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IN THIS ISSUE

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Biggest loser: Competition talks, cold cash walks in bulge battles

In-house competition may be most effective

Onsite gyms, lunch and learns, and health coaches all presumably have an impact on wellness of workers. However, if these options aren't available to employees, some simple competition can get the same results.

Sheila Kealy, RN, MS, CCM, an occupational health nurse with Reckitt Benckiser in Parsippany, NJ, says that the company's "Biggest Loser" challenges between departments have been quite successful.

"Money is the greatest incentive, especially for weight loss competitions," according to Kealy. "We track the percentage of body weight, and the total weight lost by the team. I have found a lot of employees like to win. They help push their team members along."

The employees contributed $1 a week during the weigh-in. If they gained weight, they paid an extra $1. "At the end of the competition, the winner received all the collected money," says Kealy. "We had a celebratory healthy lunch for the participants."

Incentives are key

Jennifer White, an administrative assistant at Data Dimensions in Janesville, WI, was looking for a way to top a successful weight loss program she spearheaded the previous year, which involved competitions between teams. The 2009 program pitted two teams against each other, headed by the company's President and CEO, and the Chairman. The teams lost a total of 130 and 64 pounds, respectively. Both groups logged in over 39,000 minutes of exercise apiece.

White says that it helped that "lots of incentives" were given. The per-

EXECUTIVE SUMMARY

Competitions for weight loss help to motivate employees, and money incentives are an effective way to get better results. Some approaches:
- Use money or paid time off as incentives.
- Have a celebratory healthy lunch for all participants.
- Ask local companies to participate.

son with the highest body weight percentage lost was given a choice of $500 or two paid days off. Members of the winning team all got one paid day off, plus another half day off to spend as a team in a fun group activity. These steps were taken:

Participants were given two options for a confidential weigh- in, done either at work or at the local YMCA.

Percentages gained or lost were posted in the lunchroom every week.

Individual daily exercise minutes were tracked.

The employee with the top ten total minutes at the end of the challenge was entered into a drawing to win a paid time off day.

"We saw several people continue on with their new habits," reports White. "A noon walking club continued past the end of the competition, where four or five from the challenge participated several times a week. That lasted until the cold weather set in."

Invite others to compete

Encouraged by the program's good results, White wanted to keep the momentum going. She contacted her counterparts at a few local companies and asked them to join in a three-month weight loss challenge.

"I got this idea that it might be fun to get our neighboring accounting firm to challenge us. All of a sudden, it turned into ten companies,' says White. These guidelines were used:

Each company team consisted of as many members as were interested. Each participant was weighed at the beginning, every three weeks, and at the end.

E-mails were sent out every three weeks to reflect standings.

The winning team was the one with the largest total weight reduction.

White created a flyer to encourage participation, and used a sample spreadsheet to track weight loss of participants.

For every pound lost, participating companies donated ten pounds of food to a local food bank. "Otherwise, there was no cost," says White. As a team, the company logged in 87,560 minutes of exercise.

Overall, however, the company's own internal challenge was more successful. Still, other participants in the challenge, such as the accounting firm who won, were very motivated to compete against an outside group.

If results were a little disappointing for some companies, White says that this may have been because of lack of incentives. The original plan was to make the entry fee $200 each, then give the winning company the proceeds. The food donations were used instead, when one of the companies questioned the legalities of using money.

"At the beginning, I received a lot of enthusiastic comments from people when money was involved. When push came to shove, I think that a monetary prize would have helped," says White.

SOURCES

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Compute $$ saved by *preventing* illness

Prove their worth

Preventing an illness or disease from happening in the first place may seem like "invisible" gains to many, but you don't have to settle for that. Instead, come up with figures to show the large dollar amount of savings that occurs by preventing just one costly diagnosis.

"We spend a lot of money on identifying disease when we really should be spending money preventing it," says **Linda K. Glazner**, DrPH, RN, COHN-S, CCM, FNP, FAAOHN, an occupational health consultant with Linda K. Glazner & Associates in Wausau, WI. "What I'd like to do is take some of the money spent on treatment and put it into primary prevention."

Coming up with impressive figures, which are readily available, can help you to do just that. Glazner gives the example of screening for colorectal cancer which can be done for about $1 a person. This means you can screen 25,000 employees for $25,000. "This is really dramatic, because the cost of the treatment is so expensive and prevention is so cheap," she says. "Also, the likelihood of finding at least one case is great."

