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THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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Hospitals face major barriers in tracking worker influenza shots

Even if nationally mandated, 'large inconsistencies' expected

Everyone wants to have high rates of health care worker influenza immunization, but just who gets counted in their numbers? About half of hospitals face major barriers in tracking the immunizations of credentialed or other non-employees, according to a survey by the Centers for Disease Control and Prevention.

The CDC is working to validate a National Quality Forum measure for influenza immunization of health care personnel, but first the agency must show that health care institutions can calculate the rates in a standardized way. A temporary measure has been in place for two years.

The CDC's definition of health care personnel is all-encompassing: "All persons, paid and unpaid, working in healthcare 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."

Currently, hospitals use different methods of counting their employees and non-employees who are vaccinated or who decline vaccination, says **Megan C. Lindley**, MPH, epidemiologist with the CDC's National Center for Immunization and Respiratory Diseases. "We know that things are being counted in different ways and the rates are not necessarily comparable," she says. "It makes it difficult to formally evaluate different policies for increasing influenza immunization rates when it's not certain who's being measured in those rates."

The CDC study involves three online surveys conducted during and at the end of the 2010-2011 influenza season at 216 health care institutions, including 80 hospitals, in four states. (One survey was pending as this issue went to press.) The institutions were asked to rate the ease of counting the vaccinated employees on a scale of 1 to 5. Hospitals responded that counting employees was relatively easy, with a score of 4.1. But counting credentialed non-employees, such as physicians, and other non-employees, such as contract workers or volunteers, was more difficult, with scores of 2.8 and 2.5.



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About half of the hospitals said their ability to determine the vaccination status of those non-employees was a major barrier. About a third said the time involved in collecting that information was a major barrier. The hospitals ranged in size from fewer than 75 beds to more than 500 beds.

That mirrors a more informal survey conducted by **Melanie Swift, MD**, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN, with 60 of her colleagues at hospitals around the country on an online email list serv. Those hospitals ranged from

fewer than 200 beds to more than 1,000 beds.

“By and large, people are able to provide vaccination to their direct employees and to track it,” she says. But the ability to track other non-employee groups – contractors, vendors, students, volunteers, credentialed professionals – varied widely, she says.

Can you track your staff?

Even counting employees has its challenges. In testing the National Quality Forum measure, CDC asked health care facilities to count anyone who worked for at least one day between Oct. 1, 2010 and March 31, 2011.

“Not all institutions have the capability to count their employees like that,” says Lindley. Some facilities can only provide an employee count for a single date. For example, they could determine how many employees had received their flu vaccine on Dec. 31, 2010. But they didn’t have the capacity to keep track of the continual turnover of employees.

The information available to employee health services is not always up-to-date, says Swift. “Occupational tracking systems are not robustly integrated with HR [human resource] systems in the majority of hospitals,” she says.

Some receive employment information electronically on a daily or on-demand basis. Others receive information less frequently or rely on paper records. “When you go into an occupational health program and say, ‘Show me who works here,’ you’re going to get a variety of answers,” Swift says. For example, at Vanderbilt, “because of continual turnover and replacement, in the course of a flu season, that [employee] population changes quite a bit,” she says.

Figuring out who qualifies as “health care personnel” with the potential for exposure to patients and/or infectious materials also can be daunting, says Swift. Hospitals are likely to include all their employees in their vaccination policies, even if they work in an off-site business office or other location without patient contact. In a hospital that is part of a university system, it may be difficult to determine which faculty members only work in a research lab or a classroom and those who work in the hospital setting, she says.

“There’s such tremendous variability in organizational structure,” Swift says. “In one facility, your business staff might walk down the hallway as other health care workers do. In another facility, they’re in a different county.”

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AHC Media

The current measurement of vaccination rates varies. “About half don’t count the doctors, more than half don’t count residents,” she says.

Seeking a feasible measure

The greater challenge involves tracking the myriad non-employees who enter hospitals, including contract workers such as housekeepers or nurses, vendor representatives, volunteers, students, and credentialed physicians.

The CDC evaluation will determine whether it is feasible to have a national quality measure for non-employees in health care institutions, says Findley. “What we hope from the pilot is that the data and feedback we gather are going to allow us to revise the measure that makes it still useful for the hospitals and other health care institutions but also is something within their capabilities,” she says. “The world’s greatest measure isn’t much use if no one can measure things that way.”

Hospitals also need to standardize the way they collect information for the numerator—the number of personnel who received the vaccine. About

a third (34%) accepted a verbal declaration from a health care worker and 40% accepted written or online communication that they had received the vaccine from an external provider.

The measure uses four different numerators: Health care personnel vaccinated at the institution, those vaccinated elsewhere, those with medical contraindications, and those who declined vaccination for non-medical reasons.

Although a growing number of hospitals have adopted mandatory flu vaccination policies, few in the CDC survey reported that influenza vaccination was a condition of employment, says Lindley. About 70% of the hospitals reported having a policy that requires declination statements for health care personnel who did not receive vaccine, she says. (*For a related article on mandatory flu vaccination, see p.52.*)

A workgroup of the National Vaccine Advisory Committee, an expert panel that advises the U.S. Department of Health and Human Services, is considering the issue of mandatory influenza vaccination. If that becomes a federal recommendation, Swift predicts: “Everyone would comply in

Measuring influenza vaccination of HCWs

The National Quality Forum has a time-limited (pilot) measurement of influenza vaccination coverage of healthcare personnel. It applies to various health care settings, including acute care hospitals, outpatient facilities, home health agencies, and nursing homes. It is computed with different numbers for those vaccinated, those with medical contraindications, and those declining the vaccine, as follows:

Numerator: Health care personnel in the denominator population who, during the time from when the vaccine became available through March 31:

(a) received an influenza vaccination administered at the healthcare facility or reported having received influenza vaccination elsewhere (computed separately);

(b) were determined to have a medical contraindication for receiving the vaccination (computed separately); or

(c) declined the vaccination (computed separately).

