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AHC Media

Stymied OSHA is politically incorrect in campaign season

'OSHA regs don't kill jobs, they stop jobs from killing workers.'

Growing anti-regulatory pressure and presidential politics bring new hurdles for the U.S. Occupational Safety and Health Administration, which was already known for its snail-like pace of rulemaking. The agency has delayed the release of several key regulations, and observers expect little to emerge in the midst of an election year.

The recordkeeping rule that would add a column to the OSHA 300 log for musculoskeletal disorders (MSDs) seemed on a fast-track in 2010, with implementation scheduled for 2011. It became mired in an unusually lengthy review in the Office of Management and Budget, and OSHA withdrew the rule. The agency gathered more comments and was expected to reissue it in time for the rule to become effective in 2012.

But by the fall, there was no word on an MSD column.

OSHA administrator **David Michaels**, MD, MPH, has said that issuing an Injury and Illness Prevention Program standard (I2P2), requiring employers to have a program to address workplace hazards, is his top priority. A draft version was due by June 2011, according to the agency's regulatory agenda. But again, no sign of I2P2 has emerged.

"I've been amazed at the extent to which OSHA's agenda has been affected," says **Brad Hammock**, an attorney with Jackson Lewis in Reston, VA, who specializes in occupational health law and was counsel for safety standards at OSHA from 2005 to 2008.

"There's never one thing that causes a delay in a regulatory initiative by OSHA. There are things that go on behind the scenes that have nothing to do with politics. It could be something as simple as difficult technical issues with a rule. But I suspect it's a combination of a lot of things [including politics]," he says.

Republicans have put OSHA in their sights as they criticize "job-killing" regulations. "We're coming up to an election year. Jobs are the top issue in the upcoming election and a dominant theme has been government creating an atmosphere where jobs can be created. OSHA has been an easy whipping boy, like the EPA [Environmental Protection Agency], for that theme," says

Eric J. Conn, an attorney who heads the OSHA group at Epstein Becker and Green in Washington, DC.

Injuries down, but still high in HC

The criticisms of OSHA came as the agency marked another decline in occupational injury and illness rates. Hospital injury and illness rates also declined, but at 7 per 100 fulltime workers, they remained double the rate for all private industry. Nursing homes were among the most hazardous workplaces. The health care industry was the only one to receive a cautionary comment from U.S. Secretary of Labor **Hilda L. Solis**.

"We remain concerned that more workers are injured in the health care and social assistance industry sector than in any other, including construction and manufacturing, and this group of workers had one of the highest rates of injuries and illness … ," she said in a statement. "The Department of Labor's Occupational Safety and Health Administration will continue to work with employers, workers and unions in this industry to reduce these risks."

Solis also highlighted OSHA's recent emphasis on recordkeeping enforcement. *(See* HEH, *September 2011, cover.)*

Just a couple of weeks before, House Republicans invited Michaels to a hearing before the House Committee on Education and the Workforce, Subcommittee on Workforce Protections. In his opening statement, chairman **Tim Walberg** (R-MI) cited the agency's "punitive approach to workplace safety," saying that "… many of us remain concerned whether it is the best approach to worker safety."

In his comments, Michaels detailed OSHA's successes and said, "Clearly, it's not only good business to prevent workplace injuries and illnesses, but the small amount of money that goes to fund this agency is a worthwhile investment for the general welfare of the American people."

He later told the lawmakers, "OSHA regulations don't kill jobs, they stop jobs from killing workers."

Slashing OSHA's budget?

Republicans have taken aim at OSHA by trying to constrain the agency's funding. They attached a rider to the House appropriations bill that would prevent OSHA from issuing the Injury and Illness Prevention Program rule, implementing the MSD column, or enforcing a compliance directive on stiffer fall protection in residential roofing.

Business groups such as the National Federation of Independent Business said OSHA downplayed the time and cost to employers to report work-related MSDs. (These are injuries that must be reported anyway, but employers would need to decide if they meet OSHA's definition of an MSD.) And although OSHA says the recordkeeping is "solely to improve data gathering regarding work-related MSDs," critics fear it is a first step toward a return to an ergonomics regulation. A comprehensive ergonomics rule was rescinded by Congress in 2001.