In general, though, Glazner says that the results of "prevention are harder to show, and harder for the nurse to say 'I made the difference.' In the case of colorectal cancer, you can cite the cost from the time of diagnosis to the employee's return to work. This is much less if the condition is detected early."

EXECUTIVE SUMMARY

Resources for preventing illness or disease can be hard to come by, but data can help you to prove the worth of these programs.
• Show how low-cost screening can result in significant savings.
• Track measures such as weight loss and blood pressure.
• Utilize local experts, vendors and wellness facilities.

Prove the ROI

What is your biggest hurdle in obtaining resources for prevention programs? Often, it's proving the worth of those programs, according to **Brenda Schanhofer**, wellness coordinator at Miron Construction Co. in Neenah, WI.

"Saving money on purchasing or operations is easily quantified. Improving the wellness of your workforce can be tougher to prove," says Schanhofer.

Many times, a prevention program is forced to work with minimal resources in order to accomplish its goals. "This creates the question of where you should focus your time--accomplishing your goals or proving your worth and value within the company," says Schanhofer. "It is possible, and necessary, to do both." (*See related story, p. 76*)

Your programs, in order to be effective, must be supported by upper management and embraced by the company overall. "In regards to ROI for worksite wellness programs, we sometimes get too narrow in our scope of determining the success of a program by creating a 3:1 ROI," says Schanhofer. "But we need to look at the bigger picture."

That involves rewarding wellness versus treating illness. "This is an incredibly pro-active way to manage a worksite wellness program," says Schanhofer. "If you do that, the ROI will take care of itself over a period of time. Even a ROI of 1:1 is a successful outcome for this type of program."

She recommends using these approaches:

• Look at worksite wellness as a long-term business investment.

"It must be connected to company strategy, shared with employees, and supported by upper management," says Schanhofer.

• Use certain measures to provide quantitative proof.

For example, your wellness challenges can provide statistics on weight loss, blood pressure, body mass and other biometrics. Weight loss is an easy way to gauge a successful wellness or fitness challenge, and as you begin to see results in the weight loss category, very likely you will see the same results in reducing high risk factors such as hypertension, high cholesterol, and even metabolic disorders such as diabetes and metabolic syndrome.

• Obtain statistics from your health risk appraisals.

"Determine the amount of lifestyle-related illnesses and the percentage of change over time,"

Try low or no-cost prevention strategies

Even for the most budget-sensitive programs, there are easy ways to implement low-cost initiatives that can result in great rewards down the line. Here are some suggestions from **Brenda Schanhofer**, wellness coordinator at Miron Construction Co. in Neenah, WI:

• Facilitate a company-wide weight loss challenge. "This can be little to no cost and return great rewards on employee health," says Schanhofer.

• Network with local hospitals and clinics to provide onsite blood pressure screenings and educational awareness programs. "This can also be of no cost to the company," says Schanhofer.

• Establish a walking group during the lunch hour.

• Contract with the local YMCA to provide onsite fitness classes.

Provide a pay-and-go fruit basket at work.

• Consider investing in the Weight Watchers at Work program.

"Combining small efforts with low-cost initiatives will lead to long-term culture changes within the company," says Schanhofer. "When an initiative becomes part of the worksite culture, you start to see the true success and ROI of a program."

The key ingredient in a successful educational awareness program is recruiting reputable and knowledgeable vendors who will help sustain a high standard for your program," she adds. Schanhofer recommends:

• Recruit local nutrition and fitness experts to provide lunch and learns or attend wellness fairs, such as local health club or YMCA professionals

• Ask local vendors and wellness facilities to provide cost breaks and free trial periods for your employees, including bike shops, running specialty stores, and natural and organic foods merchants.

• Network with reputable medical professionals from area hospitals and clinics. "This can increase the perceived value from employees," says Schanhofer.

"None of these ideas cost anything and can have a significant impact on your program," says Schanhofer. "Most often, vendors are willing to present at no charge, in return for acknowledgement of their business or organization." ■

says Schanhofer. "This information will also give you targets for future programs."

SOURCES

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How satisfied are workers with occ health?

