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HHS panel solicits EH perspective on controversial flu vaccination issue

'We are the interface between the policy and practice'

A proposed federal action plan is targeting influenza vaccination of health care workers, and occupational health physicians will be represented on the working group that is considering new recommendations — including possible mandates.

The American College of Occupational and Environmental Medicine (ACOEM) is a key stakeholder as the U.S. Department of Health and Human Services' inter-agency working group considers new strategies to increase immunization rates.

After all, occupational health physicians and employee health nurses are often the ones who coordinate the flu vaccination campaigns, notes **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN, and vice chair of ACOEM's Medical Center Occupational Health section.

"You need that experience at the table. We are the interface between the policy and practice," says Swift, who may be representing ACOEM as a liaison member. "We see firsthand the impact of policies like this on workers. To exclude us from that conversation would be to miss an incredibly vital piece of the picture."

ACOEM's position differs from that of the infection control organizations mentioned in the action plan. (The action plan is available at www.hhs.gov/ash/initiatives/hai/tier2_flu.)

In a 2008 position statement, ACOEM advocated using "a comprehensive approach...encompassing education, vaccination, and infection control practices" to improve influenza vaccination of health care workers. However, ACOEM did not endorse a mandatory approach that would lead to punitive consequences:

"Education and adherence to infection control practices should be mandatory. Immunization is safe but variably effective and is not a panacea for respiratory virus transmission in the health care setting...Current evidence regarding the benefit of influenza vaccination in HCW as a tool to protect

patients is inadequate to override the worker's autonomy to refuse vaccination." (The guidance is available at www.acoem.org.)

HHS will likely also solicit input through a stakeholders meeting in the spring, says **Ray Strikas**, MD, medical officer and seasonal influenza coordinator for the National Vaccine Program Office and co-chair of the inter-agency working group. "We'll make recommendations in concert with the many partners in organized health care," he says.

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Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).
Executive Editor: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Senior Managing Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).
Production Editor: **Neill Kimball**.

Editorial Questions

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

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Will Joint Commission up the ante?

The greatest impact of the HHS action plan may come from the Center for Medicare & Medicaid Services (CMS) or The Joint Commission accrediting body.

A Joint Commission standard requires hospitals to offer influenza vaccination on-site and to educate staff and affiliated "licensed independent practitioners." They also must monitor their vaccination rates and seek to improve them.

The draft HHS action plan suggests encouraging The Joint Commission to create a performance measure based on the percentage of health care personnel who are vaccinated against influenza and to establish a specific vaccination goal. Healthy People 2010 set a goal of vaccinating 60% of health care workers; the proposed 2020 goal is 90%.

According to a survey sponsored by the Centers for Disease Control and Prevention and conducted by the RAND Corp., in the 2009-2010 flu season, about 74% of hospital-based health care workers received either the seasonal or H1N1 flu vaccine (or both). Vaccination rates were lower in other health care settings. Nurses and physicians were the most likely to be vaccinated, and non-clinical support staff were the least likely to receive the vaccine.

"The Joint Commission views the vaccination of health care workers as a very important issue and we are currently in the discussion stage about the issues [in the action plan]," **Ken Powers**, spokesperson for The Joint Commission, told HEH in an e-mail response.

Does HCW vaccination save lives?

The first stage of the action plan involves reviewing existing evidence on influenza immunization, identifying current state statutes and developing model policies or statutes, Strikas says.

Alexandra Stewart, JD, an assistant research professor in the Department of Health Policy at the George Washington University School of Public Health and Health Services in Washington, DC, will research the pros and cons of an immunization mandate, Strikas says.

Stewart published a commentary in the *New England Journal of Medicine* in November 2009 stating that a New York rule mandating influenza immunization of health care workers would likely

Who are 'health care personnel'?

According to the U.S. Department of Health and Human Services:

"Health care personnel refers to all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air.

"HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, house-keeping, laundry, security, maintenance, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients."

Why do HCWs accept the flu vaccine?

- Desire for self-protection;
- Desire to protect patients;
- Desire to protect family members;
- Previous receipt of influenza vaccine;
- Perceived effectiveness of the vaccine;
- Desire to avoid missing work;
- Peer recommendation;
- Personal physician recommendation;
- Strong worksite recommendation;
- Had influenza previously;
- Belief that receiving the vaccine is a professional responsibility;
- Access to vaccination/coverage;
- Vaccinations provided free of charge; and,
- Belief that the benefits of vaccination outweigh the risk of side effects.

