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IN THIS ISSUE

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AHC Media

OSHA citations rise as agency turns up heat on HCW injury reporting

Beware of incomplete entries on 300 log

An intense focus on recordkeeping by the Occupational Safety and Health Administration could have far-reaching consequences for health care employers, changing the way they report some injuries and increasing the likelihood that they may receive citations related to their injury and illness reporting.

Already, recordkeeping citations have risen precipitously in health care facilities. In Fiscal Year 2010, nursing homes had more citations related to injury reporting than any other employer group. Failure to properly record injuries and illnesses triggered almost as many citations in hospitals as the Bloodborne Pathogen standard.

OSHA launched a National Emphasis Program on recordkeeping that runs through February 2012. Although hospitals are not one of the targeted employers in the NEP (as nursing homes are), the focus on recordkeeping is far-reaching, cautions **Brad Hammock**, an attorney with Jackson Lewis in Reston, VA, who specializes in occupational health law.

"In every inspection, compliance officers are going to look at your recordkeeping logs," he says.

OSHA Administrator **David Michaels**, PhD, MPH, has long expressed concern about underreporting of work-related injuries and illnesses. "The new leadership team at OSHA came into their roles with a belief that there was a gross level of under-reporting across [industries]," says Eric J. Conn, an attorney who heads the OSHA group at Epstein Becker and Green in Washington, DC.

"I think their expectations were misplaced, but it continues to be a strong emphasis of this administration," says Conn. "I think they consider it to be the backbone of their enforcement strategy, to identify the industries and workplaces that need their attention. Those industries and workplaces are identified only by proper and accurate injury recordkeeping."

National emphasis on recordkeeping

In the first 20 months of the recordkeeping National Emphasis Program, federal OSHA conducted 263 inspections and issued 511 violations. Seventy-two inspections and 153 violations were in nursing homes. (State-plan states also have conducted recordkeeping emphasis programs.)

Initially, OSHA targeted employers with low injury rates although they were in industries that have high overall rates. The NEP has since been changed to focus on worksites with a mid-range rate of injuries (4.2 to 8.0 lost or restricted work days or job transfers due to injury per 100 fulltime employees).

The infractions found are common recordkeeping errors, an OSHA spokesman says. They include:

Failing to record a work-related injury or illness: The injury doesn't have to be caused by a job activity to be work-related. If an employee trips and falls in the parking lot or gets scalded by coffee in the cafeteria, that's still a work-related injury. *(See related story, p. 99.)* If the work environment exacerbates a pre-existing condition — such as cleaning fumes triggering asthma — that's work-related, too. "OSHA has a very broad definition of work-relatedness," says the OSHA spokesman. "If there's anything in the work environment that caused or contributed to the cause, it's work-related." Of course, OSHA is also on the look-out for employers who willfully fail to record work-related injuries and illnesses. In September 2010, a Houston manufacturer received 83 "willful" citations for failing to record or improperly recording for "nearly three quarters of employee injuries and illnesses for more than two years before the investigation," according to the agency. The fine: $1.2 million.

Failing to report restricted work: If an employee continues working but temporarily avoids doing certain job tasks, that is considered to be restricted work, an OSHA spokesman explained. "If the employee gets hurt and they cannot do routine job functions, then we consider them restricted," he says. A routine job function is "anything an employee would be expected to do at least once a week. " OSHA has created an online "recordkeeping advisor" to help employers determine whether incidents are recordable. (http://webapps.dol.gov/elaws/osha/recordkeeping/)

Incomplete description or entry: Employers must provide a one- to two-line description of the recordable injury or illness on the OSHA 300 log. Having an inadequate description of the incident has been a primary source of citations in hospitals and other industries. The regulation also states that "all work-related needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material" must be included on the OSHA 300 log.

Failing to take privacy precautions: Hospitals also have received citations for failing to follow the privacy provisions. Employers must indicate "privacy concern case" on the OSHA 300 log and place the name and case number on a confidential list if the employee requests privacy or if the injury or illness involves: an intimate body part or the repro-

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Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).
Executive Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

Editorial Questions

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

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ductive system, a sexual assault, mental illness, HIV infection, hepatitis, or tuberculosis or sharps injuries involving blood or body fluid exposures.

More requirements to come

OSHA has some other recordkeeping issues on its agenda, and it's a good idea to pay attention to them, legal experts say. These include:

Be prepared to identify musculoskeletal disorder (MSD) injuries. By January 2012, OSHA is expected to finalize its proposed rule to create a separate MSD column on logs. OSHA is defining 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." As with other injuries, it is recordable if it is a new, work-related injury that requires medical treatment beyond first aid and/or involves restricted work or days away from work.

