



Hospital Employee Health®

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

June 2011: Vol. 30, No. 6
Pages 61-72

IN THIS ISSUE

- **How tweet it is:** Occupational health finds an audience through social networking. cover
- **Hazard letter:** OSHA, NIOSH and the Joint Commission team up to remind hospitals about important recommendations on handling hazardous drugs. 65
- **Flu shot goal:** Would a Joint Commission goal of a 90% flu vaccination rate for HCWs push hospitals toward mandatory vaccination? 67
- **A fine mess:** Medical Center in Pittsburgh sets a tough policy on hand hygiene – with possible fines or suspension. 68
- **ID standard lives:** OSHA chief: Hospitals aren't doing enough to protect their employees from infectious diseases 69
- **Sleep disturbance:** Expert: Surgeons sleepless due to nighttime on-call duty shouldn't perform elective procedures the next day. 71

Financial Disclosure:
 Editor Michele Marill, Executive Editor Gary Evans, and Consulting Editor MaryAnn Gruden report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

FDA balks at powdered-glove ban, warning label option blasted

'An excuse for manufacturers to continue to make money'

Latex gloves are back on the public agenda. The U.S. Food and Drug Administration has issued a proposed warning label for powdered gloves and is considering a ban on the use of powder in latex gloves and alternatives, even as hospitals greatly reduce their use of powdered gloves.

New cases of latex allergy among health care workers have dropped dramatically with the use of low-protein and powder-free gloves, as well as the increased popularity of latex alternatives. But three separate petitions cite risks to patients and health care workers and ask the FDA to ban powdered gloves. In fact, Public Citizen, a Washington, DC-based advocacy group, has asked the FDA to ban all latex gloves.¹

Hospitals have successfully switched to alternates to protect patients and health care workers with latex allergies, says Michael A. Carome, MD, deputy director of the Health Research Group at Public Citizen. "When we see additional dangers from latex gloves, it's hard for us to be silent on that given our role as an advocate for public health," he says.

Cornstarch powder on surgical gloves in particular poses a risk to patients, Richard Edlich, MD, PhD, distinguished professor emeritus of plastic surgery, biomedical engineering and emergency medicine at the University of Virginia Health Systems in Charlottesville, asserted in his 2008 petition to the FDA requesting a ban. It was also signed by 11 other health professionals.²

Powder from the gloves can cause granuloma and adhesion formation and leave patients with abdominal pain and inflammation, according to studies cited by the petition. The powder also increases the risk of wound infection.

The FDA's proposed warning addresses those risks, as well as the continuing risk of latex allergy: "Warning: Powdered gloves may lead to foreign body reactions and the formation of granulomas in patients. In addition, the powder used on gloves may contribute to the development of



NOW AVAILABLE ONLINE! Go to www.ahcmedia.com/online.html.
Call (800) 688-2421 for details.

irritant dermatitis and Type IV allergy, and latex gloves may serve as a carrier for airborne natural latex leading to sensitization of glove users.”

“The warning label is waste of time,” Edlich responded. “If you put all the dangers outlined [in the petition], it would take an 8 to 10 page warning on the label.”

Concurring is **Wava Truscott, PhD**, director of Scientific Affairs and Clinical Education at Kimberly-Clark Health Care in Roswell, GA and author of a second petition submitted in 2009. She cites similar concerns and discusses cases of surgi-

cal complications triggered by cornstarch powder.³ Kimberly-Clark manufactures powder-free nitrile gloves.

“To me it’s a non-action. It’s not going to help at all,” she says of the FDA proposed recommendation. “Surgeons don’t see those labels at all.”

Powder triggers occ asthma

Concerns about cornstarch powder on surgical gloves date as far back as the 1950s, but occupational health issues arose in the 1990s, when latex glove use became commonplace in the wake of HIV and the Bloodborne Pathogen Standard of the U.S. Occupational Safety and Health Administration. Health care workers became sensitized to the latex proteins, and cases of latex allergy soared. The powder became aerosolized and latex became a leading cause of occupational asthma among health care workers. (*See HEH, September 2003, p.114.*)

“In the early ‘90s, we had some very severe reactions. There was a point in time when you could find evidence of sensitization to latex in up to 10% of our worker population,” says **George L. Delclos, MD, MPH, PhD**, professor in the Division of Epidemiology, Human Genetics and Environmental Sciences at the University of Texas School of Public Health in Houston, who was a leading researcher in latex allergy.

In 1995, Edlich petitioned the FDA to ban powdered latex gloves, and in 1997, the FDA responded by requiring a label on latex gloves, stating they “may cause an allergic reaction.” Public Citizen, an advocacy group, petitioned the FDA again in 1998, arguing for a ban. “[A]nything short of a ban — such as merely this label — is a dangerous insult to the millions of patients and tens of thousands of health care workers whose lives and health are jeopardized by the continued use in health care settings of these powdered gloves,” the petition stated.

In the new petition, Public Citizen calls the FDA’s proposed label “grossly inadequate” and says it would be “laughable if the problem were not so serious for patients and healthcare providers alike.”

Still considering a ban?