Why do HCWs decline the flu vaccine?

- Fear of contracting influenza/influenza-like illness from the vaccine;
- Fear of vaccine side effects;
- Perceived ineffectiveness of the vaccine;
- Perceived low or no likelihood of developing influenza;
- Fear of needles;
- Insufficient time, inconvenience, or forgetting to get the vaccination;
- Reliance on homeopathic treatments;
- Belief that their own host defenses would prevent influenza;
- Lack of physician recommendation;
- Belief that other preventive measures would minimize or eliminate influenza risk;
- Belief that influenza is not a serious disease;
- Lack of free vaccinations; and,
- Belief that the vaccine is not necessary for individuals younger than 65 years of age. ■

be ruled constitutional. (The rule was suspended when there was a delay in vaccine supply during the H1N1 pandemic.)

"I believe that the state's right to compel health care workers to receive vaccinations will supersede their individual rights because of the state's substantial relation to protection of the public health and safety," Stewart wrote.[1]

However, a recent Cochrane Review raised questions about whether the research really shows a patient safety benefit from influenza immunization of health care workers. A review of five studies found all were "at high risk of bias."[2]

Even so, the studies did not show an effect for influenza immunization of health care workers on laboratory-confirmed influenza, pneumonia (a possible complication of influenza), or deaths from pneumonia among people who were 60 or older and living in long-term care facilities.

There was some association between immunization and influenza-like illness or mortality from all causes among elderly long-term care residents, but the authors questioned the significance of that finding. "These non-specific outcomes are difficult to interpret because influenza-like illness includes many pathogens, and winter influenza contributes less than 10% to all-cause mortality in individuals 60 or older," the authors stated.

"We conclude there is no evidence that vaccinating health care workers prevents influenza in elderly residents in long-term care facilities," they stated.

The authors suggested future research should use high-quality, randomized control trials, and should test combinations of interventions, including hand-washing, masks, early detection of influenza, anti-viral prophylaxis, isolation of patients, restrictions on visitors and policies to discourage health care workers with influenza-like symptoms from coming to work.

A must-have vaccine to protect patients?

UNC Health Care says it's ... pertussis

To keep young, vulnerable patients safe from a potentially life-threatening disease, the University of North Carolina Health Care in Chapel Hill requires employees to have a vaccine that protects against a respiratory illness.

But it's not the flu vaccine that's a condition of employment. It's the Tdap, a one-time vaccine that protects against pertussis, as well as tetanus and diphtheria.

"If they are not compliant as of November 1, they will not be working here, unless they have medical contraindications or written proof of having had the vaccine elsewhere," says **David Weber**, MD, MPH, medical director of occupational health and hospital epidemiology.

The Centers for Disease Control and Prevention recommends a single dose of Tdap for health care workers with direct patient contact, with a priority for those who care for babies younger than 12 months of age. For infants who are unvaccinated or only partially vaccinated, pertussis can be severe or even fatal.

Adults can receive the Tdap two years or later after their last tetanus booster.

Every year, about five to 10 cases of pertussis are diagnosed at the University of North Carolina Health Care, resulting in about one health care worker exposure each year. So far, there have been no hospital-based outbreaks of pertussis, says Weber. Pertussis can be difficult to diagnose because the initial symptoms mirror other respiratory diseases, says Weber.

But outbreaks elsewhere in the country have raised concerns about the disease. As of October, there were almost 6,000 suspected, probable or confirmed cases of pertussis in California — the highest since 1950 and seven times higher than in the same period last year. In the outbreak, 255 patients were hospitalized and 10 died — nine of them infants under the age of two.

California's Aerosol Transmissible Diseases Standard requires health care employers to offer the pertussis vaccine free of charge but does not mandate that health care workers receive it.

The University of North Carolina Health Care is unusual in requiring the pertussis vaccine. But Weber notes that, like other health care employers, the health system also requires immunity or vaccination with measles, mumps, rubella (MMR) and varicella.

"There are many things we require of our employees. This is just one of them," he says. "We believe to the extent possible we should provide the safest possible environment for our patients."