Marking a separate column for MSDs will make it easier for employee health professionals to track these injuries, says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, manager of Employee Health Services at Allegheny General Hospital and the Western Pennsylvania Hospital in Pittsburgh, and community liaison for the Association of Occupational Health Professionals in Healthcare in Warrendale, PA. However, she notes that different agencies, such as the Bureau of Labor Statistics and the National Institute for Occupational Safety and Health, use slightly different definitions of MSDs. "We need a clear definition and it should be consistent if they want to use it for data analysis," she says.

Reportable incidents may rise with new rules. OSHA has proposed an expansion of reporting requirements. Currently, employers must notify OSHA within eight hours if there has been a work-related fatality or inpatient hospitalization of three or more employees. The proposal would require notification of all work-related inpatient hospitalizations within eight hours and all work-related amputations within 24 hours. (This is in addition to recording the incidents on the OSHA log.)

"It's going to require reporting a much larger number of incidents to OSHA by loosening the reportability criteria," says Hammock. This would include hospitalizations that might occur for observation rather than treatment.

Beware of incentive programs. OSHA doesn't have a regulation that prohibits programs that reward employees for low injury rates, but Michaels has repeatedly expressed concern about disincentives to reporting. In fact, if an employer is found to have failed to report injuries and there is a program that creates an incentive not to report injuries, they could be subject to a "willful" violation, an OSHA spokesman said.

"We're discouraging employers from having programs in place that would discourage reporting," he says. Employers need to address hazards in the workplace, and he notes, "you can't make good decisions on information that's not there."

Be ready for electronic reporting. OSHA is expected to release a proposed rule on electronic reporting by the end of this year. This would allow for more timely sharing of occupational injury and illness data, the OSHA spokesman says. Currently, OSHA collects data annually from about 80,000 workplaces, and about 70% of them submit the information electronically.

Review your recordkeeping accuracy. With so much attention being placed on recordkeeping, it's a good idea to conduct an audit – or hire an outside counsel to do it for you, says Conn. "It's important to make sure your records are current and accurate," he says. For example, you would want to compare your logs with other sources of information about work-related injuries and illnesses, such as workers' compensation or absenteeism records. Be aware that an OSHA inspector also will interview employees and will ask about work-related injuries. ■

OSHA recordkeeping: Is it work-related?

OSHA offers the following examples as guidance on what to report on injury logs. (For more information go to: http://1.usa.gov/nFxelo)

Does an employee report of an injury or illness establish the existence of the injury or illness for recordkeeping purposes?

No. In determining whether a case is recordable, the employer must first decide whether an injury or illness, as defined by the rule, has occurred. If the employer is uncertain about whether an injury or illness has occurred, the employer may refer the employee to a physician or other health care professional for evaluation and may consider the health care professional's opinion in determining whether an injury or illness exists. [Note: If a physician or other licensed health care professional diagnoses a significant injury or illness within the

meaning of §1904.7(b)(7) and the employer determines that the case is work-related, the case must be recorded.]

An employee experienced an injury or illness in the work environment before they had "clocked in" for the day. Is the case considered work related even if that employee was not officially "on the clock" for pay purposes?

Yes. For purposes of OSHA recordkeeping injuries and illnesses occurring in the work environment are considered work-related. Punching in and out with a time clock (or signing in and out) does not affect the outcome for determining work-relatedness. If the employee experienced a work-related injury or illness, and it meets one or more of the general recording criteria under section 1904.7, it must be entered on the employer's OSHA 300 log.

Is work-related stress recordable as a mental illness case?

Mental illnesses, such as depression or anxiety disorder, that have work-related stress as a contributing factor, are recordable if the employee voluntarily provides the employer with an opinion from a physician or other licensed health care professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related, and the case meets one or more of the general recording criteria. See sections 1904.5(b)(2)(ix) and 1904.7.

If an employee's pre-existing medical condition causes an incident which results in a subsequent injury, is the case work-related? For example, if an employee suffers an epileptic seizure, falls, and breaks his arm, is the case covered by the exception in section 1904.5(b)(2)(ii)?

Neither the seizures nor the broken arm are recordable. Injuries and illnesses that result solely from non-work-related events or exposures are not recordable under the exception in section 1904.5(b)(2)(ii). Epileptic seizures are a symptom of a disease of non-occupational origin, and the fact that they occur at work does not make them work-related. Because epileptic seizures are not work-related, injuries resulting solely from the seizures, such as the broken arm in the case in question, are not recordable.

This question involves the following sequence of events: Employee A drives to work, parks her car in the company parking lot and is walking across the lot when she is struck by a car driven by employee B, who is commuting to work. Both employees are seriously injured in the accident. Is either case work-related?

