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Note: New CNE procedures. See p. 83 for details.

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AHC Media

AHA: Hospitals should create a 'culture of health' for HCWs

Set clear, measurable EH program goals

It's time for hospitals to stand up for the health and wellness of their own.

The American Hospital Association has issued a call to action for hospitals to embrace wellness and health promotion for their employees.

"[Wellness] is an important piece of what we do as health care organizations," says **Maulik S. Joshi**, DrPH , senior vice president of research for the AHA in Chicago. "You've got to be a role model [for the community]."

While hospitals are increasingly embracing the mission of wellness for their employees, outcomes-oriented programs are rarer, according to an AHA-sponsored survey of 876 hospitals, conducted in 2010. The report and survey were coordinated by the AHA's Long-Range Policy Committee.

About three out of four hospitals offer the basics: Weight loss, smoking cessation, healthy food options, health risk assessments, the survey found. But only 47% have biometric screenings, such as cholesterol and blood pressure, and only 37% offer personal health coaching to help employees alter their habits and lifestyles.

"We have been good at the initial triage, the assessment of where we all are," says Joshi. That's an important first step, he says. But it needs to be followed up with goals, strategies, and tracking of outcomes, he says.

Hospitals have the same financial incentive as other employers: Employee health and wellness programs provide a healthy return on investment. A majority of hospitals that tracked their ROI reported a return of investment of $2 or more for every $1 they spent on wellness. In fact, the AHA is promoting the sharing of "best practices" from hospitals that have developed their wellness programs. (*See related story, p. 77.*)

Healthcare reform provides a new basis for promoting wellness. The Affordable Care Act provides incentives for preventive health programs and creates a fund to invest in prevention and public health. It requires

insurers to cover some preventive services, screenings, and immunizations with no co-pay.

Importantly, the Affordable Care Act also creates "Accountable Care Organizations" for Medicare to encourage doctors and hospitals to coordinate care and emphasize prevention. "Your own employees' health is an accountable care organization," says Joshi, who notes that hospitals can focus on their own employee base to improve prevention and management of chronic diseases.

Health risk assessments and biometric screening can identify the employees who have risk factors for chronic diseases. But how can you convince them to take significant steps to improve their health?

The AHA advocates the use of employee incentives to promote participation in wellness programs. About two-thirds of hospitals already report using some incentives, according to the survey. Most of the incentives are based on participation, such as completing a health risk assessment or biometric screening, or participating in disease management or weight loss programs.

One-third of hospitals surveyed offer $100 to $300 in annual deductions from health insurance premiums. Other incentives include lower deductibles, contributions to health savings accounts, subsidized gym membership, gift cards, or small tokens such as T-shirts and mugs.

Incentives vary based on an organization's culture, says Joshi. But it's important to identify goals and measure your progress, he says. "There should be clear measurable goals for the longer term as well as the short term," he says.

Focus on sustainability

The AHA report provides seven recommendations, with some specific suggestions on goals and strategies:

• Recommendation 1: Serve as a Role Model of Health for the Community

As part of fulfilling their mission, hospitals are beacons of trust in the community. Hospitals must create robust health and wellness programs as examples to the communities that they serve.

• Recommendation 2: Create a Culture of Healthy Living

Improving the health of employees is more than implementing individual health and wellness programs or activities. Hospitals need to strive for a culture of healthy living for all employees, which starts at the top with the CEO and the board of trustees. Wellness should be a strategic priority for the hospital.

• Recommendation 3: Provide a Variety of Program Offerings

While health and wellness is more than a set of activities, it is important for hospitals to offer a variety of activities to promote health within their organizations.

• Recommendation 4: Provide Positive and Negative Incentives

Positive and negative incentives are effective in improving health and wellness program participa-

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AHC Media

Small hospital, big focus on wellness

Flexibility, incentives are key to success

Creating a comprehensive wellness program may sound like a luxury to a small, rural hospital. A fancy gym? Biometric screenings? Financial incentives? Those require resources.