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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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A look at the top 10 hazardous industries

According to the U.S. Bureau of Labor Statistics, these industries had the highest rates of work-related injury and illness in the United States in 2010:

1. Nursing and residential care facilities (State government)
2. Fire protection (Local government)
3. Travel trailer and camper manufacturing (Private industry)
4. Iron foundries (Private industry)
5. Hospitals (State government)
6. Skiing facilities (Private industry)
7. Nursing and residential care facilities (Local government)
8. Police protection (Local government)
9. Aluminum die-casting foundries (Private industry)
10. Ambulance services (Private industry)

Meanwhile, U.S. Sen. **Tom Coburn** (R-OK) has attacked OSHA in the Senate and proposed slashing the agency's budget, saying it should move away from enforcement and toward voluntary compliance programs. House Republicans also have tried to slash OSHA's budget.

How will the anti-OSHA foment impact OSHA? "These riders are political showmanship," says Conn, who said he doesn't expect them to survive the appropriations process.

Rules reduce injuries, deaths

Yet political attacks weaken OSHA, either by making it more timid or by actually altering its ability to regulate, says **Justin Feldman**, MPH, MSW, worker health and safety advocate at Public Citizen, a Washington, DC-based advocacy group.

Already, OSHA has been constrained by court decisions and corporate backlash that influences Congress and presidential administrations, he says. In a review of OSHA activity, Feldman found that rulemaking slowed under the Bush and Obama administrations. It takes about six years for OSHA to issue a rule, while it once took less than a year, he says.

In fact, contrary to the claims against it, OSHA's regulations save lives and money by preventing injuries, says Feldman. The delay of five pending regulations cost about 100,000 serious injuries, 30,000 occupational illnesses and hundreds of fatalities, based on OSHA's health analysis of the potential impact of the rules, Feldman said in his Public Citizen report.

The Bloodborne Pathogen Standard, which was not included in Feldman's report, is often cited as an example of a successful regulation. In 1983, the year the hepatitis B vaccine became available, 10,721 health care workers acquired hepatitis B. By 1999, seven years after OSHA began requiring health care employers to offer the hepatitis B vaccine, the number had dropped to 384.

The benefits of regulations to employers, employees and society are rarely acknowledged in the political arena, says Feldman.

"Facts are not all that important in politics. They're important in policy, but not in politics," he says. "The message we get from the Republicans [is that] no one's proposing that we cut back existing OSHA regulations. [But] when it comes to proposing a new one, that's too much."

Still moving at 'glacial pace'

So where does this leave OSHA? Despite the opposition from business groups, the MSD recordkeeping rule seems likely to move forward, observers say. It doesn't actually require new reporting, just identification of MSD injuries by checking a box.

Employers can use the information on MSDs to analyze their injuries. But over time, OSHA also could use the information to demonstrate that there was a "recognized hazard," one of the potential hurdles of issuing citations under the general duty clause, says Conn. "This is a major tool for them," he says.

I2P2 remains a priority for Michaels, but its fate may be determined by the presidential election. OSHA may lay low during 2012, especially on a regulation that affects all industries. "It's hard to believe they're going to be pushing [new regulations] out next year if they haven't been able to do that this year," says Hammock.

Yet delayed action is not the same thing as abandoning the regulatory efforts, notes Conn. "They move forward. They just move forward at a glacial pace," he says.

Meanwhile, regulatory action continues at the state level, with new laws on safe patient handling

(in California) and workplace violence in hospitals (in Connecticut) and state regulations such as the California Aerosol Transmissible Diseases standard.

REFERENCE

1. Feldman, J. OSHA Inaction: Onerous Requirements Imposed on OSHA Prevent the Agency from Issuing Lifesaving Rules. Public Citizen: Washington, DC, October 2011. Available at http://bit.ly/s8O2QB ■

HCWs aren't healthy — and that is costly

More chronic conditions and hospitalizations

America's health care workers may provide the best of care to their patients, but they aren't very good at caring for their own health. They have a greater burden of chronic diseases than other workers — which also means higher medical costs for their employers.

In fact, medical care and prescription drug costs for hospital workers are 10% higher than the general workforce, according to an analysis by Thomson Reuters Healthcare consulting business in Ann Arbor, MI. The analysis compared health risk and health care medical claims of 1.1 million hospital workers with 17.8 million health plan members from other industries in 2010.