Denominator: Number of persons who are working in the healthcare facility between October 1 and

March 31 who meet the CDC definition of health-care personnel (HCP).

For each influenza season, influenza vaccination coverage among HCP should be measured at the overall facility level. Additional stratification is recommended: component facility, ward, unit, and specialty; occupational group (e.g., nurse, physician, student/trainee); and HCP who perform direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring).

The term HCP refers to all paid and unpaid persons working in healthcare settings and might include (but is 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, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP.

SOURCE

National Quality Forum National Consensus Standards for Influenza and Pneumococcal Immunizations, 2008. <http://bit.ly/fdyRv9>. ■

some fashion with that, but there would be large inconsistencies in the populations covered and in the ability to enforce that.” ■

Hospital committed to mandatory policy

Over time, tracking vaccinations gets easier

At Virginia Mason Medical Center in Seattle, every health care worker, contractor, vendor, and volunteer needs to be tracked for the hospital’s strict mandatory influenza vaccination policy. That is possible thanks to an up-to-date occupational health database and a hospital-wide commitment, as managers and other departments assist in supporting the vaccination program, says **Joyce Lammert, MD, PhD**, chief of the Department of Medicine.

Virginia Mason vaccinates 5,000 employees annually, as well as about 1,300 physicians, students, volunteers, and contract workers. The effort requires more than 500 hours of time by nurses, medical assistants, or other vaccinators. The hospital hires agency nurses to assist, in addition to using peer vaccinators on the floors, nursing and pharmacy students, and nurses who are on light duty due to temporary work restrictions.¹

The policy requires the flu vaccine as a “fitness for duty” condition, much the way tuberculosis screening is required, although in a shorter timeframe. But the hospital still tries to create enthusiasm about the flu vaccine campaign.

Each fall, the vaccination campaign begins with a kick-off event, in which Virginia Mason seeks to vaccinate about 20% of its staff. About 12 to 15 vaccinators provide the flu shots to 800 to 1,000 employees within a three-hour period.

The hospital also brings the vaccine to all units and shifts with a rolling cart, and employees may obtain the vaccine from their private physician or a community provider if they bring in proof of vaccination. Managers follow up with employees who haven’t been vaccinated before the deadline.

“You need to have a strong database because you have to provide good information back to those managers,” says **Beverly Hagar, BSN, COHN-S**, supervisor of Employee Health.

The mandatory policy was especially challenging the first year it was adopted in 2005. “It’s hard to be the first,” says Hagar, noting that some employees asked, “Nobody else is doing this, why

are you making us do this?”

“We had to go through a lot of education and training for the staff,” she says. As more hospitals adopt similar policies, “it’s certainly easier,” she says.

Over time, “there’s just an assumption that everyone will get flu shots. It’s just not really a big deal anymore,” says Lammert.

Various departments in the hospital must help enforce the policy among non-employees. The medical staff office tracks credentialed physicians to make sure they have received their flu shot. When vendors apply for a temporary badge for access to the hospital, they must show proof of vaccination or be vaccinated. Human resources requires contractors to maintain the fitness for duty requirement among the contracted staff. Volunteers and students are similarly tracked when they receive hospital access badges.

Having strong support from hospital leadership is critical, says Hagar. “This isn’t an employee health project. This is an organizational project,” says Lammert. “We had a very strong cohesive core team that believed in everything we’re doing.”

Medicaid incentive for vaccine rate

Mandatory policies don’t have to result in termination in order to be effective. In 2005, the Washington State Nurses Association filed a grievance, stating that a new mandate needed to be part of the collective bargaining agreement. The union prevailed, but the hospital requires non-vaccinated employees to wear masks while they work during the flu season. In 2009-2010, 95.8% of unionized inpatient nurses received the vaccine.

Mandatory flu vaccination has since become commonplace in Washington. The Washington State Hospital Association supported mandatory vaccination and asked its members to adopt a policy. Currently, 95 hospitals have a mandatory policy, although the consequences for failing to be vaccinated vary. Some hospitals allow unvaccinated workers the option to wear a mask or take other infection control precautions, says WSHA spokesperson **Beth Zborowski**.

“There was a lot of enthusiasm from our membership around having a mandatory immunization policy as a way to protect patients and employees,” she says.

A mandatory policy also will help Washington hospitals attain a Medicaid quality incentive. Health care influenza immunization is one of five

measures that will be used to enable hospitals to receive an extra 1% in Medicaid payment. To get a perfect score of 10, hospitals must immunize 80% of their employees. (Non-employees, including credentialed physicians, are not included because of the difficulty in tracking their immunization status, according to the measure definition.)

An employee vaccination rate of 70% would earn 5 quality points, which would be enough to qualify for the incentive payment.

REFERENCE

1. Rakita RM, Hagar BA, Crome P, and Lammert JK. Mandatory influenza vaccination of healthcare workers: A 5-year study. *Infect Control Hosp Epidemiol* 2010;31:881-888. ■

Will OSHA follow CA model on new rule?

Flexibility allowed in injury prevention

Identify hazards. Take steps to address them. Train employees in safety measures. Evaluate your program and make improvements.

For some 20 years, California hospitals and other employers have followed those basic tenets to comply with the state's Injury and Illness Prevention Program standard. Now the U.S. Occupational Safety and Health Administration (OSHA) is considering a new rule that would require all employers to implement a similar program to address workplace hazards.

