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Bully pulpit: Stop workplace bullying before it causes absenteeism, turnover

Make yourself the go-to person and get it stopped

Workplace bullying is known to cause lost productivity, high turnover, injury and illness, but this problem is often completely ignored by managers and senior leaders.

As an occupational health manager, you are probably the single best person in the company for bullied workers to go to. Moreover, you can point out the hidden costs of bullying to management.

"This is part of your role. It absolutely affects the physical and emotional well-being of employees," says **Shellie Simons**, PhD, RN, an assistant professor in the Department of Nursing at University of Massachusetts Lowell. "You are the best first step. There is nobody else that really cares about the well-being of the employee."

As an occupational health professional, you should "communicate your ability and desire to assist employees," says **Donna M. Gates**, EdD, MSPH, MSN, FAAN, professor & chair at the University of Cincinnati's College of Nursing. "This can be done on a one-to-one basis when employees are seeking assistance with other health or safety issues, and by flyers, e-mail communication, and educational seminars."

The first step? Inform others about bullying's adverse impact on the workplace. "Occupational health is in a great position to do teaching on this," says Simons. "The literature is full of documentation that bullying will cause depression, headaches, stomachaches and quite a bit of absenteeism."

Presenteeism is a related issue. "When someone is bullied, they are thinking about what to do about the problem, rather than their job," says Simons.

EXECUTIVE SUMMARY

Inform higher-ups about the costs of bullying in the workplace, which includes high turnover, injury and illness, and encourage workers to report this behavior to you. Use these approaches:

- Ask about bullying when employees are seeking assistance with other health and safety issues.
- Present documentation that bullying causes depression, headaches, and absenteeism.
- Specify what will be done if bullying is reported.

What's the true cost?

"There are direct adverse effects on the workers. Then there are secondary effects and financial costs, because the organization is affected," says **Dianne M. Felblinger**, EdD, MSN, WHNP-BC, CNS, RN, a professor and women's health nurse practitioner at the University of Cincinnati's College of Nursing.

Bullied workers may have stress-related illnesses, such as hypertension, gastrointestinal problems, or sleep disorders. "There are increased health care costs that the organization ends up picking up," says Felblinger. "On a larger scale, there is increased absenteeism and turnover intention. Employee safety becomes an issue."

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Gates says it's important to know that there are psychological and physical consequences for bullied workers. Bullying can lead to stress symptoms similar to those seen with post-traumatic stress disorder, such as sleep disturbances, loss of interest in activities, irritability or anger, difficulty concentrating, substance abuse, helplessness, and depression, she explains.

"Physical symptoms may include headache, stomach problems, musculoskeletal pain, and chest pain," says Gates.

Since bullying makes it more likely for an employee to leave their job, Simons recommends calculating the cost of replacing an employee.

"There is the need to replace and retrain employees who leave due to the bullying," says Gates. "Also, there is decreased productivity due to the time and energy spent on coping with the bullying, costs for medical and psychological care, potential legal actions, and cost for sick pay and worker's compensation."

Create a policy

Work with managers, human resource representatives and safety to create a policy that promotes a zero tolerance for bullying, says Gates. This should be part of a comprehensive workplace violence policy that covers all types of violence, she advises — verbal abuse, harassment, bullying, threats, and physical violence.

"The policy should cover violence from employees, managers, and customers. It should be part of the company's commitment to a safe and healthy work environment," says Gates. (*See related story, p. 123.*)

Occupational health professionals, says Felblinger, "by and large are good interviewers, and have a way of pulling out history. Ask workers, 'What do you think this is related to?' and 'Is there something at work that exacerbates this?'"

Felblinger points to the Healthy Workplace Bill introduced by 17 states, which provides an avenue for legal recourse for workers whose health was harmed by an abusive work environment. "There is a movement going on to introduce legislation against bullying," she notes. "It is to the workplace's advantage to get on top of that curve."

