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Pushback: OSHA backs off new regs, infectious disease standard in doubt

But injury, illness prevention still a 'priority'

The U.S. Occupational Safety and Health Administration is putting the brakes on its push for new regulations.

Citing the concerns of small businesses, OSHA "temporarily" withdrew its pending recordkeeping rule requiring a separate column on the OSHA 300 log for musculoskeletal disorder injuries. Business complaints also prompted OSHA to back down on a stricter interpretation of its noise protection standard. (*See related story p. 27.*)

While the agency is still pursuing an infectious disease standard and a rule requiring employers to have an injury and illness prevention program, the most recent regulatory agenda indicates that progress will be slow on those initiatives.

OSHA administrator **David Michaels**, PhD, MPH, has said that creation of a rule requiring employers to have a robust injury and illness prevention program is his priority. (*See related story p. 28*) But the review of the potential impact on small businesses — a required first step that includes an early draft version of the new regulation — will not begin until June.

"It is unbelievable to me how they have backed off from their aggressive regulatory posture," says **Brad Hammock**, Esq., workplace safety compliance practice group leader at Jackson Lewis LLP in the Washington DC region office. "My sense is that some people in the administration — I don't know at what level or whom — are providing some direction to OSHA to ratchet back their regulatory initiatives. That's the only obvious conclusion."

Politically, the moves seem to coincide with President Barack Obama's overtures to business. In January, Obama issued an executive order directing agencies to review rules and identify ones that are "outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them . . ."

Some industry groups had complained about the MSD recordkeeping

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rule, fearing it was a first step toward re-introduction of the much-maligned ergonomics standard. The rule had been under review by the Office of Management and Budget (OMB) for an unusually long time, and this action pulls it back from that review. Barely three weeks before the withdrawal, OSHA officials responded to questions in an online chat by saying that the MSD column would become effective in 2012.

It is almost unheard of for the agency to pull a rule from the OMB review and solicit more comments, says Hammock. But OSHA said it will work with the U.S. Small Business Administration's Office of Advocacy to "seek greater input" from small businesses.

"Work-related musculoskeletal disorders remain the leading cause of workplace injury and illness in this country, and this proposal is an effort to assist employers and OSHA in better identifying problems in workplaces," Michaels said in a release. "However, it is clear that the proposal has raised concern among small businesses, so OSHA is facilitating an active dialogue between the agency and the small business community."

Bill Borwegen, MPH, health and safety director of the Service Employees International Union (SEIU), says he is confident that the recordkeeping change will survive an additional review. "Employers already have to list [MSD injuries]," he says. "[The change] would just make it easier to quickly review the extent of these injuries on the log."

Enforcement still strong

Generally, OSHA has been taking a tougher stance under Obama than in the Bush administration, with a greater emphasis on enforcement rather than voluntary compliance. The agency hired more inspectors, and inspections rose to about 41,000 in FY 2010. The agency also promised to crack down on "severe violators" with repeat inspections and higher penalties.

Rule-making has always been a tedious and difficult process for the agency. But until the recent regulatory agenda, OSHA seemed to be moving ahead steadily. The Small Business Regulatory Enforcement Fairness Act (SBREFA) review usually isn't a sticking point — but it has been delayed until June for the injury and illness prevention program rule.

"It's a very preliminary process in my view. I can't understand why they would need to push that off another six months," remarks Hammock.

In an online chat, OSHA officials said they simply were being thorough. "This is a very important project and it is important that the agency get it right," they said in response to online questions. "While we have accomplished a lot since we announced this project in the Spring 2010 Regulatory Agenda, we have much more to do. We want to gather as much information as possible in advance of SBREFA to make the process as productive as possible."

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Meanwhile, the agenda shows no new action on an infectious diseases standard before the spring. "The infectious disease rule also just appears to be stuck in mud," says Hammock. "They didn't even put a new specific upcoming action. They're still reviewing comments."

I2P2 is OSHA's priority

With delays in rule-making, it's unlikely a significant new rule could become final by 2012. "If they really want to finalize one of these major rules before the end of President Obama's first term, for a major rule like I2P2 [injury and illness prevention program] or infectious disease transmission, I think they need to have [already] proposed that rule," says Hammock.