The California standard has been well-received because of the flexibility it gives employers, says **Gail Blanchard-Saiger**, vice president of labor and

employment for the California Hospital Association in Sacramento.

"Workplaces are different and unique and they've got different issues and different resources," she says. "What we've seen recently is the workplace is changing either because of the workforce or technology or hazards. To put prescribed rules in place is really problematic."

The California standard requires employers to have "procedures for identifying and evaluating work place hazards, including scheduled periodic inspections to identify unsafe conditions and work practices." (*For more on provisions of the California Injury and Illness Prevention Program rule, see p.53.*)

"It's a goal-oriented tool – preventing injury and illnesses," says **Steve Smith**, CIH, principal safety engineer at Cal-OSHA in Sacramento. "It leaves it up to the employer to develop the program that works best for them."

The standard ensures that employers are addressing hazards even if there isn't a specific requirement, says Smith. "It is our number one [element] inspectors look at when we go into a place of employment," he says. "Is there an IIPP program? Is it covering the unique hazards of the workplace? Are employees being trained on those hazards?"

Complying with the regulation is a team effort involving safety, employee health, infection control, facilities management, and others, says **Sandra Domeracki**, RN, FNP, COHN-S, executive president of the Association of Occupational Health Professionals in Healthcare.

A safety committee meets at least monthly, and other task forces meet to address specific issues, she says. California hospitals often have an annual action plan to address their highest frequency or

Cal injury, illness prevention rule

The California regulation, which became effective in 1991, includes the following provisions:

- Identification of the person or persons responsible for the program
- A system to ensure workers comply with safe work practices
- A system of communicating with employees about occupational safety and health
- Scheduled, periodic inspections to identify unsafe

conditions and work practices and methods to correct them

- Training and instruction to employees when the program is established and then to all new employees, employees with new job assignments, when new substances, processes, procedures or equipment create a new hazard or when the employer becomes aware of a new or previously unrecognized hazard
- Small employers who are in non-high-hazard industries have less required documentation

SOURCE:

California Department of Industrial Relations: <http://1.usa.gov/h8q4FG> ■

AIHA standard calls for ongoing improvement

A voluntary standard (ANSI Z10-2005) was developed by the American Industrial Hygiene Association and approved by the American National Standards Institute in 2005, and includes the following elements:

- Goal-oriented rather than specific
- Continuous improvement model of plan-do-check-act
- Assessment and reduction of hazards and risks
- Prioritization of risks and hazards based on an

analysis of the potential frequency and duration of exposure and possible consequences

- Use a hierarchy of controls, including the elimination of hazards, if possible
- Involvement and leadership of top management and participation by employees
- Reviews to prevent new hazards from being introduced to the workplace
- Audits and management reviews to make sure the program is being implemented appropriately.

SOURCE:

Manuele FA. ANSI/AIHA Z10-2005: The new benchmark for safety management systems. *Professional Safety* 2006; 25-33. Available at: <http://bit.ly/f3Zi3V>. ■

most serious injuries, with specific target goals, she says. They also may conduct weekly safety rounds that include hazard analysis.

OSHA administrator David Michaels, PhD, MPH, has said that it is his top priority to create a rule requiring employers to have a robust injury and illness prevention program. The agency's regulatory agenda states that a review of the potential impact on small businesses—a required first step that includes an early draft version of the new regulation—will begin in June.

At stakeholder meetings held by OSHA last year, occupational health professionals, union officials, employer representatives and others posed some questions about the upcoming proposal, including:

Will the standard be prescriptive or performance-based? Employers often prefer performance-based standards because they provide the most latitude to fit the specific needs of the workplace. However, some stakeholders said they wanted specifics so they would know what could lead to a citation. "One participant emphasized the need for OSHA to clearly and consistently define the term "effective," noting that program effectiveness cannot be left to interpretation by individual OSHA inspectors," OSHA said in an online summary of a stakeholder meeting.

Will existing programs be grandfathered? Employers with existing injury prevention programs are concerned that a standard would force them to alter or rebuild, even if the program has been successful. According to a summary of a stakeholder meeting, "OSHA indicated that it is considering grandfathering existing programs that are demonstrated as effective, but also added that

no decisions have been made yet on what would constitute a comparable or effective program."

How will the program affect reporting and recordkeeping? The California standard requires employers to maintain records of "scheduled and periodic inspections...to identify unsafe conditions and work practices, including person(s) conducting the inspection, the unsafe conditions and work practices that have been identified and action taken to correct the identified unsafe conditions and work practices." Employers also must document safety and health training "for each employee." OSHA noted that in the stakeholders' meeting, "Many participants provided anecdotes about employers whose policies directly or indirectly reward employees for lowering or avoiding workplace incidents. There was a consensus among stakeholders that these policies discourage reporting of incidents and near-misses. These participants agreed that the OSHA rule should prohibit employers from implementing any program or practice that would discourage reporting of injury or illness." ■

Take the 'pulse' of your safety culture

Surveys provide anonymous feedback

The first step toward building a safety culture may be taking the "pulse" 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 be 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. (*See related story on p. 53.*)

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.) ■

OSHA Safety and Health Management Guidelines

These voluntary guidelines, issued in 1989, say that an effective program should include:

- A clear goal and objectives for meeting that goal
- Commitment from top managers and employee involvement
- Baseline and periodic comprehensive workplace surveys as well as job hazard analyses
- Analyses of injury and illness trends over time
- Correcting or controlling hazards in a timely manner
- Safety and health training of all personnel
- Holding managers, supervisors, and employees accountable for meeting their safety responsibilities
- Emergency preparedness
- A review of goals and objective at least annually

SOURCE:

U.S. Occupational Safety and Health Administration: <http://1.usa.gov/eCgtmX> ■

ACIP: Vaccinate all HCWs against pertussis

Monitoring OK for some exposed HCWs

Hospitals should provide pertussis vaccines to their health care workers free of charge, but should still treat employees with antibiotics if they have unprotected exposure to patients with

pertussis and work with patients at high risk, such as young infants, a federal vaccine advisory panel says.

