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OSHA targets workplace violence at hospitals

Assaults on HCWs remain a top problem

Hospitals are places of high emotion and drama, of pain and fear, of last resort, and sometimes of desperation. In this patient-centered world, there has been a high tolerance of aggressive or explosive behavior. But not anymore.

For the first time, the U.S. Occupational Safety and Health Administration has provided specific instructions to its inspectors about using the general duty clause to address incidents of workplace violence. Health care is included among the industries identified as "susceptible to workplace violence."

"Employers may be found in violation of the general duty clause if they fail to reduce or eliminate serious recognized hazards," OSHA's compliance directive says. "Furthermore, investigations should focus on the availability to employers of feasible means of preventing or minimizing such hazards."

The OSHA directive comes in the wake of two high-profile enforcement actions in Bangor, ME, and Danbury, CT, where hospitals were cited for failing to implement a comprehensive violence prevention program despite numerous violent incidents. Meanwhile, violence in hospitals has gained increasing attention with new state laws and pressure from unions and professional organizations.

Connecticut recently passed a law requiring hospitals to implement violence prevention programs, joining New Jersey, California, Illinois, Oregon and Washington, which have similar laws. Other states have raised the penalties for assaulting a health care worker.

While the OSHA directive doesn't require specific steps for employers to take, "it clearly identifies, from an enforcement perspective, your industry as one that has a recognized hazard," says **Brad Hammock**, an attorney with Jackson Lewis in Reston, VA, who specializes in occupational health law.

'An important step'

A single random act of violence wouldn't necessarily trigger any action by OSHA. But the compliance directive is raising awareness of the hazard. (Hospitals already were put on notice by the Joint Commission accrediting body in 2010 with a Sentinel Event Alert: http://bit.ly/rtT5rn)

"We specifically identified the health care industry as having a history of problems in this area," says an OSHA spokesperson. "We just wanted to ensure that the compliance officers recognized this and understood the proper procedures not only for finding violations, but in terms of general education of employers."

Inspectors may ask about hazard assessments, incident reviews, employee training, and a workplace violence prevention plan, according to the directive. They will interview employees and look at a variety of records, including security and police reports. *(For OSHA-recommended practices, see related story, p.123.)*

The OSHA directive is an important step, says **AnnMarie Papa**, DNP, RN, CEN, NE-BC, FAEN, president of the Emergency Nurses Association and clinical director of emergency nursing at the Hospital of the University of Pennsylvania.

"While we are certainly pleased that OSHA has issued this compliance directive, like any other tool, it must be used," she says. "This directive, along with the tools available through ENA and elsewhere, leave few excuses for health care organizations who fail to provide a safe work environment.

"While violence cannot be eliminated, it can certainly be reduced from the unacceptable levels we are currently seeing," she says. "It is now up to the health care organizations to take a more proactive approach to keeping nurses and other health care workers safe from violence."

A stream of abuse from patients

Violence has become endemic in the nation's hospitals. Acute care hospitals account for almost one in 10 of all workplace assaults that lead to lost workdays. In surveys, nurses reveal a constant stream of lesser assaults.

An online survey of 3,211 nurses by the Emergency Nurses Association found that more than half (54.8%) had experienced physical violence or verbal abuse within the past week.[1] A New Jersey survey of registered nurses found that one third had experienced violence in their hospital or nursing home.[2] (A sample survey tool, which can be used to assess workplace violence in the ER, has been inserted into this issue.)

"People come into the ER in a state of crisis, so you know they're going to be more angered — but that's doesn't mean it's right," says Papa. "I think now people are saying, 'What can we do and how can we stop it?'"

A shooting at Danbury Hospital in 2010 spurred the recent passage of the Connecticut workplace violence law. The injured nurse, who was shot three times by an elderly cardiac patient, eventually returned to work in nursing education and still is impacted by the injuries, says **Mary Consoli**, RN,

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BSN, president of the Danbury Nurses Union, an affiliate of the American Federation of Teachers. He previously was an assistant nurse manager working at the bedside. *(See HEH, October 2010, cover story.)*

Connecticut's law was designed to require hospitals to follow best practices, Consoli says. But the state laws also send a message throughout health care, she says.

"It's not part of the job to be abused," she says. "It's not part of the job to be attacked by patients. It's not part of the job to risk your life. You shouldn't have to go to work and worry if you're going to come home in one piece."

The New Jersey law was passed in 2007 in the wake of a report sponsored by the National Institute for Occupational Health and Safety (NIOSH) that highlighted gaps in reporting and training at hospitals. Now New Jersey hospitals and nursing homes are required to have a committee that develops and maintains a workplace violence prevention plan. The facilities must conduct annual workplace violence risk assessments, provide annual training, and keep a record of violent acts against employees.

"With the workplace violence committee, issues get addressed, whereas they might not have been in the past," says **Bernie Gerard Jr.**, RN, BSN, vice president of Health Professionals and Allied Employees in Emerson, NJ, a union that represents nurses and other health care workers in New Jersey and Pennsylvania.

NIOSH has launched a study of the impact of the New Jersey law. "Our central hypothesis is that the hospitals that have a high compliance with the regulation will have low rates of violence-related injury," says **Marilyn Ridenour**, RN, BSN, MBA, MPH, CPH, nurse epidemiologist with NIOSH's Division of Safety Research in Morgantown, WV.

The study may lead to a compilation of best practices that can help reduce violent incidents, she says.

Shootings are random, violence is not

Shootings at hospitals make the headlines with regularity: In Orlando, a transplant surgeon was shot and killed by a patient. A man opened fire after arguing with another man in the lobby of a medical center in Omaha. A former soldier with a small arsenal of weapons took hostages at a Savannah hospital.