Employee feed back is key

You might imagine that employees consider occupational health to be a valuable resource, and a tireless advocate for their health and safety. However, you won't really know for sure unless you ask.

Proving that employees are satisfied with the services they get from occupational health is extremely valuable for many reasons. Too often, though, evidence of this success is lacking.

"It is crucial to survey employees on what they want and need from a program," says **Brenda Schanhofer**, wellness coordinator at Miron Construction Co. in Neenah, WI. "Quite simply, if the program doesn't fit employee needs, they won't participate."

If workers don›t participate, an occupational health program fails. "Employee feedback is a key driver in any successful worksite program," Schanhofer says.

She recommends these approaches:

• **Regularly survey the employee base.**

"Make sure that the program continues to fit their needs without growing stagnant," says Schanhofer. She says that survey questions should be directed to *all* employees within the company, to ensure a comprehensive and accurate assessment.

Here are the most important questions to consider, says Schanhofer:

--Employee satisfaction;

--How well the current initiatives fit their needs;

--What components might be missing that

EXECUTIVE SUMMARY

To improve participation and plan well, survey employees on what they want and need from occupational health programs.
- Survey all employees within the company.
- Ask what components they would like to see added.
- Obtain personal stories to validate programs.

would enhance their personal satisfaction with the existing worksite wellness program.

• Utilize a variety of survey tools.

These may include online survey software tools such as Survey Monkey or Zoomerang, and "even just good old-fashioned individual employee touches," Schanhofer says.

• Don't ignore what you learn from employees.

Instead, use employee input to drive your strategic planning for the future of your prevention program. "If the employee response is valid and justifies a need for change or growth, it is essential that those steps are taken to support that," says Schanhofer. "If employee input is thoughtful and reasonable, but is not carried through into the implementation phase, that sense of ownership and interactive participation is compromised." The success of the program is then jeopardized.

• Obtain personal stories.

"Testimonials are a tremendous grassroots way of showing the impact of the program on individuals," Schanhofer says. "Sharing stories with co-workers can provide motivation to others and show qualitative results."

The stories also serve as a boost for those who have done great things to improve their wellness. "The data that is collected can be used to create more resources, and also as validation that the program is accomplishing its goals. In our current economic climate, all programs are up for review," says Schanhofer. "It is essential that the worth of programs is demonstrated in a consistent and tangible way." ■

Do you want to see back injury rates plummet?

Find out underlying reasons

Why is it that back injuries are one of the most costly and common worker's compensation injuries? "There are a lot of factors associated with back injuries that create tough challenges," according to **Kathy Dayvault**, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN.

Dayvault points to research stating that three primary reasons for work-related injuries among health care workers are organizational factors, environmental factors and personal factors.[1]

"I believe all of these factors are relative to industry as a whole," says Dayvault. For example, not having adequate time, insufficient or inadequate equipment, fewer employers to adequately perform a task, and pressure to meet deadlines are examples of organizational factors.

Also, many types of industry have areas in their workplace with limited space, and lack the proper tools to adequately perform a job safely in these areas.

The researchers noted that the most common personal factor associated with a back injury is a previous back strain or injury. "This is a factor experienced across industry type as well as in healthcare occupations," says Dayvault. "When an aging workforce and the obesity epidemic are factored in, it is easy to understand some of the tough reasons behind the challenges in reducing injuries." She recommends these approaches:

• Work with safety professionals to observe tasks.

"This can be accomplished during a walk-through," says Dayvault. Identify tasks which include awkward positions, heavy loads and defective equipment. Then, identify jobs, tasks, or individuals at risk.

"Develop a strategy for effectively addressing each of these areas to reduce injuries, specifically back injuries," says Dayvault.

According to the U.S Bureau of Labor Statistics, in 2006, back injuries alone accounted for 21.2% of lost time injuries with days away from work.

"Through observing employees perform their job and understanding the impact of the job tasks on the back, a plan for intervention can be developed that meets workplace health *and* safety objectives," says Dayvault.

• Get insight about the problem areas of the job from an employee.

"It is important to have interaction with employees regarding specific jobs and tasks," says Dayvault. "Having conversations with both previously injured *and* non-injured employees about tasks can provide a wealth of information."