This recommendation represents a re-emphasis of the importance of vaccination and post-exposure prophylaxis of health care workers. “I think the big message to hospitals is to get your health care personnel vaccinated against pertussis. It’s a very effective vaccine,” says **Alexis Elward**, MD, assistant professor of pediatrics at the Washington University School of Medicine in St. Louis and a representative of the Healthcare Infection Control Practices Advisory Committee (HICPAC) to the Advisory Committee on Immunization Practices (ACIP).

ACIP had previously expanded its Tdap recommendations to include children aged 7 to 10 who aren’t fully immunized and adults 65 and older who care for children. The idea is to “cocoon” infants among people who are all immunized against pertussis.

In addition, the American Nurses Association launched an awareness effort and rallied a coalition of nine leading professional organizations, including the American Medical Association and the American College of Pediatrics. They are urging family members, caregivers and health care providers of infants to receive the pertussis vaccine.

A study of two outbreaks in Minnesota found that health care workers are at risk from exposures, as well. In one outbreak, only 12% of cases were among health care personnel, but many of the exposed employees had received prophylaxis. In another outbreak, 52% of cases were among health care workers who contracted the disease from co-workers or patients. There were no cases identified of transmission from health care workers to patients.¹

Pertussis epidemics are cyclical, and the disease is particularly dangerous for neonates who have not yet had their first pertussis vaccine. The Centers for Disease Control and Prevention noted the “continued resurgence of pertussis” in a February “Health Alert” that advised health care providers on using PCR tests to confirm the diagnosis. In 2010, there were 8,383 cases in California alone, including 10 deaths of infants. There also were significant outbreaks in Michigan and Ohio.

The expanded recommendations encompass all health care workers, regardless of age or when they received their last tetanus booster. Vaccination should include volunteers, especially those working in pediatric hospitals or with pediatric

patients, says Elward. Tdap is recommended for women who are immediately postpartum but not for pregnant women.

Yet even vaccinated health care workers need to be evaluated for post-exposure prophylaxis, ACIP decided. An exposure is defined as being within six feet of coughing patients with pertussis for five minutes without wearing a mask.

Exposed, vaccinated health care workers can be monitored daily for 21 days for signs and symptoms rather than receiving post-exposure prophylaxis if they do not have contact with at-risk patients. Even slight respiratory symptoms should be considered a possible symptom of pertussis, says Elward. The employee would then need to be furloughed from work for five days and put on antibiotics, ACIP said.

Many hospitals may find it simpler to provide post-exposure prophylaxis to anyone who has an unprotected exposure, says **William Schaffner**, MD, an infectious disease expert who is chairman of the Department of Preventive Medicine at Vanderbilt University in Nashville, TN, and an ACIP representative from the National Foundation for Infectious Diseases.

There’s no booster for Tdap, and it’s not clear how long immunity lasts after vaccination, he notes. The bottom line: “Vaccinate everybody and if you have an exposure, give prophylaxis,” Schaffner says.

REFERENCE

1. Leekha S, Thompson RL, and Sampathkumar P. Epidemiology and control of pertussis outbreaks in a tertiary care center and the resource consumption associated with these outbreaks. *Infect Control Hosp Epidemiol* 2009; 30:467-473. ■

Back injury claims drop with no-lift law

Mandate, incentives spur change in WA

The carrot and the stick have worked in Washington state to reduce the number and severity of safe patient handling injuries.

A 2006 state law requires hospitals to establish a safe patient handling program and to purchase lift equipment – and it established a \$10 million fund for tax credits to help hospitals pay for the equipment. From 2006 to 2010, the lost-time workers compensation claims rates for back injuries related to patient handling declined by about

32% in the state's 95 hospitals, according to an analysis by the Washington State Department of Labor & Industries.

While it was difficult at first for some nurses to transition away from manual lifting, "it became just a way of doing business," says **Barbara Silverstein**, MSN, PhD, MPH, CPE, research director with the Safety and Health Assessment and Research for Prevention (SHARP) program within L&I.

The success of the Washington law is most clear when the hospitals are compared with employers who did not have a mandate. Workers' compensation claims for back injuries declined by a more modest 12.9% at Washington nursing homes, which were not covered by the law. In fact, independent nursing homes not affiliated with acute care hospitals actually had an increase in claims, the analysis found.

Mandates and incentives drove the hospitals to implement the safety program on a five-year timeframe, Silverstein says. "The legislation calls for having a joint safe patient handling committee [composed of frontline, direct care] floor staff as well as managers," she says. "They're required to meet and assess on an annual basis their safe patient handling program. They're required to have training and retraining for all staff handling patients."

In a survey used to evaluate the law, hospital direct care employees were more likely to say that safe patient handling equipment was available and routinely used in Washington than in Idaho, a comparison state that does not have a safe patient handling law or regulation.

The safe patient handling law has been a "great success story" for Washington hospitals, says **Brenda Suiter**, MHA, vice president for rural and public health at the Washington State Hosp Association in Seattle. "They're using the equipment, they like the equipment, and the data show it's working," she says.

One lift per 10 beds

The Washington safe patient handling law contained specific requirements related to equipment. By January 2010, hospitals were required to have at least one "readily available" lift per acute care unit on the same floor, one lift per 10 acute care inpatient beds, or adequate equipment for use by lift teams that respond to patient handling needs.