SOURCES

For more information about bullying in the workplace and the occupational health role, contact:

• **Dianne M. Felblinger**, EdD, MSN, WHNP-BC, CNS, RN, College of Nursing, University of Cincinnati. Phone: (513)

Many bullying policies lack 'teeth,' ineffective

Response must be clear

A zero tolerance policy for bullying will get zero results, unless it spells out clearly what will be done in response to employee reports. Here are three questions that should be answered — but are probably not — in your company's policy:

1. What behaviors are unacceptable?

Shellie Simons, PhD, RN, an assistant professor in the Department of Nursing at University of Massachusetts Lowell, says to get very specific on this.

Donna M. Gates, EdD, MSPH, MSN, FAAN, professor & chair at the University of Cincinnati's College of Nursing, says to list verbal conflicts, intimidating behaviors, angry outbursts, screaming and yelling, blaming others, sexual harassment, acts of insubordination, threatening verbal or body language, abusive language, cursing and swearing, threats of violence, and deep cynicism or anger at management.

2. How do employees report a problem?

"Clear reporting mechanisms are needed. "These need to be formalized, and people need to know what they are," says **Dianne M. Felblinger**, EdD, MSN, WHNP-BC, CNS, RN, a professor and Women's Health Nurse Practitioner at the University of Cincinnati's College of Nursing.

Many nurses who reported bullying in a recent survey said that they didn't know who to report the problem to.[1] "Some went to their managers, but the problem is that a lot of the bullies are the immediate supervisors," says Simons, the study's lead author.

In many policies on negative workplace behavior, it is unclear exactly who employees should go to for help. "Employees need to know that they can report violence, including bullying, against them or another employee without fear of retaliation," says Gates.

3. What will be done if bullying is reported?

"Policies may say there is a zero tolerance for bullying, but they don't say what they are going to do about it," says Simons.

The fact is, though, that bullying behavior is often done in plain sight and witnessed by others. "I think that if someone did an actual investigation, they could find out what actually happened," says Simons. "But the problem, the investigations are not occurring."

This is why managers must be trained on procedures for dealing with employees who exhibit aggressive or threatening behavior — and the importance of timing. "When bullying or other forms of violence are reported, the behavior should be addressed immediately by management," says Gates. "If employees report concerns and do not believe that anything is done by administration, then the reporting will stop."

REFERENCE

1. Simons SH, Mawn B. Bullying in the workplace: A qualitative study of newly licensed registered nurses. *AAOHN Journal* 2010; 58(7):305-311. ■

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Is occ health data being misinterpreted by others?

Don't give the goods away

If someone asks you for data on how many physicals you did this year, or how many drug tests were given to employees, this may sound like a pretty straightforward request. However, you need to think twice before handing it over.

"If you give your data to other departments, those departments may report occupational health metrics to key stakeholders. You don't know what the end results are going to be," says **Tamara Y. Blow**, RN, MSA, COHN-S/CM, CBM, FAAOHN, a Richmond, VA-based manager of occupational health services.

"When those business partners are reporting our metrics, they are not always motivated to give the appropriate credit to occupational health services," she adds.

Without input from occupational health, someone in senior management could easily misinterpret occupational health metrics.

"They may conclude that FMLA [Family Medical Leave Act] utilization is high because

EXECUTIVE SUMMARY

If you are asked for data involving occupational health services, take steps to ensure that the information is not misinterpreted. Before you provide the data:
- Learn why the information is needed.
- Ask who the information will be shared with.
- Offer to assist with presentation of the data.

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the administrator or nurse is not exercising due diligence and is allowing employees to abuse FMLA," she says. "There is a tendency for people to think that occupational health nurses are enabling absenteeism because they are soft touches."

Another issue is that others may try to take credit for data that reveals how occupational health programs have saved the company money. "We have the goods, and we give them away," she says.

Take ownership

While you can't simply refuse to give out data from occupational health services, you can do some things to protect yourself. "What we need to do is take ownership of our own data," she says.

Tell others that you are glad to give them what they need, but stay in the loop. Blow says to ask, "Why do you need this information?" and "Who are you giving this information to?"

"Others can't answer questions about our metrics or our data," she says. "Many of us have become very business savvy. We don't have analysts in our department, so we have to function as business analysts when articulating the value of occupational health programs."