Saint Elizabeth's Medical Center, a 25-bed critical access hospital in Wabasha, MN, has done all that – and more. Creating a culture of health is possible even for small organizations, says **Jim Root**, vice president of human resources. And it's just as important to the hospital and the community alike, he says.

At the local Rotary Club, business leaders were asking the hospital's CEO: How can you help us control our health care costs? The hospital has a proven program to provide. "We've now taken our employee wellness program and promoted that to their businesses," says Root.

Saint Elizabeth's began as many hospitals do, with an annual health fair. Employees could participate in a biometric screening that included a lipid panel, glucose test, blood pressure, and measurement of height and weight. They received a brief consult about their results, some health education, and a token gift.

"Our thought was if we can provide the education, they'll make the right choices," says Root.

To give wellness a boost, the hospital promoted activity with a "10,000 steps" program that encourages walking as exercise. Employees tracked their progress with pedometers and received small gifts, such as T-shirts or water bottles. But the people most likely to participate were those who were already active and healthy.

"We've learned over time that it's critical to tier your programs," says Root. "You need to have moderate and lower [goal] levels so every audience will see something that's achievable."

Today, about 65% of the hospital's 280 full-time or regular part-time employees participate in the wellness program. Employees who complete four key components — a biometric screen, a flu shot, getting an annual physical and a yearly dental checkup — receive $50. They then can receive up to $200 in additional incentives based on nutritional and exercise goals.

For example, nutritional challenges change every two months. Employees may track their calcium intake or servings of whole grains. "On average, we've seen an improvement in our scores of 11% in our lipid panel reading," Root says.

Saint Elizabeth's is also adding a negative incentive for tobacco users. They will pay a $50 monthly surcharge on their insurance premium unless they join a tobacco cessation program.

The hospital's fitness center is part of the cardiac rehab unit. Patients have priority, but it is also available to employees and can be used after-hours. "It's an amazing fitness center for a rural community," says Root. "Our community is extremely supportive of what we do. They've helped us fundraise for expanding our wellness center and equipping our wellness center."

The hospital also organizes worksite wellness challenges in the community, to build competition and enthusiasm around physical activity and weight loss.

Saint Elizabeth's accomplishes this without having a wellness coordinator or other staff dedicated to a wellness program. Instead, employees share the duties. The wellness team includes a dietician, human resources, community relations, and employee health.

"We take advantage of the great resources we have in our facility," says Root. In a small facility, employees are accustomed to being flexible and taking on various responsibilities. "The variety helps keep people engaged and enthused," he says. ■

tion levels. Hospitals can use incentives to increase participation and to improve outcomes.

• Recommendation 5: Track Participation and Outcomes

To track the success of their health and wellness programs, hospitals must first measure and increase participation and then build systems to track outcomes.

• Recommendation 6: Measure for Return on Investment

A strong financial case accompanies the strategic mission of striving for robust health and wellness programs. To achieve ROI, hospitals must first commit to effectively measuring ROI over

several years.

• Recommendation 7: Focus on Sustainability

For program effectiveness, hospitals must motivate employees over time, effectively communicate, and constantly reinforce wellness as a leadership priority.

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OSHA targeting ambulatory care

Surprise inspections in four states

Outpatient centers have historically attracted little attention from the Occupational Safety and Health Administration, although needle market data shows they have lagged in sharps safety. But that hands-off approach is ending with a regional emphasis program in four states.

In Alabama, Florida, Georgia and Mississippi, inspectors will pay unannounced visits to ambulatory surgery and urgent care centers and medical clinics to gauge compliance with the Bloodborne Pathogen Standard. Those centers are not required to maintain OSHA 300 logs, so little is known about their sharps injury protection, says **Billy Kizer**, MPH, CSP, team leader for enforcement programs in OSHA's Region IV.

They also are not the focus of sharps safety surveillance efforts, which mostly have collected data from hospitals. Yet there is evidence that "alternate care" sites have much lower uptake of safety devices. In 2010, GHX, a healthcare supply chain management company based in Louisville, CO, reported that about one in five blood collection needles and blood collection sets in alternate sites were conventional devices, and about half (52%) of hypodermic needles were not safety-engineered.