Neither employee's injuries are recordable. While the employee parking lot is part of the work environment under section 1904.5, injuries occurring there are not work-related if they meet the exception in section 1904.5(b)(2)(vii). Section 1904.5(b)(2)(vii) excepts injuries caused by motor vehicle accidents occurring on the company parking lot while the employee is commuting to and from work. In the case in question, both employees' injuries resulted from a motor vehicle accident in the company parking lot while the employees were commuting. Accordingly, the exception applies. ■

OSHA moves forward with ID standard

Will California or failed TB rule be the model?

As the U.S. Occupational Safety and Health Administration moves deliberatively toward an infectious diseases standard, two paradigms could spell very different fates for a proposed rule.

Is California the model, with its Aerosol Transmissible Diseases standard? Or, as some critics say, is this standard on a path similar to the tuberculosis standard, which reached the final rule stage before it was abruptly revoked?

OSHA contends that the SARS epidemic, which killed two nurses and a doctor in Ontario and sickened scores of health care workers,[1] and the H1N1 pandemic, which killed a California nurse and sickened at least 81 health care workers in the first weeks of the pandemic,[2] reflect the need for workplace protections against infectious diseases. By taking a broad approach — the standard will likely address airborne, droplet and contact transmission — OSHA puts the tuberculosis rule behind it.

"While the agency learned a great deal from the previously proposed tuberculosis rule, the agency is considering the current infectious disease activity in the larger context of standard and transmission-based precautions rather than on a disease-by-disease basis," agency officials said in response to a question posed by HEH in an online chat. OSHA was scheduled to hold a stakeholder meeting in late July to gather further comments.

But many in the occupational health and infection control communities say guidelines from the Centers for Disease Control and Prevention

are sufficient to protect health care workers and patients alike. They note that guidelines can change as new knowledge emerges about disease transmission, and although they are not regulatory, accrediting bodies expect hospitals to follow them.

The American College of Occupational and Environmental Medicine (ACOEM) has urged OSHA to use a "generic" approach to ensure that employers provide health care workers with appropriate personal protective equipment and training. "There is already precedent for the enforcement of health care worker protection from tuberculosis under the General Duty Clause," ACOEM said in a letter to OSHA.

In written comments to OSHA, the Association of Occupational Health Professionals in Healthcare (AOHP) noted that OSHA already has tools to enforce protections related to infectious disease hazards.

"We felt that with the current OSHA standards, including the general duty clause, respiratory protection program, personal protective equipment and recordkeeping, that those adequately protected the workers," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, manager of Employee Health Services at Allegheny General Hospital and the Western Pennsylvania Hospital in Pittsburgh.

Are hospitals following CDC?

But are CDC guidelines adequate to provide workplace protection for health care workers? When hospitals fail to follow recommended infection control guidelines or provide adequate protections, an outbreak may occur. In California, that failure also can lead to citations.

That extra imperative has made a difference in spurring compliance with CDC guidance, says **Deborah Gold**, MPH, CIH, deputy chief of health for Cal-OSHA in Oakland.

Case in point: Pertussis vaccination of health care workers. In 2006, a CDC advisory panel recommended pertussis vaccination for health care workers who care for infants. That recommendation was later expanded to include all health care workers with patient contact.

But as pertussis cases rose in California to the highest levels in 50 years, the California Department of Public Health found that vaccination was spotty. "Even though there had been a voluntary recommendation saying people should be vaccinated, [many] people weren't," says Gold. "The requirement in the standard helped move the vaccination program along."

Clear requirements in California meant greater protections as the H1N1 pandemic emerged, says **Bill Borwegen**, MPH, safety and health director of the Service Employees International Union (SEIU). "It was a lot easier to protect our members [with respirators] in California than it was in the rest of the country, especially when public health departments were providing conflicting advice," he says.

With the ATD standard, the requirements related to workplace protection are clearly spelled out, says Gold. "It gives everybody an understanding of what needs to be followed," she says. And if they're not, employees then have recourse to file an OSHA complaint, she says.

If employers are already in line with CDC recommendations, then they have little to worry about, she says. "A hospital or any health care facility that's doing a good job of complying with CDC guidelines is not going to find a big challenge complying with our ATD standard," she says.

What is the HCW risk?

Infection control practitioners and occupational health professionals argue that health care workers do not have higher rates of diseases than the general public — the argument that ultimately was pivotal in the scuttling of the tuberculosis standard.

"The fact that incidences among health care workers of a range of infectious diseases have not been shown to exceed population rates speaks to the effectiveness of hospital-based infection control and occupational medicine infrastructures," ACOEM said.