In its annual licensing surveys, the state Department of Health checks whether the hospitals have

the required safe patient handling policy and committee. The Department of Occupational Safety and Health also issues citations if the program isn't being implemented, Silverstein says.

"Our goal was to have safe patient handling become the standard of care in hospitals," says Suiter. "Overall, what everyone is seeing when they go out to hospitals is safe patient handling."

The requirements in the law, and the enforcement, made a difference, according to the analysis. For example, in a survey of direct care staff, 10.8% reported that their hospital did not have a safe patient handling policy in 2007, while only 3.6% reported there was no policy in 2009. More staff reported routine use of patient handling equipment in 2009, while surveys in Idaho found fewer staff reporting use of equipment.

For example, in 2009, 40% of those surveyed in Washington said that 80% to 100% of their co-workers routinely use safe patient handling equipment, while only 16% of respondents in Idaho reported that high usage.

Interestingly, Washington nurses were more likely than their Idaho counterparts to respond that they had back pain in the survey. That could be related to increased awareness about the potential impact of patient handling, or it could be related to the cumulative nature of the injuries, says Silverstein.

Getting a lift from tax credits

Financial incentives also played a key role in Washington. Hospitals used \$8.9 million of the \$10 million in credits available to purchase equipment. They were eligible for tax credits of up to \$1,000 per acute care inpatient bed.

These were largely used to install ceiling lifts. About 15 hospitals a year have been installing lifts since the legislation was enacted, Silverstein found. "Offering some kind of incentive is a really important component of jumpstarting programs," she says.

Hospitals have benefited from discounts in the state's workers-compensation fund, as well. Silverstein is still analyzing the impact of the 2006 law. But when the self-insured workers' compensation trust of the Washington State Hospital Association implemented premium discounts for safe patient handling, related injuries declined by 43%, says Suiter.

In Idaho, where there is no financial help available to fund safe patient handling equipment or

installation, hospital investments have lagged, says Silverstein. She recalls one hospital that expressed an interest in ceiling lifts, but others that did not.

“There was one hospital in Idaho, when we were doing management interviews, that was extremely proud of the fact that they were building a new hospital and they didn’t need ceiling lifts,” recalls Silverstein. “They said nurses wouldn’t use them and so they weren’t building them.” ■

When fever’s gone, HCWs still shed virus

Outbreak shows course of H1N1 pandemic

Even when health care workers return to work after being ill with influenza, they still may be shedding viable virus. That is a finding from an analysis of a small outbreak of pandemic H1N1 in the fall of 2009.¹

Viral shedding is unlikely to lead to transmission if the infected person does not have any symptoms, says **Tim Uyeki**, MD, MPH, MPP, a medical epidemiologist with the influenza division at the Centers for Disease Control and Prevention in Atlanta, who was not an author of the paper. But evidence of shedding underscores the importance of maintaining infection control measures, he says. “If you have no signs and symptoms, you’re unlikely to be transmitting,” he says.

A retreat for medical residents in Seattle in September 2009 offered an opportunity to investigate the transmissibility of H1N1. Thirty-two participants gathered for the five-day retreat and stayed in a cabin, joined at various times by 14 facilitators. On the last day of the retreat, September 25, one participant developed a cough.

By the next day, the participant was diagnosed with H1N1 pandemic influenza. Two days later, 19 participants and one facilitator had developed respiratory symptoms; influenza was confirmed in 17 of them.

Per the CDC recommendations at the time, the ill health care workers received anti-viral medication and were excluded from work for seven days. Sixteen of the 17 ill participants agreed to keep a daily symptom log, including oral temperature, complete a questionnaire, and perform a nasal wash three times a week until they had two consecutive negative results.

Fever, which is often used to determine when someone can return to work, was not associated

CNE QUESTIONS

17. According to surveys by the Centers for Disease Control and Prevention, what do hospitals report is a major barrier to tracking influenza immunization?

- A. uncooperative employees
- B. incomplete human resources database
- C. difficulty determining the vaccination status of non-employees
- D. insufficient staff to perform tracking

18. According to **Beverly Hagar**, BSN, COHN-S, supervisor of Employee Health at Virginia Mason Medical Center in Seattle, what is critical to the success of the mandatory influenza vaccination program?

- A. Strong support from hospital leadership
- B. Support from unions
- C. Support from physicians
- D. National mandate from federal authorities

19. According to **Gail Blanchard-Saiger**, vice president of labor and employment for the California Hospital Association in Sacramento, the California Injury and Illness Prevention Program rule was well-received by employers because:

- A. it is very detailed in its requirements
- B. it sets very modest goals
- C. it applies only to the largest employers
- D. it provides flexibility

20. According to the Advisory Committee on Immunization Practices (ACIP), an advisory panel to the Centers for Disease Control and Prevention, what should occur if a health care worker who is vaccinated against pertussis has an unprotected exposure and cares for young infants?

- A. Nothing. Vaccination is sufficient protection.
- B. Provide post-exposure prophylaxis because infants are at high-risk.
- C. Monitor the health care worker for symptoms for 21 days.
- D. Furlough the health care worker.

CNE Answer Key: 17. C; 18. A; 19. D; 20. B

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.

with viral shedding, according to the study. In fact, four of the ill participants never reported a fever. (Cough, myalgias, and headache were the most common symptoms.)

While those with fever only reported having the fever for a day or two, the study found that viral shedding lasted 3 to 13 days after the onset of symptoms. (The shedding was longer when tested with real-time RT-PCR than with rapid culture.) Based on a return-to-work policy of being afebrile for 24 hours, 75% of the health care workers still had virus detected by PCR and 56% had virus detected by culture.