The special emphasis program "is a great way to determine how many sharps injuries they're really having [in alternate sites] as well as making sure they're following the Bloodborne Pathogen Standard and they're providing the protection for sharps," says Kizer. "It's time that we reach out and ensure they are protecting their employees."

The attention from OSHA will send a message that outpatient centers need to get into compliance, says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic and a surveyor for the American Association for Accreditation of Ambulatory Surgery Facilities.

Cunha was surprised to find facilities that had essentially ignored the Bloodborne Pathogens Standard. "I went in the ORs and they had absolutely no safety needles," he says.

Surgeon or physician preference alone is not a sufficient reason to use conventional needles, says Cunha. The facilities must provide documentation of an exemption from sharps safety for medical reasons, he says.

OSHA's random inspections will include freestanding facilities that are owned by hospitals. However, it will not include physicians' offices, Kizer says. The regional special emphasis program will run through Sept. 30, 2012, and involves states that are under federal OSHA jurisdiction. State-plan states in the region, including Tennessee, Kentucky, North Carolina and South Carolina, may do a similar program but are not required to do so.

OSHA inspectors rarely go into outpatient centers unless there is a complaint from an employee, Kizer notes. But outpatient centers have been the focus of a different national awareness program to improve injection safety. The One & Only Campaign of the Centers for Disease Control and Prevention and the Safe Injection Practices Coalition is emphasizing the importance of using a needle and syringe only one time. Reuse of needles or syringes with multi-dose vials has led to recurrent outbreaks of hepatitis C in a variety of ambulatory care sites.

The OSHA program extends that safe injection message to worker safety. "Our hope is that we'll find that employers are doing what they're supposed to do, that employees are being protected," says Kizer. "If they're not, we can help to bring them into compliance." ■

Money motivates HCWs to be healthy

Sentara program slows the rise in HC costs

As with most employers, the cost of health insurance was rising year after year for Sen-

tara Healthcare of Norfolk, VA, an integrated health care delivery system that includes eight acute care hospitals, outpatient centers, long-term care, and Optima Health Plan, an insurance subsidiary.

Employees had access to education programs, Weight Watchers at Work, discounts at local gyms, and some disease management. The programs weren't coordinated, though, says **Karen Bray**, PhD, RN, CDE, vice president of clinical care services. "We found that they were generally underutilized," she says. In fact, they were mostly used by people who already had a healthy lifestyle, she says.

Sentara worked with Optima Health to create Mission: Health, an incentive-based wellness program.

Six months before the open enrollment period for health insurance, employees participate in a health screening that measures blood pressure, cholesterol, height and weight. Employees also report whether they smoke and if they exercise at least three times a week.

Based on that information, employees with 0 or 1 risk factor receive a premium discount of $550. Employees with two or more risk factors can receive the same discount, but they are required to have telephone sessions with a health coach.

"They have to at least speak with their health coach on a quarterly basis. If they don't, their premium reverts to the higher level and stays that way for the rest of the year," Bray says.

About a third of the employees have two to five risk factors — and about half of those people fail to maintain contact with a health coach, she says.

Taking a closer look, Sentara realized that diabetes, coronary artery disease and congestive heart failure accounted for 14% of the overall health care costs. So an additional incentive program provides an additional $460 in a medical savings account if people with one of those conditions participate in a disease management program.

"We wanted to have at least 80% participation in the programs and we achieved that," says Bray. "We wanted to be able to show improvements in those items we measure in the personal health profile. In every one but body mass index, we showed statistically significant improvements starting in the first year."

Interestingly, Sentara actually saw an initial rise in health care costs — due to the increased treatment of the diabetes and cardiac conditions. In the second year, costs dropped back down by 10%. Since then, the rate of increase in health care costs has been significantly lower than it was before the program began. Employees also have fewer risk factors. "This is an investment in your [employees'] health," says Bray.

At first, some employees were skeptical about their employer being involved in their personal health. The Sentara message: "We care about you. We're a health care organization. We should model good health for the community," says Bray.

The program has evolved, with online education, wellness awards, and eligibility for spouses to participate in the disease management program — for an additional $460 medical savings account incentive.