The Association for Professionals in Infection Control and Epidemiology (APIC) was blunt in its comments: "Because these efforts are already well-guided by other government agencies, they do not require additional monitoring by another government agency and represent a redundant and unnecessary cost burden for employers and taxpayers. "

At the Marshfield (WI) Clinic, which serves about 1.4 million patients a year, since 1994 only one employee's illness has been linked to probable transmission from a patient — a case of H1N1, says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety. "Other than that, we have not been able to document a connection between seeing a patient with a disease and an employee getting a disease," he says.

"The OSH Act [which created OSHA] says in

order to develop a standard, OSHA has to show there's a specific hazard," he says. "I don't see how they can do this without having good hard evidence that health care workers have any greater risk of developing disease than the general public."

Yet a recent transmission of meningitis in California illustrates the infectious disease hazard to first responders and emergency room personnel. A police officer responded to a call and found an unconscious person in his home — but did not wear respiratory protection when he tried to clear the man's airway. The police officer ultimately was hospitalized with bacterial meningitis.

So was a respiratory therapist who subsequently assisted in an intubation of the patient in the emergency department — without wearing a mask or respirator. CDC recommends "protection of the eyes, nose and mouth" when performing aerosol-generating procedures.[3] The ATD standard calls for the use of respirators during "high hazard procedures" (including intubation) for droplet and airborne diseases. (The ATD standard is available at www.dir.ca.gov/title8/5199a.html.)

"We're trying to [ensure that health care workers] take appropriate precautions at each level of interaction," says Gold.

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CDC sets a standard measure for flu shots

NQF measure to improve comparisons

A proposed National Quality Forum measure may standardize the way hospitals calculate their health care worker influenza immunization rates.

Currently, when hospitals report their influenza immunization rates, both the numerator and denominator may vary widely. Are they counting vaccinations among employees who have direct patient contact? Or all employees, regardless of where they work? Are they including people who worked only part of the year? Are they counting agency staff or contract workers?

The measure proposed by the Centers for Disease Control and Prevention now covers the vaccination status of three groups:

• **Employees who worked at least 30 days during the flu season.** Previously, the measure asked hospitals to include any employee who had worked for at least one day. "That [change] is going to miss a small proportion of health care personnel, but it's going to provide something that is more feasible and something hospitals may feel is more fair," says **Megan C. Lindley**, MPH, epidemiologist with CDC's National Center for Immunization & Respiratory Diseases. "To try to capture somebody who is in there for one day or one part of one day is potentially extremely challenging, particularly for a very large institution where you have people coming in and out."

• **Licensed independent practitioners.** The measure will count non-employee physicians, advanced practice nurses and physician assistants, but not all credentialed employees. Again, this will make it clearer and easier for hospitals and reduce variation, says Lindley. "We found that over 70% of the hospitals credentialed their physician assistants and advanced practice nurses, and 96% of them credential their physicians," she says. By contrast, "Fewer than 20% credentialed therapists or technicians." Counting independent practitioners who don't require credentialing could present challenges for some hospitals, she says. "You could capture the bulk of the credentialed nonemployees by restricting it to those three defined groups," she says. Nurses who are credentialed through an agency would not be counted, although the hospital could require the agency to provide nurses who have been vaccinated, she says.

• **Non-employees.** This group would be limited to students, trainees and volunteers. It would not include sales people or vendors, contract personnel, or construction workers. The previous definition of non-employees was vague and could have led to different interpretations, says Lindley." It could potentially be very, very different from facility to facility, which is contrary to the point of having a standardized measure," she says.

The numerators would be: health care personnel vaccinated at the institution and those vaccinated elsewhere, those with medical contraindications,

and those who declined vaccination for non-medical reasons.

To win endorsement from the National Quality Forum, sponsors must provide data on the feasibility of implementation and the validity and reliability of the measure, Lindley says. "With these revised definitions, this provides an extremely standardized way of measuring," she says.

Hospitals had expressed concerns, especially with measuring non-employee vaccinations, in online surveys that CDC conducted with 216 health care institutions, including 80 hospitals, in four states. About half of the hospitals said their ability to determine the vaccination status of those non-employees was a major barrier.

The revised measure represents a balance designed to make measurement easier but thorough, Lindley says. "It's better to have an extremely accurate measure of 80% of personnel than it is to have an inaccurate measure that covers 100% of personnel," she says.

One thing may not change with the definitions: The burden of collecting the information. "For hospitals, in every numerator category for the three groups, paper occupational health records were the most common data source by far," she says.