Under the current FDA proposal, even a warning label would be optional. The FDA would simply recommend that manufacturers caution consumers about the patient safety issues.

Hospital Employee Health® (ISSN 0744-6470), including The Joint Commission Update for Infection Control, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Employee Health®, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), \$499. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are \$78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media. Address: P.O. Box 105109, Atlanta, GA 30348. Telephone: (800) 688-2421.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).

Executive Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).

Production Editor: **Kristen Ramsey**.

Copyright © 2011 by AHC Media. Hospital Employee Health® is a trademark of AHC Media. The trademark Hospital Employee Health® is used herein under license. All rights reserved.

Editorial Questions

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

AHC Media

But in a separate Federal Register notice issued on Feb. 7, the FDA acknowledged the problems with powdered gloves.⁴ “FDA has considered this information and believes the petitions have raised legitimate concerns about the use of powdered gloves. However, FDA’s regulatory approach to powdered gloves must consider the risks of these gloves in light of any benefits,” the agency said.

The FDA specifically solicited comments about the benefits of powdered gloves. But the overwhelming number of comments submitted before the April 25 deadline were appeals to ban powdered gloves, many of them from nurses or physicians whose careers were impacted by latex allergy.

Truscott also notes the risk to the surgical patient, who has no choice between powdered and powder-free gloves. The powder is particularly problematic because it is designed not to dissolve so it will survive the sterilization process, she says.

So what are the benefits of powdered gloves? They are easier to don, absorb perspiration from surgeons’ hands, and are less expensive to produce, she says.

Regardless, most hospitals have already abandoned powdered gloves. A report by Global Industry Analysts of San Jose on the disposable glove market in 2010 found that only 7% of gloves in the U.S. market were powdered. Some 92% of exam gloves were powder-free and 94% of surgical gloves were powder-free, despite the increased cost of powder-free gloves, the report says. Global Industry Analysts predicts further reduction in the use of powdered gloves by 2015.⁵

“The unequivocal role played by powdered gloves in eliciting post-surgical complications is beginning to lead to a major product shift from traditional powdered latex gloves to powder-free synthetic gloves,” the report says.

A personal appeal

For Edlich, the effort to ban powdered gloves is a personal one. When he was a child, his mother’s health declined due to recurrent benign abdominal tumors and acute intestinal obstructions, which he says were linked to powder on surgical gloves. Her medical problems influenced his decision to become a physician and led him to research the impact of cornstarch glove powder.

While Edlich was at the University of Virginia, the health system switched to powder-free gloves. Many other hospitals and health systems have taken similar action, he notes. Powdered gloves

are banned in the United Kingdom and Germany.

“Warning labels are just an excuse for manufacturers to continue to make powdered gloves to make money,” he says. “There’s not one article on PubMed [the National Library of Medicine’s database of scientific literature] that says it’s safe.”

The switch to powder-free gloves has greatly reduced the occupational risk to health care workers. “The frequency of allergic reactions to latex in health care personnel has gone down dramatically,” says Delclos. “We still ask new hires a series of questions regarding latex allergy. I haven’t seen [a case] in a long time.”

REFERENCES

1. Carome MA and Wolfe SM. Petition to FDA to ban powdered and latex surgeon’s and patient examination gloves. April 26, 2011. Available at <http://bit.ly/IYK37s>
2. Edlich RF, Long WB, Gubler KD, et al. Citizen’s petition to Food and Drug Administration to ban cornstarch powder on medical gloves. September 24, 2008. Available at <http://1.usa.gov/j2eIqG>
3. Truscott W. Citizen’s petition to Food and Drug Administration to ban cornstarch powder on medical gloves. February 24, 2009. Available at <http://1.usa.gov/jibyME>
4. Food and Drug Administration. Information related to risks and benefits of powdered gloves; Request for comments. *Federal Register* February 7, 2011. Available at <http://bit.ly/kopAPH>
5. Global Industry Analysts. Disposable Medical Gloves. January 2011, San Jose, CA. ■

Social media is the message for occ health

Tweets, blogs and a brave new world

Social media is opening up new avenues for delivering health and safety information. Employee health professionals can download training videos from YouTube, track occupational health news or research on a blog or Twitter, and even communicate with their own employees through social networking sites.

“Social media is a way to connect, it’s a marketing tool,” says **Max Lum**, EdD, MPA, a consultant in communication and research translation in the Office of the Director at the National Institute for Occupational Safety and Health (NIOSH). “It’s just a more efficient way of being transparent and timely, if you manage it correctly.”

A basic glossary of social networking

Blog: A website that contains news or opinion that is regularly updated and offers the opportunity for readers to share their comments.



Facebook: An online social networking site that allows users to share updates or messages with their friends. Users can create common interest groups, and organizations can create special Facebook pages.



Flickr: A site for sharing photos and videos. Users can search for images on a specific topic or organize their own photos.



LinkedIn: A networking site that emphasizes business connections, enabling users to post a resume-like profile, recommendations, and job searches.



Myspace: A social networking site that allows users to post comments on bulletin boards that are viewed by friends. It emphasizes music and videos.