There is another reason that occupational health services needs to interpret its own data. Information can be easily misinterpreted by those who do not possess a medical background.

"Many times, occupational health nurses have to coach their non-medical bosses that medicine is not a cookbook," says Blow. "Some employee situations have to be managed on a case-by-case basis."

Offer to help the person asking for your data. "They've got to see what is in it for them," she says. "Tell them, "I will be glad to come and help answer questions. Allow me to be in these meetings so I can assist you." ■

Get rid of 'accidents waiting to happen'

Some problems hide in plain sight

Do you consider work areas as part of your "office?" If you do, you will almost certainly spot some unidentified Occupational Safety and Health Administration (OSHA) violations.

Occupational health nurse **Laurie Heagy**, RN, president of the Berks County Pennsylvania Association of Occupational Health Nurses, recalls that a subtle, but easily visible violation was spotted during one of her walk-throughs.

"The autoclave instrument solution is in a marked container. But when you pour it in the tray to disinfect, we did not have a label on the steel tray. So the solution was not identified and 'hiding in plain view,'" says Heagy.

There is no question that walking the floor can help you identify hazards that exist out in the workplace. However, **Craig Catton**, an environment, health & safety coordinator for Peoria, IL-based Caterpillar's Integrated Manufacturing Operations Division, says, it's even better to find them before they present a risk to employees.

This can be done by incorporating risk assessments into the planning phase of a new process. "When we buy a new machine, redesign a workstation, introduce a new chemical, or build a new product, there is an opportunity to eliminate the hazards before they are ever introduced into the work area," he says.

Make workers your allies

No matter how many walk-throughs you do, there is no substitute for the eyes and ears of employees. The challenge, though, is getting them to report what they see and hear.

"In some cases, things are obvious, like a missing guard. But in other cases, things are more

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EXECUTIVE SUMMARY

To identify workplace hazards, do walkthroughs and get employees engaged in the process. To encourage workers to report what they see and hear:
- Always talk to employees and the management team.
- Set a designated time to identify hazards.
- Use corrected problems as educational tools.

subtle," says **Thomas Slavin**, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines. "Too often, though, nobody says anything about it."

An employee may know his actions are dangerous or non-complaint, but feels he must take the risk in order to get the job done.

"A lot of times, something's not right but nobody has ever said anything. Everybody assumes that's the way it's supposed to be," Slavin says. "But when somebody does ask the question, all of a sudden lights go off."

If an employee is doing a lot of work with their arms above their shoulders, for instance, it may be that a work platform needs to be adjusted. "It's not a case of being an OSHA compliance expert. Just asking a few questions gets people thinking," he says.

Use these approaches to obtain employee input:

• Don't pass up a chance to connect with employees.

While out on the shop floor, Catton always makes a point of speaking to employees and the management team.

"Employees who are encouraged to communicate safety and health issues, and who feel their management will address their issues, will be more likely to report issues and potential hazards," Catton says. "If employees are engaged, you will likely find fewer health and safety hazards on the shop floor."

• Dedicate a specific time to identify hazards.

Some obvious hazards can easily be corrected by any employee, such as trip hazards from housekeeping issues or damaged tools. However, workers may do nothing to correct these accidents waiting to happen.

"Employees may continue to work with identified hazards, if they think taking time to correct the hazard will slow them down," says Catton.

For this reason, Catton recommends setting a designated time to identify hazards, such as the start of the shift or down time during the shift. "This allows workers time to focus solely on identifying and correcting potential safety issues in their areas," he says.

• Always do something when a problem is reported.

The goal is to encourage workers to continue to convey concerns. "People need to see that by bringing these things up, improvements are made in the workplace and things get done," says Slavin.

Navistar views OSHA compliance only as a "baseline," he notes. "Injury prevention, by doing a good investigation and talking to employees about what they think is unsafe, is really our focus. If you work from an injury prevention standpoint, it should take care of most of the OSHA standards," Slavin says.

• If an issue is identified and corrected, use it as an educational tool.