In September 2010, a man upset about the care his mother, a cancer patient, had received, shot his mother's surgeon at Johns Hopkins Hospital in Baltimore, then killed his mother and himself. In the wake of that shooting, two Johns Hopkins physicians reflected on the problem of violence in America's hospitals in an opinion piece in the Journal of the American Medical Association.[3]

"The perception that health care facilities located in high-crime neighborhoods are at particular risk because of local gun violence is not well supported by data," they wrote. "Health facility shootings have tended to be random, at smaller centers, and unrelated to local violence. To underscore, the shooter at our institution was 50 years old, lived out of state (with his mother), had no criminal background, held a responsible job, and had a license to carry a firearm in his home state."

Rather than installing magnetometers to detect weapons, hospitals should focus on efforts to address the more common assaults, the authors said.

Hospitals also should make sure they address the stress that results from both physical and verbal assaults by providing counseling to employees, says Papa. Nurses may feel conflicted about reporting incidents because of their concern for patients, and they often face logistical barriers to reporting incidents if they don't have an OSHA-recordable injury, says Papa.

"I would challenge organizations to be creative so they can make it easy for the nurses to report this," she says.

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OSHA: Take steps to reduce work violence

In its compliance directive on workplace violence, the U.S. Occupational Safety and Health Administration advises employers to conduct a hazard analysis, assess needs for physical changes to reduce risk, provide employee training, and implement a variety of controls, such as bright lighting and security cameras. The agency also advises employers to keep an incident log and develop a workplace violence prevention program.

Some of the key recommendations for health care administrative and work practice controls are sum-

marized below. (More information is available at the new OSHA website on workplace violence: http://1.usa.gov/6zEZBp)

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Ensure that adequate and properly trained staff is available to restrain patients or clients, if necessary.
- Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure that adequate and qualified staff is available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of "restricted visitors" for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses' stations and visitor sign-in areas.
- Review and revise visitor check systems, when necessary. Limit information given to outsiders about hospitalized victims of violence.
- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.
- Establish a system — such as chart tags, log books or verbal census reports — to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed. Review any workplace violence incidents from the previous shift during change-in-shift meetings.
- Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions).
- Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.
- Prepare contingency plans to treat clients who are "acting out" or making verbal or

physical attacks or threats. Consider using certified employee assistance professionals or in-house social service or occupational health service staff to help diffuse patient or client anger.

- Transfer assaultive clients to acute care units, criminal units or other more restrictive settings.
- Ensure that nurses, physicians and other clinicians are not alone when performing intimate physical examinations of patients.
- Discourage employees from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. Urge community workers to carry only required identification and money.
- Survey the facility periodically to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.
- Provide staff with identification badges, preferably without last names, to readily verify employment.
- Discourage employees from carrying keys, pens or other items that could be used as weapons.
- Provide staff members with security escorts to parking areas in evening or late hours. Ensure that parking areas are highly visible, well lit and safely accessible to the building.
- Use the "buddy system," especially when personal safety may be threatened. Encourage home healthcare providers, social service workers and others to avoid threatening situations.
- Advise staff to exercise extra care in elevators, stairwells and unfamiliar residences; leave the premises immediately if there is a hazardous situation; or request police escort, if needed. ■

'Violence is not part of anybody's job'

Assaults lead to stress and injury

After his cheek was fractured when a patient smashed a fist into his jaw in the emergency department, **Jeaux Rinehart**, RN, BSN, PHN, figured he'd had enough. He worked for 32 years as an emergency room nurse and loved it, but finally he could no longer tolerate patients hitting, yelling, cursing, or spitting at him.

"The violence is getting worse and worse and worse," he says. "I have to finally put my foot down and remove myself from the environment."

Rinehart's experience reveals the impact that workplace violence has on the everyday lives of hospital employees, especially those who work in high-risk units such as the emergency department or psychiatric unit. An online survey by the Emergency Nurses Association found that 26.6% of ER nurses had considered leaving the emergency department and 9.5% had considered leaving nursing because of workplace

violence.

For Rinehart, the beginning of the end came three years ago, when he was working triage and a man approached, seeking methadone. Rinehart told him that he would need to be evaluated for pain medication, but that the emergency department doesn't provide methadone.

As the patient grew angrier, Rinehart's survival instinct kicked in. He figured he needed to get out, so he turned around and headed for the rear door. (The triage room had two doors.) Before he could get there, the patient hit him on the back of the head with a billy club then swung at his face, fracturing his cheek.

Nearby, someone witnessed the incident and called a Code Strong, a signal that means "severe incident, respond immediately." The man ran off and wasn't identified. He had given a false name and information.

After he recovered, Rinehart returned to work, feeling a bit shaky and wary. Then another day, a man who was brought in by the police for a psychiatric evaluation got out of his restraints. He punched Rinehart in the face, then spewed a ball of spit at the nurse. When Rinehart restrained him, the patient said, "When I get out of here I'm going to go home and get a gun and come back and shoot you dead."

Rinehart wanted to press charges, but he faced reluctance. Often, nurses report that police discourage them from pressing charges because of the patient's mental or medical state. In this case, Rinehart persevered and the patient received a four-month jail term. He still frequents the hospital's emergency room.

Yet Rinehart has moved on, into an administrative job that takes him away from the patients he once was devoted to treating. (Rinehart, who is from Seattle, asked *HEH* not to mention the name of his hospital.)

"Violence is not a part of anybody's job," he says. "You wouldn't take it at home, in the store or on the bus. Why would you take it at work?"

Sometimes Rinehart walks through the emergency department. "I hear patients yelling at each other and the staff. It brings back all the memories of why I did what I did," he says. "It was the right decision."

Nurses seek better reporting

Police officers sometimes bring people to the psych unit of Antelope Valley Hospital in Lancaster, CA, to be evaluated because of aberrant behavior. But when hospital workers call the police because of an assault by a patient in the psych unit, they seem surprised that someone would want to file a report, says charge nurse **Colleen Sichley**, RN, BSN.