Twitter: A site that allows short posts, or “tweets,” of up to 140 characters. Users can follow the tweets of other users on their Twitter account or smart phone.



Yammer: A closed social networking site with discussion boards for internal use at a business or organization.



YouTube: A video-sharing website. ■

All logos depicted are property of their respective companies and AHC Media claims no partnership with or endorsement from Facebook, Flickr™, LinkedIn®, Myspace®, Twitter, Yammer™, or YouTube™.

NIOSH has made savvy use of social media as a way to disseminate its scientific research and recommendations beyond the usual news releases and journal articles. The agency puts out about 10 to 15 tweets per week and has almost 100,000 Twitter followers. Its science blog has had 400,000 views since it started in 2007 and has posted thousands of comments.

You can find NIOSH photos on Flickr, videos on YouTube, and information on Wikipedia. NIOSH also maintains Myspace and Facebook pages. “We’re a research organization that puts out a huge amount of information,” says Lum, who notes that NIOSH researchers produce 200 to 250 peer-reviewed journal articles each year. Social media provides another way to reach the public and share information, he says.

Growth is slow but steady

While NIOSH is at the front edge of social media in occupational health, other occupational health groups are starting to explore its use. (*See resources on p.65.*)

For example, employee health professionals can connect through the Association of Occupational Health Professionals in Healthcare (AOHP) on LinkedIn, Facebook, or Twitter. The growth of those AOHP sites has been slow but steady, as members become more familiar with using social media for professional networking.

“The majority of communication is still done by email, but I’d like to explore the use of social media. It’s definitely in its infancy in our field,” says **Curtis Chow**, NP, PA-C, COHN-S, employee health coordinator at Mercy Medical Center in Redding, CA who monitors the sites for AOHP.

For example, Chow has used social media to share health and safety links and to spread the word about upcoming conferences or job openings. He envisions the sites as a way to brainstorm about common dilemmas, such as complying with recordkeeping or other regulations.

The format offers advantages over email, Chow says. “If someone tweets and you respond, anyone who’s following you sees it. Or on Facebook, whoever’s connected with you can see what you posted. It reaches more than one person at a time,” he says.

The U.S. Occupational Safety and Health Administration has made only modest forays into social media. The agency tweets through the U.S. Department of Labor account and sometimes issues videos on YouTube. OSHA administrator David Michaels, MD, MPH, and other OSHA officials have answered questions via live web chats.

Some individuals focused on occupational health and safety also maintain Twitter accounts or blogs. For example, **Brad Hammock**, an attorney with Jackson Lewis in Reston, VA, specializes in occupational health law and maintains a blog

OSHA, NIOSH, et al blogs, tweets, tubes

National Institute for Occupational Safety and Health: Science blog (www.cdc.gov/niosh/blog/), Twitter (twitter.com/niosh/), Flickr (www.flickr.com/photos/niosh/), YouTube (www.youtube.com/user/NIOSHSafetyVideos), Facebook and MySpace.

U.S. Occupational Safety and Health Administration: YouTube (www.youtube.com/usdepartmentoflabor), Twitter (twitter.com/USDOL) through the U.S. Department of Labor.

Association of Occupational Health Professionals in Healthcare: Twitter (twitter.com/#!/AOHP_Org/following), Facebook and LinkedIn. Links are available at www.aohp.org.

OSHA Law Blog: Attorney Brad Hammock maintains an OSHA Law Blog (www.oshalawblog.com/) and Twitter account (twitter.com/brad_hammock). ■

and Twitter account. He tries to stick to factual updates and doesn't offer legal opinions on his blog.

He has noticed that his posts and tweets are picked up and linked or re-tweeted. "It creates a loop of information-sharing that you didn't have five years ago," he says. "It's such an effective way to transmit information."

Beyond the generation gap

The main barrier to social media may simply be discomfort with a new way of communicating. After all, aren't tweets just for celebrities? Or teenagers?

Lum didn't take it too seriously at first when his sons were on blogs or YouTube or Facebook. But then he attended a meeting of the American Marketing Association and learned that marketing professionals were using social media to reach out to a new generation of consumers.

Each type of social media has its benefits. Tweets are short bursts of information, but can link to websites — an ideal way to spread the word about a conference or workshop. Blogs allow readers to scroll through everyone's comments.

Lum, who was previously the director of the

NIOSH Office of Communications, saw the potential for open government through these tools. "It really started with an idea to see if we could get more transparency and reach a larger audience," he says.

Now, NIOSH is exploring creating an "app" — an iPhone application — that would help people select the right respirator. "When I get that first app out I think it will be really impressive to my children," says Lum. ■

Protect HCWs from hazardous drugs

NIOSH, OSHA, TJC align on message

Make sure your health care workers are handling hazardous drugs safely. That is the key message to hospitals in a joint letter from three leading safety agencies: the U.S. Occupational Safety and Health Administration, the Joint Commission accrediting body, and the National Institute for Occupational Safety and Health.

The letter, which was to be mailed to all U.S. hospitals, does not add any new information or regulatory action. Instead, it underscores the importance of the 2004 NIOSH alert (<http://1.usa.gov/ierb5Q>) and the 2010 updated list of antineoplastics and other hazardous drugs (<http://1.usa.gov/ddQ3IC>).