"The identified issue can be communicated at daily start up meetings to encourage other employees to look for the same issue in their areas," says Catton. "It is also a way to recognize the employees who helped identify and correct the issue."

SOURCES

For more information on encouraging workers to report safety issues, contact:

• **Thomas Slavin**, Safety and Health Director, Navistar International, Warrenville, IL. Phone: (312) 836-3929. E-mail: tom.slavin@navistar.com. ■

Don't simply treat, discover root cause

'The avenue is there for investigation'

When an employee comes to you and tells you his shoulder is bothering him, you can do one of two things. You can either treat the problem and send him on his way, or you can dig deeper.

Thomas Slavin, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines, recommends the latter approach. He notes that the Japanese term "genchi genbutsu" is used in the Lean Manufacturing process, which translates as "go see the problem."

"The most effective occupational health profes-

EXECUTIVE SUMMARY

If an employee reports an injury, going to the worksite may tell you the real cause of the problem. To learn the root cause:

• Keep asking additional questions.

• Investigate an employee's symptoms before the injury becomes severe.

• Use the opportunity to learn about other personal health issues.

sionals that I've worked with are the ones who actually go to the worksite to see what the person is doing, when someone comes in with a problem," he says.

By doing so, you may learn the real cause of the employee's pain or symptom. "A lot of things can be discovered when you see what their actions are. The symptom they come in with is really just a clue. And it's an important clue, that maybe no one else is aware of," says Slavin.

Take what a "root cause attitude," he advises. "People come in with a problem, but there are reasons for that problem," he says.

One investigative technique is the "Five Why," which means asking "Why?" repeatedly to get at the underlying cause of a problem. If an employee comes in with a foreign body in his eye, the reason is because he wasn't wearing safety glasses.

"A lot of people will stop there, and just say, 'You are not following the rules.' But you have to keep asking why," says Slavin. "When you start going deeper and asking additional questions, you uncover problems that can be corrected. There are a lot of benefits when you do correct them."

It may be that the glasses don't fit, fog up, that the person can't do a quality job with the glasses, or the lighting is poor.

Often, too, an employee has symptoms before an injury becomes severe. "When someone is having some pain, that is the first early indication that you need to look into that deeper," says Slavin.

Great opportunity

"The employee in your office for shoulder pain offers you a great opportunity to connect with the employee, as well as his or her department," says **Carol S. Harris**, RN, BSN, COHN-S/CM, an occupational health nurse at Replacements, a Greensboro, NC-based supplier of old and new china, crystal, silver, and collectibles with 550 employees.

By asking routine questions about the shoulder pain, you might discover a personal health issue that makes the employee more subject to occupational injury than another employee doing the same job.

"This is a great way to connect with that employee during the health investigation, evaluation and perhaps medical intervention to improve that individual's health," she says. "In doing so, the potential is there for he or she to become a more productive employee."

There may be a problem at home that is negatively impacting the employee's health. "Once again, this shoulder evaluation may afford the employee time to address emotional problems," she says.

Simple questions during the exam about work processes can open the door for questions about morale or other issues that are creating a problem.

"This may not be the case, but the avenue is there for investigation," says Harris. "Saying, 'Let's go look at your job process together' speaks volumes to that employee. You show concern for them, and validate their importance."

When you go out into the field, the employee's co-workers then see your concern for their safety. "Spend time in the department to watch the employee do the job that is in question," she recommends.

As a result of these observations, you're in a better position to offer suggestions for work practices to decrease potential injuries in the future. "Demonstrate sincere concern for the employee," Harris says. "Then provide support for the management team by demonstrating concern for department safety, as well as production."

SOURCE

For more information on learning more about an employee's injury, contact:

• **Carol S. Harris**, RN, BSN, COHN-S/CM, Replacements, Greensboro, NC. Phone: (336) 697-3000, ext 2044. E-mail: carol.harris@replacements.com. ■

It's not enough to know PPE isn't worn: Learn why

ID reasons for non-compliance

Is personal protective equipment (PPE) uncomfortable, too hot, poor-fitting or unattractive looking? The reality, very often, is that employees won't wear it.

