal law has required the use of safety-engineered devices for almost eight years.

So why are health care workers still using kits that contain conventional devices? In our January issue, *Hospital Employee Health* will explore lingering gaps in sharps safety. We'll also provide some expert advice on benchmarking of bloodborne pathogen exposures and share how one hospital sought the best sharps devices. ■

HEH salary report in next issue!

Look for our exclusive annual salary and career report for employee health professionals in the January issue — a timely guide in these uncertain economic times. ■

COMING IN FUTURE MONTHS

- Novartis takes returns on nonsafety flu vaccine syringes
- Tackling persistent challenges in sharps injuries
- Benchmarking needlesticks: What is the denominator?
- Using a self-assessment tool to boost your sharps program
- How one hospital decided on the best sharp

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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The Joint Commission Update for Infection Control

News you can use to stay in compliance

'The numbers don't match': Joint Commission urges more infection-related sentinel event reporting

Leading IP cites caveats that may explain discrepancy

Citing a dramatic disconnect between the tens of thousands of patients dying annually with health care-associated infections (HAIs) and the paltry number that actually are being reported as sentinel events, The Joint Commission is urging hospitals to file the voluntary reports to help improve patient safety.

"The question here is — we've got a lot of data, we've got lot of sentinel events — where are the infections?" said **Louise M. Kuhny**, RN, MPH, MBA, CIC, senior associate director of standards interpretation at the Joint Commission. "The CDC is saying we are having 90,000 infection [deaths] a year, the mortality is high, we have all these problems; where are the infections? We would like to know because it doesn't seem that they are being reported through the sentinel event database."

At a recent Joint Commission meeting in Chicago, Kuhny revealed that of the 4,977 sentinel events reported from 1995 through March 2008, only 104 were infection-related. "We certainly know that there were way more than 104 infection-related events in 12-13 years," she said. "We are encouraging this reporting."

The most recent data only underscore the trend of underreporting, as The Joint Commission received fewer than 15 sentinel event reports related to infection in 2007.

"We're concerned . . . because the numbers don't match," Kuhny said. "We're not getting the reporting. We're not getting [reports of] noncompliance with this, either. [Hospitals] probably have all the systems in place to report, yet we know that all of this morbidity and mortality is [occurring]. In 2007, we didn't even have 15, and we know that there are tens of thousands out there."

Indeed, according to the most recent published data, the Centers for Disease Control and Prevention estimates that 5%-10% of hospitalized patients develop an HAI, corresponding to approximately 2 million HAIs associated with nearly 100,000 deaths each year in U.S. hospitals.[1]

Patient safety goal established in 2004

To be fair, it was not until issuance of its 2004 patient safety goals that The Joint Commission officially called for unanticipated patient deaths and serious injuries related to HAIs to be investigated as sentinel events requiring a root-cause analysis (RCA). **(See Q&A, p. 2.)** NPSG.07.02.01 — which remains in place for 2009 — calls for hospitals to:

"Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care-associated infection.

Rationale: A significant percentage of patients who unexpectedly die or suffer major permanent loss of function have health care-associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo an RCA. The RCA should attempt to answer the following questions: Why did the patient acquire an infection? Why did the patient die or suffer permanent loss of function?

Elements of Performance: The hospital manages all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection as sentinel events (that is, the hospital conducts an RCA).

The root-cause analysis addresses the management of the patient before and after the identification of infection."

How often are HAI events unanticipated?

The "unanticipated" aspect of the definition may be part of the problem, as patients being kept alive by invasive devices may certainly have an HAI among their end-term sequela. In addition, reporting the RCA results is voluntary, but strongly encouraged to identify trends and improve patient safety. "It is a voluntary reporting system, so not all sentinel events of any kind must be reported," said **Denise Murphy**, RN, MPH, CIC, vice president and chief safety and quality officer at Barnes-Jewish Hospital in St. Louis. "I think hospitals report those that are most serious in terms of *how* they happened. All sentinel events mean harm, but those that can educate us most in terms of process breakdowns to look out for are what most executive teams would demand be reported."

A frequent lecturer at infection prevention meetings, Murphy has urged IPs to embrace the Joint Commission initiative and conduct RCAs as warranted. "HAIs that are unexpected or 'unanticipated' are what we should be counting," she said in a separate interview after The Joint Commission meeting. "We do that here and do a sentinel event investigation — including a debriefing as soon as we learn of the event — followed by a root-cause analysis. The 'unanticipated' aspect is why you don't see 100,000 HAIs being reported to The Joint Commission."