Recent research demonstrates the continuing hazard to health care workers, even when they use protective equipment and safe work practices, such as biological safety cabinets. A study by NIOSH research biologist **Thomas Connor**, PhD, found that 60% of wipe samples in work areas tested positive for contamination with antineoplastic drugs, including carts, trays, countertops, IV bags, and even floors in patient rooms.¹

In a companion study, **Melissa A. McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore, found that nurses and pharmacists were 20% more likely to have a chromosomal abnormality than a control group if they had 100 or more chemotherapeutic drug-handling events. The likelihood of chromosomal abnormalities rose with greater exposure.²

Meanwhile, Washington became the first state in the nation to enforce protections for health care workers working with hazardous drugs. In April,

Gov. Chris Gregoire signed a law that requires health care facilities to comply with the NIOSH alert and 2010 update and to protect health care workers from exposure.

The Washington legislature passed the law unanimously after a series of stories in the Seattle Times told of health care workers who had handled chemotherapy drugs and later developed cancer. The Department of Labor & Industries will draft regulations that are “consistent with and [do] not exceed provisions” of the NIOSH recommendations. The regulations also can be updated to incorporate any future changes by NIOSH.

“There is strong and convincing evidence that these drugs pose a significant risk to health-care workers,” **Michael Silverstein**, assistant director, L&I’s Division of Occupational Safety and Health, said in a statement. “This legislation ensures workers who provide lifesaving treatment for others aren’t placed at risk themselves.”

Research into links between cancer and health care occupations has been difficult because cancer registries typically don’t include occupation. The Washington legislature also passed a law requiring the Washington State Cancer Registry to collect information on occupation.

“It’s a start at connecting employee exposures to adverse health outcomes,” says **Marty Polovich**, PhD, RN, AOCN, associate director of clinical practice at the Duke Oncology Network in Durham, NC. “I wish some other states would do the same.”

No new national regulations

Nationally, there has been no movement beyond voluntary guidelines and recommendations, despite the known toxicity of many hazardous drugs. NIOSH has defined hazardous drugs as those that have been shown to have one or more of six effects on humans or animals: carcinogenicity, teratogenicity or other developmental toxicity, reproductive toxicity, organ toxicity at low doses and genotoxicity. There are currently 157 drugs on the list. NIOSH continues to review drugs for a future update.

“Chemicals like this are regulated in other industries. They’re not regulated in health care,” notes Connor.

OSHA’s Director of Occupational Medicine, **Rosemary Sokas**, MD, MOH, notes that OSHA can use the “general duty clause” that requires employers to maintain a workplace free of serious hazards, and the agency is working toward an

Injury and Illness Prevention Program standard that would require employers to find and fix hazards. While chemotherapy presents both risks and benefits to patients, workers experience only the risks, Sokas said in an emailed response to HEH. “This is why worker protection is so important,” she said.

Connor and McDiarmid welcomed the joint letter as a way to increase awareness and spur better compliance with the recommendations. “I certainly would like to see this alert enforceable in the other 49 states,” says McDiarmid. “It’s evidence-based. The standard of practice is there.”

Although hospitals have made progress in protecting workers from hazardous drugs, concerns remain. Even when containment isolators are used to prepare hazardous drugs, for example, contamination can spread once the items are removed, says Connor. “You’re generating contamination inside the isolator. You’re contaminating everything that goes in and everything that goes out,” he says. “The products themselves can be contaminated.”

Further research is needed to determine the safest practices, he says. Meanwhile, the 2004 NIOSH alert details procedures for reducing exposures. For example, the alert cautions workers to use appropriate personal protective equipment and safe work practices even when they are using a closed-system device to transfer hazardous drugs from their original packaging to dosing equipment. “Remember that a closed-system transfer device is not an acceptable substitute for a ventilated cabinet and should be used only within a ventilated cabinet,” the alert states.

It’s important to maintain vigilant adherence to the recommendations to reduce the risk of exposure, says Connor. “The study we did showed that even when people think they’re doing a good job, they’re still not entirely protecting their workers. There still is potential for exposure,” he says.

By turning the NIOSH recommendations into requirements, Washington state is likely boosting compliance, says McDiarmid. “A lot of organizations find the resources they didn’t think they had [to provide worker protections] when it’s a standard as opposed to a guideline,” she says. “I would at a minimum want the regulated community to know that the science is quite good as to what the hazards are and what the solutions and strategies are.”

REFERENCES

1. Connor TH, DeBord DG, Pretty JR et al. Evaluation of antineoplastic drug exposure of health care workers at three

university-based US cancer centers. *J Occup Environ Med* 2010; 52:1019-1028.

2. McDiarmid MA, Oliver MS, Roth TS et al. Chromosome 5 and 7 abnormalities in oncology personnel handling anticancer drugs. *J Occup Environ Med* 2010; 52:1028-1034. ■

Jt. Comm. Proposes 90% flu shot goal

Standard modeled after HHS plan

Proposed changes in a Joint Commission infection control standard may accelerate the trend toward mandatory influenza vaccination policies.