Coaching is an integral part of the success, says Bray. "People understand intellectually what they're supposed to do. But to execute a plan requires some help," she says. ■

Why are 1 in 3 sticks linked to hypodermics?

Lack of reg compliance, widely used

About one out of every three needlesticks occurs with a hypodermic syringe — a device that is available with many types of safety features. As thousands of needlesticks continue to occur from hypodermic needles, hospitals need to do a better job of protecting health care workers from bloodborne pathogens, safety experts say.

In 2009, for example, 884 of 2,889 sharps injuries reported by Massachusetts hospitals involved hypodermic needles. Massachusetts hospitals are required by state law to report their sharps injuries. Almost one-third of those injuries (274, or 31%) involved devices that lacked safety features.[1] A similar proportion of sharps injuries (31%) involved hypodermic needles in the 2007 EPINet surveillance data of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

"Clearly, those are most often cases where people are not complying with both state and federal regulations to use appropriate devices," says **Angela Laramie**, MPH, epidemiologist with the Massachusetts Department of Public Health Occupational Health Surveillance Program.

As the Needlestick Safety and Prevention Act

enters its second decade, there has been a renewed push for further progress. In a regional emphasis program, U.S. Occupational Safety and Health Administration inspectors will target bloodborne pathogen hazards at outpatient centers in Florida, Alabama, Mississippi and Georgia. (*See related article on p. 76.*) Under president Karen A. Daley, PhD, MPH, RN, FAAN, who acquired HIV and hepatitis C from a needlestick, the American Nurses Association relaunched its Safe Needles Save Lives campaign. In addition, Becton, Dickinson and Company of Franklin Lakes, NJ, the largest needle and syringe manufacturer in the world, has created a new web site to highlight the stories of health care workers who had mucocutaneous exposures. *(See related article on p. 79.)*

Devices in kits cause 20% of injuries

Why are needlesticks with hypodermic needles so persistent? One reason for the higher numbers is mathematical: "They've always accounted for the highest proportion of injuries because they're the most commonly used device," notes **Jane Perry**, MA, associate director of the International Healthcare Worker Safety Center.

There also is easy availability of conventional hypodermic needles because they are used in pharmacies and for other non-patient-related tasks, she says. "[The data] shows that there's a continuing need to analyze our needlestick data and look for areas where we need to address lack of use of safety devices," she says.

Laramie evaluated sharps injuries that occurred from 2006 to 2009. One in five (20%) of all sharps injuries occurred with devices that were supplied in pre-packaged kits for procedures. There is a particular problem with kit suppliers including syringes and needles with no sharps injury prevention features, says Laramie.

Hospitals that insist on safety devices in the kits are often told they will need to purchase customized kits — at a much higher price, she says. "The custom kits should be the ones lacking sharps injury prevention features," she says.

The lack of sharps safety features in kits has been a longstanding problem, says Perry. "There appears to be a Catch-22 where the company is saying, 'We're supplying what the customer wants,' and the hospitals are saying, 'This is what the suppliers are supplying us with.' Something has to break that [cycle]," she says.

Task analysis ID's best practice

There are circumstances in which health care providers say they need to use conventional needles to perform a procedure. Yet those cases should be evaluated to see if safer options are possible, says **June Fisher**, MD, director of the TDICT (Training for Development of Innovative Control Technologies) Project in San Francisco. A task analysis can help OR nurses determine the best devices that provide safety as well as meet the needs of the procedure, she says.

For example, one hospital was using conventional syringes or not engaging safety syringes because the same patient would receive multiple injections of a local anesthetic. The chief resident tracked the usage and found that the anesthetic was typically applied four times. So prior to each procedure, four safety syringes were drawn with Novacaine and the safety feature was engaged after each use, Fisher says.

The cost of the additional syringes was outweighed by the reduction in risk of needlesticks, which can involve costly follow-up or post-exposure prophylaxis and unnecessary anxiety for health care workers, she says.

Searching for a better device

Not all safety features are equally effective. That finding in a French study has triggered a reevaluation of sharps injuries and the devices that cause them.