“These results raise essential considerations regarding exclusion policies for infected health care personnel,” the authors concluded. “Because febrile and afebrile health care personnel had similar virologic shedding durations and viral loads, the absence of influenza by real-time RT-PCR or culture might be preferable to the absence of fever as a criterion for health care personnel who are returning to work in settings where they place others at high risk.”

The authors note that viral shedding doesn’t necessarily equate to transmissibility. “Persons who are not symptomatic are unlikely to be transmission risks,” comments Uyeki. “But we need more data to understand the risk of transmission from someone who is asymptomatic but infected.”

The lessons from this outbreak also might have limited application to seasonal influenza. In this case, no one had pre-existing immunity to the pandemic strain and the vaccine was not yet available.

But it still underscores the need to be vigilant about infection control, says Uyeki. “Annual influenza vaccination is the best way to prevent influenza and is recommended for all health care personnel,” he says. “Nevertheless, influenza vaccine effectiveness varies from season to season and is not 100%. Even vaccinated persons may still develop influenza illness from influenza virus infection. That highlights the importance of infection control measures to prevent and control nosocomial transmission.”

REFERENCE

1. Kay M, Zerr DM, Englund JA, et al. Shedding of pandemic (H1N1) 2009 virus among health care personnel, Seattle, Washington, USA. *Emerging Infectious Diseases* 2011; [Epub ahead of print] Available at: <http://1.usa.gov/dOwKdf>. ■

Better container design reduces sharps injuries

Injury during or after disposal still a risk

About one in 10 sharps injuries occur during or after disposal of devices. Those exposures can be prevented with improvements in sharps containers and disposal methods, safety experts say.

“There continue to be disposal-related injuries, so there’s continued room for improvement,” says **Jane Perry**, MA, associate director of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

Injuries occur when containers are not emptied frequently enough and workers leave sharps on top of the containers or in work areas. Injuries during or after disposal also may occur when the safety mechanism isn’t activated on the device, she says.

“If you have a high percentage of unactivated safety devices, the risk of a health care worker being injured while introducing a device into a box or disposing of it is greater,” Perry says. “There are hospitals that regularly audit their sharps boxes to see the rate of activation.”

Sharps container design also can address some of the risks involved with disposal. Fourteen Ascension Health hospitals adopted a new safety-designed sharps container and experienced an 81% decline in container-associated injuries. Overall disposal-related sharps injuries declined by 57%.¹

The Ascension hospitals used a system produced and maintained by Daniels Sharpsmart of Chicago. The containers have a large opening, a sensitive tray that opens easily to accept the sharp, and a locking mechanism that doesn’t allow sharps to be placed in the container when it is full.

COMING IN FUTURE MONTHS

■ Should you restrict sleepy surgeons?

■ Best practices for a ‘culture of wellness’

■ OSHA head David Michaels talks to AOHP

■ Ergonomics and the aging workforce

■ In search of a better HC respirator

CNE OBJECTIVES

After reading each issue of Hospital Employee Health, the nurse will be able to do the following:

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

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“The door should be sensitive enough that it will tip the sharp straight in and close itself off when the sharps container is full,” says Terry Grimm, a Hamilton, New Zealand-based medical microbiologist and consultant with Daniels who helped design the containers.

Protruding, unactivated sharps create a risk of a needlestick from an unknown source, which requires extensive follow-up and post-exposure prophylaxis and creates anxiety for injured health care workers, says Kay Richter, RN, CIC, associate health nurse at St. Vincent Hospital in Indianapolis. “The exposure that occurs from an

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unknown needlestick is devastating,” she says.

The SharpSmart system also involves regular replacement of the boxes by the vendor, who sterilizes and compacts the contents so it can be disposed in regular waste. Previously, nurses were responsible for taking full sharps containers to the biohazard room.

This reduces a nursing task while also reducing the costly and environmentally sensitive biohazard waste stream from the hospitals, says Richter. Eleven Ascension hospitals using the system reduced their sharps waste by 28% with reusable containers. Other vendors offer a similar service.

Safer devices and better training are critical to reduce sharps injuries, notes Grimmond. But it's also important to “engineer out” the risks as much as possible, he says. “If you design a [disposal] container around health care worker behavior, it will reduce injuries,” he says.

REFERENCE

1. Grimmond T, Bylund S, Anglea C, et al. Sharps injury reduction using a sharps container with enhanced engineering: A 28 hospital nonrandomized intervention and cohort study. *Am J Infect Control* 2010; 38:799-805. ■



The Joint Commission Update for Infection Control

News you can use to stay in compliance

Reality Check: Joint Commission drops 90% hand hygiene compliance expectation

Leading hospitals had a shocking 48% baseline



The Joint Commission has amended an infection control standard that called for hand hygiene compliance of more than 90%, conceding that the expectation was too high after a group of eight leading hospitals could muster only an 82% rate in a performance improvement project.

The original goal of the project was to achieve and sustain 90% compliance. Collectively, the hospitals came up short, causing the Joint Commission to rethink the wording in its hospital standards. Previously, the standard called for hos-

pitals to demonstrate hand hygiene compliance at a rate greater than 90%. A hospital that failed to comply would receive a Requirement for Improvement (RFI) and have 90 days to show improvement to 90%.¹

"Because of this project, we now know how difficult it is to reach 80% — let alone 90%," says **Melody Dickerson**, RN, MSN, a Robust Process Improvement (RPI) Black Belt at the Joint Commission. "Now the standard says the hospital needs to work to improve compliance."

Though ultimately a success story to a large degree, the Joint Commission project had one other rather startling footnote: the baseline hand hygiene compliance rate at the hospitals was a collective 48%.