OSHA first tried to develop a rule requiring injury and illness prevention programs more than a decade ago. After gathering comments from hundreds of stakeholders, OSHA issued a "draft proposed rule" for SBREFA review in 1998. The agency never issued a proposed rule, and the item was withdrawn from the regulatory agenda in 2002, during the Bush administration.

Meanwhile, 12 states have adopted requirements for employers to have programs designed to identify and address workplace hazards. OSHA issued voluntary guidelines in 1989.

Based on those models and the prior draft, an OSHA rule would likely include requirements for management commitment and employee involvement in the program, worksite analysis, hazard prevention, and training. It would represent a change in perspective from responding to injuries to eliminating hazards. And it would be "the most significant action that the agency took in rulemaking in decades," says Borwegen.

In fact, taking a slower, cautious approach may help OSHA build its case and prepare for opposition, he says. "It's David Michaels' number one priority," says Borwegen. "The ability to get this standard out will be a major measure of success of this administration."

In the online chat, OSHA didn't comment on political considerations. But the Republican majority in the House brings new potential obstacles. In the past, Congress rescinded an ergonomics rule and limited enforcement of OSHA requirements for fit-testing of respirators in health care.

Rep. Darrell Issa (R-CA), the new chairman of the House Committee on Oversight and Government Reform, asked more than 150 trade associations to identify regulations that they consider to be "burdensome." OSHA's proposal to create an

OSHA backs down from stricter noise rule

Agency reconsiders less emphasis on PPE

Business groups raised an uproar over proposed changes in the interpretation of the noise protection rule, and the U.S. Occupational Safety and Health Administration heard them.

In January, OSHA withdrew its proposal and promised to hold a stakeholder meeting and consult experts about noise protection.

The proposed re-interpretation of the Occupational Noise Protection standard would have changed "feasible administrative and engineering controls" to mean "capable of being done" or "achievable." They would have been considered to be economically feasible as long as they didn't threaten the financial viability of the business.

OSHA said employers shouldn't choose ear protection rather than other methods of controlling the noise hazard simply because personal protective equipment is less expensive. Under the new interpretation, employers would rely on PPE only if the administrative and engineering controls weren't completely effective in reducing the noise hazard.

The U.S. Chamber of Commerce and the National Association of Manufacturers, among others, argued that the new interpretation would be costly and would lead to job losses.

"We are sensitive to the possible costs associated with improving worker protection and have decided to suspend work on this proposed modification while we study other approaches to abating workplace noise hazards," OSHA administrator David Michaels, PhD, MPH, said in a statement.

OSHA also said it will "initiate a robust outreach and compliance assistance effort to provide enhanced technical information and guidance on the many inexpensive, effective engineering controls for dangerous noise levels."

injury and illness prevention program rule was on the list of several leading industry organizations, including manufacturers, lumber dealers, and the die casting industry.

For example, the National Lumber and Building Material Dealers Association told Issa the rule might "disrupt safety programs that have measurable successes. We are also concerned that it may allow OSHA investigators to substitute their judgment of the employer's plan on how to achieve compliance or how to address an injury not regulated under a specific standard."

The American College of Occupational and Environmental Medicine (ACOEM) supports the creation of an injury and illness prevention rule, with involvement of frontline workers to help identify hazards, says **Pat O'Connor**, director of government affairs in Washington, DC. "We would hope that occupational health providers [also] would be an integral part of developing and implementing an I2P2 program," he says.

Michaels views an I2P2 rule as a way to reduce a myriad of hazards without the onerous task of making individual rules. "We recognize that we cannot have standards for all hazards," OSHA said in the chat. "This is the reason we are moving toward requiring employers to have Injury and Illness Prevention Programs."

Infectious disease rule in limbo

Opposition may build on other pending OSHA actions. Infection preventionists have aired their concerns about an infectious disease standard.

"While we understand OSHA's interest in creating a standard that maximally protects HCWs from infectious agents, we have concerns about the potential scope and breadth of this potential undertaking," **Richard Whitley**, MD, FIDSA, the president of the Infectious Diseases Society of America wrote to OSHA. "The advantages of establishing a new standard for [health care workers] can be easily outweighed by the unforeseen consequences caused by such a standard, particularly if the standard is not supported by scientific evidence."