Hospital workers were 31% more likely to be hospitalized because of being overweight or obese and 32% more likely to be hospitalized with congestive heart failure than other workers. They also were significantly more likely to be hospitalized for asthma, hypertension, HIV, diabetes and mental health.

The findings were surprising because many of these health care workers are advising or caring for people with those same conditions, says **Kreg Sherbine**, consulting manager for the Healthcare business, which helps employers analyze their medical data and evaluate their wellness programs.

"Chronic conditions are often manageable," he says. "One would think that people who know about health care and appropriate health behaviors would be less susceptible to chronic conditions."

However, it isn't always easy to be healthy if you work in health care. Shift work can affect sleep patterns and even diet, says Sherbine. And health care workers have high levels of work-related stress, he says.

"There's pressure to perform at the highest level every single minute of every day," he says. "The evidence in the literature is that stress and mental health issues can exacerbate physical health issues."

Time for an onsite clinic?

Hospitals are beginning to embrace wellness as a way to enhance their employees' health and help control medical costs, says **Andrew Halpert**, MD, senior consultant with Towers Watson in San Francisco, which helps employers develop and evaluate wellness programs and analyze their costs and benefits.

The study's findings on chronic conditions among hospital workers mirrors what Halpert has found in analyzing claims data for hospitals, he says. In response, hospitals have begun to change the work climate with healthier food in the cafeteria and smoke-free policies, he notes.

A broad-based wellness program, including health coaching, financial incentives, and worksite wellness challenges to motivate employees, can produce a return on investment in three to five years, he says. "You have to have a good program, promote it heavily and change the culture," he says.

Sherbine advises employers to take a close look at their medical claims. Wellness offerings should be tailored to their population, not just follow a generic model, he says. "Before an organization launches into solutions, they need to really understand the problem," he says. "That ought to drive the development of programs to help the population manage its health."

It might also pay off for hospitals to offer some disease management or basic primary care in an employee health clinic, says Sherbine. The analysis found that hospital employees were 22% more likely to visit the emergency department but had fewer visits to a physicians' office.

For hospital workers, visiting the ER is often more convenient than taking time off to see a doctor. An onsite clinic would make it easier for them to manage their chronic conditions, says Sherbine. "We are working with a number of clients who are considering onsite clinics," he says.

Ideally, hospital workers should model healthy habits, says Halpert. "Your goal should be to do better than the general population," he says. ■

Wellness a winner for hospitals, HCWs

OhioHealth helps employees become healthy

Almost six years ago, OhioHealth in Columbus began to face up to a problem: Many employees at the multi-hospital system in central Ohio were unhealthy. They were smokers, overweight, physically inactive, stressed out.

Chronic diseases were getting them down. They were also costing the health system in higher medical costs and greater absenteeism. The medications for asthma alone could run hundreds of dollars a month for a single patient. The health system is self-insured and pays 80% of employees' premium costs.

OhioHealthy, a comprehensive wellness program, began in 2006 with a program targeting employees with asthma or diabetes. Pathways to Wellness provided the medications at a significant discount — or even free — if employees met with a pharmacist quarterly to monitor their progress. Diabetics needed to get quarterly A1c blood tests, annual eye exams and ongoing foot care.

The pharmacists coordinated with the employees' physicians as they helped employees manage their conditions.

"We really want [employees] to have the best quality of life they can have," says **Linda Wagner**, RN, MA, NE-BC, clinical director of OhioHealthy, noting that employee wellness also benefits employers. "If they feel better, they can be more productive," she says.

Over the years, OhioHealthy has evolved and added new programs, from nicotine replacement therapy for smoking cessation to wellness incentives. It is also gathering outcomes information to evaluate the impact of the wellness program.

If employees and their covered spouses or partners participate in the biometric screening and online health risk assessment, their insurance premiums have not gone up. Employees who do not complete the screening and assessment pay an extra $10 per biweekly pay period or $20 for coverage that includes a spouse or partner.

A pedometer program encourages employees to exercise for incentives. If they take 20,000 steps in a day, they receive 100 points. The points accumulate so that someone who is physically active can receive up to $500 a year. There are kiosks on hospital campuses to download the pedometer totals and to monitor health indicators such as blood pressure, body fat, and body mass index.

OhioHealthy Heart is a cardiovascular program for people with risk factors who receive extra assessments (such as a lipid profile) and education sessions.