Despite the risk of injury, employees don't always wear appropriate safety equipment, according to 98% of safety professionals surveyed by Dallas, TX-based Kimberly-Clark Professional—and 30% report this having happened on numerous occasions.

Increasingly high noncompliance with PPE protocols is a serious threat to worker health and safety, according to **Gina Tsiropoulos**, Kimberly-Clark's manufacturing segment marketing manager. "Because non-compliance remains an issue, we will continue to see work-related injury as a

result," Tsiropoulos says.

Eye protection was cited as the "most challenging" PPE category by 42% of respondents. Nearly three out of five workers who experienced eye injuries were found not to be wearing eye protection at the time of the accident, or were wearing the wrong type of eye protection for the job, according to the Bureau of Labor Statistics.

"Clearly, we have a circumstance where workers are either not wearing safety glasses altogether, or are wearing the wrong kind or poorly-fitted eye protection," says **Deanna L. Thornton**, safety business leader for North America at Kimberly-Clark.

While the goal is always to prevent the injury, if an incident does occur it can serve as a "wake up call" to workers, Tsiropoulos says.

Test results demonstrating changes in hearing can reinforce loss related to misuse of, or failure to use, hearing protection. "Always ask questions such as 'Could gloves have prevented this hand injury?' or 'Could a bump cap or hard hat have prevented the laceration on the scalp from an overhead pipe?'" says Thornton.

Listen up

Hearing protection was the second most challenging area with PPE, the survey found.

"I think most occupational safety and health professionals think that more protection is better," says **Laurie Heagy**, RN, COHN-S, president of the Berks County Pennsylvania Association of Occupational Health Nurses. "In the case of hearing, I'm not sure that is the correct approach."

Heagy says that she is looking into using hearing protection devices that do not attenuate quite so much noise. She worries that the higher attenuating devices are decreasing compliance, because they block so much noise that the employee cannot hear normal speech.

"We have seen people modify the plugs to make it look like they are in, but they cut them in half or use other methods so they can hear. This defeats the purpose of wearing them," says Heagy. "In an area that is only a few decibles above the OSHA [Occupational Safety and Health Administration] limit, you don't need a plug with a Noise Reduction Rating of 28 or 30. It is really overkill."

Heagy says that manufacturers should provide lower attenuating options, so that employees can be protected without isolating them from communication with their coworkers and supervisor.

"I had to tour two plants recently, and I got a really good fit on the hearing protection devices that they gave us," says Heagy. "I was frustrated because I barely heard anything that anyone was saying during the tours. It made me see what the employees go through."

Hearing protection devices should be selected with a goal of reducing the environmental noise to safe levels as directed by OSHA, and not to eliminate all sound entirely, Thornton says. "This type of 'overprotection' is impractical as well as dangerous," she adds. "Employees must be able to hear sounds to perform their jobs safely and effectively."

EXECUTIVE SUMMARY

There is high noncompliance with personal protective equipment (PPE) by employees, due to the equipment being uncomfortable, poor fitting and unattractive. Some solutions:

- Share information on actual injuries as a wake-up call for workers.
- Allow workers to test out PPE.
- Offer more than one type of PPE.
- Require workers to identify all lapses in compliance.

SOURCES

For more information on improving compliance with personal protective equipment, contact:

- **Laurie Heagy**, RN, COHN-S, President, Berks County Pennsylvania Association of Occupational Health Nurses. E-mail: lheagy@hotmail.com.
- **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, Clinical Assistant Professor, Occupational Health Nursing Program, University of North Carolina at Chapel Hill. Phone: (919) 966-0979. Fax: (919) 966-8999. E-mail: susan.randolph@unc.edu. ■

The needlestick that changed her life

ANA pres recalls injury that led to HIV, HCV

Karen Daley, PhD, MPH, RN, FAAN, remembers the stick as if it happened in slow-motion, the details still clear to her 12 years later.

She had helped a co-worker draw blood from a patient in the emergency department. She turned to reach behind her for the sharps container. Mounted high on the wall, it was overfilled, but she couldn't see it well because it was above eye level. As she released the device, she felt a deep

puncture through the index finger of her gloved hand. Someone else's needle had stuck her. Source patient unknown.