An analysis of 435 sharps injuries at 61 hospitals in France found that passive devices, such as self-blunting needles that are activated automatically during use, were involved in the fewest injuries. "Semi-automatic" devices, in which the user must apply extra pressure to activate the safety mechanism, such as some retractable syringes, were associated with the next fewest injuries. Those with a "toppling shield" that requires one-handed activation to cover the needle were more effective than sliding shields, which often require two-handed action and were the least effective, the authors said.

In 2010, Massachusetts began asking hospitals to provide information about the safety mechanisms. "Hopefully in the future we can make some statements about the mechanism [involved in injuries after use]," Laramie says.

Continued on p. 80

Nurses share stories on blood exposures

'It was just a drop. It wasn't much.'

For **Cheryll Collins**, the moment of fear didn't come with the sharp prick of a needlestick. It was a sudden splatter of blood — a mere drop in the eye. From a patient with end-stage AIDS and hepatitis C.

Collins worked in the busy ICU of a large medical center. The patient had just been taken off a respirator. "There were several nurses in the room," she recalls. "The patient hadn't been combative up until that point. I placed the IV. She didn't flinch. When I decided to release the safety chamber she jerked her arm away."

A bit of blood in the chamber spurted out and splashed Collins in the face. "Blood exposure happens so often, every day," she says. "It was just a drop. It wasn't much. You don't think about just a couple of drops."

Collins says she might have just washed out her eye and gone on her way, without even reporting it. But her eye was still healing from the Lasik surgery she'd had just a few days earlier. And she knew the status of her patient.

Collins now has a message for other nurses: "This happened to me. It changed my life. It doesn't have to happen to you."

She has a platform thanks to a new website by Becton, Dickinson and Company of Franklin Park, NJ, which is promoting awareness of exposures related to insertion of short peripheral IV catheters in its "Making Safety Safer" campaign. (www.bd.com/bloodcontrol.)

"This forum is designed to raise awareness, to allow people to share their stories [about mucocutaneous exposures,]" says **Rudy Onia**, MD, BD medical affairs director. "It's an issue that's not widely spoken about."

Mucocutaneous exposures are much less frequently reported than needlesticks. In the EPINet surveillance data of the international Healthcare Worker Safety Center of the University of Virginia in Charlottesville, there were 247 blood or body fluid exposures reported by 29 hospitals in 2007. About half of those (48.6%) involved a nurse.

Face and eye protection are rare, the data show. Only 2.4% of health care workers reporting exposures were wearing goggles and 4.5 % wore face shields.

Onia says BD wants to promote the use of personal protective equipment and provide awareness about exposure risks and devices that reduce the risk of exposure. "Because there is a perception that the risk [of seroconversion from a mucocutaneous exposure] is low, people accept it as being completely normal," he says.

The risk of a single mucocutaneous exposure is thought to be about one in a thousand for HIV (0.09%).[1] "It's a little lower [than the risk from a needlestick], but it's still a very real risk and it's a recognized risk," says Onia.

After the blood splash, Collins washed her eye for more than five minutes. She received antivirals for post-exposure prophylaxis, which she had to take for three months. She struggled with nausea, vomiting, fever and flu-like symptoms from the anti-viral medications, even though she took anti-emetics.

She also lived with the constant fear that she had acquired a life-threatening illness. Follow-up testing assuaged those fears but never really erased them. She did not acquire HIV or hepatitis C, but her concerns remained.

"I realized how much danger we put ourselves in every day as nurses. It was absolutely life-changing," she says.

Scan this code to watch a video testimonial of Cheryll Collins' blood exposure experience. To download a free code reader for your smartphone device, go to http://reader.kaywa.com/

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1. Centers for Disease Control. Updated U.S. Public Health Service Guidelines for Management of occupational exposures to HIV. *MMWR* 2005; 54(RR09):1-17. ■

Continued from p. 78

The Bloodborne Pathogen Standard of the U.S. Occupational Safety and Health Administration requires hospitals to update their exposure control plans each year and to evaluate new technologies.