ACOEM suggested that OSHA rely on the "general duty clause" (which requires employers to maintain a workplace free of serious hazards) or on a more generic standard requiring hazards to

OSHA chief: Focus on preventing tragedies

'Fundamental change in workplace culture'

On January 18, OSHA administrator David Michaels, PhD, MPH, gave a speech to the advocacy group Public Citizen in Washington, DC. Here is what he had to say about an Injury and Illness Prevention Program rule:

For most of the 20th century, workplace safety and health reform has been reactionary — the result of a tragedy, such as the wave of reforms following the death of 146 garment workers in the Triangle Factory fire in New York, 100 years ago on March 25.

We are now a decade into a new century, and OSHA's focus must be on preventing tragedies before they happen. Government can't be the only watchdog for workers; there simply aren't enough inspectors to cover the country. The burden of workplace safety and health must lie with employers. Last year we announced that OSHA is working toward proposing a rule that would require employers to implement an Injury and Illness Prevention Program.

This effort is part of the Department of Labor's new initiative — Plan, Prevent, Protect. It represents the most fundamental change in workplace culture since the passage of the OSH Act.

With this change, employers would be required to take an active approach to ensuring safe and healthful conditions for their workers. There will be no more waiting for a worker to get sick, hurt or killed to address a problem; no waiting for OSHA to show up to do an inspection; no playing a deadly game of "catch me if you can" with the government while risking the lives of workers.

This plan would make it mandatory for employers to develop a plan to find and fix their workplace hazards — and not just the hazards covered by OSHA standards, but all recognized hazards.

Since announcing this regulatory effort almost a year ago, we have held a series of stakeholder meetings and conducted critical research. We are poised to begin a small business review this summer, and we are committed to persuading business owners that this plan is in their best interest.

be addressed. OSHA is simply not flexible enough to adapt to changes in infection control, ACOEM said in its comments.

"ACOEM is concerned that an OSHA standard addressing the broad range of infectious agents other than bloodborne pathogens will take years to develop and finalize, that the knowledge base on which some of its components will be based will be outdated by the time the standard is passed, and that it will not be possible for OSHA to further develop its guidance to respond to novel infectious threats or advancements in our understanding of infectious disease transmission," it said.

California's Aerosol Transmissible Disease standard is thought to be a possible model for an OSHA standard, but OSHA indicated an interest in covering a range of transmission modes.

In the online chat, OSHA officials said the agency "has not yet determined the scope of OSHA's rulemaking for Infectious Disease. We are currently reviewing the information received in response to the [request for information] in order to determine what action OSHA should take in this area."

In other regulatory areas, OSHA said it would update the permissible exposure limits for chemicals. Rather than going through an extensive rule-making process to set PELs for dozens of chemicals, OSHA said it is considering "programmatic approaches" to updating limits. "We are currently in the process of selecting 10 to 15 chemicals to begin targeting through our enforcement efforts," the agency said.

Meanwhile, OSHA is continuing its National Emphasis Program on record-keeping, targeting employers with low rates of injury in high-risk industries. (The target list includes nursing homes but not hospitals.) OSHA is actively discouraging programs that provide incentives for non-reporting of injuries. "We take injury reporting very seriously because failure to recognize and report injuries leads to failure to investigate injury causes. If injuries are not investigated, it is more difficult to prevent future injuries from occurring," the agency said.

It's not clear how OSHA will respond to the president's order to review existing regulations.

"It's hard right now to say what effect this might have on the health care industry, either [related to] current regulations or regulations in the future," says O'Connor. ■

OSHA's safety and health management checklist

As part of its voluntary guidance, OSHA offers this checklist for an effective workplace safety and health management system. More information is available at www.osha.gov/dsg/topics/safetyhealth/index.html.

Management commitment and employee involvement

- Develop and communicate a safety and health policy to all employees.
- Demonstrate management commitment by instilling accountability for safety and health, obeying safety rules and reviewing accident reports.
- Conduct regular safety and health meetings involving employees, managers and supervisors.
- Assign responsible person(s) to coordinate safety and health activities.
- Integrate safety and health into business practices (e.g., purchases, contracts, design and development).
- Involve employees in safety and health-related activities (e.g., self-inspections, accident investigations and developing safe practices).
- Recognize employees for safe and healthful work practices.

Worksite Analysis

- Evaluate all workplace activities and processes for hazards.
- Reevaluate workplace activities when there are changes in processes, materials, or machinery.
- Conduct on-site inspections, identify hazards and take corrective actions.
- Provide a hazard reporting system for employees to report unsafe and unhealthful conditions.
- Investigate all accidents and near misses to determine their root causes.