The odds, seemingly, were in Daley's favor. What's to say that source patient had a blood-borne disease? Even if he or she did, the rate of conversion for hepatitis C is estimated at just 5 in 1,000 (.5%) and at 3 in 1,000 (.3%) for HIV. At first, she was inclined to just rinse off her finger and ignore the injury.

"I wanted to just forget about it and go home," she recalls.

She reported to urgent care for evaluation because her co-worker urged her to do so. She declined the post-exposure prophylaxis for HIV because she was aware of the toxic nature of the side effects of the anti-viral medicines. Even when she began to have symptoms — weight loss, nausea, fatigue, abdominal pain — she didn't connect them to the needlestick. After all, she was suffering from emotional stress because of the recent death of her brother.

But Karen Daley, now president of the American Nurses Association in Silver Spring, MD, was doubly unlucky. She became infected with both hepatitis C and HIV from that needlestick. It was a moment that altered her life — and made her a vocal advocate for sharps safety.

"When my needlestick occurred, few employers were making safety devices available to workers. Only 15% of employers provided any type of sharps safety device," says Daley.

Laws spurred sharps safety

California became the first state to mandate safety-engineered sharps devices in 1998. In 1999, when the National Institute for Occupational Safety and Health issued an alert to hospitals regarding sharps injuries, an estimated 600,000 to 800,000 health care workers were being stuck every year.

Yet hospitals were still arguing that new safety devices were too expensive. "You hope employers and workers will do the right thing for the right reason. That's not always the case and it wasn't the case here," says Daley. Daley traveled the country, speaking out about her needlestick and its dire consequences — and the simple device that could have saved her health. She testified before state legislatures and Congress, and helped promote ANA's campaign, "Safe Needles Save Lives."

Other states began requiring the use of safety devices, but the passage of the Needlestick Safety and Prevention Act in 2000 propelled the issue forward with a mandate that employers purchase the safety devices.

Now, when Daley has her blood drawn for regular lab work, she is gratified to see the nurse or phlebotomist using safety equipment.

"Nurses who practice now as recent grads don't know there was a time when we didn't have access to these devices. It's just the norm," she says.

Maintaining enforcement is critical, she says.

"I want every nurse in the country and every employer to realize what their obligation is under this law, and I want to see them comply with that," she says.

Moving forward after stick

The day that Daley learned she was both HCV and HIV positive was her last day of work as a practicing nurse. Emotionally, the news was devastating.

"I was dealing with a life-threatening illness," she says.

Physically, she was in bad shape. She developed acute hepatitis and she had a high HIV viral load. She went on a year-long therapy for hepatitis C and was able to clear the infection. She also took anti-viral drugs for HIV, which was a struggle.

"I had a difficult couple of years trying to get on a regimen that was tolerable for me," she says. "At one point, I had to stop the entire treatment. I couldn't eat. The fatigue was so excessive."

She tried about four different drug protocols until finding one she could maintain. She has been on the same drug regimen for seven years. As ANA president, Daley is committed to working on some of the remaining gaps in sharps safety — the lack of access to safety devices in the OR, the failure of some employers to include frontline nurses in device selection (as required), the lack of availability of safety devices in some categories. Most of all, Daley wants to promote a culture of safety that compels workers to report their injuries and that encourages timely post-exposure prophylaxis.

"Where there are opportunities for us to make the workplace a healthier, better place, we have an ethical obligation to do so," she says. "We've still got some work to do." ■

CDC: Monitor HCWs for flu symptoms

Guidance stresses masks, vaccine

During last year's H1N1 influenza pandemic, health care workers inadvertently transmitted flu to their co-workers, in some cases triggering a hospital-based outbreak. That and other information about H1N1 transmission helped shape new guidelines from the Centers for Disease Control and Prevention that rely on vaccination, respiratory hygiene, and monitoring of ill employees by employee health professionals.

"When it's spreading in the community you have to be vigilant for symptoms," says **John Jernigan**, MD, MS, medical epidemiologist with CDC's Division of Healthcare Quality Promotion and an author of the guidelines. "More efficient recognition and handling of the ill health care workers can make a big difference in transmission."