Some employees expressed concerns about the pertussis requirement, but Weber says many more were happy that the health system was requiring it. Because it's required, any adverse effects would be covered by workers' compensation, he notes. So far, there have not been any serious side effects. About 40% of employees had a sore arm after vaccination, he says.

Meanwhile, vaccinating against influenza has been somewhat more problematic because the vaccine must be given annually to about 5,000 employees. This year, UNC Health Care will track employees who receive the vaccine elsewhere (such as at local stores) as well as those who are vaccinated by occupational health.

The system's goal is to vaccinate 80% of employees against seasonal influenza. The goal is one of several linked to a bonus incentive. ■

Common metrics needed

Demonstrating an actual benefit to patients is important before subjecting employees to a mandate that requires not one-time but annual vaccination, says Swift. Hospitals that implement mandatory policies also should collect data on nosocomial flu before and after the policy change to gauge the impact, she says.

"It's very important that we not lose sight of the intent of these policies and ensure we have metrics in place to evaluate their success and failure – namely, nosocomial flu rates," she says.

While it's not yet clear whether HHS will recommend flu vaccine mandates for health care workers, Strikas says other measures still will be emphasized, such as education of health care workers about influenza. "Multiple approaches are necessary to get this done," he says.

Meanwhile, health care facilities need a more standardized approach to measuring influenza vaccination, including a common definition of health care personnel and method of measuring rates, he says. *(For more information, see above story.)*

In 2010-2011, about 160 million doses of flu vaccine will be available. "We have the opportunity with relatively abundant vaccine this year and [many strategies] to do a much better job of getting people vaccinated," he says.

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Special Report: 10 years after needlestick law

Needlestick risks remain, but safety goal fades away

National surveillance of injuries still lacking

Editor's note: In this issue, we continue our special report on needle safety issues. Safety needles are now commonplace at hospitals around the country, but sharps injuries persist — both from conventional and safety devices. The problem may lie in selection of the device, inadequate training — or, as in the OR, in resistance to sharps safety advances.

Eliminating needlesticks was once an official federal goal. The Centers for Disease Control and Prevention promoted it as a "health care challenge." More modestly, Healthy People 2010 set a measurable goal of reducing needlesticks among hospital-based health care workers by 30%.

Today, those goals have disappeared. Healthy People 2020 doesn't include a needlestick prevention goal because of the lack of a national surveillance system.

Of course, the National Institute for Occupational Safety and Health (NIOSH), the U.S. Occupational Safety and Health Administration (OSHA), and others continue to promote sharps safety. But the demise of a goal also reflects a lower profile for the continuing problem of needlesticks.

Ten years after the Needlestick Safety and Prevention Act, much work remains to be done, but the momentum has waned. After an initial dramatic decline in needlesticks, injuries have reached a plateau.

"We were more active in the area," acknowledges **Teri Palermo**, RN, public health adviser and coordinator of the Healthcare and Social Assistance Sector for NIOSH in Morgantown, WV. "But it doesn't mean it's something we feel is less important."

Palermo notes that the Centers for Disease Control and Prevention added needlesticks to its National Healthcare Safety Network (NHSN), an Internet-based system to collect data on hospital-acquired infections and certain types of adverse events. NIOSH is not a partner with that system, but reducing sharps injuries and improving surveillance are part of the agency's National Occupational Research Agenda. "It's still a goal to eliminate needlesticks," says Palmermo.

However, so far the NHSN has primarily focused on patient safety issues, such as healthcare acquired infection. "CDC and DHQP [the Division of Health Quality and Promotion] is committed to ensuring the safety of everyone in the health care setting," says DHQP deputy director **Michael Bell**, MD, including patients and visitors. He notes that the safety emphasis has broadened with the success of needlestick prevention. "You're going to see the occupational health component of NHSN continue to grow. It's going to be multidimensional," he says.

Bell also notes that prevention of bloodborne pathogen exposures will be part of the update of the guideline on infection control for health care personnel that is currently underway.

Meanwhile, NIOSH no longer is receiving earmarked funding for preventing HIV and other occupational bloodborne pathogen risks, says **Ahmed Gomaa**, MD, ScD, MSPH, medical officer in NIOSH's Division of Surveillance Hazard Evaluation and Health Studies. NIOSH has continued publishing documents on sharps injury prevention but new areas of research lack funding, he says. "We definitely are not finished yet. We have a lot of work to do," he says.