Hazard Prevention and Control

- Eliminate and control workplace hazards (e.g., engineering controls, workstation design and work practices).
- Establish a preventive maintenance program.
- Keep employees informed of safety and health activities and conditions.
- Plan for emergencies (e.g., create an evacuation plan, train employees and conduct fire drills).
- Record and analyze occupational injuries and illnesses.

Training for employees, supervisors and managers

- Provide training on specific safe work practices before an employee begins work.
- Provide additional training for new work processes and when accidents and near misses occur.
- Provide refresher training on a routine basis.

HCWs face higher injury risk at public hospitals

Assaults, soreness and even falls are frequent

Health care workers at public hospitals are at much greater risk of injury than workers at private hospitals, according to new data from the U.S. Bureau of Labor statistics.

Assaults are significantly higher at both state and local hospitals, the data reveal in the first-ever BLS report of injury data for the nation's public hospitals. Soreness and pain are also higher at local hospitals, as is the overall injury rate. Injuries are sky-high in all categories at state hospitals, which are predominantly psychiatric facilities.

The overall injury rate in private hospitals was 138.6 per 10,000 fulltime employees in 2009, but it was 173.1 in local hospitals and 372.1 in state hospitals. Meanwhile, state and local workers are less likely to be covered by safety and health regulations.

Public employers are not covered by the U.S. Occupational Safety and Health Administration in the 25 states that do not run their own safety and health programs or have programs that specifically cover public workers (Illinois, New York, Connecticut and New Jersey).

"There's an incredible amount of variability [in enforcement] across the states that have the state plans," says **Katherine Cox**, MPH, MEd, director of the health and safety program at the American Federation of State, County and Municipal Employees (AFSCME).

"In states that don't have state plans, public sector workers don't have any coverage at all," she says. "It's up to good contract language or a state that tries to do the right thing to keep employees safe."

State and local hospitals are riskier workplaces in part because of their circumstance and mission. Local hospitals are often trauma centers, where violence in the community sometimes spills into the emergency room. State hospitals include psychiatric facilities that house the criminally mentally ill.

Public facilities also have suffered from budget constraints that lead to staffing shortages. "With the fiscal crisis, there have been hiring freezes and major cuts in services," says **Jonathan Rosen**, MS, CIH, director, of the Occupational Safety and Health Department at the New York State Public Employees Federation, an affiliate of the AFL-CIO.

With fewer co-workers to back them up, health care workers are more vulnerable to assaults as well as patient handling and other hazards, he says.

Staffing linked to HCW risk

At a large, state psychiatric facility, just walking alone on the campus can be dangerous. In October, co-workers at Napa State Hospital in California found Donna Gross, a 54-year-old psychiatric technician, dead on a patio. She had been strangled. A patient with a previous history of violent crimes was arrested in the killing.

Napa State is a 400-acre campus that houses about 1,200 patients — most of them referred by criminal courts, a state mental hospital, or the Department of Juvenile Justice. Forensic patients were able to roam within a 70-acre secured area, which has guard kiosks at its perimeter.

"It was a very stormy day in Napa the day Donna Gross was murdered. It was darker than usual," says **Tony Myers**, state president of the California Association of Psychiatric Technicians. "She had gone on a break. In between the time she left and when she was found, it was alleged he attacked her. He was found with some of her possessions."

State psychiatric hospitals are not required to have the same staffing ratios as required of private hospitals by California law, Myers notes.

Meanwhile, state hospitals must take the patients that are sent to them. "They bring [prisoners] to our admissions unit and they take the shackles off and now they're in a clinical setting," he says. "They're the potentially most dangerous individuals in the state. If the courts say you will take this person, they take them."

After the murder, the hospital required patients to be escorted by a staff member when they walked on hospital grounds. Then, in December, another employee was assaulted while escorting a patient. The employee was hospitalized and the patient was arrested.

Unions have asked for a better alarm system and security coverage. "We've said all along that we need more staff to provide the services," says Myers.

The Napa incidents are just a high-profile example of the risks that exist in many state psychiatric hospitals across the country, says Rosen. "You will find astounding rates of violence, some as high as 100 incidents per 100 employees per year, which in the field of occupational safety and

health is unheard of. In the most difficult wards, that's what exists," he says.