Meanwhile, there has been some continued progress in preventing sharps injuries. Although the number of sharps injuries has remained steady, the rate has declined, says Laramie. "When we looked at the rate of injuries with hypodermic needles and syringes between 2002 and 2009, and we used licensed beds as our denominator, we did see a statistically significant decline," she says.

The needlestick law places the onus on employers to purchase safety devices, with input from frontline health care workers. But manufacturers will need to work with hospitals to provide devices that are effective and easy to use, Laramie says.

"The manufacturers have the ability and the responsibility to remove as many barriers as possible in order to make it possible for the right products to get into the hands of the clinicians," she says.

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Better lift programs raise bottom line

Policies, leader support make difference

Safe lift programs save money, and they save more if they are comprehensive and have leadership support. That finding from a new study of workers' compensation and lift-related injuries in long-term care provides a strong, new underpinning for the financial benefits of safe patient handling.

"Now we finally have the data: There's a good return on investment. It will pay for itself," says **Melissa A. McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore, which collaborated on the study with the National Council on Compensation Insurance

Power lifting: Keys to a better lift program

The following elements were associated with a higher safe lift index – and lower workers' compensation claims:

- For residents not able to move around on their own, do procedures require powered mechanical lift use?
- For residents not able to move around on their own, do their care plans require the use of powered mechanical lifts?
- When a CNA's job performance is being evaluated, how often is the use of powered mechanical lifts mentioned?
- Are newly hired certified nursing assistants (CNAs) trained in how to use powered mechanical lifts?
- May two caregivers lift a resident manually?
- Director of Nursing's preference for powered mechanical lifts to move from bed to chair (or vice versa) for residents weighing 150 pounds.
- Director of Nursing's preference for powered mechanical lifts to move from bed to chair (or vice versa) for residents weighing 90 pounds.
- Director of Nursing's perception of barriers: difficult to use in the residents' bathrooms.
- Director of Nursing's perception of barriers related to resident concern about falling during a lift.
- Director of Nursing's perception of barriers: maintenance/battery/sling problems.
- Stringency of lift policy enforcement: if the policy is violated, is the employee fired, suspended but not fired, warned but not suspended or fired, or retrained only?

SOURCE:

Restrepo T, Schmid F, Shuford H, et al. Safe lifting programs at long-term care facilities and their impact on workers compensation costs. NCCI Research Brief, 2011. Available at http://bit.ly/m6AOCP ■

What should your lift policy include?

The following elements should be addressed in a safe lift policy, according to the National Institute for Occupational Safety and Health:

- Manual lifting is unsafe for residents and staff and is not permitted.
- Minimum standards for the lifting program.
- Transferring needs of each resident are assessed and reassessed as a resident's transferring needs change.
- The amount of lifting equipment required.
- Requirements to select appropriate lifting methods.
- Training requirements for caregivers.
- Responsibilities for all caregivers.

SOURCE:

Safe lifting and movement of nursing home residents, National Institute for Occupational Safety and Health, Cincinnati, OH, 2006. ■

(NCCI) in Boca Raton, FL.

Previous studies have demonstrated cost-savings from safe patient handling programs in hospitals and nursing homes. For example, a 2004 case study showed that an investment of $158,556 in lift equipment and training resulted in a savings of $55,000 a year in workers' compensation costs, providing a return on investment after just three years.[1]

This study adds a new dimension: The quality of the overall program makes a difference in cost savings.[2] "When you have a stronger program, it does seem to reduce your frequency and total cost in claims due to lifting," says **Tanya Restrepo**, an economist with NCCI and lead author of the study.

Lifts are now commonplace in nursing homes, so the study authors couldn't simply compare facilities with a lift program and those without one. Instead, they created a safe lift index based on 11 variables related to the facility's policies and procedures, the preferences of the director of nursing, barriers to safe lifting and lift policy enforcement. *(See box on p. 80.)* The study included only facilities that had a lift program in place for three or more years – or about half (48%) of the facilities surveyed.

Nursing homes with a higher safe lift index score had fewer workers' compensation claims and lower total cost of claims, the study found. "Having lifts is a necessary requirement but not the only requirement to reducing frequency," says Restrepo.