For example, Gomaa would like to see research on design changes in the operating room environment that could reduce sharps injury risk. *(For more on operating room risks, see related article on p. 140.)*

Employee health professionals also would like to learn more about effective ways to further reduce needlesticks. "Our concern is that although the numbers have decreased, we're

Home health workforce, sharps injuries grow

Nurses often not provided safety devices

As the nation's population ages, a growing number of registered nurses, certified nursing assistants and nurses' aides will be working in patients' homes rather than in hospitals. But many of them will be working without the basic safety devices that most nurses now take for granted, safety experts say.

"Home health is the fastest growing sector in health care, yet they're not having the benefit of the changing landscape in safety needles. That's not fair," says **Robyn Gershon**, DrPH, professor of socio-medical sciences and associate dean for research resources at the Mailman School of Public Health at Columbia University in New York City.

A study of occupational hazards among home health nurses in New York state found that safety equipment was lacking. Only 14% were provided with sharps containers, 9% had safety needles and syringes, and only about one in four had safety butterfly needles (23%) or safety lancets (26%).[1]

The primary reason, says Gershon, is economic. "It's really about the finances," she says. In some cases, the home health agency is not providing the proper safety devices because they are more expensive, she says. In other cases, the home health nurse uses the devices that patients have in their home, and those do not have to have safety features. In fact, the safety versions may not be fully reimbursed by insurers, Gershon notes.

Not surprisingly, fewer safety devices means more sharps injuries. A study of home health nurses in North Carolina found that almost one in 10 (8.9%) had a blood exposure in the past year. The exposure rates were highest among nurses who had worked in home health for less than five years and for contract nurses or those who worked part-time.[2]

Researchers also found that nurses often didn't use personal protective equipment that would prevent blood exposures, and the primary reason was because the equipment wasn't provided by employers.

"There's a national policy to protect health care workers. The policy is to provide them with safety medical devices and PPE. It's not working," says **Jack K. Leiss**, PhD, head of the Epidemiology Research Program at the Cedar Grove Institute for Sustainable Communities, a non-profit research organization in Mebane, NC.

Granted, it's more difficult to enforce the bloodborne pathogen standard in a home care environment. "[The U.S. Occupational Safety and Health Administration] doesn't regulate the home environment," says Gershon. "Yet there are workers in that home environment and they're unprotected in multiple ways."

In Fiscal Year 2009, for example, OSHA conducted just three inspections of home health agencies that included bloodborne pathogens concerns and issued 12 citations.

"Home health is very unique. It's very distinct from the hospital setting. It's a lot more challenging," acknowledges **Dionne Williams**, MPH, a senior industrial hygienist with OSHA.

Employers are still responsible for providing safety equipment and training, she says. But they do not have control over the work environment — the patient's home — so they aren't responsible for making sure employees use the equipment, she says.

And in some cases, the employer isn't even responsible for the devices. "Employees may have to administer the meds, but use the devices that the patients supply," Williams says. In that instance, employers would still be responsible for providing sharps containers.

Sharps safety in home health care may be a growing issue as the nation ages and the nature of health care delivery changes. According to the U.S. Bureau of Labor Statistics, the employment of registered nurses will rise twice as fast in home health as in hospitals through 2018.

An increased emphasis on worker safety in health care overall would benefit home health nurses, says Gershon.

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still seeing significant exposures with the safety devices," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, community liaison and past executive president of the Association of Occupational Health Professionals in Healthcare in Warrendale, PA, and employee health coordinator at Western Pennsylvania Hospital in Pittsburgh. "We would still see value in continu-

ing research efforts to mitigate those risks and to continue to reduce the injuries."

Research also is needed to determine why safety devices often aren't activated, says **Jane Perry**, MA, associate director of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville. "There's definitely still room for growth and improvement of device design," she says.

OSHA: We still care about needlesticks

In the initial years after passage of the Needlestick Safety and Prevention Act, enforcement actions rose. It is consistently one of the most frequently cited standards in hospital inspections. But recently, citations have declined to earlier levels.

