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The Joint Commission Update for Infection Control  
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## Fit-test problems raise questions about pandemic N95 respirators

*California 'recalls' 3M 8000s due to poor fit of HCWs*

The release of millions of N95 filtering facepiece respirators during the novel H1N1 pandemic has revealed a potentially serious problem in preparedness: N95 respirators have different fit characteristics, and not all of them can be successfully fit-tested on health care's predominantly female work force.

In January, California "recalled" millions of respirators in its pandemic stockpile after Kaiser Permanente complained that the 3M 8000 model could not be successfully fit-tested. All the employees initially failed the fit-test, and even after technical assistance from 3M, 60% failed the quantitative fit-tests. Even those who passed the fit-test lost an effective face seal during routine movements, California officials say.

The California Department of Public Health (CDPH) asked 3M to replace the 3M 8000s, a model that has since been discontinued, with the 3M1860 or 1860s, popular models in health care. "It is now evident that contrary to the representations of 3M representatives in 2006, the Model 8000 Particle Respirator will not adequately protect health care workers, and that the state's entire inventory of Model 8000 Particle respirators is not suitable for its intended purpose," CDPH director **Mark Horton**, MD, said in a letter to 3M. (This issue involves only the 3M 8000, not a series of models; for example, the 3M 8210 and 8511 have very different fit characteristics.)

3M spokeswoman **Jackie Berry** emphasized that the 3M respirators are not defective. "When properly used and fitted it does reduce exposure to the H1N1 virus. There are absolutely no performance issues with the product," she says.

The concerns about fit still were being addressed when *Hospital Employee Health* went to press. "We take any concerns related to the products very seriously. We're in discussions with [the California Department of Public Health] to try to reach some type of resolution," says Berry.

Meanwhile, the National Institute for Occupational Safety and Health

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(NIOSH) conducted an evaluation of the 3M 8000. Initial tests showed that it still passed the agency's certification requirements, which primarily involve filtration capability. NIOSH also was testing the fit on a panel of 40 individuals.

NIOSH has proposed adding fit-characteristics — a "total inward leakage" test — to the certification requirements for N95 filtering facepiece respirators. Still, even if the rule is adopted swiftly, the new criteria would be phased in and would not become fully effective for at least a couple of

years, says **Roland Berry Ann**, deputy director of the NIOSH National Personal Protective Technology Laboratory in Pittsburgh. **(For a related article on the development of respirators designed for health care, see p. 27.)**

When planning a stockpile of protective gear for health care workers, it's important to have more than one model of respirator, safety experts say. A respirator may fit certain facial sizes or characteristics but not others. Ideally, a respirator that fits a wide range of facial features and is available in multiple sizes is the best choice for a stockpile.

Those involved in purchasing decisions also should consult occupational health professionals and industrial hygienists who can provide technical expertise, safety experts say.

In 2006, the California Department of Public Health used federal pandemic preparedness funds to build its stockpile of respirators. CDPH requested the 3M 1860 or 1860s but was told that the respirator wasn't available in sufficient quantity, says CDPH spokesman **Michael Sicilia**.

"3M was involved in advising the state of California in the purchase," he says. "We were assured by 3M that this was a perfectly good respirator [for health care workers]."

The 32.4 million 3M 8000 respirators represented about 60% of the state's stockpile of 50 million respirators and cost about \$7.4 million, reports Sicilia. About 8.5 million respirators from the stockpile, including 5.1 million of the 3M 8000, were shipped to 34 local health departments and 61 health care facilities to protect health care workers from the novel H1N1.

The 3M 8000 is a respirator with few features, says **Deborah Gold**, MPH, CIH, senior safety engineer in the research and standards health unit at Cal-OSHA in Oakland. For example, it has only one strap and no padding at the nose bridge. CDPH did not consult with the California Division of Occupational Safety and Health (Cal-OSHA) in the purchase.

It's important for stockpiled respirators in pandemic planning to fit the typically smaller female face, since the health care work force is predominantly female, says Gold. "It's important to have some idea that a stockpile of respirators is likely to fit a high percentage of all individuals or a significant percentage of a certain type of individuals," she says. "To ask health care facilities to fit-test 100 people with little chance that even half are going to be able to use this respirator is a big use of resources."

**Roger Richter**, senior vice president of

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Editor: **Michele Marill**, (404) 636-6021, ([marill@mindspring.com](mailto:marill@mindspring.com)).

Associate Publisher: **Coles Mckagen**, (404) 262-5420, ([coles.mckagen@ahcmedia.com](mailto:coles.mckagen@ahcmedia.com)).

Senior Managing Editor: **Gary Evans**, (706) 310-1727, ([gary.evans@ahcmedia.com](mailto:gary.evans@ahcmedia.com)).

Director of Marketing: **Schandale Kornegay**.

Senior Production Editor: **Nancy McCreary**.

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### Editorial Questions

For questions or comments call **Michele Marill** at (404) 636-6021.



professional services with the California Hospital Association in Sacramento, told *HEH* that he was not aware of other hospitals or health systems that had problems with the 3M 8000. However, by late fall, H1N1 cases had declined and hospitals may have been relying on their own supplies of respirators, he says. The 3M 8000 was not a model that was commonly used in health care, he says.

The Centers for Disease Control and Prevention in Atlanta also purchased millions of the 3M 8000 model for its national strategic stockpile, but CDC has not had any complaints, says spokesman **Richard Quartarone**.

Some 18.2 million of the 76 million N95 respirators distributed from the national stockpile were the 3M 8000, he says. In all, the 3M 8000s made up 30% of the N95s respirators in the 100 million stockpile.