By having a conversation with previously

EXECUTIVE SUMMARY

Many factors associated with back injuries are particularly challenging, including insufficient space, equipment, or staff, as well as obesity and an aging workforce. Some effective interventions:
• Do a walk through with safety professionals.
• Obtain insight from both previously injured and non-injured workers.
• Develop prevention strategies with ergonomists and other occupational health professionals.

injured employees, you can arrive at the root cause of a back injury. This may involve poor design, required productivity, or employees required to use inadequate or poorly kept tools.

"Understanding how specific injuries have occurred will help develop a strategy of prevention," says Dayvault. By interviewing employees who are currently performing the job, insight can be gained of how injury is avoided. This can help employees who currently perform a job associated with a high back injury rate.

"Through observing employees performing their job and understanding the impact of the job tasks on the back, a plan for intervention can be developed that meets workplace health *and* safety objectives," says Dayvault.

• Use statistical data from the first report of injury, as well as diagnoses from health care claims and associated costs.

It is best to use data from both resources, as back injuries may have occurred among workers who were hesitant or discouraged from reporting workplace injuries, Dayvault explains.

"Cost information is important to show upper management the impact of injuries on the bottom line," says Dayvault. "Having the ability to show return on investment speaks volumes. This may be necessary to bring about change." This is especially true if there are significant costs related to programs aimed at reducing back injuries.

• Involve other professionals.

Use other experts as your resources, such as ergonomists and other occupational health professionals. "They can assist with understanding the full impact of the task on the human body, as well as developing prevention strategies," says Dayvault.

Other members of the management team should also be included, especially if cost and workplace design are going to be impacted. "Physical therapists can offer insight in needs for work hardening programs to assist injured employees, or as an aid in reconditioning employees who have been absent for an extended period of time," adds Dayvault.

REFERENCE

1. Springer PJ, Lind BK, Kratt J, et al. Preventing employee injury: implementation of a lift team. *AAOHN J* 2009; 57(4):143-148.

SOURCE

For more information on prevention of back injuries, contact:
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ID root causes of specific injury types

Managing each case to closure

Imagine being an occupational health nurse at a plant that had 10% of its workforce off work, because of work-related injuries or illnesses. That was the challenge facing consultant **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH.

"The overwhelming problem was upper extremity cumulative trauma disorders," says Strasser. "I worked with a team, and our approach was multifaceted."First, ergonomists were brought in to help with the root causes of the injuries. "A comprehensive ergonomics program was developed to 'stop the bleeding.'"

The plant did not have a return to work program, so a policy and comprehensive program was developed. "We began to return employees to transitional duty," says Strasser. "The program was critical with new cases, so that workers could remain at work. The nurse's role as case manager was critical to the ultimate success."

Goals for each case

"Most importantly, we developed a workers' comp management team to manage *each* case to closure," says Strasser. "There were a lot of open cases." A goal was developed for each case, such

as return to full duty or return to a permanent alternate job. The team worked diligently, meeting weekly, to realize the particular goal of each case.

"Fortunately, it was a state that allowed full and final settlements, as there were individuals who would never be able to return to the plant for various reasons, and settlement was the best option," says Strasser.

ID cost drivers

Strasser says that the simple answer to identifying cost drivers is "examine the data." Most workers' compensation insurers and third party administrators (TPAs) make a lot of data available to companies in standard reports, as well as through customized reports.

"The workers' comp 'loss runs' contain information that can help target strategies to deal with the costs," says Strasser. This can help you answer questions such as, "Are new cases or old cases driving costs?" "Does one plant or department have dramatically increased claims?" "Are costs due to a particular type of injury or illness?" "Are medical costs increasing more than industry norms?"

"The insurer or third party administrator is available to help examine the data to identify cost drivers," says Strasser.

SOURCE

For more information on identifying workers' compensation cost drivers, contact:

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Cal-OSHA cites hospital for meningitis exposure

Two hospitalized, notifications delayed

The unprotected exposure of a respiratory therapist who later developed bacterial meningitis triggered the first citations under California's new Aerosol Transmissible Disease Standard – with fines of $101,485, including two "willful" violations, the strongest possible penalty, against Alta Bates Summit Medical Center in Oakland, CA. The medical center has appealed the citations, but did not reply to a request for comment as this story was being filed.