In 2002, OSHA issued 128 citations to hospitals under the bloodborne pathogens standard. In 2009, there were 81 such citations. The violations were common ones: Failure to have an exposure control plan or to update it annually, or failure to have appropriate safety devices.

OSHA will continue to cite employers under the standard, says Dionne Williams, MPH, a senior industrial hygienist with OSHA. "Bloodborne pathogens has been and will continue to be something of interest to OSHA," she says, noting that OSHA is in the "pre-rule" stage for an infectious disease standard and injury and illness prevention program standard, both of which could interconnect with efforts to reduce bloodborne pathogen exposure.

This summer, OSHA solicited comments in a review of the Bloodborne Pathogens Standard. Many comments supported the standard, with suggestions for small changes. The American College of Occupational and Environmental Medicine called the standard "probably one of the most cogent and successful OSHA regulations seen over the past 40 years."

The International Healthcare Worker Safety Center urged OSHA not to weaken the standard. More attention is needed in the operating room and in alternate settings, such as home health care, where the health care workforce is projected to increase substantially, Perry told HEH. *(See related article on p. 138.)* Little data is available on sharps injuries that occur in physicians' offices, outpatient centers, home health, or other locations, she says.

Even hospitals have room for improvement. While safety devices have almost completely replaced conventional ones in some categories, there are still gaps in the availability of safety technology, Perry notes. Hospitals need to make an effort to locate safety devices as new products become available, she says.

"A lot of hospitals have gotten the structure in place for exemptions to the requirement to use safety. Is that just going to continue from year to year, giving these exemptions?" she says.

New safety designs needed

Numbers tell the good-news, bad-news story of sharps injuries in hospitals. Injuries declined swiftly as hospitals adopted safety devices, and from 1993 to 2006, needlesticks had declined by about 32%, according to EPINet surveillance data from the International Healthcare Worker Safety Center.

But in recent years, there has been little further reduction in sharps injuries. For example, Texas public hospitals and other public health care facilities report needlesticks annually. The tally in 2008 was virtually the same as in 2004.

In Massachusetts, where all hospitals must report sharps injury data annually, needlesticks declined from 3,413 in 2002 to 3,126 in 2008 — a reduction of 8%. Hypodermic needles and syringes continued to account for 31% of injuries, and one-quarter of those injuries (27%) occurred with conventional needles — even though safety syringes are readily available and widely used.[1]

"The occurrence of injuries with [safety-engineered sharps injury prevention features] raises important questions about the effectiveness of the current technology used to prevent sharps injuries," **Angela Laramie**, MPH, epidemiologist with the Sharps Injury Surveillance Project in the Massachusetts Department of Public Health in Boston, wrote in comments to OSHA. "The extent to which injuries involving [safety devices] are due to flaws in the design of the devices or the lack of experience and training in using these newer devices needs to be examined."

Too often, employers are not fully involving frontline workers in the evaluation and selection of safety devices, as required by the OSHA standard, says **June M. Fisher**, MD, director of the TDICT (Training for Development of Innovative Control Technologies) Project in San Francisco.

"[With that process,] you will more than likely

pick the appropriate tool," says Fisher. "Not all the devices will suffice for everybody."

Employees also need sufficient opportunity for training, she says. If health care workers are comfortable with the devices they're using, they're more likely to activate the safety features, she says.

Of course, the best solution lies with new technologies that eliminate the sharp entirely (such as nasal administration of vaccines) or use a passive safety feature that does not require activation by the user, Fisher says.

Preventing sharps injuries must be a sustained, ongoing effort because technology can never completely remove the risk, says Perry.

"We here at the center never thought that eliminating needlesticks was necessarily a realistic goal, given the technology we currently have," she says. "As long as you have a sharp object and it's being used on patients in unpredictable situations, people will still get stuck." ■

OR remains a sharps safety hold-out

Surgeons, nurses push for safer devices

Amid the successes in sharps safety in hospitals in the 21st century, there is one glaring gap: The operating room. Sharps injuries there remain as much of a problem as they were in 2000, when the Needlestick Safety and Prevention Act was signed into law.

Safety advocates, including some surgeons who have emerged as sharps safety champions, are hoping that the momentum is finally beginning to change.

"We do now have a critical mass to make some change," says **Ramon Berguer**, MD, FACS, chief of surgery at Contra Costa Regional Medical Center in Martinez, CA. "We have the data. We have second-generation devices that are well-made and well-marketed. We have the endorsement of leading surgical associations."