“When the N95 respirators were purchased by the Strategic National Stockpile, in order to get the number they needed, they had to go to a wide variety of manufacturers and get a wide variety of respirators,” Quartarone says.

Concerns about the 3M 8000 underscore the need for fit-testing to ensure that respirators are protective, says Berry Ann. “It does highlight the importance of fit-testing to be sure that the respirator fits [an individual], and you need to have an assortment [of models] because no respirator fits everyone,” he says. “If you’re one of the people it fits . . . you would be protected.” ■

## In search of the perfect HC respirator

*VHA seeks prototypes of a new design*

Imagine the perfect respirator for health care workers: They wouldn’t mind wearing it for an entire shift. They wouldn’t have any trouble communicating with each other or with patients. Yet it would protect them from infectious diseases, and it wouldn’t cost too much.

Anyone can dream. But a group, spearheaded by the Veterans Health Administration (VHA) in collaboration with the National Institute for Occupational Safety and Health (NIOSH), is trying to make this a reality.

The VHA issued a notice in the *Federal Register* asking for proposals from manufacturers who want to collaborate with Project B.R.E.A.T.H.E. (Better

Respiratory Equipment using Advanced Technologies for Healthcare Employees). The manufacturers would need to meet a list of criteria that broadly meet these goals: Respirators should perform their intended functions effectively and safely. Respirators should support, not interfere with, occupational activities. Respirators should be comfortable and tolerable. Respiratory protective programs should comply with federal standards and guidelines, state regulations, and local policies.

The project is on a fast track. Manufacturers would be expected to develop a prototype within six to 12 months and to be able to produce respirators within six months.

“There’s no shortage of need [for better respirators],” says **Lewis J. Radonovich**, MD, and director of Biosecurity Programs for the Office of Program Development at the North Florida/South Georgia Veterans Health System in Gainesville, FL. “The 2009 pandemic made it very clear to the public health and health care communities that respirator problems are a significant issue for health care workers.”

### ***Current models are ‘intolerable’***

Currently, health care workers don’t tolerate N95 respirators very well. Radonovich and colleagues studied tolerability in 27 health care workers who wore eight different respirators or surgical masks for an entire eight-hour shift, with two 15-minute breaks and one 30-minute lunch break.

In more than half the sessions (59%), health care workers stopped wearing the masks or respirators because they could not tolerate them. Their complaints included diminished speech communication, heat, pressure, and dizziness. The powered air-purifying respirator (PAPR) and N95s with an exhalation valve were the best tolerated; the N95 worn with a surgical mask over it was the least tolerated.<sup>1</sup>

Short-term use — such as wearing a mask to treat the occasional tuberculosis patient — doesn’t seem to be much of a problem, notes Radonovich. But during a pandemic, or with a newly emerging pathogen such as SARS, health care workers need continuous protection.

“Prolonged wear is a lot different than short-term wear. No matter what you put on, it appears there is substantial discomfort if it is worn for hours and hours,” he says.

Yet this is a problem that must be solved, he notes. “If you look across other occupations, there are settings where workers have equipment

that's worn for long periods [such as] the mining industry," Radonovich says. "It's conceivable that workers can learn to wear respirators for long periods. We need to do our job in the health care sector and respirator manufacturing sector to produce a respirator that's as comfortable as possible."

What is it that bothers health care workers most about respirators? What would they like to see in a respirator?

A survey of 159 health care workers at two hospitals revealed that most found them to be too hot (80%) and had experienced difficulty breathing (64%) or difficulty communicating verbally (78%) while wearing them. Only 24% reported N95 respirators to be comfortable most of the time or always, and almost 90% said they would rarely or never be able to tolerate wearing an N95 most of the time or always.<sup>2</sup>

"There hasn't been much research assessing the features that health care workers would want in respirators," says **Aliya Baig**, RN, MPH, MSN, former associate with the VA respiratory project. The survey "helps confirm some of the assumptions that have been made," she says.

However, health care workers aren't longing for an elastomeric or powered-air purifying respirator (PAPR). The surveyed health care workers said they want a disposable respirator that is comfortable and can be worn with facial hair. They also would like a respirator that doesn't require fit-testing.

The preferences of health care workers will play a role in the development of the new respirators. Radonovich envisions the VHA working with more than one manufacturer — possibly one large and one small. The system's massive work force — some 180,000 health care workers — will provide an ample platform for testing designs and getting feedback. (Health care workers will need to simulate work functions as they test out respirators because they can only use NIOSH-certified respirators on the job.)

"We are open to considering radical changes, completely new designs that are completely innovative," says Radonovich.

The VHA is developing a detailed list of criteria. "We're challenging our partners to think about how we can combine all the 28 different needs we have and turn them into something that the health care sector will want to buy," he says.

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## Bullying takes toll on HCWs and patients

*Joint Commission: Zero tolerance for intimidation*

Compared with carcinogenic chemicals and infectious diseases, workplace bullying may seem like more of an annoyance than a health risk. Yet bullying is a hazard in health care that is linked with poor outcomes for employees and patients alike. Workplaces that allow bullying and intimidation suffer from low satisfaction ratings as well as injuries and poorer patient care.

Concern about bullying was strong enough to inspire new performance requirements in the leadership standards of The Joint Commission, the Oakbrook Terrace, IL-based accrediting body. As of 2009, hospitals must have a code of conduct that defines "acceptable and disruptive and inappropriate behaviors" and must have a process for dealing with the inappropriate behaviors.

The standards apply to managers and employees alike — as well as to physicians. They are an important aspect of the leadership standard that calls for hospital leaders to create a culture of safety, says Joint Commission senior vice president **Paul Schyve**, MD.