For example, the death or injury of an ICU patient who develops ventilator-associated pneumonia (VAP) despite the use of infection prevention "bundles" and other cutting-edge interventions is tragic but not completely unanticipated. "[However,] if you have a 30-year-old patient undergo elective surgery, not wake up after anesthesia, require mechanical ventilation and then get a VAP, this was not anticipated or expected and should be debriefed and followed up with an RCA," Murphy explains. "The RCA would look into all aspects of patient safety and why such an adverse event occurred. In fact though, it might be written up as an unanticipated surgical outcome [instead of] the VAP."

By the same token, if a 30-year-old patient undergoes an elective knee replacement due to a sports injury — as opposed to a serious underlying illness such as juvenile diabetes — and then develops a surgical-site infection (SSI), that could be considered a sentinel event, she notes.

"The SSI was not anticipated in a healthy 30-year-old," Murphy says. "Now, even there, a superficial SSI would not be counted. But if the 30-year-old came into the hospital for three incision-and-drainage surgeries, had months of antibiotic therapy, then lost the prosthetic knee due to infection — there is your sentinel event."

Caveats and cost benefits

Thus, given Murphy's points, there is more to the picture than the jarring juxtaposition of the numbers.

"I am not trying to make excuses — HAIs are always horrible outcomes," Murphy says. "But they are not always unanticipated. The patient's underlying conditions at the time of admission or time of a procedure will often help dictate whether or not this was a totally unanticipated outcome that led to death or permanent disability — or risk thereof. The 'risk thereof' is where you could end up investigating every thing as a sentinel event."

In that sense the "cost benefit" of doing an RCA must be considered. "I don't mean dollar cost," she says. "I mean that infection prevention and control programs have finite resources, and we have to decide every day how to best 'spend them.' Taking the time to educate health care teams, assess the safety of our patient care processes, help teams redesign patient care, and build in prevention is where I'd put most of our resources. And I'd use those IP resources to debrief and help risk management do a root-cause analysis every time an HAI was unanticipated and led to death or serious disability."

Reference

1. Yokoe DS, Classen D. Improving patient safety through infection control: A new health care imperative. *Infect Control Hosp Epidemiol* 2008; 29:S3-S11 ■

Joint Commission's Q&A on HAIs as sentinel events

(Editor's note: The following frequently asked questions were posted on The Joint Commission web site regarding the issue of health care-associated infections and sentinel events. They were marked as most recently

reviewed in March 2008.)

Q. Regarding the "manage as sentinel events" requirement, how do we know which cases should have a root-cause analysis?

A. The intent of this requirement is to manage any unanticipated death or major permanent loss of function as a sentinel event, *even if* the patient acquires a nosocomial infection, not simply because the patient has acquired an infection. This is really a reminder of an existing requirement, not a new requirement. The decision to designate and review an occurrence as a "sentinel event" should be based on the outcome of the case (unanticipated death or major permanent loss of function), not on any presumptive cause.

Q. If this is not a new requirement, why make it a national patient safety goal?

A. Even though the requirement for root-cause analysis in response to an *unanticipated death or major permanent loss of function* is not new, many cases that meet this definition have not been considered sentinel events — apparently because infection was associated with the outcome. In other words, there has been an assumption that the presence of infection excludes a case from consideration as a sentinel event. This is not, and never has been, an intended exclusion. As a result, there are very few cases of infection-associated sentinel events in the Sentinel Event Database (in relation to other types of sentinel events and to the number of infection-associated cases known to be occurring annually). The Joint Commission believes that managing these cases as sentinel events will provide additional information, not so much about the infection itself, but about managing patients at risk for infection and who have acquired an infection. In this manner, the new goal, while not necessarily a new requirement, will contribute to reducing the risk of patient harm from health care-associated infection.

Q. Many patients who die with nosocomial infections are very sick and may have multiple other problems. How do we determine whether the patient's death was "unanticipated?"