"Where did we ever give anyone the right to assault someone else?" says Sichley. "If a mentally ill person assaults a police office or a fireman, I believe there are penalties."

About a year ago, another nurse in Sichley's unit went into a patient's room to medicate her. The patient suddenly grabbed her by the hair and started smashing her head against the floor. The nurse was out of work with head and neck injuries for more than six months, Sichley says.

Many other incidents occur with threats, kicks, slaps — aggressive behavior that doesn't result in injury. The California Nurses Association sponsored a bill to strengthen the state's current workplace violence law by requiring improved reporting, training and response to incidents. "There would actually be some legal consequences for assaults against health care workers," Sichley says.

Meanwhile, Sichley tries to look out for her coworkers. "My goal as a charge nurse is to make sure my staff members are safe and all my patients are safe," she says. "If I get a feeling that something is wrong, I'm on the phone trying to get medication or security.

"When I see a patient who is very tense, punching their fists, jaws tight, those are the people I think are ready to blow. We try to find a quieter place and give them some attention. Some calming medication often helps to reduce that," says Sichley.

Better staffing would help, as well, both in providing back-up for employees and reducing the frustration patients feel when they have to wait for care, she says."I want to help people get better," says Sichley. "I didn't realize I was going to be hurt along the way." ■

Flu shot mandates spur a backlash

Fed panel split on recommendation

Late in her pregnancy and fearful of the flu vaccine, the nurse wanted to hold off on immunization. At her hospital, though, the flu vaccine was mandatory. Get the shot or lose your job, her supervisor told her.

She was worried about thimerosal in the vaccine, even though the Centers for Disease Control and Prevention says the vaccine is safe and recommends flu shots for pregnant women. Faced with the dilemma, she resigned.

"This is a basic human rights issue, sovereignty over our own bodies," asserts **Barbara Skurnowicz** of Bloomfield Hills, MI, president of Michigan Health Care Professionals for Vaccine Choice, an organization formed in response to the growing number of hospitals mandating flu vaccination. She related the story of the nurse to explain why some health care workers are balking at vaccination.

While mandatory influenza vaccination of health care workers gains momentum, so does a backlash. Skurnowicz's organization, for example, is lobbying the Michigan legislature to allow a waiver for health care workers who decline vaccination for medical, religious or philosophic reasons, similar to the waivers available from childhood vaccination.

Concerns about the punitive nature of some mandatory policies have led to some back-pedaling. A working group of the National Vaccine Advisory Committee (NVAC), a federal panel that advises the U.S. Department of Health and Human Services, recently took a straw poll on whether to recommend mandatory vaccination of health care workers. Only 12 of 25 members wanted a full mandate, with exceptions only for medical contraindications or religious beliefs.

In a written statement to the panel, the U.S. Occupational Safety and Health Administration noted that flu vaccine technology is "problematic" and that the protection the vaccine provides is variable. "[T]here is insufficient scientific evidence for the federal government to promote mandatory influenza vaccination programs that do not have an option for the [health care personnel] to decline for medical, religious and/or personal philosophical reasons," OSHA said.

Exceptions to the mandate?

The split opinions on the NVAC panel reflect debate about how to define "mandatory" and whether to emphasize other methods to increase immunization. The panel is charged with making recommendations on reaching the HealthyPeople 2020 goal of at least 90% influenza vaccination of health care workers.

The most recent CDC survey showed that 71% of hospital-based health care workers received a flu vaccine last year, and that 13% of health care workers had a mandate from their employers. *(See* HEH, *October 2011, p. 111.)*

"All of the experts want healthcare workers to accept flu vaccination if they can," says **Melanie Swift,** MD, FACOEM, medical director of the Vanderbilt Occupational Health Clinic in Nashville and a member of the panel.

"Everyone agrees education about the vaccine is important to reduce fears. Everyone agrees that people with medical contraindications to the vaccine should not be fired. No controversy there," she says. "But experts are divided on how to handle individuals with religious, philosophic or personal objections to vaccine."

Those who support a mandate frame it as a patient safety issue — vulnerable patients who could be harmed by unvaccinated health care workers who acquire influenza. It is supported by major professional organizations, including the American Hospital Association, the American College of Physicians, the American Public Health Association and several infection control associations.

Bill Borwegen, MPH, safety and health director of the Service Employees International Union (SEIU) and a member of the working group, asserts that the risk to patients of acquiring influenza from health care workers has been overstated.

"When all of the hospitals that have mandatory programs haven't been able to show any reduction in influenza among their patients [even after] five or six years, it's hard to make the case that the science has been firmly established that in fact the vaccine makes that much of a difference," he says.

Borwegen also has warned that vaccine mandates that lead to the firing of health care workers could just lead to more skepticism about vaccines.

In fact, Skurnowicz's group works with Michigan Opposing Mandatory Vaccination (MOM), which advocates for "the right of individuals and parents to make their own vaccine choices."

Skurnowicz says concern about the flu vaccine is based on scientific evidence and not myths or misconceptions. She cites the Cochrane review of vaccine effectiveness in which the authors concluded: "Influenza vaccines have a modest effect in reducing influenza symptoms and working days lost. There is no evidence that they affect complications, such as pneumonia, or transmission."[1]

Skurnowicz's twin daughters are anesthesia nurses, and both have had serious adverse reactions to other vaccines, she says. If they were required to have the flu vaccine, they would resign. "No one should be required in this country — not in America, not now, not ever — as a condition of employment to be vaccinated with anything," she says. ■

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OSHA: Exercise for back pain recordable

Working with trainer is like physical therapy

Imagine this scenario: A nurse has soreness and back pain related to patient handling and other work duties. A certified athletic trainer recommends a regimen of stretching and exercises to reduce the pain. Does that make the injury recordable?