"When we first started this project all the organizations thought that they were around 80%–85%," she says. "It was only when we did a true non-biased measurement that we found exactly where we were. It was surprising and shocking,

Hospitals picked hand hygiene as top patient safety challenge

Hand hygiene was chosen as "the number one patient safety challenge" by eight leading hospitals for the first Robust Process Improvement (RPI) project by the Joint Commission Center for Transforming Healthcare.

The eight hospitals that participated in the Joint Commission hand hygiene project are:

- Cedars-Sinai Medical Center, West Hollywood, CA: 950 beds, teaching

- Exempla Lutheran Medical Center, Wheat Ridge, CO: 400 beds, nonteaching
- Froedtert Hospital, Milwaukee, WI: 486 beds, teaching
- The Johns Hopkins Hospital, Baltimore, MD: 1,041 beds, teaching
- Memorial Hermann The Woodlands, TX: 252 beds, nonteaching
- Trinity Health-St. Joseph Mercy Health System, Ann Arbor, MI: 537 beds, teaching
- Virtua, New Jersey: 270 beds, nonteaching
- Wake Forest University Baptist Medical Center, Winston-Salem, NC: 872 beds, teaching

Top 10 reasons HCWs fail to wash hands

A distracted worker with hands full

In a hand hygiene improvement project by the Joint Commission's Center for Transforming Healthcare, the following common barriers to compliance were observed across the eight participating hospitals.

- Ineffective placement of dispensers or sinks
- Hand hygiene compliance data are not collected or reported accurately or frequently
- Lack of accountability and just-in-time coaching
- Safety culture does not stress hand hygiene at all levels
- Ineffective or insufficient education
- Hands full
- Wearing gloves interferes with process
- Perception that hand hygiene is not needed if wearing gloves
- Health care workers forget
- Distractions

but when you look at the literature that's about where most people are."

Historically, the odds of a health care worker having washed their hands before touching a patient have been roughly equivalent to a coin flip. Heads the patient wins, tails they could be joining the 100,000 souls lost every year to health-care-associated infections (HAIs). However, many hospitals in the project have reported a decline in HAIs as their hand hygiene compliance rate dramatically increased, the Joint Commission reported. Though the compliance level jumped an impressive 34% at the hospitals overall, the reality is that a disturbing number of patient encounters are still carried out with unwashed hands.

"It begs the question: Was greater than 90% even an obtainable goal when you consider where you're starting from?" says Dickerson, one of the project leaders. "What we found through this process is that some organizations are greater than 90%; others have not had as great of success. A lot of that depends where you start from."

Hand hygiene the top problem

Though the baseline levels—assessed through using non-biased hand hygiene observers or "secret shoppers"—were disappointing, the participating hospitals were not complacent. They all listed hand hygiene compliance as their top patient safety problem after agreeing to collaborate on The Joint Commission Center for Transforming Healthcare's first Robust Process Improvement (RPI) project by. (*See list of hospitals, p. 1.*)

The project started in December 2008, when representatives from the eight hospitals met to define the scope of the project, which is the first step in the five-step Six Sigma methodology: define, measure, analyze, improve, control. From April 2009 through August 2010, the participating hospitals defined and measured hand hygiene, according to a Joint Commission report on the project.

The hospitals identified the major barriers to hand hygiene and worked on developing targeted solutions for each root cause or contributing factor.

"Probably the big three are hands full, distractions and gloves," Dickerson says. Concerning the latter, a recurrent problem is non-clinical staff members going from room to room without changing gloves.

"A big part of it is an education problem," Dickerson says. "And part of it is changing people's perception. They perceive that if they put on gloves they don't need to wash their hands and that is, in fact, not the case. So it is education, but it also requires change management."

Project solutions were developed and change enacted according to the Joint Commission's Targeted Solutions Tool (TST), which allows organizations to customize solutions to address their specific barriers to excellent performance. (*See related story, p. 3.*) Hand hygiene was defined as washing or cleaning hands with an alcohol based foam or gel or soap upon entry and exit of a patient care area or environment. Information was gathered by using the hand hygiene observers and "just-in-time" coaches.

"The just-in-time coaches give immediate feedback to someone when they see them not washing their hands," Dickerson says. "In the early stage of the project we did have them collect data because there are contributing factors that we can't see, like distractions or [a worker's] perception that hand hygiene is not required."

Although any staff member in an organization could be trained to be a hand hygiene observer,

members of the leadership teams were encouraged to participate as just-in-time coaches. Ultimately, the goal was to engage all staff to do just-in-time coaching, which will lead to sustained improvements.

"You need to work with the staff to implement solutions so they feel like they have been a part of the process," she says. "Then you see this whole culture shift within the unit. Now all of a sudden everyone is a just-in-time coach. If somebody from another department comes on the floor -- and it's not just nurses, it's laboratory, dietary, environmental services, volunteers -- and they are not washing their hands they, are reminded by [all] staff."

Making HH a part of work flow

A prime objective was helping workers blend hand washing into their routines, making it a part of the process rather than a separate task.

"One thing a lot of hospitals found when they were going through this project is that you may have a lot of alcohol based hand rubs in the patient care areas, but [they are not] where they need to be," Dickerson explains. "They need to be in your line of work flow. You track the path that they take when they enter the room and you want

to have a hand hygiene dispenser at the place where they stop, which might be next to a computer where they do their charting."

Visual reminders—including posters on walls in units, on elevators and by dispensers, and stickers on dispensers—were used to some extent by all the hospitals. It's a familiar approach, but one take home point is that signage needs to be switched out regularly so it doesn't become lost in the woodwork. In addition, visual cues and reminders also can help workers who become distracted.

"Some places will implement a code word, a phrase that is code for 'wash your hands,'" she says.