Falls, overexertion also high

Other hazards abound in public facilities, from overexertion to falls. The condition of aging facilities may be a culprit — slippery flooring, narrow corridors, poorly designed work areas.

"The decisions about funding in a public facility are oftentimes political decisions rather than good clinical [decisions]," says Cox. "They are competing with roads and bridges and all the other infrastructure issues that public dollars are spent on."

The Center for Medicare & Medicaid Services (CMS) requires hospitals to comply with OSHA's Bloodborne Pathogens Standard, even if they are not otherwise subject to other OSHA regulations. Even public hospitals must have safe sharps devices, an exposure control plan that is updated annually, and frontline worker input into the device selection.

The Protecting America's Workers Act would have expanded OSHA's authority to cover public workers, but despite a large number of sponsors in the House and Senate, the bill did not pass in the last Congressional session.

"History shows us that people who have had OSHA coverage have had remarkable reduction in injuries and illnesses as a result of the [Occupational Safety and Health] act," says **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU).

For example, a recent study found that nurses in Washington state, which has a law requiring the use of lift equipment, have greater access to lifts than nurses in Idaho, which has no state law. Hospitals in Washington also were more likely to have safe patient handling policies, reported **Barbara Silverstein**, MSN, PhD, MPH, CPE, research director with the Safety and Health Assessment and Research for Prevention (SHARP) program of the Washington State Department of Labor & Industries in Olympia.

But neither public nor private hospitals are specifically required to purchase lift equipment to assist with patient handling, unless they are covered by a state law. (OSHA can cite employers under its "general duty clause" that requires workplaces to be free of hazards that are "likely to cause death or serious physical harm," but it is much more difficult for OSHA to cite employers for hazards under that provision.)

"A lot of health care hazards are not covered by OSHA standards," says Rosen. "There's no OSHA standard on workplace violence. There's no OSHA standard on patient handling. There's no OSHA standard on aerosol infectious diseases."

Ironically, while public facilities suffer from a lack of funding, they could actually save money by preventing costly injuries, says Rosen. ■

Take the 'pulse' of your safety culture

Surveys provide anonymous feedback

The first step toward building a new safety culture may be taking stock of the one you've already got. Do your employees believe that managers care about employee safety? Do they feel comfortable alerting managers to hazards? Do they use personal protective equipment when it's recommended?

One way to measure your safety climate is through a confidential employee perception survey. The National Safety Council, a non-profit, membership-based safety organization based in Itasca, IL, provides one such survey through its consulting service.

The council presents the results as percentiles, comparing the results to a database of more than 500 companies. While most of those companies are not in health care, the basic tenants of a safety culture apply across disciplines, says **Terry Miller**, manager of employee perception surveys.

"All industries are unique in certain ways when you get down to the specifics, but there are many more commonalities from one industry to another," he says. "There are certain components or factors that separate a good safety program from one that is mediocre and poor."

Analyzing injuries and injury rates can certainly tell you about hazards that need to addressed, but they aren't the best information, asserts Miller. Ideally, you want to prevent the injuries from happening in the first place. In fact, the U.S. Occupational Safety and Health Administration is in the early stages of drafting a rule that would require the identification of hazards before they cause injury.

Injuries also may fluctuate based on a variety of factors. "Safety culture is really the collective value and norms that an organization has that are more timeless and universal than a program or the way

[employers] are handling a particular situation," says Miller. "It's an attitude that is long-lasting and pervasive. It takes longer to change culture or implement a good culture."

The National Safety Council predominantly uses paper questionnaires, which can be provided to employees at an orientation, staff forum, or safety event. The results show a ranking of safety issues — from those that demonstrated a strong commitment to safety to safety items that compared poorly with national norms.

For example, employees can agree or disagree (on a five-point scale) that "safety takes a back seat to everyday tasks" or that "I can protect myself and my coworkers through my actions on the job."

Surveys can be customized to obtain employee perceptions of specific safety programs. And employees can add written comments.

Employee perception surveys provide a way to get broad employee input — beyond the handful of employees who may serve on safety committees, says Miller.

Surveys also can be a way to emphasize to employees and managers that you want to hear about near-misses and hazards so they can be addressed. That is "the hallmark of a good program," says Miller.