Intimidating behavior "destroys the culture of safety," he says. "If you want to have consistent safety, you need to have a culture of safety. There is a cycle of being able to report [errors], to talk about things, to trust that it won't be held against you, but in fact will be used to make improvements."

The Joint Commission's strong stance is bolstered by recent studies that reveal the impact of workplace bullying. For example, researchers at the University of Illinois at Chicago found that higher levels of workplace harassment were associated with illness, injury, and assault. Other stress factors, such as not having as much decision-making latitude, did not have the same link.<sup>1</sup>

"Sometimes you're going to feel overwhelmed or not have enough time, but you don't expect someone to yell at you or swear at you," explains **Kathleen Rospenda**, PhD, associate professor of psychology at the University of Illinois at Chicago.

Bullying does not differ by gender — men are as likely to be bullied as women, studies show. But unskilled employees and those who work with clients or patients, including health care workers, face higher rates of bullying, one study showed.<sup>2</sup>

The stress in health care, particularly coupled with staffing constraints, may set the stage for intimidation and retaliation, says **Evie Bain**, RN, MEd, COHN-S, FAAOHN, associate director and coordinator of the health and safety division of the Massachusetts Nurses Association in Canton, MA. “It’s part of the whole violence spectrum we see in health care,” she says.

### ***Bullying is ‘systemic’***

The bottom line: When a physician blows up at a nurse or a supervisor belittles an employee, it is not just a clash of personalities or a reaction to a stressful day. “We argue that workplace bullying is a systemic issue, not a purely personal one,” says **Loraleigh Keashly**, PhD, associate professor in the department of communication at Wayne State University in Detroit, who has researched workplace bullying and directs a graduate program in dispute resolution.

That view is shared by The Joint Commission, which requires hospitals to educate health care workers at all levels and to adopt a “zero-tolerance” stance toward the worst behaviors.

Bullying often stems from a power play — a more powerful person acting aggressive or asserting his or her control over someone else. But co-workers also can intimidate.

“If you look at the statistics the studies have tended to show that it’s more likely to come from somebody higher in the hierarchy,” says Schyve. “But it’s actually widespread across all levels, including from nurse to nurse. Any time it occurs, no matter what the relation is, [bullying] will decrease the trust of the culture.”

Bullying and intimidation are widespread. Based on research literature, Keashly says 10% to 14% of the working population in the United States was exposed to workplace bullying in the past 12 months. Even those who are not the direct target of the aggression are negatively affected, she adds.

Meanwhile, failing to act to stop aggression or harassment in the workplace just leads to more of the same, she says. “I think some people start taking on these behaviors because there are no consequences and it’s permitted,” Keashly says.

Changing the organization’s culture isn’t easy. That’s why The Joint Commission released the

new performance standards about 18 months before they became effective.

But now when surveyors visit hospitals, they look for the written code of conduct and they ask employees if they feel they can speak up about concerns, errors or near-misses without fear of retribution, says Schyve.

The Joint Commission does receive complaints. “We continue to have reports of intimidating behavior,” says Schyve. “Changing the culture in this way is not something that happens overnight.”

There are effective steps that can be taken, both by individuals and organizations. Keashly learned of one surgical unit that addressed rising hostility and tension. Anyone on the surgical team could yell out, “Tempo!” Everyone would then tone down their behavior. “It’s a very gentle way of letting someone know that everyone needs to stop and look at their behavior, because we’re heading on the wrong track,” says Keashly.

In another case, nurses created a “code white.” If a nurse was being mistreated by a physician, a nurse would call out a “code white,” and the location on the address system and available nurses would gather to observe. Their presence alone would support the nurse who was being intimidated and would put the physician on notice to moderate his or her behavior.

Veterans Affairs is taking a systemic approach to improving civility through its program called CREW (Civility, Respect, and Engagement in the Workplace). (See related article on p. 30.) “An organization can have a profound influence on the quality of the working environment,” says Keashly.

Some steps to take to address bullying and intimidation in the workplace include:

- **Look for indications of human resource problems.** A unit with unusually high levels of sick leave or turnover may warrant a closer look, says Keashly. Job satisfaction surveys may be one way to monitor the workplace climate, she adds.

- **Allow for informal feedback.** Ideally, employees work with a team approach and feel comfortable airing their concerns. For example, some units may begin a shift with a short “huddle” in which employees can raise issues. But informal mechanisms also are valuable, says Keashly. That includes peer advisers or ombudsmen, who can be a conduit to management and can provide confidentiality to the employee bringing the concern. Some health systems have contracted with outside providers, such as EthicsPoint of Lake Oswego, OR ([www.ethicspoint.com](http://www.ethicspoint.com)), to provide a confidential reporting hotline.

• **Be prepared to take action, when necessary.** The policy should apply to all members of the health care team, from physicians to nurses to managers, says Schyve. “Sometimes there’s a tendency to take more severe action against a nurse than against a physician who is bringing in patients,” he says. “For this to really be a culture in which there is trust, it needs to be just. ‘Just’ means you need to treat people equally.”

• **Take a proactive approach.** Don’t just respond to problems when they arise, but actively seek to build a collaborative atmosphere that encourages openness, says Schyve. “If you’re trying to create a culture of safety, you as the leaders need to really be on top of this issue,” he says.

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# Joining the CREW builds civility at VA

*Culture change being better outcomes*

You can’t just mandate a civil workplace. You have to build one.

That is what the Veterans Affairs (VA) health system is doing, one unit at a time. Today, more than 750 units at 150 facilities have adopted CREW — Civility, Respect, and Engagement in the Workplace, a program that is supported by psychologists and specialists in culture change at the VA’s National Center for Organization Development in Cincinnati.