Or, to put it another way, "it's not enough to have the lifts," says **Pat Gucer**, PhD, assistant professor in the Occupational Health Project at the University of Maryland School of Medicine, who developed the safe lift index. "You need the policies and procedures in place to maximize the use of those lifts."

Lifts catch on at nursing homes

The NCCI study found a promising trend in long-term care, which has high rates of injury due to overexertion. Nursing homes have been purchasing lift equipment.

"When we first started collecting the data and thinking about the study we thought we might look at facilities that have a program versus facilities that don't have a program, but most of the facilities that answered our surveys had powered mechanical lifts in place," says Restrepo. "A large percentage also used them routinely."

In 2005, one in four (26%) long-term care facilities had two or fewer lifts per 100 residents. By 2007, that had dropped to 10%. The median ratio of lift equipment also rose, from 3.8 lifts per 100 residents in 2005 to 5.7 lifts per 100 residents in 2007.

Most of the facilities actually exceeded the ratio of lift equipment that is recommended by the National Institute for Occupational Safety and Health (NIOSH) — one full-body lift for every eight to ten non-weight-bearing residents and one sit-stand lift for every eight to ten partially weight-bearing residents.[3] In fact, the average ratio was one for every three non-weight-bearing (0.351) or partially weight-bearing (0.329) residents.

Nursing homes may have begun by using lifts out of necessity to move bariatric patients, then discovered the benefits for other residents who needed assistance, says McDiarmid.

Beyond the increased availability of lift equipment, the most effective programs in the study had a combination of important elements, including robust policies that required the use of lifts and mandated appropriate training of the certified nursing assistants (CNAs). They provided for rigorous enforcement of the lift policy. The prefer-

ences of the director of nursing and perception of barriers to using the lifts also played an important role, as reflected in the safe lift index, says Restrepo.

"The institution's commitment to effectively implementing a safe lift program appears to be the key to success," the study concluded.

NCCI is continuing to analyze the data to quantify how changes in the variables affect workers' compensation claims. If enforcement of a safe lifting policy becomes more stringent, for example, the analysis will determine how much that affects the magnitude of claims, says Restrepo.

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Older workers have more serious injuries

Prevent work-related falls

As the health care workforce ages, the severity of work-related injuries is increasing, requiring new strategies for protecting workers. At the top of the list: Preventing falls, which are already the second most common cause of reportable injury in hospitals.

About one in five injuries in hospitals (21%) involve workers who are 55 or older, according to 2009 data from the U.S. Bureau of Labor Statistics. Almost one in four (23%) registered nurses who are injured are 55 or older. By comparison, older workers sustain 16.5% of injuries overall in general industry.[1]

A higher proportion of workplace injuries are occurring among older workers, and those workers are likely to have more serious consequences, according to data from the National Institute for Occupational Safety and Health (NIOSH). The median number of days away from work due to injury increases with age and is greatest for workers who are 65 and older, according to the analysis.[2]

"If employers and others don't take some concrete steps to check this trend, the numbers of injured older workers will continue to grow in the future," says **Dawn Castillo**, MPH, chief of the surveillance and field investigations branch in NIOSH's Division of Safety Research in Morgantown, WV.

The impact of aging on occupational injuries is especially important in health care. Almost half (45%) of RNs are 50 or older, according to the 2008 National Sample Survey of Registered Nurses, conducted by the Health Resources and Services Administration (HRSA). The average age of employed RNs is 46.3.

"The older workers experience more catastrophic injuries. A fracture is more costly than a sprained ankle," says **Jennan Phillips**, DSN, RN, assistant professor at the University of Alabama at Birmingham School of Nursing, who spoke on aging at the annual conference of the American Association of Occupational Health Nurses (AAOHN) in Atlanta in May.

Fracture risk higher with age

As people age, their physical changes affect their lives at work as well as at home. They may have bifocals or reading glasses that suddenly alter their depth perception as they're walking, says Phillips. They may have less muscle strength and poorer balance.