[*Editor's note: More information about the National Safety Council's employee perception surveys is available at www.nsc.org/surveys.*] ■

CDC: Notify EMS of life-threatening diseases

Hospitals required to provide info promptly

When emergency responders transport an incoming patient who is later found to have a potentially life-threatening disease, they need to receive prompt notification from the hospital about the exposure risk. The Centers for Disease Control and Prevention has proposed a list of the diseases for which hospitals must notify the emergency medical services.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 requires the notification and calls for the U.S. Department of Health and Human Services to list the diseases covered by the act.

"If an exposure occurs, there's to be an exchange of information in a very timely manner — no later than 48 hours," says **Katherine West**, MSEd, CIC, BSN, a consultant with Infection Control/Emerging Concepts in Manassas, VA, who works with emergency medical services around the country.

The importance of timely notification was highlighted in a recent incident in California. On Dec. 3, 2009, an Oakland police officer responded to a 911 call to check on someone who had failed to show up for work. Finding the person unconscious in his home, the officer tried to clear his airway and called for emergency medical assistance. The officer didn't wear respiratory protection, but paramedics from the Oakland Fire Department and a local ambulance service did.

By the next morning, the hospital, Alta Bates Summit Medical Center, determined that the patient had *N. meningitidis*, but didn't notify Alameda County Public Health Department until Dec. 7, more than 78 hours after meningitis was first suspected, according to a Cal-OSHA citation. The police officer contracted meningitis and spent five days in the hospital. (See related article in July 2010 *HEH*.)

Medical facilities "have an immediate responsibility to notify their designated infection control officer for the emergency medical services or law enforcement" under the Ryan White Act, says West.

"This law, when it came to be, was one of the most important pieces of legislation for fire rescue and law enforcement."

Infections requiring notification

NIOSH proposed the following potentially life-threatening infectious diseases on a notification list. (Newly emerging infectious diseases that fit the criteria may be added to the list.)

- Routinely transmitted by contact or body fluid exposures
  - — Hepatitis B (HBV).
  - — Hepatitis C (HCV).
  - — Human immunodeficiency virus (HIV) infection.
  - — Rabies (Rabies virus).
  - — Vaccinia (Vaccinia virus).
- Routinely transmitted through aerosolized airborne means
  - — Measles (Rubeola virus).
  - — Tuberculosis (*Mycobacterium tuberculosis*) infectious pulmonary or laryngeal disease; or extrapulmonary (draining lesion).
  - — Varicella disease — chickenpox, disseminated zoster (Varicella zoster virus).

• Routinely transmitted through aerosolized droplet means

— Avian Influenza (Avian influenza A virus).

— Diphtheria (*Corynebacterium diphtheriae*).

— Meningococcal disease (*Neisseria meningitidis*).

— Mumps (Mumps virus).

— Plague, pneumonic (*Yersinia pestis*).

— Rubella (German measles; Rubella virus).

— SARS-CoV.

— Smallpox (Variola virus).

— Viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified). ■

Safe patient handling reduces VA injuries

35% drop in national roll-out of program

The model for safe patient handling is now a national norm.

For years, employee health professionals have traveled to the VISN8 Patient Safety Center of Inquiry at the James A. Haley Veterans' Hospital in Tampa to learn about elements of an effective program. The Veterans Health Administration has now rolled out safe patient handling to 153 VA facilities across the country.

Those VA hospitals have become catalysts for safe patient handling in their communities. And they have seen a 35% drop in injuries related to patient handling — even though only about half the equipment is currently in place. (The VHA committed $180 million to purchase safe patient handling equipment for its hospitals and nursing homes.)

While adequate equipment is important, the key to success lies in the strategies and policies that support the program, says **Mary Matz**, MSPH, CPE, patient care ergonomic program manager for the VHA. "Employees are basically being asked to totally change the way they do their work. That's not easy," she says.

The VA roll-out provides for a designated coordinator in each facility. It is critical to have a "champion" who will promote the program enthusiastically, says Matz. "There are usually one or two people who become passionate about safe patient handling," she says.

That is a lesson learned from more than 10 years of research into safe patient handling at the VHA center in Tampa. In 2000, Matz and her colleagues implemented a program at VA hospitals throughout Florida and Puerto Rico, with equipment, algorithms to assess patients' needs, peer leaders to help co-workers use the devices, and "safety huddles" to share progress and setbacks. Injuries declined by 30%, modified duty days dropped by 70%, and lost-time days declined by 18%.