The benefits go far beyond cost-savings. "When you find someone who is hypertensive and didn't know it, and who can then begin treatment, that's hard to put a dollar amount on," says Wagner. "As a health care professional, it gives you a good feeling about what you're doing."

In one case, a nurse was just 10 pounds below the weight cutoff for having gastric bypass surgery. Rather than gain weight to qualify for the surgery, she was determined to lose it on her own. With support from OhioHealthy, she lost about 100 pounds.

"The nurse met her goals and her life has turned around," says **Lisa Meddock**, MBA, manager of benefits administration at OhioHealth. "She's off her diabetes medications. She's happier. She was able to lose all the weight she wanted to lose through a gastric bypass without going through surgery."

That is the kind of success story that OhioHealthy aims to achieve. ■

Seek best practice for protection

Respirator use still a problem after H1N1

Two years after the emergence of the H1N1 pandemic, hospitals are still learning lessons that may help avert serious problems in a future outbreak. Respiratory protection in particular became a contentious issue during the pandemic, and it remains an area of concern.

Even in California, where hospitals had a clear set of requirements to follow under the state's new Aerosol Transmissible Diseases standard, there were gaps in respiratory protection plans, according to recent research sponsored by the National Institute for Occupational Safety and Health (NIOSH). Researchers are now comparing respiratory protection in California to other regions of the country.

"The vast majorities of hospitals had a written program, but it didn't necessarily cover all of the [required] elements," says **Barbara Materna**, PhD, CIH, chief of the Occupational Health Branch of the California Department of Public Health.

Written policies at 15 of the 16 hospitals in the study called for health care workers to use N95s when in close contact with patients with suspected or confirmed H1N1 pandemic influenza, "but they

didn't necessarily have everything in place to ensure that the respiratory program was effective," Materna says.

Only 29% of unit managers surveyed said they audited the proper use of respirators by employees on their units.

To help hospitals improve their respiratory protection, the REACH project (Respirator use Evaluation in Acute Care Hospitals) has produced a toolkit, including a checklist that can be used to evaluate a respiratory protection program. *(For a sample checklist, see p. 139.)*

NIOSH is working with the Joint Commission accrediting body to publish a best-practices monograph by the end of 2012, says **Maryann M. D'Alessandro**, PhD, associate director for science at NIOSH's National Personal Protective Technology Lab (NPPTL) in Pittsburgh.

For example, one measure that helps improve proper use of respirators is placing a sign outside of airborne infection isolation rooms reminding employees to don a respirator, she says. Best practices strategies revealed in the REACH project will be included in the monograph. NIOSH and the U.S. Occupational Safety and Health Administration also have developed a training video that can be used to educate health care workers. (www.cdc.gov/niosh/npptl/).

The lessons learned during the H1N1 pandemic "helped us focus our activities to inform the workers and hospital administrators," says D'Alessandro.

HCWs need respirator training

Respiratory protection in health care has been fraught with both controversy and confusion. During the H1N1 pandemic, guidance from the Centers for Disease Control and Prevention and local and state health departments sometimes conflicted.

Although N95s are not used with seasonal influenza, the CDC advised that they should be used when caring for patients with suspected or confirmed pandemic influenza. Some infection control professionals felt N95s were only necessary with aerosolizing procedures, but the U.S. Occupational Safety and Health Administration vowed to enforce the CDC guidelines.

Currently, CDC recommends using a facemask when caring for a patient with seasonal influenza but wearing an N95 respirator when performing aerosol-generating procedures.[1]

"My hope is that people will start to get past this [prior conflict] and gain an understanding of how respirators work to protect employees," says Materna.

That protection relies on a proper fit and training of employees. Too often, they don't understand when to use respirators, which device to select and how to don it and doff it properly to avoid contaminating themselves, says Materna.

In REACH, researchers observed health care workers using respirators or asked the employees to demonstrate how to wear them. Some risked contaminating their hands or face by failing to remove their personal protective equipment in the correct order, she says.

Hospitals also need to evaluate their respiratory protection program, to make sure employees know when and how to use the equipment, she says. "Respiratory protection is an important tool to protect workers" that should be used in conjunction with other infection control measures, says Materna.

"Healthcare workers are a valuable resource and we want them to be able to work when other people are sick and need care," she says.