In a recent letter of interpretation, the U.S. Occupational Safety and Health Administration says "therapeutic exercise" is a form of physical therapy and is therefore considered a "medical treatment" and subject to reporting.

Here's what **Keith Goddard**, director of OSHA's Directorate of Evaluation and Analysis, said in response to a question to the agency:

"OSHA discussed the issue of therapeutic exercise in the preamble to the final rule revising OSHA's injury and illness recordkeeping regulation. See, 66 FR 5992, January 19, 2001. OSHA stated that it considers therapeutic exercise as a form of physical therapy and intentionally did not include it on the list of first aid treatments in Section 1904.7(b)(5)(ii). Section 1904.7(b)(5)(ii)(M) states that physical therapy or chiropractic treatment are considered medical treatment for OSHA recordkeeping purposes and are not considered first aid. Section 1904.7(b)(5)(iii) goes on to state that the treatments included in Section 1904.7(b)(5)(ii) is a comprehensive list of first aid treatments. Any treatment not included on this list is not considered first aid for OSHA recordkeeping purposes.

"Please be aware that if a treatment is administered as a purely precautionary measure to an employee who does not exhibit any signs or symptoms of an injury or illness, the case is not recordable. For a case to be recordable, an injury or illness must exist. For example, if, as part of an employee wellness program, [a certified athletic trainer] recommends exercise to employees that do not exhibit signs or symptoms of an abnormal condition, there is no case to record. Furthermore, if an employee has an injury or illness that is not work-related, (e.g., the employee is experiencing muscle pain from home improvement work) the administration of exercise does not make the case recordable either.

"Your letter also requested specific guidance on several questions concerning the administration of exercise. For purposes of this response, we presume that all of the questions relate to the administration of exercise as a treatment for work-related injuries."

Q: Would the providing of an employee with a written home exercise program (including sets/reps and resistance) constitute first aid or medical treatment?

A: This constitutes medical treatment.

Q: If the [certified athletic trainer] utilizes stretching to relieve their symptoms, does this service constitute medical treatment or first aid?

A: This constitutes medical treatment.

Q: Is the number of times seen for care significant in determining recordability?

A: No. The number of times seen for care is not a factor when determining OSHA recordability. The focus is on the type of treatment rather than the number of times such treatment is administered.

Q: Is the duration or intensity of the care significant in determining recordability?

A: No. The duration or intensity of the care does not determine recordability. Again, the focus is on the type of treatment.

Q: Are the numbers of follow-ups significant in the recordability of the care?

A: No. The number of follow-up visits to receive care does not determine the outcome for an OSHA recordable.

Q: Is there a general guideline that [a certified athletic trainer] can use to know if they are crossing the line from first aid to medical treatment?

A: In general, first aid can be distinguished from medical treatment per Section 1904.7(b)(5)(ii) and 1904.7(b)(5)(iii). As noted above, Section 1904.7(b)(5)(ii) states that the list of first aid treatments included in Section 1904.7(b)(5)(iii) is comprehensive. Any treatments not included on the list would not be considered "first aid" for OSHA recordkeeping purposes. ■

EH rounds build support for safety

Listen to employees, gather facts

Injury reports don't tell the whole story about hazards in the hospital. The best way to find out what you need to know is to talk to employees.

That is the value of "rounding," a method of gathering information and feedback based on the common

medical practice, says **Sharon Petersen**, MHA, RN, COHN/CM, corporate employee health manager at Intermountain Health Care in Salt Lake City, UT.

"The objective is to build some clear communication at all levels in the organization and actively engage employees and physicians in looking at process improvements," says Petersen, who spoke at the annual conference of the Association of Occupational Health Professionals in Healthcare (AOHP) in September, which marked the 30th year of the organization.

Intermountain Health Care encompasses about 32,000 employees over a 450-mile geographic area, including 23 hospitals and more than 150 physician clinics. Petersen oversees the work of about 40 employee health professionals, and she wanted to make sure there was consistency throughout the organization.

Petersen also wanted a way to get feedback from employees about their health and safety needs. "It's all about health and wellness and accident prevention," she says. "Those are the crucial services we can provide to employees. If we aren't out there rounding and identifying the issues, we're not going to be in front of those accidents."

Rounding can be formalized, with objectives, or can be informal. But here are some important elements, says Petersen:

Use rounding to build relationships with employees. Employees are busy and you don't want to disrupt them. But they also are a vital part of the employee health paradigm, notes Petersen. "The accountability for employee safety doesn't only belong to employee health, it belongs to employees," she says. "We wanted to focus on that in a positive way."

Petersen suggests spending just 10 minutes talking to each employee. You can focus on one or two issues you have identified, but let the employee do most of the talking, she says. "Focus on listening, letting the employees talk, soliciting their ideas and suggestions," she says.

She says employee health professionals should do their rounds at least quarterly, but preferably monthly. Notify employees that you will be coming by and share any specific questions you have in advance, she says.

Gather factual information. You don't want to get involved with gossip or hearsay. Your job is to gather actionable information that pertains to employee health. It may help to have specific objectives each time you round. For example, if you noticed patient handling injuries despite your safe patient handling program, you might want to find out whether there are barriers to using the equipment. How comfortable are employees with the equipment? Do they need more training — or more slings? Is the equipment accessible?

Put it in writing. You can use an informal tool to record employee comments when you go on your rounds. Then follow up on questions or issues that have been raised so that employees can see that you took their concerns seriously.

Leverage your efforts. Part of your mission is to raise the profile of employee health. You also can do that by becoming involved in various hospital committees — or at least getting an occasional spot on the agenda. This includes the safety committee, sharps committee, environment of care committee, human resources committee, risk management, infection control and quality. You'll also want to connect with managers to follow up on issues you've identified or employee concerns.