The American College of Surgeons endorsed blunt suture needles, double-gloving, using a neutral zone for passing instruments, and other safety devices in the OR, although adoption of those safety efforts has been slow.

Berguer, a member of the ACS Committee on Perioperative Care, has been a vocal proponent of sharps safety in the OR. With Janine Jagger and Elayne Kornblatt Phillips of the International Healthcare Worker Safety Center, he co-authored an analysis of sharps injuries at 87 hospitals around the country from 1993 to 2006. It showed that sharps injuries actually rose by 6.7% in the OR while they declined by 31.6% elsewhere in the hospital.[1]

That information may be a turning-point in the effort to improve sharps safety in the OR. "It was very sobering," says **Linda Groah** RN, MSN, CNOR, NEA-BC, FAAN, executive director and CEO of the Association of periOperative Registered Nurses (AORN). It caused the association to question, "What can we do to enforce the practices that we know make a difference?" she says.

AORN recently issued "A Call to Arms to Prevent Sharps Injuries in Our ORs" through its *AORN Journal*.[2] The association also plans to release a toolkit for reducing OR sharps injuries, which will be available on the web site (www.aorn.org).

Two-thirds of sharps injuries in the OR are incurred by nurses and surgical technicians, according to data from the center's Exposure Prevention Information Network (EPINet). "Decisions made by one member of the team affect the risk of other members of the team. To me, that's the key leverage point I'm taking to my colleagues," says Berguer.

Start with a hospital policy

Sharps safety in the OR needs to be an institutional mandate, says Berguer. It may be expressed in a policy that is developed by OR leadership, including the OR manager and chief of anesthesia, he says. "The OR is a service center that physicians contract with. They have a right to regulate their workplace safety," he says.

If sharps safety becomes a commonplace policy in hospitals, then surgeons will have no choice but to adapt, he says.

AORN's toolkit will include a sample policy. Hospital leadership needs to "embrace this issue," says Groah. That means setting expectations for safety and taking a close look at the OR injuries, she says. "If there continue to be sharps injuries [after adoption of a policy], I think ultimately there needs to be critical analysis of why those injuries occurred," she says.

If a surgeon continually fails to follow hospital

policy on safe practices, such as maintaining safe zone for passing instruments, hospital leadership should follow through by curtailing privileges, Groah says.

Outside enforcement is unlikely because the U.S. Occupational Safety and Health Administration rarely inspects ORs, unless there is a complaint. But OSHA does expect hospitals to be using some safety devices, including blunt suture needles in the OR, says senior industrial hygienist **Dionne Williams**, MPH. "We know there's a lot of evidence showing blunt sutures are capable of being used for certain kinds of closures," she says.

Employee health can play a role by sharing sharps injury data and educational material with OR staff and physicians. As independent contractors, surgeons aren't necessarily aware of the hazards and how they can be reduced, says Berguer. "I don't think it's clear for many surgeons what the problem is and why they should change," he says.

An OR sharps safety policy at Contra Costa Regional Medical Center mandates the use of hands-free passing and of safety-engineered scalpels. The hospital strongly encourages the use of blunt suture needles and double gloving, says Berguer.

Berguer himself has switched to blunt suture needles, which are now more widely available in a variety of sizes. While he once had needlesticks about twice a year, now he says he hasn't had a needlestick in three years.

"There is an initial increase in pressure that is required to penetrate the tissue [with blunt suture needles]," he says. "As with all safety measures, there's a minor inconvenience. I personally like it because it reminds me that I'm using a safe device."

Berguer believes that the safer sharps will eventually be like other safety initiatives that took time to gain acceptance but eventually became the standard. "The data is so overwhelming it would be very hard to make any rational argument against it," he says.

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Injured nurses struggle with financial loss

'Workers' compensation fails the nurse'

"I was injured at work almost seven years ago. I am still going through financial difficulties. I can never return to nursing. I am left with a lot of nerve damage to my legs and continuous back pain. I receive about $400 biweekly from worker's comp. This is nowhere near my pre-injury pay. Learning to live with pain and limited mobility and chronic money problems has been the worst of it all. — Nurse's post on an online forum of Work Injured Nurses' Group (WINGUSA)."