The guidance, *Prevention Strategies for Seasonal Influenza in Healthcare Settings*, promotes a variety of measures to prevent transmission of influenza. As expected, it treats H1N1 as a seasonal rather than a pandemic strain, and it advises the use of droplet and contact precautions. Masks are sufficient protection, except when performing aerosol-generating procedures, CDC says. "To effectively prevent transmission, it's going to take a multifaceted approach," says Jernigan. The most important preventive measure is annual influenza vaccination, according to the guidance.

"Achieving high influenza vaccination rates of HCP and patients is a critical step in preventing healthcare transmission of influenza from health care personnel to patients and from patients to health care personnel," it states. CDC did not address the issue of mandatory influenza vaccination of health care workers.

Infection control organizations such as the Society for Healthcare Epidemiology of America (SHEA) recently released position papers favoring mandatory vaccination. The Advisory Committee on Immunization Practices (ACIP), an expert panel that advises CDC, is considering the issue and will report at its June meeting, Jernigan noted. The National Vaccine Advisory Committee is also considering whether to recommend mandatory vaccination of health care workers.

In the meantime, the CDC offers some guidance directed at employee health professionals. According to the guidance, they should establish procedures for:

- tracking absences;
- reviewing job tasks and ensuring that personnel known to be at higher risk for exposure to those with suspected or confirmed influenza are given priority for vaccination;
- ensuring that employees have prompt access, including via telephone to medical consultation and, if necessary, early treatment;
- and promptly identifying individuals with possible influenza.

"Health care personnel should self-assess for symptoms of febrile respiratory illness," CDC stated. "In most cases, decisions about work restrictions and assignments for personnel with respiratory illness should be guided by clinical signs and symptoms rather than by laboratory testing for influenza because laboratory testing may result in delays in diagnosis, false-negative test results, or both."

CDC acknowledges that airborne transmission may occur with influenza, but notes that "the relative contribution of the different modes of influenza transmission is unclear." While previous H1N1 guidance advised health care workers to wear N95 respirators when caring for patients with suspected or confirmed influenza, the current guidance recommends donning a mask when entering a patient's room.

"Mask use and hand hygiene do actually reduce the transmission of influenza in health care settings," says Jernigan.

Vaccination and prompt treatment with antiviral medications are even more important for health care workers at higher risk of complications from influenza — such as pregnant or morbidly obese workers or those with chronic health conditions.

CDC does not recommend reassignment, but notes: "Work accommodations to avoid potentially high-risk exposure scenarios, such as performing or assisting with aerosol-generating procedures on patients with suspected or confirmed influenza, may be considered in some settings, particularly for health care personnel with more severe or unstable underlying disease."

[Note: A copy of the influenza guidance is available at www.cdc.gov/flu/professionals/infectioncontrol/ healthcaresettings.htm.] ■

OSHA may crack down on sleepless doctors

Considering petition on long work hours

The problem of fatigued medical residents has gotten the attention of the U.S. Occupational Safety and Health Administration.

Public Citizen, a consumer and health advocacy group, the Committee of Interns and Residents/SEIU Healthcare, a union that represents resident physicians, and the American Medical Student Association petitioned OSHA to regulate work hours of medical residents and got a surprising, same-day response.

"We are very concerned about medical residents working extremely long hours, and we know of evidence linking sleep deprivation with an increased risk of needle sticks, puncture wounds, lacerations, medical errors and motor vehicle accidents. We will review and consider the petition on this subject submitted by Public Citizen and others," Assistant Secretary of Labor for OSHA **David Michaels**, PhD, MPH, said in a statement.

"It is clear that long work hours can lead to tragic mistakes, endangering workers, patients and the public. All employers must recognize and prevent workplace hazards. That is the law. Hospitals and medical training programs are not exempt from ensuring that their employees' health and safety are protected," he said.