And importantly, they are more prone to fracture if they fall, Phillips notes. The NIOSH analysis found that older workers were more likely to have work-related fractures than sprains. Fractures led to a median of 32 days away from work for workers who are 55 or older, and a median of 42 days away from work for workers 65 or older.

There are some important steps employers can take to minimize the risk of falls, says Phillips. For example, walkways and stairways should be well-lit. Floors need to be kept dry and spills should be wiped up promptly, she says. *(For more information on fall prevention, see* HEH, *April 2011.)*

Preventing falls benefits workers as well as patients and visitors. "While we believe there are certain types of injury events that are more likely among the older workers, in most cases efforts to protect these workers are going to pay dividends by providing protections to the entire workforce,"

says Castillo.

Injury analysis should include information on age so employee health professionals and risk managers can consider the needs of older workers as the workforce ages, says Castillo. Older workers also may need some awareness about how medical conditions can affect their injury risk, including reduced vision, arthritis, or osteoporosis.

Workplace wellness programs also can help employees cope with chronic diseases and improve strength and flexibility, says Phillips. "The worksite is going to be an excellent place for delivery of health promotion and primary care," she says.

Interestingly, older workers are less likely to be injured due to overexertion than younger workers. They might realize their limitations and may be less likely to perform hazardous lifts, says Castillo. Older workers also may have fewer injuries because their experience makes them more cautious or able to avoid hazards, she says.

"It points to the needs for more research to understand the complexities of safety and health for older workers," she says.

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OSHA extends comment deadline on MSD rule

The U.S. Occupational Safety and Health Administration (OSHA) briefly reopened the comment period on the proposed rule to record work-related musculoskeletal disorders (MSDs). The comments came from May 17 to June 16, about a month after two teleconferences focused on concerns of small businesses.

"The more feedback the agency receives from small businesses on this topic, the better informed we will be in crafting a proposed regulation that protects workers without overburdening employ-

CNE OBJECTIVES

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

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

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- Progress in treatment of HCV
- The most dangerous jobs in America?
- Changes ahead in labeling of chemicals
- Update on OSHA's injury prevention standard
- Improving needle safety in home health

ers," OSHA administrator **David H. Michaels**, MD, MPH, said in a statement.

According to an OSHA summary of the teleconferences, some employers expressed concern that employees would report MSDs that were not work-related and that MSDs might be over-reported as work-related even by physicians.

For the purposes of the proposed recordkeeping, OSHA defines an MSD as "a disorder of the muscles, nerves, tendons, ligaments, joints, cartilage or spinal discs that was not caused by a slip, trip, fall, motor vehicle accident or similar accident."

The proposed rule would require employers to check a box on the OSHA 300 log indicating that a work-related MSD occurred. ■

CNE QUESTIONS

1. A report by the American Hospital Association determined that approximately two-thirds of hospitals currently do not provide incentives for employees to participate in wellness programs.
   A. true
   B. false

2. According to **Angela Laramie**, MPH, one reason needlesticks from hypodermic needles are continuing to occur is:
   A. kits used in procedures are packed without safety devices
   B. physicians object to using safety devices
   C. safety devices aren't adequate on hypodermic needles
   D. hypodermic needles with safety devices are too expensive.

3. A study by the National Council on Compensation Insurance and the University of Maryland School of Medicine found that the cost-savings of safe lifting in nursing homes are related to:
   A. the total number of lifts
   B. the ratio of lifts to residents
   C. the overall program, including policies and preferences of the director of nursing
   D. the attitudes of certified nursing assistants toward lift equipment

4. According to data from the National Institute for Occupational Safety and Health (NIOSH), older workers are more likely:
   A. to be injured than younger workers.
   B. to retire due to injury.
   C. to report injuries.
   D. to have more days away from work due to an injury.

Dear *Hospital Employee Health* Subscriber:

This issue of your newsletter marks the start of a new continuing medical education (CME) or continuing nursing education (CNE) semester and provides us with an opportunity to tell you about some new procedures for earning CME or CNE and faster delivery of your credit letter.

Hospital Employee Health, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options. Our intent is the same as yours — the best possible patient care.

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- 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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