CREW pays off in better outcomes, says **Linda Belton**, FACHE, director of organizational health at the Veterans Health Administration in Ann Arbor, MI. “The higher the level of civility in your work unit, the lower your sick leave . . . [and you have] lower EEOC [Equal Employment Opportunity Commission] complaints, higher employee satisfaction, higher patient satisfaction,” she says. Units are also more likely to meet their performance requirements and be safer, she says.

CREW began in 2005 with a pilot project

involving eight units at eight facilities. “It’s really engaged around the people you work with every day,” says Belton.

It begins with a commitment of support from hospital leaders — in writing. The facility conducts an assessment, which includes a short Civility Scale given to the unit’s members. The items are rated on a five-point scale from strongly disagree (1) to strongly agree (5):

- **(Respect):** People treat each other with respect in my workgroup.
- **(Cooperation):** A spirit of cooperation and teamwork exists in my workgroup.
- **(Conflict Resolution):** Disputes or conflicts are resolved fairly in my workgroup.
- **(Co-worker Personal Interest):** The people I work with take a personal interest in me.
- **(Co-worker Reliability):** The people I work with can be relied on when I need help.
- **(Antidiscrimination):** This organization does not tolerate discrimination.
- **(Value Differences):** Differences among individuals are respected and valued in my workgroup.
- **(Supervisor Diversity Acceptance):** Managers/Supervisors/Team leaders work well with employees of different backgrounds in my workgroup.

Facilitators, or “champions,” from the unit attend face-to-face training sessions and provide monthly updates via phone calls and written reports. The unit also has regular CREW meetings, which are a critical aspect of the program, says Belton. “[Employees] are asked their opinions. They’re given a platform, sometimes for the first time in their employment,” she says. “We talk about having honest conversations where you can say the difficult things that need to be said.”

In one unit, for example, a physician aired a gripe about how long it took nurses to retrieve an EKG machine when a patient was crashing. The physicians envisioned nurses walking slowly despite the dire need. A nurse explained that they literally ran across the multi-acre campus to borrow the machine from the emergency department. As a result of the conversation, the unit requested the purchase of an EKG machine — which was approved.

No one had ever realized that solving the problem would be that easy, says Belton. “They were able to participate in the resolution of the problem and they felt empowered to do that in the future,” she says.

CREW does not specifically address intimidation and bullying; its focus is on the positive. “We visualize what civil behavior is and that’s what

we go for," she says.

There are some cases in which an individual is causing problems on a unit. That must be dealt with through human resources procedures, Belton says.

CREW simply sets the stage for a workplace that values respectfulness. "If you can create that environment where people have honest conversations, some level of trust and respect one another, then they're less likely to engage in bullying and they're less likely to permit bullying to occur," she says. "A healthy organization is a place where patients want to come to receive care and employees want to work."

Attaining a culture change by working with one unit at a time may seem like a long, slow process. But eventually, the entire organization has a new climate, Belton says. "When you have a certain percentage of your work units participating in CREW, that becomes a tipping point," she says. "Satisfaction and other metrics go up all around the facility." ■

## Joint Commission offers advice on action steps

The Joint Commission's Leadership standard (LD.03.01.01) includes two elements of performance related to intimidation and bullying:

- **EP 4:** The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
- **EP 5:** Leaders create and implement a process for managing disruptive and inappropriate behaviors.

The Joint Commission suggests hospitals take actions to address the issue:

- **Educate all team members** — both physicians and nonphysician staff — on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.
- **Hold all team members accountable** for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.
- **Develop and implement policies and**

**procedures/processes appropriate for the organization that address.**

- **"Zero tolerance" for intimidating and/or disruptive behaviors**, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero-tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.

- **Medical staff policies** regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for nonphysician staff.

- **Reduce fear of intimidation or retribution** and protect those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior. Nonretaliation clauses should be included in all policy statements that address disruptive behaviors.

- **Respond to patients and/or their families** who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.

- **Determine how and when to begin disciplinary actions** (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).

- **Develop an organizational process** for addressing intimidating and disruptive behaviors that solicits and integrates substantial input from an interprofessional team including representation of medical and nursing staff, administrators and other employees.

- **Provide skills-based training and coaching** for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. Cultural assessment tools can also be used to measure whether or not attitudes change over time.

- **Develop and implement a system for assessing staff perceptions** of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.

- **Develop and implement a reporting/surveillance system** (possibly anonymous) for detecting unprofessional behavior. Include ombuds services and patient advocates, both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor

system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.

- **Support surveillance with tiered, nonconfrontational interventional strategies**, starting with informal “cup of coffee” conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. These interventions should initially be nonadversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. Make use of mediators and conflict coaches when professional dispute resolution skills are needed.

- **Conduct all interventions within the context of an organizational commitment** to the health and well-being of all staff, with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.

- **Encourage interprofessional dialogues** across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.

- **Document all attempts to address intimidating and disruptive behaviors.** ■

## HCWs still stuck with nonsafety sharps

*‘I don’t like it’ not a reason for exemptions*

Almost 10 years after the Needlestick Safety and Prevention Act created a legal mandate for safer sharps, health care workers still are being stuck with convention devices.

In some cases, health care facilities may have documented an exemption in the exposure control plan, noting the need for the preferred device. But exemptions need to be reviewed annually — and as new technologies evolve, many of the remaining conventional devices should be replaced with safer alternatives, needle safety experts say.

Needlestick surveillance from Massachusetts

illustrates the problem: More than one quarter (29%) of injuries involving hypodermic needles and syringes in 2007 occurred with devices that lacked safety features, even though those safety devices are readily available. Overall, more than half (57%) of all sharps injuries for which safety information was available involved conventional devices.