No new national stockpile

In the post-pandemic analysis, respirator supply remains a major issue. The national stockpile has not been replenished, says **Roland Berry Ann**, deputy director of NPPTL. "Therefore, it may be better to have local and regional stockpiles rather than depending on a CDC strategic national stockpile," he says.

Hospitals need to determine how they would supply respirators during a pandemic or outbreak of an emerging airborne infectious disease, he says. For example, hospitals could turn to reusable respirators, such as powered air-purifying respirators (PAPRs) or elastomerics. Or they could arrange for a local stockpile, such as through distributors, a consortium of users of the same respirator products or by storing extra respirators onsite, he says.

In the REACH study, 50% of unit managers reported that there were shortages of N95 respirators during the H1N1 pandemic.

One bright spot: Respirator manufacturers developed new production sites during the surge of demand and may have greater capacity to respond to a future event, Berry Ann says.

REFERENCE

1. Centers for Disease Control and Prevention. Prevention strategies for seasonal influenza in healthcare settings. September 20, 2010. Available at http://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm. Accessed on October 17, 2011. ■

Respirator Program Evaluation Checklist			
1	Y	N	Is there a written policy which acknowledges employer responsibility for providing a safe and healthful workplace?
2	Y	N	Has an individual been designated as the respiratory protection program administrator (RPA) with overall responsibility for development and implementation of the respiratory protection program?
			Does the written respiratory protection program include the following required elements?
3	Y	N	written designation of a program administrator;
4	Y	N	an evaluation of hazards and identification of appropriate respirators for specific job classifications and/or tasks;
5	Y	N	procedures for medical evaluations of employees required to use respirators;
6	Y	N	fit testing procedures for tight-fitting respirators;
7	Y	N	procedures for proper use of respirators;
8	Y	N	procedures and schedules for storage, inspection, and maintenance of respirators;
9	Y	N	procedures for training employees regarding the respiratory protection program;
10	Y	N	a description of the training curriculum;
11	Y	N	procedures for voluntary use of respirators;
12	Y	N	procedures for regular evaluation of the program;
13	Y	N	Is the written program readily available to any employee included in the program?
14	Y	N	Is there a record of medical clearance for each employee required to wear a respirators?
15	Y	N	Is there a record of a fit test or fit test screening for each respirator user from within the last year?
16	Y	N	Have users been trained in the proper use, maintenance, and inspection of respirators?
17	Y	N	Are workers prohibited from wearing respirators with a tight-fitting facepiece if they have facial hair or other characteristics which may cause face seal leakage?
18	Y	N	Are respirators stored appropriately so as to prevent them from becoming damaged or deformed?
20	Y	N	Are the users wearing the respirator for which they have passed a fit test?
21	Y	N	Are N95, or more protective, respirators always worn by employees in areas occupied by a suspected or confirmed case of airborne infectious disease?
22	Y	N	Are PAPRs always worn by employees in areas where a high hazard procedure is being performed on a suspected or confirmed case of airborne infectious disease?
23	Y	N	Are respirators inspected by the users before each use?
24	Y	N	Are respirators being donned and doffed correctly?
25	Y	N	Are PAPRs cleaned and disinfected after each use?
26	Y	N	Is there a mechanism for users to report problems with respirator use?
27	Y	N	Is there a mechanism for users to provide feedback about the effectiveness of the program?

Source: Occupational Health Branch, California Department of Public Health, California REACH Project

Don't make an N95 fashion statement

Altering respirators voids NIOSH approval

Beware of the beautiful respirator. Efforts to make a fashion statement with an N95 respirator degrade the protective qualities and negate its approval by the National Institute for Occupational Safety and Health, says **Roland Berry Ann,** deputy director of NIOSH's National Personal Protective Technology Lab.

Some companies have sold approved respirators that are altered with colorful designs. But the design elements change the performance of the respirator, says Berry Ann. "They are tested and approved with the entire filtering surface available for air to flow

through," he says.

Health care workers also need to understand that they can't alter the respirator, whether they're simply adding a colorful sticker, coloring it with markers, or attaching a colorful piece of cloth, he says.

"That cross sectional area, [even if it's small], will make a difference in t he breathing resistance," he says.

NIOSH also cautions consumers to make sure they're purchasing NIOSH-approved N95 respirators. For example, one "face mask" sold to the public as an N95 was not NIOSH-approved. NIOSH tested the mask and found it had 80% leakage.