A. This determination is based on the condition of the patient at the time of admission to the organization. A death or major permanent loss of function should be considered a sentinel event if the outcome was not the result of the natural course of the patient's illness or underlying condition(s) that existed at the time of admission. For example, an otherwise healthy patient who is admitted for an elective procedure, develops a wound infection, becomes septic, and dies should be considered a sentinel event. However, cases in which the patient is immunocompromised or elderly with multiple comorbidities are more difficult to classify. The knowledge that a certain percentage of patients with a given condition will die does not mean that the death of any one of these patients is "anticipated." If, at the time of admission, the patient's condition is such that he or she has a high likelihood of not surviving the episode of care (e.g., the hospitalization), then that patient's death would not be considered a sentinel event. Otherwise, it should be managed as a sentinel event, that is, a root-cause analysis should be conducted.

Q. How should I go about doing a root-cause analysis on an infection?

A. Just as the identification of an occurrence as a sentinel event is not dependent on whether the patient did or did not have an infection, the root-cause analysis we are looking for is not just an analysis of the infection (if there was one), but of the event itself, i.e., why did the patient die or suffer major permanent loss of function. It is anticipated that this analysis will identify system and process factors that through appropriate redesign can reduce the risk of serious adverse patient outcomes even as the risk of nosocomial infection remains high.

Q. I am an [infection preventionist], and my day is already full with the usual surveillance, analysis, and prevention activities. How can I do all these root-cause analyses and still have time for my regular important work?

A. There is no expectation that the burden of conducting the analysis will be placed on the infection control professional, although if there were an associated infection, the IP's participation on the root-cause analysis team could be very beneficial.

Q. Won't this require a significant increase in our surveillance activities?

A. No, there is no expectation for increased or otherwise modified surveillance activities.

Q. Where is the evidence that root-cause analysis will help reduce the risk of health care-acquired infections?

A. The efficacy of root-cause analysis to identify system failures and thus direct improvement

has been convincingly demonstrated over the past several decades in most high-risk fields and, more recently, in health care for the broad array of serious adverse events that occur. While it is true that the effectiveness of root-cause analysis specifically for reducing harm from nosocomial infections has not been proven, that may be only because it hasn't been given an adequate chance with this specific type of event. Nor has the traditional rate-based approach, by itself, been sufficient. Perhaps a combined approach might move us further along. ■

Tips to conduct your annual IP risk assessment

Bring in key partners in setting priorities

Under standard IC.01.03.01, The Joint Commission requires that the hospital identifies risks for acquiring and transmitting infections. This is done primarily through an annual risk assessment, which forms the bedrock for the infection prevention program activities, emphasized **Barbara M. Soule**, RN, MPA, CIC, Joint Commission practice leader in infection prevention and control services.

"The risk assessment is the foundation of your infection prevention program," she said recently in Chicago at a Joint Commission infection control conference. "If you do it well and come up with your priorities it provides focus for your activity and resources."

Soule offered the following tips and key elements of an infection prevention risk assessment:

Partnerships

Form partnerships with:

- Key stakeholders, e.g., physicians, nurses, technicians, laboratory, special support services, administration to provide data and information, experiences, concerns reflecting their responsibilities, e.g., ICU staff, occupational health, biomedical services, risk management.
- Those who have the information you need.
- Opinion leaders in the organization.
- Leadership for support and endorsement.

Team

- Create a team to help analyze the information from the assessment
- Engage three to five key staff to work as a team on the assessment
- Patient safety and performance improvement staff or committees to assist

Gather Data and Information

- Organization Data
- Gain access to key reports in the organization, e.g., services provided, populations served and characteristics and volumes, special environmental issues.
- Tap into organization data (medical records, lab records, admission and discharge numbers
- Review IC program surveillance data

Scientific Data

- Review the literature for new trends in infection control journals and other sources
- Link to key web sites (e.g., health departments, CDC, APIC, SHEA, IDSA)

Community Data

- Connect with the local health department to identify trends that may affect infection risk in the facility
- Issues of emerging pathogens and bioterrorism plans

Systematic Methods and Templates

- Develop a systematic way of looking at data
- Turn qualitative data into quantitative when possible
- Develop a ranking scheme to determine highest priorities
- Team ranks data to determine priorities

Educate Others to Assist in Assessment

- Provide support and guidance for others to perform their risk assessments:
- Provide an educational session
- Share organization's IC data from surveillance, outbreaks, morbidity, mortality
- Design a simple template
- Create ease of performing and submitting information

Disseminate the Information

- Market the risk assessment importance and share results.
- Develop concise, clear report with key points highlighted
- Acknowledge those who participate in the process ■

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