Rounding provides a framework for addressing safety issues and it can net some goodwill for employee health. "Our employee health nurses have reported back that employees and managers are very, very receptive to this," says Petersen. "The employees really appreciate them coming out."

They're left with a greater awareness of employee health and the valuable service it can provide, she says. ■

Many HCWs don't know correct PPE sequence

Train on selecting, removing PPE

Your annual training in the use of personal protective equipment may not be good enough. According to a study of PPE use during the H1N1 pandemic in Canada, most health care workers don't know how to choose the right items or how to put them on or take them off correctly.

In observations of 110 health care workers, only 6 (6%) performed all the steps correctly in a study by the Public Health Agency of Canada in Ottawa, which was presented at the spring conference of the Society for Healthcare Epidemiology of America (SHEA). The researchers observed health care workers at seven hospitals in Ontario and Manitoba during the second wave of H1N1, between February and April of 2010.

Only 29% of the health care workers selected the appropriate PPE and 29% removed it in the correct

sequence. *(See sequence box, below.)* The performance varied by unit. Fewer people removed their PPE correctly in the intensive care unit and emergency department than in pediatrics.

These findings, which have not yet been published, raise questions about the effectiveness of the training that health care workers receive. In the United States, the Occupational Safety and Health Administration requires annual training along with respirator fit-testing.

Training isn't sufficient, says **David Weissman,** MD, director of the Division of Respiratory Disease Studies at the National Institute for Occupational Safety and Health (NIOSH) in Morgantown, WV.

"To get high levels of adherence requires real dedication to develop a safety climate," he says. "You have to develop an atmosphere of adherence. It's a challenge and it requires continuous effort. It isn't something you can fix and then it's fixed permanently. You achieve high levels by exerting a lot of energy and then maintaining it over time."

The Centers for Disease Control and Prevention provides posters to remind health care workers how to don and doff PPE. (http://1.usa.gov/99V4Ci)

Health care workers may not realize why the order of removing PPE is so important, says Weissman. "If equipment isn't removed properly and in the proper sequence with attention to detail, the worker could potentially contaminate their hands and create the risk of infecting themselves or infecting or colonizing others," he says. ■

Sequence for donning PPE

1. Gown: Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back. Fasten in back of neck and waist.

2. Mask or respirator: Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit-check respirator.

3. Goggles or face shield: Place over face and eyes and adjust to fit.

4. Gloves: Extend to cover wrist of isolation gown.

Sequence for removing PPE

1. Gloves: Outside of gloves is contaminated! Grasp outside of glove with opposite gloved hand; peel off. Hold removed glove in gloved hand. Slide fingers of ungloved hand under remaining glove at wrist. Peel glove off over first glove. Discard gloves in waste container.

2. Goggles or face shield: Outside of goggles or face shield is contaminated! To remove, handle by head band or ear pieces. Place in designated receptacle for reprocessing or in waste container.

3. Gown: Gown front and sleeves are contaminated! Unfasten ties. Pull away from neck and shoulders, touching inside of gown only. Turn gown inside out. Fold or roll into a bundle and discard.

4. Mask or respirator: Front of mask/respirator is contaminated — DO NOT TOUCH! Grasp bottom, then top ties or elastics and remove. Discard in waste container.

Source: Centers for Disease Control and Prevention: http://1.usa.gov/oL84bY ■

Rehab patients gain from safe lifts

Improve functional independence

Safe patient handling has been a hallmark of employee health. But perhaps it should also be a rallying point for patient safety advocates.

When it is easier to get patients out of bed, their rehabilitation improves, says **Margaret Arnold,** PT, CEES, coordinator of rehabilitative services at Bay Regional Medical Center in Bay City, MI.

A recent study of 94 stroke patients at Bay Regional provides evidence of that. Patients who received their rehabilitation while therapists and caregivers used safe patient handling equipment and protocols had overall higher functional independence measure ratings compared with patients who were treated before the medical center adopted a comprehensive safe patient handling program.[1]

"Some [physical therapists] said using the equipment was going to make patients more dependent, but … the patients with strokes did slightly better using the equipment," Arnold says. At the same time, employee injuries declined by almost 80% hospital-wide. Before implementing safe patient handling, Bay Regional had about 80 or 90 injuries related to patient handling each year. In the

eight months of 2011, there were just 10.

Unpublished data also show a reduction in pressure ulcers when there is a safe patient handling program, says **Stephanie Radawiec**, PT, DPT, MHS, MBA, a clinical consultant with Diligent, an equipment manufacturer based in Addison, IL. That is an increasingly important outcome for hospitals because pressure ulcers are a "never event" that isn't covered by Medicare, she says.

'One of the myths'

Still, convincing physical therapists and others in rehab care to use safe lifting equipment can be a challenge. "It's surprising how much resistance there is to the change," says Arnold.

Often, the therapists are concerned that patients will become too dependent on lift equipment, Radawiec says. "[That] is one of the myths we work with," she says.

Some physical therapists don't realize the wide range of equipment that is available, including lifts that can help partially dependent patients ambulate, such as a sit-to-stand lift. Meanwhile, as patients are heavier, they need for lift assistance is even greater. For example, ceiling lifts with ambulation slings can be used to protect patients from falling.

"Once the staff member understands what the equipment can do for them a light goes on. They get it," she says.

Bay Regional has focused on education to promote safe patient handling and works to make therapists comfortable with the equipment, says Arnold. Safe patient handling coaches are available on every shift in every unit to help employees and encourage them to use the equipment.

The safe patient handling committee meets monthly to review progress. If someone is injured during patient handling, the committee conducts a root cause analysis to determine whether changes are needed.

Meanwhile, Arnold emphasizes the benefits to patients when she talks to her colleagues. Working with a sore back will make it even more difficult to help patients in their rehabilitation, she tells them. "If we're not at our best, we can't give our patients our best," she says.