The petition, which was also signed by some leading physicians in sleep medicine or preventive medicine, asks for a maximum of 16-hour shifts and 80-hour work weeks for all medical residents. It was submitted about two months after the Accreditation Council for Graduate Medical Education [ACGME] released proposed standards that include new limits on duty hours that emphasize greater limits on first-year residents.[1] An ACGME task force drafted the proposed standard after considering oral and written testimony from medical organizations and others.

At issue: How long can medical residents work without suffering from fatigue that can increase medical errors, decrease patient safety, and impact the doctors' health and safety? Who should regulate those work hours — the accrediting body that oversees medical education or OSHA?

"[ACGME] is not doing a good job of keeping the residencies compliant with the rules," says **Charlie Preston**, MD, MPH, a health researcher at Public Citizen and medical resident in the Department of General Preventive Medicine at the Johns Hopkins School of Public Health in Baltimore. "We need a governmental body to regulate, like we do in other industries."

However, ACGME asserts that it should be responsible for monitoring resident duty hours as a part of the broader focus on quality medical education. ACGME also plans to implement an annual Patient Safety and Quality Assurance review of every institution that sponsors residency programs.

"ACGME strove to make the new standards evidence-based, and to make them reflect the experience and best practices of the medical profession," ACGME said in a statement. It noted that OSHA had rejected a previous petition in 2002.

Fatigue clearly can lead to worker errors, and in some industries — trucking, airline, nuclear power — the public expects governmental limits on work hours to protect the public. Studies also show that fatigue can increase medical error rates, motor vehicle crashes, and needlesticks.[2,3]

"If policy is to be based on evidence and not opinion, the federal government is obligated to protect resident physicians and their patients by reducing resident physician work hours," the advocacy groups state in their petition. (The petition is available at www.wakeupdoctor.org.)

ACGME acknowledged the concerns about fatigue, alertness and error, but noted that the evidence is clearest for first-year residents (interns). The proposed ACGME standard places greater limits on interns than on other medical residents.

The OSHA petitioners oppose that two-tiered system, noting that fatigue is a biological issue. "We would just say that sleeplessness and fatigue applies to everybody," says Preston. "It's possible interns may make more mistakes when they're sleep-deprived than upper-year residents, but it's still unsafe for those groups."

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CNE OBJECTIVES/INSTRUCTIONS

The CNE 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.

COMING IN FUTURE MONTHS

■ What you can—and can't—tell others about a worker's health

■ Use monetary incentives to solicit employee ideas

■ Do you suspect an employee is lying about an injury?

■ Stop documentation omissions for OSHA-recordable injuries

Answers: 16. D; 17. D; 18. A. 19. C.

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PS Form **3526**, September 1999 *(Reverse)*

CE QUESTIONS

16. Which is recommended for policies that address the problem of bullying in the workplace?
A. Policies should avoid specifying a specific individual to report the problem to.
B. Policies should remain general about behaviors that constitute bullying, without naming specific behaviors.
C. The organizations should avoid doing an investigation if bullying is witnessed by others.
D. The policy should be specific as to what will be done if an employee reports that bullying is occurring.

17. Which is recommended regarding eliminating workplace safety hazards?
A. Don't set a designated time to identify hazards, such as the start of the shift.
B. Avoid discussing hazards during the down time of the shift.
C. After an issue is identified and corrected, avoid discussing this specific issue at staff meetings.
D. While you are doing walk-throughs, make a point of speaking to employees and the management team.

18. Which is particularly important for occupational health professionals to avoid doing regarding sharing of data, according to **Tamara Y. Blow**, RN, MSA, COHN-S/CM, CBM, FAAOHN, a Richmond, VA-based manager of occupational health services?
A. Allowing data to be misinterpreted by those who do not possess a medical background.
B. Sharing any data on utilization of the Family Medical Leave Act with human resources.
C. Offering to assist the person asking for the data.
D. Asking who the information will be given to.

19. Which is recommended to improve compliance with personal protective equipment (PPE?)
A. Don't require employees to identify lapses in PPE compliance involving other workers.
B. Offer only one type of PPE, instead of giving employees more than one choice.
C. Require employees to identify any lapse in PPE compliance.
D. Don't give employees the opportunity to test out different PPE products.