“There are still needlestick injuries that occur every single day. There are [U.S. Occupational Safety and Health Administration] citations every week of institutions that are not in compliance,” says **Ron Stoker**, MS, executive director of the International Sharps Injury Prevention Society, which maintains a list of available safety devices on its web site, [www.isips.org](http://www.isips.org).

“Some [employers] are very lax about being in compliance,” he reports. “One of the most frequent violations is that the exposure control plan is not kept updated with at least an annual review of what sharps safety products are available.”

In fact, failure to maintain an exposure control plan and failure to update the plan are the most common citations under the Bloodborne Pathogens Standard. “We would want to make sure that they’re looking to see if any new development has happened with regard to technology,” says **Dionne Williams**, MPH, a senior industrial hygienist with OSHA specializing in the prevention of bloodborne pathogen exposures. “You need to have someone look at devices each year,” she adds.

### ***OR is a problem area***

It can be difficult to keep abreast of new technology. But too often, health care facilities simply aren’t purchasing readily available devices, needle safety experts say.

The operating room remains a problematic area. The Massachusetts surveillance data, for example, found that one-third of sharps injuries (34%) occurred in operating rooms; 23% of all injuries involved suture needles, although blunt sutures are available and considered appropriate for fascia closure.

Conventional needle devices end up in the OR, as well. This is particularly a problem with pre-packaged kits, which include needles and syringes, says **Angela Laramie**, MPH, epidemiologist with the Sharps Injury Surveillance Project in the Massachusetts Department of Public Health in Boston. “We have heard from many hospitals that the standard kit comes with devices lacking sharps injury prevention features. In order to make a change to

the products included in the kits, hospitals need to place a special order for a custom kit, which often results in an increased cost.”

As far as OSHA is concerned, however, cost should not be a guiding factor in the protection of health care workers, notes Stoker. And when they fail to provide adequate safety devices, employers open themselves to potential citations and fines from OSHA, as well as the expenses associated with testing and treating bloodborne pathogen exposures, he says.

Meanwhile, the design of sharps safety devices has greatly improved, providing even stronger reason to take a new look at devices. **June M. Fisher**, MD, director of the TDICT (Training for Development of Innovative Control Technologies) Project in San Francisco, advises hospitals to conduct a task analysis to evaluate the activities that require sharps devices, then to evaluate the available safety devices that will meet the hospital’s needs. (Evaluation forms are available at [www.tdict.org/evaluation2.html](http://www.tdict.org/evaluation2.html).)

Yet Fisher and others would like to see more research evaluating the different types of safety designs. “We don’t have appropriate performance standards for the safer devices,” she says.

Laramie concurs. “While there has been research comparing the use of devices with and without sharps injury prevention features, demonstrating the efficacy of devices with safety features in reducing sharps injuries, there has been little, if any, research comparing the different types of sharps injury prevention features,” she says. “The various devices with sharps injury prevention features need to be evaluated as well to determine which are most effective.”

Some health care facilities seek consistency when it comes to sharps safety exemptions. In other words, disliking a safety device isn’t reason enough to grant an exemption.

“If a provider in our facility needs to use a nonsafety needle they need to [file] an exception form stating what procedure it is specifically that they need this needle for,” says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic. “We don’t grant general exemptions.”

Providers also must detail what other safety measures they will take if they’re going to use a nonsafety needle, he says. Cunha notes that Marshfield Clinic has about 40 clinical centers. “If one [provider] says I need an exception for a specific procedure, but other providers doing the same procedure don’t need an exception, I can’t

grant that,” he says.

Cunha and his colleagues also inspect sharps containers to see if safety devices have been activated. Repeated failure to activate safety features could point to the need for retraining — or for the re-evaluation of safety devices, he says.

Even 10 years after the development of stronger needlestick prevention requirements, many devices still aren’t available in a safety version, Cunha says. “There are ways of putting a safety device on a lot of products that don’t have them now,” he says.

Consumer demand may play a role in the development of new products. But ultimately, new regulatory measures may be needed to press manufacturers to produce new designs or to stop manufacturing some conventional needles, he says. ■

## Home health looks for ‘backup’ plan

*HCWs face patient handling challenge*

Call it the perfect storm: Patients with dementia or serious chronic illness being treated in the home. Rising levels of obesity. Aging health care workers. A lack of safety equipment.

Safe patient handling is a challenge in a hospital setting. But when someone’s home is the workplace, how can you make it safe for the worker?

Safe patient handling experts have been turning their attention to home health care, which is the fastest-growing segment of the health care profession. According to 2008 data from the U.S. Bureau of Labor Statistics, home health care has about twice the rate of serious injuries from “overexertion” (those involving days away from work) as in general industry (53.9 injuries per 10,000 full-time workers compared to an overall average rate of 27.9.)

The Nurse and Health Care Worker Protection Act, or HR 2381, the safe patient handling bill that is pending in Congress, would include home health workers. And the National Institute for Occupational Safety and Health (NIOSH) is developing “tip sheets” to help home health aides identify and reduce a variety of hazards, including patient handling and bloodborne pathogens.

“It’s definitely a forgotten group. Out of sight, out of mind,” says **Sherry Baron**, MD, MPH, coordinator for occupational health disparities and a medical epidemiologist with the National Institute

for Occupational Safety and Health in Cincinnati. "It's very challenging to set up people's homes to follow all the safe handling requirements."

Few home health workers have access to hoists or other lift equipment and few of them use equipment. In a NIOSH study of 744 home health workers, those who helped patients transfer in and out of bed or with other movements or repositioning were significantly more likely to report back, shoulder/neck and leg/foot pain.<sup>1</sup>

"[Lift devices are] an intervention that appear to be underused," says co-author **Traci Galinsky**, PhD, research psychologist with the human factors and ergonomics research section of NIOSH in Cincinnati and a captain in the commissioned corps of the U.S. Public Health Service. "Home health care workers could benefit from them, but our data indicate that only a small percentage of workers are actually using them."