In 2008, 16,560 hospital employees injured their backs at work badly enough to require days away from work — more such injuries than workers in any other industry, according to the U.S. Bureau of Labor Statistics. In addition to pain and lost work time, those health care workers also suffer significant financial losses, says **Anne Hudson**, RN, a back-injured nurse from Coos Bay, OR, who founded WING USA (Work Injured Nurses' Group USA).

Hudson and occupational health consultant **William Charney**, DOH, of Newfane, VT, are now asking the American Nurses' Association and other unions to step up to help their injured colleagues by creating a special fund.

"Workers compensation at best is inadequate to meet the needs of injured workers," says Hudson, who co-authored a book with Charney (*Back Injury Among Healthcare Workers: Causes, Solutions, and Impacts*, Lewis Publishers, 2004) and donates all royalties to help back-injured nurses. "It's slow. People are denied care...and [provided] incomplete and inadequate care. They're never made whole."

Workers' compensation laws vary widely across the nation and often tie benefits to the statewide average weekly wage. That means higher paid workers, such as nurses, will feel a greater income loss from their injury, says **Carol Telles**, JD, senior analyst with the Workers Compensation Research Institute in Cambridge, MA.

For example, Iowa provides a maximum of $1,366 weekly for permanent total disability, while Arizona provides a maximum of $461.60 weekly, according to a 2009 survey by the research institute. "It's not the goal of workers compensation to make

workers whole in terms of income benefits," says Telles. "It's to replace a certain portion of those benefits and that portion varies by state."

The definition of a permanent disability also may be restrictive, Telles says. The workers' compensation system is designed to respond to the accidents of the industrial age, such as when workers were at risk of amputation, she says.

Losing the safety net

For nurses, the greatest risk of long-term occupational injury is from work-related musculoskeletal disorders. Hudson herself suffered a back injury as a bedside nurse. She struggled to win workers' compensation benefits but was unable to return to the hospital because of a lack of accommodations for her lifting restriction. Hudson currently works as a public health nurse, which makes hers a re-employment success story (although her wages are far lower than they were as a bedside nurse).

She says she fields frequent calls and emails from other back-injured nurses who are having trouble making ends meet, whether or not they receive workers' compensation benefits.

"[Employers] may cover a muscle strain but deny the spine injury, which is the disabling portion of the claim," she says. "That's just one example of the way workers compensation fails the nurse."

Back-injured nurses may lose their jobs, their health insurance, and their safety net, says Charney. "They lose all their capability of monetary support," he says.

The American Nurses Association advised Hudson and her fellow nurses to bring up the issue through the House of Delegates, a governing body of nurse representatives from each state.

Nancy Hughes, MS, RN, director of ANA's Center for Occupational and Environmental Health, says she has heard from some injured nurses and encouraged them to work through their "constituent member associations," or the affiliated state nursing associations.

Bill Borwegen, MPH, health and safety director of the Service Employees International Union (SEIU), stresses that a bigger fix needs to occur through the workers' compensation system.

"Every study shows workers comp only provides a very small percentage of income replacement and coverage for medical related costs," he says. "The bulk of the payment comes out of the Social Security system when nurses become injured and apply for disability benefits." That means

CNE QUESTIONS

21. According to data from the Massachusetts Department of Public Health, almost one-third (31%) of sharps injuries occur with what device, despite the widespread availability of safety devices?
A. IV systems
B. Butterfly needles
C. Suture needles
D. Hypodermic needles and syringes

22. A survey of home health nurses in New York state found few of them have sharps containers or other safety devices. According to lead author Robyn Gershon, DrPH, professor of socio-medical sciences and associate dean for research resources at the Mailman School of Public Health at Columbia University in New York City, what is the likely reason?
A. Hazards are lower in home health.
B. Safety devices are more expensive.
C. Safety devices are not needed in home health.
D. Home health nurses choose not to use safety devices.

23. An "action plan" on health care worker influenza immunization from the U.S. Department of Health and Human Services suggests what step by The Joint Commission to encourage vaccination?
A. A performance measure on flu immunization.
B. A mandated education campaign.
C. A minimum acceptable level of vaccination.
D. Mandatory influenza vaccination programs.