In other words, most hospitals can't obtain this vaccination information simply by querying a database. Still, she says, "we were heartened that 70% of hospitals only had one person working on this [data collection]," an indication that it didn't require multiple personnel, she says. ■

In tornado aftermath, hospital 'a refuge'

HCWs support each other — and community

April 27 in Tuscaloosa, AL, started with eerie expectation, with warnings of severe weather and reports of tornadoes. By the afternoon, "it was very quiet, very dark and quite warm," says **Beth Francis**, SPHR, vice president for human resources for the DCH Health System in Tuscaloosa. "We knew the area was quite susceptible to being hit."

As the sky grew darker, televisions throughout DCH Regional Medical Center flickered with ominous weather reports. Tuscaloosa was in the path of a monster storm — a mile wide with winds of 190 miles per hour. Hospital employees began moving patients into the hallways. The lights went out, and the generators kicked on. Just a block away, the tornado blasted through the college town, wreaking devastation. Some of the hospital's windows blew out, but otherwise the hospital was unscathed.

Emergency preparedness plans helped the hospital establish its command center and guided it through the disaster and aftermath. But ultimately, it was the dedication of employees that carried the day as the hospital became an anchor for a shattered community.

Some people had huddled in the hospital's large parking garage to seek protection from the tornado. "After the tornado came through, [the

How prepared are nation's hospitals?

The assessment of hospital preparedness varies depending on the type of disaster, according to a report by the National Center for Health Statistics. The 2008 National Hospital Ambulatory Medical Care Survey, which included 294 hospitals, found that:

- Almost all hospitals (more than 93%) had emergency response plans to address chemical accidents or attacks, natural disasters, epidemics or pandemics, and biological accidents or attacks.
- About 80% of hospitals had plans that covered nuclear or radiological accidents or attacks or explosive or incendiary accidents or attacks.
- About one in 10 hospitals did not have an internal disaster drill in the last year. Half conducted more than one internal drill.
- The median number of N95 masks per hospital was 432, and the median number of personal protective suits with powered air-purifying respirators per hospital was 10.
- Less than a third of hospitals (30.6%) addressed mass medication distribution to their personnel in their drills, and only about a third (32.5%) addressed mass vaccination.
- Hospitals were more likely to address general disaster scenarios in their drills than pandemics (58.5%) or chemical accidents or attacks (55.6%).

Source: National Health Statistics Reports: Hospital Preparedness for Emergency Response: United States, 2008. March 24, 2011. Available at http://bit.ly/rs3jdJ ■

hospital] became a place of refuge," says Francis. "People were just walking through the doors to get care. People who had lost their home were just walking over this way."

DCH Regional Medical Center eventually treated about 1,000 people who had been injured by the tornado, from mild concussions or fractures to life-threatening trauma. Eventually, authorities would determine that 43 people died in Tuscaloosa from that tornado.

In a disaster, hospital administrators must be able to expand their capacity even while employees wrestle with the same difficulties as the rest of the community. In fact, about 300 employees were affected personally by the tornado, some of them facing catastrophic damage to their homes, says Francis. One part-time employee, a student, was killed in his home.

Yet employees continued to report for work — even beyond their scheduled shifts. "We didn't have to call nurses in. People came on their own," she says. "Physicians who didn't [even] work here came to help. They were put to work. You had people who were working who didn't know if their house was standing."

Hospital sets up employee 'store'

Offers of help also poured in, and the health system mobilized to support employees and the community.

The Employee Assistance Program quickly responded to various needs, from the practical to the emotional. The hospital opened a "store," with personal items, such as shampoo, razors, and diapers, clothes, including color-coded hospital scrubs, and other household needs. The items were donated. Employee just needed to complete a checklist of their needs and they would be delivered to their unit.

There was an outpouring from around the country. St. Tammany Parish Hospital in LA, for example, sent gift cards from Winn-Dixie, Target, Walmart, and Lowes. The DCH Foundation set up a M*A*S*H* fund, which raised about $300,000 to assist employees. Unaffected employees could donate their unused paid-time-off in lieu of money.

The hospital also created a resource center for employees, a place where they could meet with representatives from the American Red Cross, legal counsel, construction contractors, or the credit union.

Ultimately, the tornado taught Tuscaloosa about resilience and caring. When a massive tornado hit Joplin, MO, about a month later, DCH Medical Center offered assistance. St. Johns Regional Medical Center there took a direct hit. The tornado shattered the windows and sent glass flying throughout the hospital, as the building shook and some patients were flung about. Five patients died due to the tornado, according to news reports.

"We appreciate everything that people have done for us. It makes you want to help others," says Francis.

Even months after the tornado, clean up continued. "We are moving along. And so is Tuscaloosa," Francis says. ■

NIOSH: Go on a sharps safety 'blitz'

Site offers easy-to-create posters, evaluations

If your sharps injuries have reached a plateau and you are having a hard time making progress on needlestick prevention, it may be time for a blitz.