One problem: Medicare and some insurance companies only reimburse for mechanical lifts, and under certain circumstances. Patients need to be aware of what is covered, Galinsky says.

There actually are devices for the home health market that have improved portability. For example, track-mounted lifts function similarly to ceiling-mounted lifts and some track models have frames that can be repositioned or disassembled. Also, some devices have detachable motors and lift mechanisms that can be easily transported for use in multiple homes.

Nurses or aides can take nonpowered sit-to-stand devices, transfer boards and collapsible portable floor lifts in their cars, says **Lynda Enos**, RN, MS, COHN-S, CPE, nursing practice consultant/ergonomist with the Oregon Nurses Association in Tualatin.

In one pilot study, a home health provider in Oregon is storing equipment in a community-based warehouse. Nurses assess patients for their mobility and the need for equipment, and families can then borrow necessary devices, she says.

Yet it also is critical for home health providers to invest in equipment for their employees, Enos notes. "The home health equipment is already available," she says. "We've got to get over the [challenge] of how to get it to the home."

The potential risk of working without equipment is great. While hospital employees may be able to ask for help with a manual lift, the home health worker often is on his or her own.

"Manual patient handling by an individual caretaker should be limited to situations in which the patient has a lot of weight-bearing capability

## CNE questions

9. The California Department of Public Health requested replacement of the 3M 8000 models of N95 respirators in the state's stockpile because:
  - A. they were the wrong size.
  - B. most health care workers could not be successfully fit-tested with the respirators.
  - C. the respirators are defective.
  - D. the respirators do not work against infectious diseases.
  
10. The Joint Commission "Elements of Performance" on intimidating and disruptive behaviors applies to which segment of health care?
  - A. Hospital leaders
  - B. Physicians
  - C. Nurses and technicians
  - D. All hospital staff, leaders, and physicians
  
11. According to surveillance in Massachusetts, what proportion of needlesticks involving hypodermic needles and syringes were with devices that lacked safety features?
  - A. 8%
  - B. 17%
  - C. 29%
  - D. 54%
  
12. According to safety experts, home health workers rarely use lift equipment in patient handling because:
  - A. their patients do not like the equipment.
  - B. equipment isn't designed for home use.
  - C. they don't have access to the equipment.
  - D. they haven't been educated about equipment.

**Answer Key: 9. B; 10. D; 11. C; 12. C.**

## CNE instructions

**N**urses participate in this continuing nursing 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

and doesn't have dementia," says Galinsky.

## Reference

1. Waters T, Collins J, Galinsky T, et al. NIOSH research efforts to prevent musculoskeletal disorders in the health care industry. *Orthop Nurs* 2006; 25:380-389. ■

## Steps to take to reduce back injury in home health

These following tips were adapted from "Suggestions for preventing musculoskeletal disorders in home health care workers," published in *Home Healthcare Nurse*.<sup>1</sup>

- **Assess the tasks provided for the patient and ways the patient may be able to accomplish some tasks without assistance.** Independence builds self-esteem, and the more tasks a patient can perform without assistance, the less exertion must be applied by the home health worker.

- **Consider rearranging furniture, if the patient is agreeable, to maximize open space around the patient's bed, chair, and primary transport paths.**

- **Remove obstacles that could impede the ability to safely handle the patient.**

- **Look for fall hazards in the patient's walking paths, such as from the bedroom to the bathroom, eating area or sitting area.** For example, remove or secure rugs and remove cords.

- **When possible, use assistive devices, such as transfer sheets or mechanical lifts.** Patients also may use some devices that allow them more independence, such as seat lifts, a trapeze bar, or grab bars. If the devices are prescribed by a physician, they may be partially or fully covered by insurance.

## Reference

1. Parsons KS, Galinsky TL, and Waters T. Suggestions for preventing musculoskeletal disorders in home healthcare workers. *Home Healthc Nurse* 2006; 24:158-164. ■

## Patient handling may up risk of assault

*Study bolsters need for home health lifts*

Here's yet another reason to improve patient handling: Health care workers involved in patient handling tasks may be at greater risk of assaults from patients.

In a study of 677 home health care workers, 94% of the workers who reported having been assaulted by a patient at least once in the past 12 months said they routinely performed patient handling tasks, such as transferring patients from a bed to a chair. In all, 29 (8%) of the 373 workers who routinely handled patients reported having been assaulted. In contrast, only two (0.7%) of 304 home health care workers who did not routinely handle patients reported assaults.

"Patient handling interventions are a promising way to not only reduce overexertion and injury of the worker and falls for the patient, but also assaults by patients," says the study's lead author, **Traci Galinsky**, PhD, research psychologist with the Human Factors and Ergonomics Research Team of NIOSH in Cincinnati and a captain in the Commissioned Corps of the U.S. Public Health Service. (The study has not yet been published.)

Unfortunately, lift and transfer devices are much less common in home health care than in institutional settings. (See related article, left.)

Assaults by patients have a negative impact on both the worker and on patient care. Assaulted health care workers may suffer from fear, anxiety, cognitive difficulties, reduced job performance and satisfaction, and depression, studies have shown.

Galinsky and her colleagues found that when they felt concerned for their safety, assaulted workers were more likely to shorten home visits, compared with workers who had not been assaulted. "When a visit is shortened, it's going to have a negative impact on care quality," she notes. "In safety training, [home care workers are told], 'If you feel threatened, leave.' That is a necessary

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safety strategy, but the unfortunate side effect of that is reduced care quality.”