Senior administrators are supportive. In fact, they often ask employees about the lift equipment when they conduct rounds, says Arnold. "They will ask staff, 'Show me how to use this piece of equipment,' and 'Which patients are you using this with?'" says Arnold. "It really lets the staff know this is an important issue."

REFERENCE

1. Arnold M, Radawiec S, Campo M, and Wright LR. Changes in functional independence measure ratings associated with a safe patient handling and movement program. *Rehabil Nurs* 2011; 36:138-144. ■

Correct CNE questions for October issue

Correction: The wrong CE questions ran in the October issue of HEH. *We apologize for the error. Here are the correct questions for the stories in the* HEH *October issue:*

1. According to the Centers for Disease Control and Prevention, people with egg allergy may be able to have the flu vaccine if:
   A. they haven't had an allergic reaction in the past three years.
   B. they aren't allergic to cooked eggs.
   C. they have only ever had hives as their allergic reaction.
   D. No one with egg allergy can receive the flu vaccine.

2. A survey by the Centers for Disease Control and Prevention found that less than half of unvaccinated health care workers believe:
   A. their vaccination could help protect people around them.
   B. the vaccine reduces the risk of influenza.
   C. vaccination is safe.
   D. they are susceptible to influenza.

3. In a study of an outbreak of pandemic H1N1 in 2009 at a Chicago hospital, the hospital-based transmission was mostly:
   A. from patients to health care workers.
   B. from health care workers to patients.
   C. from health care workers to their coworkers.
   D. from visitors to patients.

4. Michigan hospitals have signed onto a Healthy Food Hospitals pledge, which includes a promise to:
   A. only serve low-calorie items in the cafeteria.
   B. purchase locally grown food.
   C. stop serving fried foods.
   D. talk to patients about a healthy diet.

CNE QUESTIONS

1. The U.S. Occupational Safety and Health Administration issued a compliance directive to inspectors about workplace violence which says:
   A. there's a new standard employers must follow to prevent violence.
   B. the general duty clause requires employers to address the recognized hazard of workplace violence in health care.
   C. local law enforcement should handle cases of workplace violence.
   D. workplace violence is covered by state laws and regulations.

2. According to an online survey by the Emergency Nurses Association, about how many ER nurses have considered leaving the emergency department because of violence?
   A. 15%
   B. 27%
   C. 44%
   D. 75%

3. According to the U.S. Occupational Safety and Health Administration, if a certified athletic trainer recommends a regimen of exercise to relieve an employee's work-related back pain:
   A. it is not considered to be a recordable injury.
   B. that treatment is equivalent to first-aid.
   C. whether it must be recorded depends on the type of exercise program and its length.
   D. the injury should be recorded on the OSHA 300 log.

4. In a study by the Public Health Agency of Canada in Ottawa, how many health care workers were able to remove their personal protective equipment in the proper sequence?
   A. 12%
   B. 29%
   C. 37%
   D. 62%

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. ■

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.

COMING IN FUTURE MONTHS

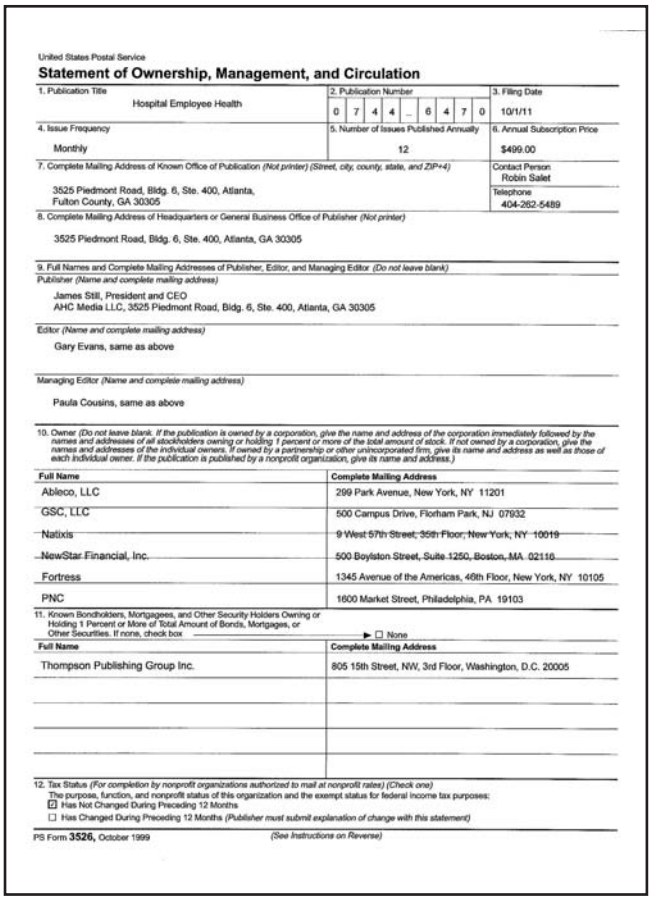
■ To see a worst-case scenario, watch 'Contagion'

■ Nurses at risk of carpal tunnel syndrome?

■ A simple solution to hand hygiene

■ NY advocates push for 'zero lift'

■ Will politics derail OSHA?