Alta Bates failed to promptly report the case of bacterial meningitis as soon as it was suspected in initial tests and failed to conduct a prompt exposure analysis or to readily offer prophylaxis, according to the California Division of Occupational Safety and Health (Cal-OSHA). An Oakland police officer, who was first on the scene and discovered the unconscious patient at his home, also was hospitalized with bacterial meningitis.Both the respiratory therapist and police officer required intensive care unit treatment, but both survived. The case highlights the importance of a swift response to exposures and the use of personal protective equipment to protect employees from unidentified infectious diseases, says **Deborah Gold**, MPH, CIH, senior safety engineer in the research and standards health unit at Cal-OSHA in Oakland.

"We hope the discussion generated by this case will cause other hospitals to look at what they're doing and make sure their procedures are in place," she says. "This is a bad outcome. This could have had a much worse outcome."

California's Aerosol Transmissible Diseases Standard requires employers to report aerosol transmissible disease exposures to the local health officer within 72 hours and to conduct post-exposure follow-up of employees. The standard covers diseases that require airborne or droplet precautions, including *Neisseria meningitides*.

Nationally, the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires hospitals to notify emergency responders that they transported a patient with an airborne infectious disease. That report is supposed to occur within 48 hours of determination of the disease. The act calls for the Secretary of U.S. Health and Human Services to create a list of life-threatening infectious diseases and those that can be transmitted through the airborne route.

Meanwhile, the U.S. Occupational Safety and Health Administration recently alerted employers that it will be gathering information on occupational exposure to infectious diseases in health care settings. *(See related article on p.x.)*

Standard requires prompt notification

The Oakland case began on Dec. 3, 2009, with

a call to 911. Someone had failed to show up for work, and his co-workers were concerned. A police officer, first on the scene, found the person unconscious in his home, tried to clear his airway, and called for emergency medical assistance.

The police officer didn't wear respiratory protection, but paramedics from the Oakland Fire Department and a local ambulance service did. In the emergency department, at least 10 people worked on the patient to save his life, including a respiratory therapist who assisted in the intubation.

By the next morning, Friday, Dec. 4, initial results from blood and cerebrospinal fluid indicated that the patient might have bacterial meningitis. That finding should have prompted an immediate call to the local public health officer, says Gold.

On Sunday, further blood testing confirmed *N. meningitides* but, again, that wasn't immediately reported, according to Cal-OSHA. The hospital contacted the Alameda County Public Health Department on Monday afternoon, Dec. 7, according to the citations, more than 78 hours after meningitis was first suspected.

That delay in reporting, along with two other previous cases of delayed reporting, led to a "willful" citation with a $5,000 fine. "There is a requirement of prompt notification of the health department so they can start contact tracing," says Gold. "Exposure investigations are much more effective when done promptly."

On Dec. 9, the police officer was admitted to Kaiser Permanente Walnut Creek Medical Center with meningitis; he spent five days in the hospital. On Dec. 10, the respiratory therapist was admitted to John Muir Medical Center in Walnut Creek; he remained hospitalized for 11 days.

On Dec. 11, Alta Bates Summit Medical Center conducted a belated exposure analysis and contacted potentially exposed employees, Cal-OSHA says. Two potentially exposed employees in the radiology department weren't notified until Dec. 15, and a charge nurse who had been in the emergency department when the patient was treated was never included in the exposure analysis or post-exposure evaluation and treatment, according to the citations.

Those failures triggered another "willful" citation with a fine of $70,000. Willful violations are defined as incidents in which "the employer knew hazards existed which could lead to serious physical harm or a fatality and took no action to correct the hazards and comply with the appropriate regulations," Cal-OSHA says.

Cal-OSHA also cited the hospital for an incomplete aerosol transmissible diseases exposure control plan, as well as incomplete fit-testing and training.

The Oakland Police Department also was cited for nine violations, including failing to notify the officer of his exposure, failing to provide a medical evaluation, and failing to inform the fire department or ambulance service. The Oakland Fire Department was cited for similar notification failures. All three employers were cited for failing to comply with the ATD standard.

The incident underscores the importance of prompt notification, evaluation and prophylaxis, says Gold.