Another consequence may be higher turnover among employees. Researchers at the Mailman School of Public Health at Columbia University in New York City found a strong link between verbal and physical assaults of home health workers and job dissatisfaction and retention.<sup>1</sup>

## Reference

1. Sherman MF, Gershon RR, Samar SM, et al. Safety factors predictive of job satisfaction and job retention among home healthcare aides. *J Occup Environ Med* 2008; 50:1,430-1,441. ■

## 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 the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the health care industry at large;
- **cite** solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals. ■

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# The Joint Commission Update for Infection Control

*News you can use to stay in compliance*

## Joint commission drops controversial patient safety goal

*HAI deaths as sentinel events still required, but widely underreported*

The Joint Commission has dropped a controversial infection prevention patient safety goal that recommended sentinel event investigations of unanticipated patient deaths and serious injuries due to health care-associated infections (HAIs). In doing so, however, The Joint Commission emphasized it was not discouraging such investigations, which indeed remain a requirement under existing sentinel event standards.

"It is already addressed through our sentinel event policies, so actually it was a redundant requirement," says **Maureen Carr**, project director of Standards and Survey Methods at The Joint Commission. "The reason for this revision was to really make sure that we were focusing on things that should be national patient safety goals. The feeling was that this was really covered under the sentinel event policy. We were already bringing attention to it there, and it wasn't needed as a national patient safety goal."

All accredited organizations must follow sentinel event policies, which call for root-cause analysis (RCA) of "events that result in unanticipated death or major, permanent loss of function not related to the natural course of illness," Carr says. "That would include [HAIs]."

As part of a renewed emphasis on infection prevention, the measure was first included in the 2004 patient safety goals and remained in effect through 2009. It was not continued in the 2010 patient safety goals. According to The Joint Commission, the RCA in such cases was to address "the management of the patient before and after the identification of infection."

The goal was plagued by underreporting, with The Joint Commission citing the apparent disconnect between the number of HAI deaths nationally and the paltry number of reports it was

receiving. (See *The Joint Commission Update for Infection Control*, December 2008.) For example, The Joint Commission received some 15 sentinel event reports related to infection in 2007. Yet, according to the Centers for Disease Control and Prevention, 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.<sup>1</sup>

### **Bottom line: Continue RCAs**

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 was voluntary, but strongly encouraged to identify trends and improve patient safety. Resource and time constraints almost certainly inhibited reporting by hospitals and individual infection preventionists, but the bottom line is that unanticipated patient deaths or serious injuries due to HAIs still should be investigated as sentinel events.

"Absolutely, if you have somebody that dies, then we are normally doing a root-cause analysis on it anyway," emphasized **Sue Dill Calloway**, RN, MSN, JD, director of hospital patient safety at OHIC Insurance Co./The Doctors Co. in Columbus, OH. "Infection control is extremely important, but they thought [the requirement] was already reflected in the other standards. They still have a lot of infection control stuff in the [2010 patient safety goals] with central lines, surgical infections and multidrug-resistant organisms."

Indeed, against the backdrop of underreporting of sentinel events, the sweep of the 2010 goals raises the question of whether The Joint

Commission is pushing infection prevention programs beyond their resources.

"Part of it is having a culture and leadership that is actually going to have the FTEs so the infection preventionist doesn't feel like they are drowning and they can't get the basics done," Calloway says. "The Joint Commission has eight pages of infection control standards and [they include requirements] that you have enough people and resources."

They do not require a specific staffing formula, however, and that may be part of the problem. The Joint commission "just says 'sufficient staffing' and that's pretty darn broad," she says.

## 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. ■

# Keys to compliance with the new 2010 MDRO goal

*Include C. diff, gram negatives*

Given that some trace the very founding of hospital infection prevention programs back to the first volleys in the longstanding battle with multidrug-resistant organisms (MDROs), it comes as little surprise that The Joint Commission has made these bugs the focus of a National Patient Goal for 2010. At the same time, it signals that the threat posed to increasingly frail patients by methicillin-resistant *Staphylococcus aureus* (MRSA) and other MDROs may actually be on the rise.

The price of keeping so many patients alive through cutting-edge interventions and transplants is that there are ever more targets for these resourceful, ever-evolving pathogens. But dramatic reductions in infection rates in recent years also signal that infection prevention has devised a few tricks of its own, and some of these hard-earned strategies coupled with ongoing vigilance may yet turn the tide toward patient safety.

"Patient safety goals are kind of a subset of our standards," explained **Louise M. Kuhny**, RN, MPH, MBA, CIC, senior associate director of standards interpretation at The Joint Commission. "The purpose of them is to put a spotlight on critical issues in patient safety and patient quality. Obviously, health care-associated infections have

risen to the level of national concern, and therefore we are putting out some more requirements to help focus energy and efforts on preventing HAIs."

The Joint Commission's 2010 patient safety goal (NPSG.07.03.01) calls for hospitals to implement evidence-based practices to prevent HAIs due to MDROs. This requirement applies to, but is not limited to, epidemiologically important organisms such as MRSA, *Clostridium difficile* (*C. diff*), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria, the goal states. Of course, infection preventionists have pointed out that *C. diff* by biological definition does not technically fall into the category of an MDRO.

"We know that microbiologically *C. diff* is technically not an MDRO," Kuhny noted during a recent Joint Commission webinar on the issue. "However, it behaves like an MDRO, and we have chosen to put it under this goal in an effort to make sure that it is addressed as well as the other [pathogens]. It behaves like an MDRO because it requires isolation and has limited antimicrobial therapy."