The National Institute for Occupational Safety and Health (NIOSH) has launched a new website called STOP STICKS to help health care facilities create an awareness campaign (www.cdc.gov/niosh/stopsticks/).

The concept is to create short, targeted campaigns, perhaps lasting a month or 8 weeks with new messages every week or two, says **Thomas Cunningham**, PhD, a behavioral scientist with NIOSH's Education and Information Division in Cincinnati.

"This is intended to saturate the environment with messages to raise awareness. Hopefully that impacts behavior," he says.

An effective blitz would be tailored to one area, such as the emergency department or operating room, he says. "It tends to be more effective if it's focused in a specific area rather than the entire facility all at once," he says.

"The first major step in conducting a blitz is to understand your audience," he says. For example, NIOSH provides pre-tests for the OR and other areas, as well as observation evaluation forms. The blitz can then be developed around weaknesses or misconceptions, he says. (See sample OR form inserted in this issue.)

Facilities also can create data displays just by plugging numbers into ready-made charts, avail-

able on the website. There are even sample articles for the hospital newsletter.

"The idea was to give the target audience some feedback about the actual conditions they're working in, things that are much more relevant to their specific situation, and to communicate that risk," says Cunningham. "Everything is very customizable."

Yet if the medium is the message, the NIOSH site needed to alter its awareness, as well. The site launched with "stock" photos of a gloved hand and a needle — and it wasn't safety engineered. The pictures of unsafe sharps were quickly removed. ■

Hospital discovers smarter way to lift

Physical ability tests plus lifts = safety

At Georgetown (SC) Hospital System, preventing injuries begins with an equation: The physical abilities of newly hired employees must meet the physical demands of the job.

That plan not only addresses the potential for injuries, but it also shines a light on the needs of the job tasks compared to the abilities of the workforce. So when it turned out that too many prospective nurses couldn't attain the medium/heavy requirements of the job, Georgetown Hospital System reduced the job's exertion level through a new program called Smart-Lift program.

Now, more newly hired nurses pass the physical agility tests — and fewer are injured, says **Kathy Dowling**, RN, BSN, manager of Employee Health Services. "Our injuries have decreased, and our workers' compensation premiums have gone down," she says.

New hires and those who are transferring into a new position take the physical agility test with an isokinetic machine, which provides resistance equivalent to the force applied to the machine. The test requires specific movement patterns, such as knee and shoulder flexion and extension. It is then analyzed by Industrial Physical Capability Services (IPCS), Inc., of Hudson, OH.

"It's a workout," says Dowling. "It gives us a physical picture of that person's strength. It shows you where there might be some weakness in an extremity."

For example, initially new nurses were required to be able to exert 35 to 50 pounds of force occasionally, 15 to 20 pounds of force frequently, and 10 pounds constantly to move objects using an isokinetic machine. But only about 70% of newly hired nurses were passing, Dowling says.

"We would give them conditioning and strengthening exercises and allow them to come back and retest after 90 days, after they had time to exercise and increase their strength," she says.

Red, yellow, green mark patient needs

The solution: Lower the lifting requirements of the job. With the Smart-Lift program, the pass rate rose to 92%.

Smart-Lift is incorporated into the routine patient assessments and electronic medical record. At admission, each patient receives a mobility score, which indicates what type of lift equipment should be used. That score is updated by a reassessment every 24 hours.

The results are color-coded. If a patient's score is zero, then they need no assistance with transferring. A green magnet is placed on their door.

A score of 1 to 5 indicates the need for some assistance, typically a gait belt. The door magnet is yellow. Patients with a 6 to 10 need help rising to a standing position, which indicates the use of a sit-to-stand lift. The magnet is red with an ST.

Those with intermediate lifting needs (scores 11 to 14) are indicated with a red magnet, and those who need full lift assistance, using the Arjo Maxilift, are indicated with a red magnet and MT.

"We used a very visual system so anyone going into the room knows immediately by looking at the magnet what level of assistance the patient needs," says **Sandra Raynes**, RN, MEd, nursing operations director at Waccamaw Community Hospital in Murrells Inlet, SC, one of the system's two hospitals.

The patient assessments are based on a number of factors, including: the patients' medical condition, the medications they receive, their ability to support their weight, their ability to follow instructions, or whether they're experiencing dizziness, and their weight and body mass index. Patients with respiratory compromise or fatigue also may need more assistance. With a computer-based algorithm, nurses simply answer a series of questions and receive a score total for the patient.