The Joint Commission accrediting body, based in Oakbrook Terrace, IL, requested comments on changes that would set a goal of 90% for influenza vaccination of staff and licensed independent practitioners, such as physicians, by 2020.¹

While the Joint Commission is not specifically advocating mandatory influenza vaccination, hospitals that have rates above 90% often have such a policy.

“We think we can get there [with voluntary programs] through education,” says Bill Borwegen, MPH, health and safety director with the Service Employees International Union (SEIU). “But if this is a de facto mandatory requirement, we think it’s a massive overreach that isn’t demonstrated by scientific evidence.”

In fact, the Joint Commission is recommending a goal, not a policy, says **Robert Wise**, MD, vice president of the division of standards and survey methods. “We are not suggesting it be a manda-

tory requirement. This [decision] is really at the level of the hospital,” says Wise, who notes that the target date is in nine years.

The Joint Commission cites the 90% goal in the U.S. Health and Human Services Action Plan to Prevent Healthcare-Associated Infections.² However, the action plan simply notes the Healthy People 2020 goal of 90% vaccination of health care personnel. It also points out the variation in vaccination rates among different health care settings and differences in measurement among different facilities.

“Coverage among health care personnel working in hospitals was over 60%, while for those health care personnel in long term care facilities coverage is well below 50%,” the action plan says. “Healthcare settings should tailor their strategies to their setting, workforce, and region.”

The Joint Commission plans to issue a final standard before the start of the 2012 flu season, Wise says. The accrediting agency aims to raise the dialogue and emphasize the importance of increasing vaccination rates, he says. Hospitals may choose to avoid the pushback that can occur with mandatory policies, including potential legal issues if employees are unionized, by opting for voluntary programs, he says.

“There is more attention now than ever before about this issue and there’s more debate than ever before. We’ll find out what’s successful and what’s not, and people will learn from each other and how to achieve [the goal],” he says.

The Mayo Clinic in Rochester, MN, has achieved a vaccination rate of about 80% with a voluntary program. **William Buchta**, MD, MPH,

Proposed flu standard changes by TJC

The Joint Commission’s proposed changes in the influenza vaccination standard for hospitals include the following:

- The hospital includes in its infection control plan the goal of improving influenza vaccination rates. (For more information, refer to Standard IC.01.04.01)
- The hospital sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020. (Note: The HHS Action Plan to Prevent Healthcare-Associated Infections is available at: <http://1.usa.gov/m19whI>)

- 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. ■

medical director of the Employee Occupational Health Service, notes that the Joint Commission will judge hospitals on their compliance with their own policies and program aimed at meeting the goal, not on the attainment of the goal itself.

“I think you can stay within the Joint Commission standards without making it mandatory, you just have to be very careful in how you word your policy,” he says. “They’re very forgiving about not meeting goals as long as you have a plan.”

For example, Buchta says he could envision a policy that sets a mandate in units with especially vulnerable patients, such as bone marrow transplant or neonatal intensive care. Employees in those units who did not want to be vaccinated could transfer to other positions in the hospital but would not lose their jobs, he says. A policy also would have to account for years in which there are vaccine supply disruptions, leading to lower vaccination rates.

Meanwhile, as the years go by, technology changes.

“Hopefully, we’ll have a better vaccine by 2020,” he says, noting that a mandatory vaccine policy would be easier to implement and more acceptable if it was a one-time vaccine. “Hopefully in five to ten years this argument will be a moot point. That’s what I would love to see.”

REFERENCES

1. The Joint Commission. Standards Field Review: Influenza Vaccination of Staff and Licensed Independent Practitioners. Oakbrook Terrace, IL. April 5, 2011. Available at <http://bit.ly/dKioP>.
2. U.S. Department of Health and Human Services. HHS action plan to prevent healthcare-associated infections: Influenza vaccination of healthcare personnel. Available at <http://1.usa.gov/m19whI>. ■

No hand hygiene? It could cost you

Outbreak spurs UPMC to set fines

At the first sign of nosocomial spread of *Acinetobacter baumannii*, the University of Pittsburgh Medical Center Presbyterian took a bold stance. Hospital employees and physicians would be held accountable for their hand hygiene.

That meant nurses could be sent home if they failed to follow hand hygiene procedures and physicians could be fined \$1,000 — or even lose their

hospital privileges.

The tough policy got everyone’s attention. The heightened awareness of infection control helped stem an outbreak, as cases of acinetobacter declined. It also showed how education and commitment could rally health care workers around hand hygiene.

“We have not fined a single physician nor have we had to send a single employee home, which is what we wanted,” says **Holly Lorenz**, RN, MSN, chief nursing officer at UPMC Presbyterian and chief nurse executive at UPMC’s 21 hospitals. “It was a great opportunity for us to heighten everyone’s awareness. ‘Wash your hands.’ That’s the No. 1 prevention, whether you’re in the hospital or at home, to prevent the spread of infection.”