"We're lucky that somebody didn't die. Both of the exposed employees had families with children at home. This could have had a worse outcome," she says. "But we had two employees hospitalized for a significant period of time with a life-threatening disease. It was probably preventable if they had been informed of their exposure and provided treatment." ■

ED nurses seeking protection from violence

OSHA standard needed, nurses say

"Two dead in Tennessee Hospital Shooting" – *New York Times*, April 19, 2010

"Shooting Inside Danbury Hospital" – *Hartford Courant*, March 3, 2010

"Gunman Opens Fire Inside North Carolina Hospital" – *FoxNews*, February 15, 2010

Violence erupts in emergency rooms across the country with a troubling frequency. The worst cases make the headlines, but for emergency room personnel, it is the daily volley of physical and verbal assaults that create a stressful and hazardous work environment. Amid a growing concern about safety in Emergency Departments, emergency room nurses are pressing for a workplace violence standard, rather than the current voluntary guidelines, from the U.S. Occupational Safety and Health Administration.

One in four emergency room nurses experienced

20 or more acts of physical violence at work in the past three years, according to a 2009 survey by the Emergency Nurses Association (ENA). About 20% reported experiencing 200 or more incidents of verbal assault in the past three years.

The emergency department is inherently stressful for patients, who may be feverish or fearful or in pain. "There's a lot of anxiety and frustration that comes with going to an emergency department," says **Bill Briggs**, RN, MSN, CEN, FAEN, president of ENA in 2009 and trauma program manager at Tufts Medical Center in Boston. "That's compounded by a crowding situation. You add to that a problem with alcohol abuse and drug abuse and a significant mix of mental health patients. You can have quite a volatile situation."

That makes work a hazardous, stressful place for emergency personnel. Two-thirds of the nurses reported that they do not feel safe in the emergency department.

The emergency room events fuel a stream of violent events that make acute-care hospitals the site of more work-related injuries from assaults than any other workplace, according to 2008 data from the U.S. Bureau of Labor Statistics. Combined with psychiatric care and long-term care facilities, health care facilities were the site of more than 10,000 reported assaults that resulted in injury. That represented about 47% of all work-related injuries from assaults in 2008.

Violence in the Emergency Department "is pervasive throughout the country," says Briggs. The ENA survey found high levels of physical and verbal assault in urban, suburban, and rural hospitals, he says, with a slightly higher incidence on the night shift or among male nurses.

Assaults should not be tolerated

Workplace violence is not an issue solely of security. Limited access entries and security guards are ubiquitous in the nation's emergency departments. But beyond those necessary tools, hospitals need to promote a culture in which physical or verbal assaults are not tolerated, says Briggs.

In the survey, nurses who reported fewer barriers to reporting events also reported experiencing fewer incidents.

"There was less reported violence in hospitals that had a culture of reporting," he says. Hospitals need to make it clear that violence against its health care workers is unacceptable, he says. "You would never go into a supermarket, not like the price of an item, punch the cashier and get away with it," he says. "If you went to a bar and got obnoxious, you'd be thrown out."

Briggs has experienced the violence in emergency departments. "I've been kicked and hit and shoved and spit on," he says. One employer implemented a two-day violence prevention training program for the ED that included physicians, nurses, security officers and clerical staff.

They learned how to spot the warning signs and how to diffuse tense situations or agitated patients or visitors. "It truly reduced the violence," he says.

Diane Gurney, RN, MS, CEN, ENA president and a retired manager of an emergency department in Hyannis, MA, was once slapped so hard by a psychiatric patient that she had to wear a neck brace for days. In the Emergency Department, she has been slapped, spit at, and yelled at. But she is gratified by the attention the issue has been receiving.

Fourteen states have passed laws making it a felony to assault health care workers, although those laws are not always consistently enforced, ED nurses say. *(See related article on p.x.)*

"When I go across the country to talk to people, it is stunning to hear what some of them have been subjected to," says Gurney.

Violence erupts in rural hospital

Last February, a bar fight spilled into the emergency department of Scotland Memorial Hospital in Laurinburg, NC. According to news reports, at 3 a.m., a 31-year-old Domario Covington was being treated for a laceration to his neck that he received in the fight when another man came looking for him and his girlfriend. The man identified himself as a family member, so he was allowed to visit the patients. He brandished a gun and began shooting, leaving Covington in critical condition and running out only after the gun jammed.