NIOSH provides information about misleading representation or revocation of approval of respirators at www.cdc.gov/niosh/npptl. ■

CA law calls for hospital lift teams

Seven states require safe pt handling

Lift teams are now the law in California. After seven years and five vetoes, a safe patient handling bill was signed by Gov. **Jerry Brown** that requires hospitals to have "trained lift teams or other support staff trained in safe lifting techniques."

California joins seven other states that have laws requiring hospitals to maintain a safe patient handling program. "We are extremely pleased that nurses and patients and health care workers are going to be safer in California," says **Bonnie Castillo**, RN, government relations director of the California Nurses Association in Sacramento, which sponsored the legislation.

While many hospitals have developed minimal-lift programs, the adoption of safe patient handling across the nation varies widely. The U.S. Bureau of Labor Statistics reported that the incidence rate of musculoskeletal disorders requiring days away from work rose by 5% among nurses in 2009, although it dropped by 5% in private industry overall.

Hospitals have a rate of overexertion due to lifting that is about double the rate for general industry *(24.5 per 10,000 fulltime equivalent workers, compared to 12.8 in private industry)*.

As many as 20 states have discussed proposals for encouraging or requiring safe patient handling in health care, but the issue has failed to get traction nationally. Congress did not act on a bill that would have required safe patient handling programs and would have provided $200 million in grants to health care facilities to purchase lift equipment.

"We're looking for California's success to be that spark for renewed effort for the nation," says **Anne Hudson**, RN, a back-injured nurse from Coos Bay, OR, who founded WING USA (Work Injured Nurses' Group), which lobbied for the legislation.

RNs coordinate lifts

The path to the California law was not an easy one. A safe patient handling bill first passed the California legislature in 2004, but it was repeatedly vetoed by then Gov. Arnold Schwarzenegger. He said the law was unnecessary, and he expressed concern about the financial burden on hospitals and the need for flexibility.

The new law applies only to hospitals. It requires employers to maintain a "patient protection and health care worker back and musculoskeletal injury prevention plan." Registered nurses assess patient lift needs and oversee the lifts: "As coordinator of care, the registered nurse shall be responsible for the observation and direction of patient lifts and mobilization, and shall participate as needed in patient handling in accordance with the nurse's job description and professional judgment."

Nurses care for designated patients and because of staffing ratios they can't necessarily help other nurses with lifts, says Castillo. That's why the hospital needs to assign trained staff to help with lifts, she says.

"It's based on the RN assessment with regards to what is needed and required for each particular lift," she says. "What's important is that the hospital maintains at all times adequate numbers of personnel who are trained and have the up to date safe equipment to do the more complex lifts."

The California Hospital Association opposed the bill. It didn't provide enough flexibility for hospitals that have different patient populations and lift needs — such as pediatric hospitals or units or neonatal units, says spokeswoman **Jan Emerson-Shea**.

"We don't believe a one-size-fits-all approach is the right way to address the issue," she says. The issue is real, and hospitals have been working on it for a number of years."

Hospitals also were concerned about the bill's restriction on disciplining employees who refuse to assist with a lift, she says. The law states: "A health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or the lack of trained lift team personnel or equipment shall not, based upon the refusal, be the subject of disciplinary action by the hospital or any of its managers or employees."

States have taken very different approaches to safe patient handling. Texas, the first state to pass a law

on the subject, requires hospitals to have safe patient handling programs but doesn't mandate the use of lift equipment. In 2006, Washington was the first state to require the use of lift equipment. The state also provided financial assistance to purchase equipment through tax credits.

Minnesota followed in 2007 with a similar law and grant fund. Ohio provided an interest-free loan fund for nursing homes to purchase lift equipment.

The California law has a glaring omission because it does not apply to nursing homes, where back injuries from patient lifting are even more common than in hospitals. It simply wasn't politically possible to get a more encompassing bill, says Castillo.

Meanwhile, efforts will continue for a national safe patient handling law, says Hudson. She hopes to enlist bipartisan support for a comprehensive approach. "[This] highlights the need for a national standard to cover all health care workers across all health care settings," she says. ■

New spotless spotlight shines on EVS workers

Housekeepers are part of 'medical team'

Cleaning patient's rooms may not seem like the most important job in the hospital. But envi-

Hired hands can boost no-lift efforts

Contracted lift teams offer new option

As hospitals ramp up their efforts to provide safe patient handling, there's also an increase in the services available to help them. In fact, even beyond training and traditional consulting, hospitals now can hire contracted lift teams.