Hardy bacteria a threat in ICU

Acinetobacter is a gram-negative bacteria that has been especially troubling in recent years because it has developed resistance to multiple antibiotics. While it is not a threat to healthy people, it can cause serious problems in a hospital environment, says **Alexander J. Kallen**, MD, MPH, medical officer in the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention.

“It is very hardy in the environment and it can live for a very long period of time on surfaces,” says Kallen, who notes that acinetobacter can be spread by contaminated equipment or on the hands of health care workers.

UPMC Presbyterian typically saw two to three patients a month in the 156-bed ICU who had acinetobacter. When surveillance showed that five ICU patients had the bacteria, the hospital sprang into action.

“This is one of those infections that we’ve got to crush and attack immediately,” says Lorenz. “One of our worries with this infection is that because it is resistant to some of our newer drugs, we’re relying on antibiotics that are older. Those old antibiotics are a lot more toxic to the body.”

Infection control worked with hospital executives and human resources to develop the outbreak-related policy. They placed a blue line above the door of rooms with patients with acinetobacter (in addition to the usual sign indicating the level of infection control precautions needed). Antiseptic hand gel containers were ubiquitous. Monitors observed whether employees and physicians performed hand hygiene and offered reminders.

The disciplinary action only went into effect if

UPMC's fines policy on hand hygiene

Non-physician staff. Anyone found to be (a) noncompliant with infection control measures (does not wear appropriate personal protective equipment, observe hand hygiene practices, or clean equipment such as stethoscopes as expected) after being asked to do so and pertaining to MDR Ab patients, or (b) uncooperative with monitoring personnel will be sent home immediately.

Physician staff. It is imperative that the physicians of UPMC Presbyterian be equally diligent and compliant with these measures — indeed, the physicians should set an example for all other hospital personnel. Accordingly, the Medical Executive Committee and UPMC Medical Education Program have adopted the following policies to take effect immediately:

Attending Physicians. Any attending physician found to be (a) noncompliant with infection control measures (does not wear appropriate personal protective equipment, observe hand hygiene

practices or clean equipment such as stethoscopes as expected) after being asked to do so and pertaining to MDR AB patients, or (b) uncooperative with the monitoring personnel will be fined \$1,000. Record of this occurrence will be placed in the individual's credentialing file, and the individual's department chair will be informed of this occurrence. Repeat noncompliance or failure to pay the fine within one week will result in immediate relinquishment of hospital privileges.

UPMC Medical Education-sponsored trainee. Any member of a UPMC ME-sponsored Training Program or Graduate Medical Trainee found to be (a) noncompliant with infection control measures (does not wear appropriate personal protective equipment, observe hand hygiene practices, or clean equipment such as stethoscopes as expected) after being asked to do so and pertaining to MDR AB patients, or (b) uncooperative with the monitoring personnel will be sent home immediately, fined \$250, and referred to the program director for disciplinary action. Record of this occurrence will be placed in the individual's program file, and the department chair will be informed. ■

an employee, physician or medical resident was not compliant despite a reminder.

Awareness lasts beyond outbreak

Both awareness and surveillance were important aspects of the infection control campaign. The hospital held educational forums for workers with patient contact, including housekeeping and maintenance. Patients were identified with a banner bar on the electronic medical record, and if they were transferred to another department for tests, they wore a yellow gown and had a yellow gown draped on their blanket.

“We sent a special announcement to every associate at the hospital through email. We used screensavers on PCs and we have a robust physician communication module here through our MedCall, our communication for physicians,” says Lorenz.

By also initiating surveillance culturing of some of the patients admitted to the ICU, the hospital was able to detect patients coming with acinetobacter, an infection that is sometimes seen in long-term care facilities or in patients who are admitted with wounds from trauma. UPMC also randomly cultures the hands of health care workers, with

their consent. They have not found acinetobacter on hands of employees, says Lorenz.

“Our attention to hand hygiene has always been high,” she says. “We just upped the ante for an infection we wanted to make sure we could minimize what's in our hospital.”

With the enhanced vigilance, the cases of acinetobacter dropped. But the hospital is still benefiting from the new awareness, and infection control is a routine topic at staff meetings. “We're keeping this in the forefront of all our caregivers' minds,” says Lorenz. ■

OSHA: Infectious disease standard still on table

Would be closely aligned with CDC

Hospitals aren't doing enough to protect their employees from infectious diseases, U.S. Occupational Safety and Health (OSHA) administrator **David Michaels**, PhD, MD, told employee health professionals in a recent Webinar for members of the Association of Occupational Health Professionals in Healthcare (AOHP).

“Healthcare-acquired infections are a persistent problem. We believe the increasing levels of drug-resistant microorganisms in health care settings really tell us we should do something much more comprehensive than we’ve done now,” he said. “Most current infection control efforts are intended primarily for patient protection and there really isn’t enough done on worker protection.”

OSHA plans to issue a regulation patterned after the Bloodborne Pathogen Standard that would address diseases that are spread by airborne, droplet, and contact transmission, Michaels said. He touted the success of the Bloodborne Pathogen Standard, which received a positive response in comments as part of a recent regulatory review.