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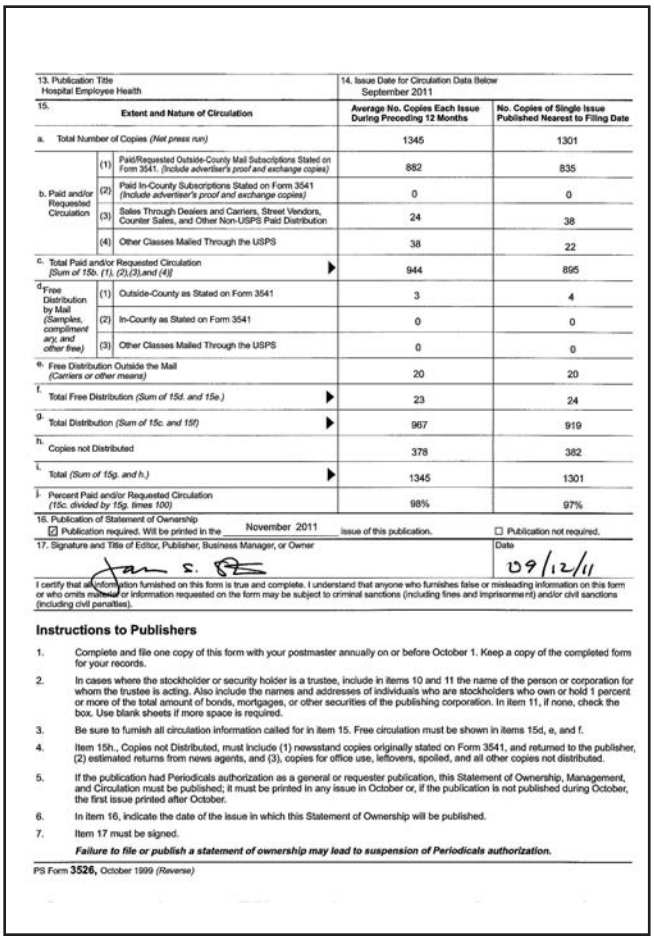

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The Joint Commission Update for Infection Control

News you can use to stay in compliance

Joint Commission: New year will usher in new CAUTI prevention requirements

Phase in pt safety goal now, be up to full speed by 2013

The Joint Commission's new National Patient Safety Goal (NPSG) on preventing indwelling catheter-associated urinary tract infections — which emphasizes prompt removal of unnecessary devices and surveillance for CAUTIs — is effective January 1, 2012 for hospitals.

Though there has been some historical tendency to dismiss these as relatively low priority infections, the Centers for Disease Control and Prevention cited a staggering annual mortality figure in a recently posted surveillance document, stating that "more than 13,000 deaths are associated with UTIs."[1,2]

"The urinary tract is the most common site of healthcare-associated infection, accounting for more than 30% of infections reported by acute care hospitals," the CDC reports. "Virtually all healthcare- associated urinary tract infections are caused by instrumentation of the urinary tract. CAUTI can lead to such complications as cystitis, pyelonephritis, gram-negative bacteremia, prostatitis, epididymitis, and orchitis in males and, less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality."

Indeed catheter use in and of itself is associated with negative outcomes other than infection, including nonbacterial urethral inflammation, urethral strictures and mechanical trauma, the Joint Commission notes. "The length of time that a catheter is in place contributes to infection, so limiting catheter use and duration are important to preventing infection," the Joint Commission recently stressed.[3]

More than a quarter of the patients with an indwelling urinary catheter for two to 10 days will develop bacteriuria, and a quarter of these will develop a CAUTI. Approximately 450,000 CAUTIs occur annually in hospitals, the Joint Commission reported, citing estimates of the excess cost per case of $1,200 to more than $2,700 and a total annual cost of some $400 million.[4-8] Moreover, the Centers for Medicare & Medicaid Services (CMS) lists CAUTIs among the healthcare associated infections targeted for non-reimbursement.

"The healthcare-associated conditions that CMS will not cover are high cost or high volume or both; result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines," the Joint Commission states.

CAUTI surveillance may be targeted to areas with a high volume of patients using indwelling catheters, the Joint Commission states. High-volume areas should be identified through the hospital's risk assessment as required in IC.01.03.01. In that regard, what if your risk assessment reveals CAUTIs are not an issue at your hospital? The Joint Commission recently answered that question *(see Q&A, p. 2)* providing clarification that included this statement:

"This new NPSG has a phase-in period during 2012, during which surveyors will be

ensuring that hospitals are planning and preparing for full implementation in 2013. Starting in January 2013, a hospital that has decided, based on its risk assessment, that CAUTI surveillance is not indicated should be prepared to discuss this decision with its survey team and provide a clear rationale. Even if surveillance is not performed, the insertion and management requirements of the goal must still be implemented."

According to the Joint Commission, NPSG.07.06.01 requires hospital infection control programs to "implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections. (Evidence-based guidelines for CAUTI include the "Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals": http://ow.ly/70gaN The CAUTI patient safety goal is not applicable to pediatric populations. "Research resulting in evidence-based practices was conducted with adults, and there is not consensus that these practices apply to children," the Joint Commission notes. ■

Follow the fab four

The elements of performance for the CAUTI prevention safety goal are as follows:

1. During 2012, plan for the full implementation of this NPSG by January 1, 2013.

Note: Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating timelines, identifying resources, and pilot testing.

JC Q&A: What if CAUTI a low risk?

The Joint Commission recently posted the following answer to a frequent asked question on catheter-associated urinary tract infections (CAUTIs).

Q: My facility performs a risk assessment every year as required by IC.01.03.01. We consider a wide range of infection risks, and we rank them per IC.01.03.01 EP 5. Our risk assessment shows CAUTI is a very low patient risk; there are many other higher priorities. Must I perform surveillance for CAUTI because of the new NPSG.07.06.01 even though my risk assessment does not identify it as a priority?

A: NPSG.07.06.01 is a new goal on catheter-associated urinary tract infection (CAUTI) that was published in the July 2011 edition of Perspectives.

Reasons for this goal are captured in the following quote from the Perspectives article: "The Joint Commission's Patient Safety Advisory Group, a group of external national experts on patient safety issues, recommended that NPSG.07.06.01 for CAUTIs be considered for adoption. CAUTI is the most frequent type of health care–acquired infection (HAI), and represents as much as 80% of HAIs in hospitals. The frequency of CAUTIs creates a patient safety and quality concern."