"When that person with the gun started shooting, [employees and patients] were seeking shelter and were afraid," says marketing coordinator **Karen Gainey**. "They didn't know if the shooter was going to come after them or if he was just intent on shooting the patient. Thankfully, his gun jammed. If it had not, we don't know what he would have done."

The hospital has since changed its policies. For example, patients in the emergency department now must indicate who will be visiting them, and the visitors must show identification. The hospital

also created a special code that would send immediate help to the emergency department.

The 104-bed rural hospital seems an unlikely spot for an eruption of violence. "It was incredibly shocking that this could happen in a small rural area such as ours, a small community hospital such as ours," says Gainey. "It just goes to prove that we're living in a world that is changing.

"It doesn't matter where you live. Terrible things happen and there are people who are intent at hurting others," she says. "We have to improve security matters and we're working to keep our staff, our patients and our visitors safe." ■

Assaultive patient 'just tired of waiting'

ED nurse suffered a dislocated jaw

For emergency room nurse **Rita Anderson**, RN, CEN, the assault was as sudden and unpredictable as a stroke of lightning.

She was at a major trauma center, making rounds with a physician at 11 p.m., when a 16-year-old girl lying on a stretcher said she needed to go to the restroom. Anderson immediately stopped her rounds to check with the girl's nurse. When she learned the girl couldn't get up to use the restroom, she began looking for a curtained area where she could have privacy to use a bedpan.

Anderson, a petite nurse who weighed about 115 pounds, was about to push the stretcher of the girl, who weighed almost 300 pounds. She leaned over to explain that they were moving to a curtained area when the girl suddenly sat up and socked her in the jaw.

The punch sent Anderson flying backward toward the nurses' station. It dislocated her jaw and caused her to miss about a month of work.

As chair of government affairs for ENA, Anderson had lobbied for a New York law that made it a felony to assault an emergency room nurse. But when she called the police, they hadn't even heard of the law. They eventually arrested the patient, but prosecutors allowed the case to expire beyond the statute of limitations.

Meanwhile, on the day of her assault, before she realized the extent of the damage to her jaw, Anderson continued to work. The girl eventually told Anderson why she had hit her: "She said she was just tired of waiting," Anderson recalls.

Today, Anderson still works in an emergency department in a community hospital in suburban Phoenix. She hasn't had another serious incident, but other types of violence are endemic.

"Nursing as a group has almost accepted it as a part of practice, that you're going to get hurt or bitten or kicked," she says. "To me, it's not an acceptable way to treat me. The amount of physical violence is bad, but the amount of verbal abuse that emergency nurses take is phenomenal. Not a day goes by that I don't get screamed at by someone, for things that aren't my fault."

Anderson continues to push for hospitals to provide the security and violence prevention programs that will keep emergency department staff safe. "I want nurses to understand that it's not acceptable to just let something like that happen," she says. ■

Physical therapists slow to adopt lifts

PTs under-report, work through pain

For many years, "body mechanics" was the mantra of physical therapy. Position yourself correctly as you lift and you can avoid injury, the physical therapists said.

Physical therapists suffered injuries under that philosophy, many of them hidden by underreporting. As patients became heavier and more chronically ill, the risk grew. Today, that burden has been acknowledged and physical therapists are becoming proponents of safe patient handling as a way to protect health care workers while rehabili-

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tating patients.

"They were embarrassed," says Kenneth J. Harwood, PT, PhD, CIE, vice president of practice and education at the American Physical Therapy Association in Alexandria, VA, explaining why physical therapists often failed to report their patient handling injuries. "You were considered the `go-to' person to prevent injuries, so you were less likely to report an injury. They were doing self-treatments and working injured."

Prevalence studies reveal the risk of injury. "Over half the therapists are experiencing work-related pain each year," says researcher **Marc Campo**, PT, PhD, OCS, associate professor in the physical therapy program at Mercy College in Dobbs Ferry, NY.

In one study, Campo and colleagues found that therapists who transferred patients six to 10 times a day were 2.4 times more likely to develop low-back injuries than those therapists who did not perform transfers.[1]

Many of those physical therapists continued to work through pain. In focus groups, physical therapists who suffer from work-related pain said they altered treatment plans or avoided some activities because of their pain. They worried that they would not be able to continue in their careers.[2]

But Campo says he is detecting a shift in attitude, especially among younger therapists. APTA also is actively promoting safe patient handling. "In some of the studies we're doing now, we're finding that therapists believe in safe patient handling," says Campo. "There's a belief among some that it may actually improve the [patient] outcomes."