By mid-2011, Waccamaw Community Hospital had only seven patient handling injuries among its

600 employees. That compares to 26 such injuries in 2009 and 19 in 2010. The Smart-Lift program was implemented in mid-2009. Georgetown Hospital System also fares well in comparison with the most recent available national data from the U.S. Bureau of Labor Statistics, which shows a rate of 6.7 injuries per 100 employees for hospitals nationally in 2009. The hospital system's rate is 2.56.

Although the system purchased some new lift equipment, hospitals already had much of the equipment needed to reduce injuries. They just needed a consistent and easy way for nurses to know when to use it and additional training to help nurses become comfortable with it, says Raynes.

"We've worked really hard to make it a [safety] culture," she says. "Once something becomes a culture, it's expected. They realize how important it is for them to use it." ■

Safe lifting a healthcare triumph

CDC lauds progress in preventing injury

It's official: Safe patient handling is one of the U.S. public health achievements of the decade.

Alongside tobacco control, improved maternal and infant health, and reduction in motor vehicle deaths, the Centers for Disease Control and Prevention cited safe patient lifting and other occupational health advances as among the Ten Great Public Health Achievements for 2001 to 2010.

"In the late 1990s, an evaluation of a best practices patient-handling program that included the use of mechanical patient-lifting equipment demonstrated reductions of 66% in the rates of workers' compensation injury claims and lost workdays and documented that the investment in lifting equipment can be recovered in less than three years," the CDC said in its report. "Following widespread dissemination and adoption of these best practices by the nursing home industry, Bureau of Labor Statistics data showed a 35% decline in low back injuries in residential and nursing care employees between 2003 and 2009."

This citation refers to work by **Jim Collins**, PhD, MSME, associate director for science in NIOSH's Division of Safety Research in Morgantown, WV.

CNE QUESTIONS

9. According to OSHA, an injury is work-related if:
   A. it happened during working hours.
   B. anything in the work environment caused the injury or contributed to the cause.
   C. it was not a pre-existing condition.
   D. it occurred while performing a work task.

10. According to Deborah Gold, MPH, CIH, deputy chief of health for Cal-OSHA in Oakland, an Aerosol Transmissible Diseases standard was necessary because:
   A. infectious disease outbreaks continue to occur.
   B. not all health care workers are vaccinated against influenza.
   C. not all hospitals comply with guidelines from the Centers for Disease Control and Prevention.
   D. CDC guidelines do not protect workers.

11. According to the revised proposal for a National Quality Forum measure on influenza immunization of health care workers, which of the following would be included as "licensed independent practitioners"?
   A. physician assistants
   B. physical therapists
   C. medical residents
   D. OR technicians

12. A National Institute for Occupational Safety and Health study of best-practices in safe lifting in nursing homes showed a reduction in workers' compensation claims and lost workdays of how much over three years?
   A. 35%
   B. 52%
   C. 66%
   D. 75%

In a seminal study conducted with BJC Healthcare in St. Louis, Collins helped implement a "zero lift" program in long-term care facilities with one lift for every eight patient rooms. The program included intensive training of staff, safe-lifting "ergorangers" to help reinforce the training, and algorithms to assess patients' dependency and lift needs.

The payback of the safe lift program was swift. "The initial investment of $158,556 for lifting

equipment and worker training was recovered in less than three years on the basis of post-intervention savings of $55,000 annually in workers' compensation costs," Collins told a U.S. Senate panel at a hearing in 2010. "This is significant given that cost is an often-cited barrier to purchasing lifting equipment and establishing safe patient lifting programs."

Interestingly, assaults on caregivers during resident transfers also declined with use of mechanical lifts, Collins says. ■

HEH's sister pub receives top prize

National Press Club honors Hospital Infection Control & Prevention

We are honored to announce that Hospital Employee Health's sister publication -- *Hospital Infection Control & Prevention* has been awarded First Place in the Newsletter Journalism Award category by the National Press Club in Washington, DC.

The award was given for a special report on patients infected with hospital-associated methicillin-resistant Staphylococcus aureus (MRSA.) "MRSA Patient Stories," a two-part series in the Nov-Dec 2010 issues of *HIC*, claimed top prize in the category of Best Analytical Reporting in Newsletter Journalism. While putting some pressure on the Centers for Disease Control and Prevention to adopt more aggressive measures against the pathogen, the report lent a human face to the annual toll of MRSA.

These powerful narratives may do more to change the culture and practice of infection prevention in the nation's hospitals than a thousand clinical reports to Congressional committees. Change is coming in infection prevention because from the patient's perspective a 300-page CDC guideline with a phone book of references is a doorstop indictment of an approach that has failed. A child is dead and her mother draws her breath in pain to tell her story.