“The evidence is pretty clear. This standard has contributed to the prevention of thousands of cases of hepatitis B and of HIV in health care workplaces,” he said.

Although he didn’t directly address concerns about an infectious diseases standard, Michaels seemed to refer to statements by infection control practitioners that a standard isn’t necessary and potentially would conflict with existing and future public health guidance. “We’re looking to do this in a way that closely aligns us with the overall approach to infection control used in existing CDC [Centers for Disease Control and Prevention] guidance and industry standards,” he said.

Seeking fundamental change

Overall, Michaels said OSHA has “a common-sense agenda,” with an emphasis on injury prevention rather than creating many new standards. In late spring or early summer, OSHA is expected to release a draft of an Injury and Illness Prevention Program standard that would require employers to conduct hazard assessments and take action to address the hazards.

“We’re trying to move toward a fundamental change in the way many employers think about safety and health,” he said. “Instead of waiting for a government inspector to come or [for] a workplace injury or illness or fatality...this regulation would require all employers to do what many, many employers do now, which is to set up a process to find and fix the hazards they have.”

Michaels urged employers not to give employees rewards for days or weeks without injuries. Even a pizza party could discourage employees from reporting injuries — which is contrary to the goal of ferreting out hazards, he said.

CNE QUESTIONS

21. According to Curtis Chow, NP, PA-C, COHN-S, what is the advantage of Facebook and Twitter for sharing occupational health information?
 - A. Anyone connected to the sites can see your posts.
 - B. They have occupational categories.
 - C. They are faster than email.
 - D. They offer optimal privacy.
22. What was the purpose of a recent letter from OSHA, the Joint Commission and NIOSH related to hazardous drugs?
 - A. There are new regulations that must be followed by workers preparing hazardous drugs.
 - B. Closed-system devices must be used with certain hazardous drugs.
 - C. OSHA will have new inspections on hazardous drug practices.
 - D. Hospitals should follow the NIOSH recommendations related to hazardous drugs.
23. After an outbreak of *Acinetobacter baumannii*, what change did the University of Pittsburgh Medical Center Presbyterian make in its hand hygiene policy?
 - A. Employees with patient care responsibilities must use soap and water, not hand gel.
 - B. Health care workers must carry hand gel with them to use before and after patient visits.
 - C. Nurses who do not perform hand hygiene after being reminded to do so could be sent home.
 - D. Health care workers must have short nails and wear no nail polish.
24. While the FDA considers a ban on powdered gloves, what step is it proposing to take?
 - A. Requiring a warning label for gloves to be thoroughly washed before surgery.
 - B. Recommending a warning label that powder on gloves may cause granulomas in patients and contribute to latex allergy.
 - C. Requiring new manufacturing techniques to minimize powder.
 - D. Requiring manufacturers to list the amount of powder in gloves on labels.

Answers: 21. A; 22. D; 23. C; 24. 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 this issue, you must complete the evaluation form provided in this issue and return it in the reply envelope provided to receive a credit letter.

“The minor injury or what’s sometimes called a near-miss [is a] predictor of more serious injuries, but these incentive programs stop people from reporting those less severe injuries so the prevention never takes place,” he said.

Michaels also vowed to use the general duty clause of the Occupational Safety and Health Act, which requires employers to keep their workplace free of hazards that can cause serious injury. He noted that in January, OSHA cited a psychiatric hospital in Bangor, ME, for failing to reduce the hazard of workplace violence. “We found at least 115 instances between 2008 and 2010 in which employees at the psychiatric hospital or the clinic there were assaulted on the job by a violent patient,” he said.

OSHA also cited Danbury (CT) Hospital for failing to address workplace violence. (See *HEH*, October 2010, p.109.)

“Workplace violence is like any other hazard. We can predict it, we can predict where people are going to be hurt, and there are ways to reduce risk,” he said. “We’re not in rulemaking [for a standard in this area], but we certainly take this very seriously. We will issue citations if we see workplace violence that should have been prevented.” ■

There’s the rub: The risk of sleepy surgeons

Expert: No elective surgery after a night of call

Just as hospitals are set to comply with new restrictions on medical resident hours to reduce fatigue, a leading sleep expert is questioning the schedules that could lead to sleep deprivation among practicing surgeons.

A surgeon who has been awake 22 of the past 24 hours due to on-call duty should re-schedule elective surgery or at least inform patients and allow them to decide whether to continue with the elective surgery, says **Charles Czeisler**, PhD, MD, director of the Division of Sleep Medicine at Harvard School of Medicine in Boston. Czeisler and two colleagues presented this perspective in a recent article in the *New England Journal of Medicine*.¹

Preferably, hospitals should not permit the scheduling of elective surgery during the day after a surgeon has had nighttime call duty, he says.

“In those instances where the institution does

not implement safer policies regarding surgeon’s work schedules prior to operations, at least patients have a right to know,” he says. “That is certainly not the ideal situation because it creates a burden on patients and inefficiencies for hospitals. The far more sensible thing is to implement a program where this does not happen.”