## Wary of the rise of gram negatives

By the same token, questions have been raised about the inclusion of gram-negative bacteria, she noted. Gram negatives have yielded center stage to MRSA and other gram-positive bacteria in recent years, but they appear on the way to an unwelcome comeback with such threats as emerging carbapenem-resistant *Klebsiella pneumoniae*. Thus, The Joint Commission included gram-negative bugs in the goal, but it is leaving it up to individual hospitals to decide which, if any, gram-negative problem they should address. Indeed, the whole MDRO effort should be preceded by a risk assessment. The patient safety goal calls for infection preventionists to conduct periodic risk assessments for MDRO acquisition and transmission. (See goal, p. 3.) This may be part of a general infection control risk assessment (required in IC.01.03.01) or separated out, Kuhny said.

"This is the same type of thing but it needs to be focused directly on MDROs," she explained. "In terms of paperwork and how you structure the risk assessment, you can choose to have it either as one part of your bigger, general infection control risk assessment or you could break it out in a separate document. It doesn't matter to us, as long as you can point to it when the surveyors visit."

Based on the results of the risk assessment, the hospital educates staff about HAI and MDRO prevention strategies at hire and annually thereafter.

## MDRO goal starts with risk assessment

The Joint Commission's 2010 patient safety goal to prevent multidrug-resistant infections (NPSG.07.03.01) includes the following key aspects and elements of performance:

- Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

**Note:** This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

### Rationale for NPSG.07.03.01

Patients continue to acquire health care-associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care-associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

**Note:** Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of health care-associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

### Elements of Performance for NPSG.07.03.01

1. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission.

2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care-associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.

**Note:** The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within

the hospital.

3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection strategies.

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. **Note:** Surveillance may be targeted rather than hospitalwide.

5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:

- Multidrug-resistant organism infection rates using evidence-based metrics
  - Compliance with evidence-based guidelines or best practices
  - Evaluation of the education program provided to staff and licensed independent practitioners
- Note:** Surveillance may be targeted rather than hospitalwide.

6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.

**Note:** The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

**Notes:** The alert system information may exist in a separate electronic database or may be integrated into the admission system.

The alert system may be either manual or electronic or a combination of both.

Each hospital may define its own parameters in terms of time and clinical manifestation to determine which readmitted patients require isolation. ■

"We recognize that education will be different for different providers," Kuhny said. "You're going to teach physicians different things than you teach nurses aides and housekeepers. You can definitely customize education and determine

what kind of approach you want to take. It can be written, web-based learning, face-to-face — as long as you can demonstrate that the education has been performed."

As part of achieving the goal, the hospital also

must educate patients — and their families as needed — who are infected or colonized with an MDRO.

“The minimum requirement here is that you provide education for those people that come up positive for an MDRO, either an infection or colonization,” Kuhny said. “Many organizations are choosing to go beyond that and do some basic MDRO education for everyone, but our minimum requirement is that you do it for those people that are infected or colonized.”

The MDRO goal calls for the hospital to implement a surveillance program for multidrug-resistant organisms based on the risk assessment. “You may do targeted surveillance,” Kuhny said. “That means based on your risk assessment, you can choose which organisms, which units, which types of services you want to target in your surveillance program and prioritize.”

### **Measure and monitor**

The hospital must measure and monitor multidrug-resistant organism prevention processes and outcomes including the following:

- multidrug-resistant organism infection rates using evidence-based metrics;
- compliance with evidence-based guidelines or best practices;
- evaluation of the education program provided to staff and licensed independent practitioners.

The monitoring process includes both outcome and process measures, which will likely vary significantly from one organization to another.

“So, your outcome measure here is actual infection rates,” Kuhny said. “How many people have a negative outcome and are actually infected? Then there are a minimum of two required process measures. The first one is whether people are complying with practices. One example here of something that you might do is measure isolation compliance. Are people wearing the gowns and gloves when designated?”

The hospital must then provide the MDRO surveillance data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

“This is a really important thing,” she stressed. “Key stakeholders go from your frontline staff up to — we hope — your board members. Everyone that has some decision-making [responsibility] in the organization concerning MDROs should get the surveillance data so they have feedback and know how they are doing. The frontline staff decide many

times who gets isolated and how the precautions are going to be implemented. The board members decide what resources are available to support such programs.”

Then, the hospital implements policies and practices aimed at reducing the risk of transmitting MDROs, ensuring they meet regulatory requirements and are aligned with evidence-based standards. Organizations should compare their existing policies and procedures with relevant guidelines and update as needed.

When indicated by the risk assessment, the hospital should implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms. The alert system may be either manual or electronic or a combination of both of these methods.

“This means when the laboratory test comes back positive — a culture or what have you — will the people who need to know, know quickly?” Kuhny said.

Turnaround times are not going to be specified by The Joint Commission, but remember new — both new admissions and new culture results — reporting should be determined based on needs related to both isolation and treatment, she said. “The people who need to know are those making the isolation decisions, which is usually the nursing staff,” she said. “In addition, the people who are making a treatment decision. Are we going to treat this MDRO — do we need to prescribe antimicrobials? How quickly did that information get to those people?”

### **Don't 'batch' reports**

Daily batching of these reports is generally discouraged.

“If you are only transmitting this information once a day it may very well not meet the needs of your patients,” Kuhny said. “We would encourage you to do it on a more timely basis.”

When indicated by the risk assessment, the hospital then implements an alert system that identifies readmitted or transferred MDRO-positive patients. This means that all patients must be identified, but it does not mean that isolation is appropriate or required in all circumstances.

“This does not mean that all patients that ever had an MDRO need to be isolated when they are readmitted to the organization,” Kuhny said. “It just means that the information about that previous positive result needs to get to the people that need it.” ■