The lingering question after such efforts is whether the gain can be maintained rather than slowly lapsing toward baseline levels.

"The last step is in the control phase -- unlike other projects that organizations may have gone through for hand hygiene and other things," Dickerson says. "They do this great project -- focus on this one aspect of care for weeks or months -- and then all of a sudden you're working on something else. That's a really strong message to the staff that it was 'the flavor of the week' and now we are on to something else."

Thus it's critical to maintain observations,

A tool to target the solution

From getting started to holding the gain

In a hand hygiene improvement project by the Joint Commission's Center for Transforming Healthcare, participating hospitals used a Targeted Solutions Tool (TST). Available to all accredited organizations, the Joint Commission TST model provides the user with the data collection tool, data entry programming, self-supported observer training module and real-time reporting of compliance rates complete with charts that can be downloaded and printed for display.

The TST includes a six-step process:

Step 1: Getting Started. This first step includes determining who will be on the team and understanding stakeholders involved in the process. For example, in the ICU the hospital's dietary staff does not see patients, so their buy-in would be low. But on the medical/surgical unit, they deliver trays to every patient.

Step 2: Training observers entails training hand hygiene data collectors, or observers, and just-in-time coaches. It involves giving them the tool to begin collecting data and documenting contributing factors and compliance. The tool has a structured education program and a test at the end.

Step 3: Measuring compliance comprises collecting data and entering in data tool, a Web-based application that is part of the TST.

Step 4: Determining factors includes getting charts, which includes compliance charts, analysis charts and means chart.

Step 5: Implementing solutions by analyzing data from charts to identify the top three contributing factors for failure to wash hands. For each contributing factor, the TST provides a set of implementation guidelines.

Step 6: Sustaining the gain, which means rethinking the data collection plan to continue to monitor the process. Keeping compliance at a high rate requires continuous reinforcement.

(Editor's note: The Joint Commission TST and related materials are available at: <http://bit.ly/91ODmt>)

though at a lower rate than during the active phase of the project. "It won't be the 10 to 20 observations that you were collecting during the active phase of the process but it might be 10 observations a week," she adds. "Continue to share that information with staff and [make sure you] continue to see improvement in your numbers over the long term. It seeds the message to staff that this has an ongoing importance to our organization."

REFERENCE

1. Joint Commission for Transforming Healthcare. Hand hygiene project: Best practices from hospitals participating in the Joint Commission Center for Transforming Healthcare Project. November 2010: <http://bit.ly/fqI2yb> ■

Joint Commission pushing for flu shot improvement

Expanded standards under field review

As this issue went to press, more stringent standards for influenza immunization of hospital workers were under consideration by the Joint Commission. As proposed in a field review open to comment through May 17, hospitals would have to document and report flu immunization efforts more completely and strive for continuous improvement.

Infection control standard 02.04.01 currently requires that hospitals establish an annual influenza vaccination program that is offered to licensed independent practitioners and staff. The Joint Commission is proposing adding the following stipulations and performance aspects to the standard:

- The hospital includes in its infection control plan the goal of improving influenza vaccination rates.
- The hospital sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020.
- The hospital develops a written description of the methodology used to determine influenza vaccination rates. All hospital staff and licensed independent practitioners are to be included in the methodology for determining the influenza vaccination rates.
- The hospital evaluates the reasons given by

staff and licensed independent practitioners for declining the influenza vaccination at least annually.

- The hospital improves its vaccination rates according to its established goals and at least annually.
- The hospital provides influenza vaccination rate data to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other staff at least annually.

(For more on the Joint Commission field review on flu immunization in hospitals and other settings go to: <http://bit.ly/ew1yv2>) ■

Joint Commission ready to partner up

TJC center to link with Partnership for Patients

The Joint Commission has pledged its full support for the recently formed Partnership for Patients, a public-private effort to make hospital care safer by reducing health care associated infections and other preventable adverse events.

The Joint Commission applauded the Centers for Medicare & Medicaid Services' leadership in developing a multi-faceted framework for addressing critical safety and quality issues. The framework is unique because the federal government recognizes that hospitals need to be given assistance with innovative and customized tools in order to achieve effective and sustainable solutions to these difficult problems, TJC noted.

"We hope that The Joint Commission and its Center for Transforming Healthcare will play a vital role in the Partnership for Patients by identifying and testing solutions for preventing patient harm and improving the continuity and effectiveness of care, as well as providing technical assistance to health care organizations as they seek to implement these solutions," TJC said in a statement.

By the end of 2013, the Partnership for Patients aims to decrease preventable hospital-acquired conditions by 40% and reduce by 20% hospital readmissions caused by preventable complications during a transition from one care setting to another.

(For more information on the partnership go to: <http://1.usa.gov/gj8iFV>) ■

Hospital Employee Health

2011 Reader Survey

In an effort to learn more about the professionals who read *HEH*, we are conducting this reader survey. The results will be used to enhance the content and format of *HEH*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by July 1, 2011.

In future issues of *HEH*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Joint Commission requirements A B C
2. OSHA requirements A B C
3. CDC guidelines A B C
4. Occupational exposures A B C
5. Ergonomic issues A B C
6. Immunization programs A B C
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8. Workers' compensation A B C
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 B. employee health nurse
 C. occupational health director/manager
 D. employee health/infection control manager
 E. other _____

21. How large is your hospital?

- A. fewer than 100 beds
 B. 100-200 beds
 C. 201-300 beds
 D. 301-500 beds
 E. more than 500 beds

24. What department do you report to?

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- B. Chief Medical Officer
- C. Chief Operating Officer
- D. Nursing

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- C. bachelor's degree
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- E. other _____

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