The Joint Commission recognizes that a variety of surveillance approaches are appropriate for various types of infections. For example, NPSG.07.04.01 on catheter-associated bloodstream infection requires that all catheters be monitored; EP 4 states surveillance must be "hospital-wide, not targeted".

However, NPSG.07.03.01 on multidrug resistant organisms allows for the risk assessment to drive surveillance, hence EP 4 says surveillance may be "targeted rather than hospital-wide". In a similar fashion, NPSG.07.05.01 on surgical site infection allows organizations to determine which surgeries to monitor, and EP 5 states, "Surveillance may be targeted to certain procedures based on the hospital's risk assessment."

NPSG.07.06.01 on CAUTI does not specify either hospital-wide or targeted surveillance. In fact, it does not specifically require that surveillance for CAUTI be performed at every accredited hospital. Rather, it allows for each organization to decide, based on its risk assessment (IC.01.03.01) whether CAUTI is a priority warranting surveillance. Having said this, The Joint Commission urges organizations to review the scientific literature and consensus-based guidelines when considering CAUTI surveillance. ■

2. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:

— Limiting use and duration to situations necessary for patient care

— Using aseptic techniques for site preparation, equipment and supplies

3. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:

— Securing catheters for unobstructed urine flow and drainage

— Maintaining the sterility of the urine collection system

— Replacing the urine collection system when required

— Collecting urine samples

4. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:

— Selecting measures using evidence-based guidelines or best practices

— Monitoring compliance with evidence-based guidelines or best practices

— Evaluating the effectiveness of prevention efforts

The draft National Patient Safety Goal was made available for field comment on The Joint Commission's website from December 2, 2010 through January 27, 2011. More than 1,000 responses were received with most responses from accredited organizations. A majority of field review respondents (more than 70%) agreed that a new National Patient Safety Goal should be introduced for CAUTI, the Joint Commission said.

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VA programs cuts CLABSIs by >50%

Pull — not push — does the education trick

The Joint Commission targets central line–associated bloodstream infections in its 2011 national patient safety goals, with NPSG.07.04.01 calling for hospitals to "implement evidence-based practices to prevent (CLABSIs)."

A recently published paper on a Department of Veteran's Affairs (VA) project on CLABSI reduction used the requisite bundles, but focused on education and spreading the word in a manner appropriate to each VA facility[1]. The result was a decline from 3.8 CLABSI infections per 1,000 line days to 1.8 per 1,000 line days.

Marta Render, MD, one of the researchers on the project, said the focus had to be on learning because the VA is a "gargantuan system. We had to think about how to get learning out to people who needed it. We did not want to have to push this out to everyone, but have them pull it in."

The project focused on projecting a need — which encourages people to want to help — and encouraging them to find what works for them to achieve the shared end goal, says Render. Many facilities had some or all of what they needed in place; others needed to get better at data collection. Some needed help in creating a team in the ICU. In each case, Render and her team were there to

coach and talk them through strategies. But what they did in the end was specific to their own needs and their own facilities.

To spread the knowledge, they developed web-based tools and kits, including the critical development of the daily goal sheet. "It is a great tool that changed the way we work together," Render says.

If a patient was on pressors and the physician wanted that patient off, the sheet would include goals that led to that end — pushing two liters of fluid but not more. The physician knows to go back and check that goal sheet and ask how the patient is doing and reevaluate the goal if necessary. "The nurses will keep track, and we create the expectation that certain things will happen. We give people permission to speak up if something doesn't seem right. Even the residents know what the expectation is."

Once implemented and data collection started, Render and the team worked with outliers, conducting structured interviews and setting achievable goals — find a team leader in the next week, check the data the next day. Then the team would follow up on those goals, finding out what went wrong if the goal was not achieved and suggesting potential solutions.

Render thinks that building buzz around the topic also helped. They would print and leave around the ICU scholarly papers about CLABSI reduction. The physicians would inevitably pick them up and read them. She also says that concentrating on getting a single champion on board helped many facilities get great results. The team leader would take one amenable physician and do training with him or her, then another. It made the process seem exclusive and special. "Pretty soon people would clamor for the training."

The results were initially rolled out in ICUs, but have since been spread to other inpatient units and VA community living centers. CAUTI and ventilator-associated pneumonia are next on the list.

REFERENCE:

1. Render ML, Hasselbeck R, Freyberg RW. Reduction of central line infections in Veterans Administration intensive care units: an observational cohort using a central infrastructure to support learning and improvement. *BMJ Qual Saf* 2011: 20:725-732. ■

JC Q&A: Active testing for MRSA

The Joint Commission recently posted the following answer to a frequently asked question on screening for methicillin-resistant *Staphylococcus aureus* (MRSA).

Q: Is MRSA screening required for all patients? If not, are there certain high-risk patients that must be screened?

A: IC.01.05.01 EP 1 requires that, "When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus." Also, NPSG.07.03.01 EP 7 states, "Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines)." Please refer to the CDC/HICPAC guideline entitled "Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006": available at http://ow.ly/70gHk

The HICPAC guideline lists two sets of interventions, designated as "general" and "intensified, tier 2". Tier 2 interventions are not recommended of all facilities, but rather just those that meet criteria listed in the guideline. These criteria include failure to decrease MDRO rates as well as the first occurrence of an epidemiologically significant organism. Screening, also known as active surveillance cultures (ASC), is listed under the category of "intensified interventions" (recommendation V.B.5.b).

Therefore, unless an organization meets the criteria for "intensified, tier 2" interventions, Joint Commission surveyors would not expect these to be in place. Consequently, active surveillance cultures are not required at all accredited facilities.

However, please note that LD.04.01.01 EP 2 requires compliance with applicable law and regulation. Many state legislatures have enacted law or regulation that requires active surveillance cultures for particular patient populations. The Joint Commission would expect these to be done per LD.04.01.01. ■