24. According to **Carol Telles**, JD, senior analyst with the Workers Compensation Research Institute in Cambridge, MA, higher paid workers come up short under workers' compensation because:
A. they aren't fully covered by it.
B. maximum payments are based on the statewide average weekly wage.
C. the payments are based on the type of injury.
D. there is a maximum total pay-out.

Answers: 21. D; 22.B; 23. A; 24. B

individual employers do not face the full burden of compensating injured workers, he says.

"I'm not suggesting ANA or anyone can create a fund that's going to make you whole," says Hudson. "That's not realistic. But certainly there could be something to [help injured nurses] meet immediate needs. There should be some place nurses can turn for help."

Others try to help nurses

Meanwhile, there are some other efforts to help injured nurses. Nurses House, established in 1922 as a Long Island, NY, respite for weary nurses, now provides a fund to assist nurses in need. However, the organization says it can only help about half of those who apply.

"Over the past three years, we've helped nearly 300 nurses, with grants totaling almost $300,000. That's an admirable record, but the truth is, we can't keep pace with the ever-increasing demand," Nurses House says on its website. "In fact, with current levels of charitable giving, we can only assist about half of those seeking our help. While many nurses face truly dire circumstances, there are simply not enough funds in reserve to help them all."

The Minnesota Nurses Association has addressed one potential gap in workers' compensation by placing language in contracts assuring continued health insurance for injured nurses for 24 months. The California Nurses Association has targeted the issue of work-relatedness of injuries. A bill in the 2009 California legislature would have created a presumption that certain injuries or illnesses, including neck or back injuries, are work-related unless the employer proves otherwise.

The California Chamber of Commerce opposed the bill, saying that hospital workers should not be given special legal status. "The fact that hospital employees face specific types of risks in the workplace is not a justification for altering the legal standard for determining what is or is not an industrial injury," the chamber argued. ■

New rapid test identifies active TB

Test may improve early detection

A new rapid tuberculosis test promises to help reduce health care worker exposures through early identification of patients.

The test, called Xpert MTB/RIF, can be performed in less than two hours. In a study involving 1,462 patients with suspected TB, the test correctly identified 98% of those with culture-confirmed tuberculosis and 98% of those with drug-resistant tuberculosis. It also correctly ruled-out tuberculosis in 99% of the patients who did not have TB.

The test isn't available yet in the United States — it isn't approved by the Food and Drug Administration — but already TB experts are touting its prospects.

"The goal right now is to recognize the people who have the symptoms of tuberculosis and to make a presumptive diagnosis and put them in isolation. In the United States, I think they're doing a pretty good job [of doing that]," says **Gerald Mazurek**, MD, captain in the U.S. Public Health Service and medical officer and epidemiologist in CDC's Division of TB Elimination.

However, there's always a risk that the symptoms of TB will be misconstrued for another respiratory illness and that other patients and health care workers could be exposed before the patient is placed in isolation, he says.

The Xpert MTB/RIF amplifies the nucleic acid in a sputum sample and can identify sensitivity to rifampin, an anti-viral. The test can therefore indicate not only whether a patient has TB, but whether he has a drug-resistant strain.

The testing procedure is simple and involves mixing a reagent with the sputum sample in a cartridge, shaking it and incubating it at room temperature for 15 minutes, and inserting the cartridge into the testing instrument. The remaining steps are automated. "It is definitely user-friendly," says Mazurek.

The test can be used to diagnose active TB but cannot detect latent infection, says Mazurek. ■

COMING IN FUTURE MONTHS

- Occ health goals of Healthy People 2020
- Is health care getting safer?
- A new look at asthma in health care
- Recordkeeping of MSD injuries
- Safe patient handling and fall prevention

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.

CNE INSTRUCTIONS

Nurses 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 this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter.

Hospital Employee Health

HEH120110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

Please make label address corrections here or PRINT address information to receive a credit letter.

Account # _____
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Zip _____
Fax: _____
Phone: _____
E-mail: _____

CNE Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your credit letter.** Thank you.

CORRECT ● **INCORRECT** ✓ ✗ ⊖ ⊘

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees.	○	○	○	○	○	○
3. 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.	○	○	○	○	○	○
4. 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.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I am satisfied with customer service for the CNE program.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.
11. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number (required for nurses licensed by the state of California) _____

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