Czeisler has been a proponent of greater restrictions on work hours of medical residents to allow more time for sleep. As of July 1, new rules of the Accreditation Council for Graduate Medical Education limit the work hours of first-year residents to 16-hour shifts. First-year and “intermediate-level” residents must have at least eight hours off between shifts.²

Those restrictions still fall short of what Czeisler, other sleep experts and advocates for medical residents say is necessary to reduce the risk of error due to fatigue. (See *HEH*, November 2010, p.127.) In its 2009 report, “Resident Duty Hours: Enhancing Sleep, Supervision and Safety,” an Institute of Medicine panel cited gaps in compliance with the ACGME standard that left residents “susceptible to acute and chronic sleep deprivation.”³

Some have argued that residents need long shifts, especially in specialties such as surgery, to allow them adequate opportunities for training and for continuity of care of patients. But there’s no imperative for a surgeon to perform an elective procedure while sleep-deprived, says Czeisler.

A retrospective study of surgical and obstetrical procedures found an 83% increase in the risk of complications in patients who had elective procedures performed by surgeons who had less than six hours of opportunity for sleep the night before because of on-call duty.⁴

“It came to our attention that it was routine practice for surgeons to schedule elective procedures even when they’re on call the night before,” Czeisler says. “This had to do with the fact that the on-call schedules were established often completely independently of the scheduling of elective

COMING IN FUTURE MONTHS

- Are hospitals ready for another pandemic?
- Study: Safe patient handling lowers comp costs
- Too many sticks from hypodermic needles
- Building a culture of safety
- Why going green will help HCWs

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.

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482

Fax: (800) 284-3291

Email: tria.kreutzer@ahcmedia.com

Address: AHC Media
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

BINDERS AVAILABLE

HOSPITAL EMPLOYEE HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail binders@ahcmedia.com. Please be sure to include the name of the newsletter, the subscriber number and your full address.



If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at www.ahcmedia.com/online.html.

If you have questions or a problem, please call a customer service representative at (800) 688-2421.

EDITORIAL ADVISORY BOARD

Consulting Editor
MaryAnn Gruden
MSN, CRNP, NP-C, COHN-S/CM
Association Community
Liaison

Association of Occupational
Health
Professionals in Healthcare
Coordinator
Employee Health Services
West Penn Allegheny Health
System
Western Pennsylvania Hospital
Pittsburgh

Kay Ball, RN, PhD, CNOR, FAAN
Perioperative Consultant/
Educator, K&D Medical
Lewis Center, OH

William G. Buchta, MD, MPH
Medical Director, Employee
Occupational Health Service
Mayo Clinic
Rochester, MN

Cynthia Fine, RN, MSN, CIC
Infection Control/
Employee Health
San Ramon (CA) Regional
Medical Center

June Fisher, MD
Director
Training for Development of
Innovative Control Technology
The Trauma Foundation
San Francisco General Hospital

Guy Fragala, PhD, PE, CSP
Consultant/
Health Care Safety
Environmental Health
and Engineering
Newton, MA

Janine Jagger, PhD, MPH
Director
International Health Care
Worker Safety Center
Becton Dickinson Professor of
Health Care Worker Safety
University of Virginia
Health Sciences Center
Charlottesville

Gabor Lantos
MD, PEng, MBA
President

Occupational Health
Management Services
Toronto

JoAnn Shea
MSN, ARNP
Director
Employee Health & Wellness
Tampa (FL) General Hospital

Sandra Domeracki Prickitt
RN, FNP, COHN-S
Employee Health Coordinator
Marin General Hospital/Novato
(CA) Community Hospital
Executive President, Association
of Occupational Health
Professionals in Healthcare
San Rafael, CA

procedures.”

Some hospitals already prohibit that practice, he says. “There are some institutions where this routinely happens and some where it very rarely happens,” he says.

In a letter to the same issue the New England journal, the American College of Surgeons said surgeons should be educated about the impact of fatigue on performance and should make the decision about whether to inform patients, reschedule surgeries or request assistance.

REFERENCES

1. Nurok M, Czeisler CA, Lehmann LS. Sleep deprivation, elective surgical procedures, and informed consent. *N Engl J Med* 2010; 363:2577-2579.
2. Pellegrini CA, Britt LD, Hoyt DB. Sleep deprivation and elective surgery. *N Engl J Med* 2010; 363:2672-2673.
3. Institute of Medicine. Resident duty hours: Enhancing sleep, supervision, and safety. National Academies Press, Washington, D.C., 2009.
4. Rothschild JM, Keohane CA, Rogers S, et al. Risks of complications by attending physicians after performing nighttime procedures. *JAMA* 2009; 302:1565-1572. ■

Hospital Employee Health

HEH060111TM

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

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

Account # _____
 Name: _____
 Company: _____
 Address: _____
 City: _____
 State: _____
 Zip _____
 Fax: _____
 Phone: _____
 E-mail: _____

CNE Evaluation

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

CORRECT ● **INCORRECT** ○

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

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees.	○	○	○	○	○	○
3. Describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the health care industry at large.	○	○	○	○	○	○
4. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I am satisfied with customer service for the CNE program.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CNE program?

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____
Nursing license number (required for nurses licensed by the state of California) _____