When the study ended, some hospitals found a way to keep their safe patient handling coordinators — and others let the position go. With no support, the peer leaders were unable to keep up a consistent program. "If you didn't have a program to support the technology and change the culture, then the equipment oftentimes was not used," says Matz.

The VA-wide roll-out of safe patient handling, which began in 2008, provides for ongoing support. A directive issued in 2010 details the responsibilities for safe patient handling and states: "It is VHA policy that a [safe patient handling] program to protect caregivers and patients from injuries due to patient handling and movement must be established and maintained in all VHA facilities and that new construction and renovation projects must incorporate appropriate and necessary patient handling and moving equipment at all VHA facilities."

"Our directive mandates a facility coordinator or champion and peer leaders in each unit or area where patient handling occurs," Matz says.

Turning around the mindset

Loma Linda (CA) VA Healthcare System illustrates why a facility "champion" is so important. When **Tony Hilton**, RN, MSN, FNP, MPH, CRRN, came to Loma Linda in 2009 as the new safe patient handling coordinator, she found some equipment, but it was rarely used. In fact, many of the ceiling lifts had lost their charge and needed new batteries. Slings were hard to find. The staff saw the equipment as more of a bother than a benefit.

Hilton knew that her first task was to turn around the mindset about safe patient handling and to develop an excitement about the program.

She began by building relationships, one-on-one, with employees and managers. Armed with floor plans of the facility, she identified areas where patients would enter and receive care and visited them to assess their needs. She rated the areas based on the risk of injury so she could implement her program in stages, beginning with the greatest need. The intensive care unit, emergency room, nursing home, rehabilitation, and the transport team were her highest priority.

"I spent a lot of one-to-one time with the staff and managers, trying to understand what the problems were," she says.

She also learned about safe patient handling successes. She attended staff training at the San Diego VA hospital, which had a long-standing program. She went to a national conference on safe patient handling and movement. *(See editor's note for more information.)* And she started regular conference calls among the coordinators at the five hospitals within her region, so they could share their experiences and solicit advice.

She also created a business plan, detailing what she wanted to accomplish and a timeline.

Hilton knew that her first and greatest challenge would be to turn around the negative feelings about safe patient handling equipment and generate buzz for her program. As she recruited unit peer leaders, she promoted the benefits to them personally and to their patients.

Peer leaders — who could be RNs, LPNs, health technicians, or aides — could get a career boost from helping lead an initiative. They would help reduce the risk of injury to themselves or their coworkers. Patients would have fewer pressure ulcers and lower risk of healthcare-associated pneumonia. "I gave people a vision of where we could be in the future," she says.

Hilton wanted people with commitment and drive. Within three months, she recruited 63 peer leaders from various units and shifts.

Creating enthusiasm with peer leaders

Hilton knew that her peer leaders, employees, and even managers needed training, support, and "buy-in." She started with a day-long training session for her peer leaders, giving them small incentives, such as T-shirts, pens, mugs and lanyards. She provided annual training for employees, and included safe patient handling in annual competency testing.

She promoted the program on the hospital's intranet, and added prompts to the electronic medical record to ask for the dependency level of patients. The medical record also includes a link to algorithms to help employees determine which equipment is appropriate and information on use of the equipment.

The enthusiasm was infectious. Hilton held a vendor fair to get feedback on equipment. About 400 employees showed up. She responded to employee concerns by re-working ceiling lift tracks so the patient could be moved any place in the room, and she upgraded slings. "They can't spend a lot of time thinking about a piece of equipment," she says. "The equipment needs to fit the needs of the staff and the patient."

Hilton held monthly meetings on the day shift and night shift with her peer leaders, and she created a raffle with small prizes to reward employees who were "caught in the act" of using equipment appropriately. She also has a safe patient handling committee. Half of the members are frontline employees who use the equipment.

In a year, injuries dropped by more than 40% — even though Hilton was encouraging employees to report injuries. She celebrated with a cake and promoted the success on the intranet. Another cause for celebration came when Loma Linda was recognized as one of the top three VA facilities nationally for safe patient handling, she says.

Building success on success

Hilton now is focusing on "building success on success." She also wants the VA hospitals to spur safe patient handling in their communities. Hilton has already partnered with Arrowhead Regional Medical Center in San Bernadino.

The safe patient handling program is probably the biggest occupational safety and health initiative ever implemented by the VA, says Matz. It involves not just patient care, but other areas in the hospital, such as maintenance and laundry services.