"When they removed her from life support they warned us that she would only live for a few minutes," **Beth Reimer** told *HIC*, recalling her six-week old daughter Madeline "Maddy" Renee Reimer. "My daughter actually lived for 13 minutes and I was able to hold her as she took her last breath."

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

- The ethics of mandatory flu vaccination
- OSHA puts the heat on nursing homes
- I2P2 rule set to be unveiled
- Workplace violence in hospitals gains attention
- How safe patient handling fits with fall prevention

MRSA is now killing more Americans annually than HIV/AIDS. This is in part a story of intersecting epidemics, one declining to a chronic condition while the other gains new footing in the community. Still, the vast majority of these bacterial infections are acquired in the nation's hospitals by patients seeking treatment for some other malady. They literally never see it coming. The individual stories of these patient's – some 20,000 of them lost every year — often die with them.

Infection preventionists, health care epidemiologists, employee health professionals and other clinicians have been fighting the scourge of MRSA for decades. However, in part two of our report we revealed that data from the Veterans Affairs (VA) hospital system — at that time still unpublished — found that as much as 76% of the 100,000 invasive MRSA infections occurring annually could be prevented. Going beyond current CDC guidelines, the VA has adopted a bundle approach that features aggressive MRSA testing and patient isolation in all of its 153 hospitals.

The CDC is aware of the findings, but balks at urging widespread implementation of the VA policy. "Our job here at CDC is to make sure that all health care is safe — not to tackle a specific organism at the exclusion of others," **Michael Bell**, MD, deputy director of the CDC division of Healthcare Quality Promotion, says in our report.

Indeed, *HIC* interviewed clinicians who similarly cautioned against tailoring infection control efforts against a single pathogen, arguing instead for a standard precautions approach that includes flexibility to go to more enhanced measures. As bad a bug as MRSA has been, there are troubling signs of emerging pan-resistance in other pathogens, including a broad array of gram negatives. For example, New Delhi metallo-beta-lactamase (NDM-1) — a virtually untreatable gram negative bacterial enzyme that originally emerged in hospitals in India — continues to spread globally.

"If I come into a hospital — whether I have MRSA, VRE or multidrug resistant acinetobacter — it doesn't matter how you label me," says **Patti Grant**, RN, infection preventionist and a member of the *HIC* editorial board. "This [screening approach] is taking us all back to relying on an isolation sign or a patient label to practice basic good infection prevention and control. We need to put our resources where we can actually start preventing infections at the bedside. I don't think labeling people with MDROs is going to be the answer." ■

Hospital Employee Health

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. employee health nurse
- O B. employee health manager
- O C. employee health director
- O D. infection control practitioner
- O E. occupational health director
- O F. other _____

2. What is your highest degree?

- O A. LPN
- O B. ADN (2-year)
- O C. diploma (3-year)
- O D. bachelor's
- O E. master's
- O F. PhD
- O G. MD
- O H. other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary health care position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to 89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. In which area is your facility located?

- O A. urban
- O B. suburban
- O C. medium-sized city
- O D. rural

7. In the last year, how has your salary changed?

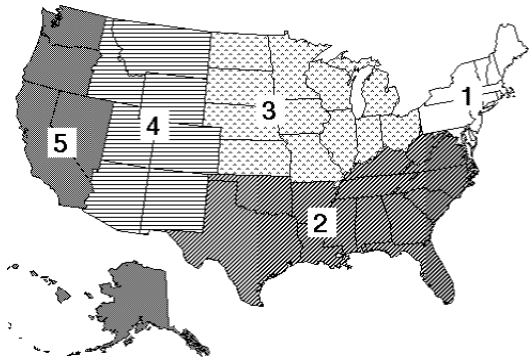
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for-profit

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11. How long have you worked in employee health?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

12. How long have you worked in health care?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

13. Which certification best represents your position?

- O A. RN
- O B. COHN-S
- O C. NP
- O D. CIC
- O E. FACOEM
- O F. LVN
- O G. CCM
- O H. Other_____

14. How many hours a week do you work?

- O A. less than 20
- O B. 20-30
- O C. 31-40
- O D. 41-45
- O E. 46-50
- O F. 51-55
- O G. 56-60
- O H. 61-65
- O I. 65+

15. If you work in a hospital, what is its size?

- O A. <100 beds
- O B. 100 to 200 beds
- O C. 201 to 300 beds
- O D. 301 to 400 beds
- O E. 401 to 500 beds
- O F. 501 to 600 beds
- O G. 601 to 800 beds
- O H. 801 to 1,000 beds
- O I. >1,000 beds
- O J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2011

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media, P.O. Box 105109, Atlanta, GA 30348.