APTA is developing an online course that will teach physical therapists how to integrate safe patient handling programs into their practice.

Leslie Pickett, PT, now an ergonomics and injury prevention specialist at Swedish Medical Center in Seattle, suffered an injury just nine months after she became a physical therapist. She was working with a stroke patient and was transferring her to a chair when suddenly the patient became rigid and threw herself backward.

The sudden movement jolted Pickett forward, and she felt a surge of pain in her back. The incident caused Pickett to have a herniated disc with radicular pain and numbness in her leg.

"It was very hard on me because I was so new and I felt really embarrassed. I'm supposed to be the expert in moving people. How could this happen to me?" she recalls. "There's a lot of shame, pressure to feel that you have to come back to work right away."

The experience made Pickett an early proponent of safe patient handling. When the Washington state legislature passed a law in 2006 requiring hospitals to adopt a safe patient handling program, Pickett headed the committee at Swedish Medical Center and helped draft the hospital's policy.

REFERENCE

1. Campo M, Weiser S, Koenig KL, Nordin M. Work-related musculoskeletal disorders in physical therapists: a prospective cohort study with 1-year follow-up. *Physical Therapy* 2008; 88:608–619.
2. Campo M and Darragh AR. Impact of work-related pain on physical therapists and occupational therapists. *Physical Therapy* 2010. Available online at http://ptjournal.apta.org/cgi/content/abstract/ptj.20090092v1. ■

CE OBJECTIVES / INSTRUCTIONS

The CE objectives for Occupational Health Management are to help nurses and other occupational health professionals to:

- Develop employee wellness and prevention programs to improve employee health and productivity.
- Identify employee health trends and issues.
- Comply with OSHA and other federal regulations regarding employee health and safety.

Nurses and other professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this semester's activity, you must complete the evaluation form provided in the **December** issue and return it in the reply envelope provided in order to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you.

CE QUESTIONS

1. Which is recommended regarding weight loss programs involving competitions between employees or departments?
   A. Do not make weigh-ins of employees confidential.
   B. Avoid using money as an incentive.
   C. Remember that costs of competitions are often prohibitive.
   D. Offer paid time off or money as incentives.

2. Which is recommended to gauge employee satisfaction with occupational health services?
   A. It is not advisable to survey all employees within the company.
   B. It is not necessary to use employee input during the implementation phase.
   C. Use employee testimonials to motivate others to participate.
   D. Avoid asking workers to name specific components they would like to see in existing programs.

3. Which is an effective way for occupational health managers to reduce back injury rates?
   A. Do walkthroughs alone, not accompanied by safety professionals.
   B. Identify root causes by talking with previously injured employees.
   C. It is not necessary to obtain insight from non-injured employees.
   D. Use data only from health care claims, not injury reports.

4. Which is true regarding management of workers' compensation cases, according to Patricia B. Strasser, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH?
   A. A comprehensive ergonomics program is rarely cost-effective.
   B. Transitional duty is not a good approach for new cases.
   C. Goals should be set for each open worker's compensation case.
   D. Insurers or third party administrators are not helpful resources for data analysis.

Answers: 1. D; 2. C; 3. B; 4. C.

Dear *Occupational Health Management* Subscriber:

This issue of your newsletter marks the start of a new continuing nursing education (CNE) semester and provides us with an opportunity to review the procedures.

Occupational Health Management, sponsored by AHC Media LLC, provides you with evidence-based information and best practices that help you make informed decisions concerning employee health and safety. Our intent is the same as yours: the best possible patient care.

The objectives of *Occupational Health Management* are to:
• develop employee wellness and prevention programs to improve employee health and productivity;
• identify employee health trends and issues; and
• comply with OSHA and other federal regulations regarding employee health and safety.

Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You then can compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form we will mail you a letter of credit. This activity is valid 24 months from the date of publication. The target audience for this activity is occupational health managers.

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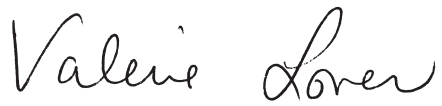
Sincerely,



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