Each hospital must shape the program to meet individual needs, she says. "You have a generic template, but there are so many variables, not just in a facility but even at the unit level," she says. "There has to be someone in the leadership position who has a good ability to problem-solve."

The VA research has helped influence other changes. For example, for the first time, the 2010 edition of the Guidelines for Design and Construction of Health Care Facilities calls for a patient handling assessment as part of planning for health care facility projects. The guidelines are published by the Facility Guidelines Institute in Dallas, TX, in partnership with the American Society for Healthcare Engineering of the American Hospital Association.

Meanwhile, Hilton continues her mission to promote safe patient handling. "If each of us in the VA mentored one hospital, can you imagine what a difference that would make?" she says.

[*Editor's note: The 11th annual Safe Patient Handling & Movement Conference will be held in Lake Buena Vista, FL, March 28-April 1.*

More information on the conference and other VA resources are available at www.visn8.va.gov/patientsafetycenter/safePtHandling/default.asp.] ■

Setting the bar... low Healthy People 2020

Injury rate goal almost met before start of decade

Healthy People 2020, the nation's blueprint for a healthier populace, includes several occupational health goals — but with very low expectations for progress.

The objectives set a goal of 10% improvement in the next decade in the overall injury rate, work-related fatalities, assaults, skin disorders and diseases, and the rate of cases involving overexertion or repetitive motion that led to days away from work.

However, Healthy People 2020 used 2008 as the baseline — and the goal for a reduced injury rate was almost met by 2009, a year before the program began. In 2008, the U.S. Bureau of Labor Statistics reported an injury rate for general industry of 4.0 per 100 fulltime workers. In 2009, the rate dropped to 3.7. The goal for 2020 is a rate of 3.6. The rate of overexertion cases involving days away from work already dropped by 5% from 2008 to 2009 — from 26.4 to 25 per 10,000 fulltime workers.

By contrast, Healthy People 2020 sets a goal for reducing healthcare-associated infections by 75%.

The 10% goal was a default target based upon the difficulty of changing population-based measures, says **Carter Blakey**, acting deputy director of the Office of Disease Prevention and Health Promotion and the lead for community strategies

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

CNE QUESTIONS

9. OSHA administrator David Michaels has said creating an injury and illness prevention program rule is his top priority. It would require employers to:
A. hire occupational health physicians
B. report a greater number of work-related incidents
C. identify hazards and abate them
D. create a safety committee

10. According to Jonathan Rosen, MS, CIH, director, of the Occupational Safety and Health Department at the New York State Public Employees Federation, an affiliate of the AFL-CIO, what is a major reason that public hospitals have high injury rates than private hospitals?
A. They don't have employee health services.
B. They have staffing shortages due to budget constraints.
C. They have older workers.
D. They are larger than private hospitals.

11. Since the Veterans Health Administration expanded its safe patient handling program to 153 facilities, patient handling injuries have declined by how much?
A. 25%
B. 35%
C. 45%
D. 55%

12. What is the Healthy People 2020 goal for reducing the rate of occupational injury per 100 fulltime workers?
A. 10%
B. 20%
C. 33%
D. 50%

Answers: 9. C; 10. B; 11. B; 12. A

COMING IN FUTURE MONTHS

- 10th anniversary look at OSHA's revised bloodborne standard
- Preventing injuries in an aging workforce
- Momentum builds on mandatory influenza vaccination
- How do you measure quality in occ health?
- Checklist: Preventing slips and falls

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.

at the U.S. Department of Health and Human Services. With more aggressive goals in Healthy People 2010, only about 20% of the targets were met, she says.

"To be effective, [the advisory committee] felt the Healthy People 2020 targets should be achievable and realistic," she says.

The National Institute for Occupational Safety and Health (NIOSH) provided input on the occupational health and safety objectives but didn't have the metrics to establish a higher goal, based on the Healthy People 2020 criteria, says **Lore Jackson Lee**, MPH, workgroup coordinator for the occupational safety and health focus area in Healthy People 2020. Lee is in the NIOSH Office of Planning and Performance in Atlanta.

"We aren't limiting ourselves to trying just to have a 10% improvement," Lee says.

It's possible to change the goals over the course of the decade, Blakey says. "We're developing a process that will allow us to take a look at the objectives and allow for some updates and revisions," she says. ■