Atlas Lift Tech, based in San Francisco, provides customized safe patient handling services to hospitals around the country — including contracted lift teams.

It's not much different from contracting other hospital services, such as housekeeping, dietary or transport, says **Eric Race**, PEMT, president and founder of Atlas Lift Tech. The company carries liability, workers' compensation and errors and omission insurance, he says.

"We will provide a successful and sustainable program … [that is] cheaper, easier and faster with less risk to the hospital," he says.

Despite its name, Atlas Lift Tech isn't based on hiring burly guys who use brute force in manual lifting. Hospitals must buy appropriate equipment, and the lift team members are required to use equipment. In fact, Atlas Lift Tech helps hospitals select vendors and provides clinicians to train hospital workers in the use of equipment.

"A physical therapist will educate a physical therapist, and an RN will educate an RN," says Race. "This allows for a core understanding of what safe patient handling is in their particular environment."

The lift teams generally function as safe patient handling peer leaders, helping with lifts as well as training hospital employees on lifting, says Race. The lift teams perform the most challenging lifts, but they don't do all lifts in the hospital, he says.

A software program allows the staff to coordinate with lift team members and request lifts, based on a nursing assessment, he says. "The nurses are ultimately overseeing the lift teams," he says. "This is still the hospital's program. We're just providing them with the resources that create essentially a turn-key solution [to safe patient handling]."

As hospitals evaluate the success of their safe patient handling efforts, they often seek outside resources. Marin General Hospital in Greenbrae, CA, is trying to find a way to increase the use of the hospital's lift equipment.

"One of the barriers that comes up repeatedly is time. There's a sense that it takes longer to use mechanical equipment than it does to perform a lift manually," says **Julie Lavezzo**, CHEM, director of Safety, Security and Transportation.

Marin General is looking for help to improve staff training in safe patient handling and to make employees more comfortable with the equipment, she says. "We want our staff to know how to safely and effectively manage patient mobilization activities," she says.

The cost of lift teams — and consulting and training services — varies based on the particular needs of a hospital, says Race. But the cost of patient handling injuries is well-known in the industry. "We're always going to be less than their [workers' compensation] loss history," he says. ■

ronmental service workers save lives in their own way — by preventing the spread of infections. A new spotlight on their role may boost the resources, communication and training focused on this group of workers.

"Clean Spaces, Healthy Patients," a national initiative of the Association for Professionals in Infection Control and Epidemiology (APIC) and the Association for the Healthcare Environment (AHE), stresses the links between infection control professionals and environmental services.

Within hospitals, the departments are becoming aligned. Although employee health isn't a formal part of the APIC/AHE initiative, EH professionals are often part of the dialogue, as well.

"Historically, we have been two of the departments in health care that have been underresourced," says **Marita Nash**, MBA, CHESP, director of Environmental Services and Linen at Hunterdon Medical Center in Flemington, NJ, and a member of the Clean Spaces advisory panel. "Together, we solicit the resources to address that need."

Meanwhile, the Service Employees International Union (SEIU), which represents more than 1 million health care workers, has been training hospital-based environmental services workers in green practices — and in some basics about the difference between cleaning and disinfection and the problem of healthcare-acquired infections.

"We're giving them a fundamental understanding of the importance of their role,' says **Bill Borwegen**, MPH, health and safety director of SEIU in Washington, DC.

Microbes on mouses

The surfaces in a patient room and the nurses' station are prime culprits for fomite spread of infectious diseases, and research has increasingly found microbes on common items: stethoscopes, bed rails, computer keyboards, telephones. Studies have even found bacteria on doctors' neck ties[1] and doctors' coats and nurses' uniforms.[2]

Better training of housekeepers can reduce the contamination. A study at Rush Medical Center in Chicago found that training and monitoring of housekeepers improved the cleaning of surfaces in patients' rooms — and reduced the transmission of vancomycin-resistant enterococci (VRE).[3]

At Hunterdon Medical Center, the training includes sessions on communication among professionals and non-professionals — an effort to break down the hierarchical barriers. Environmental service workers are part of the "medical team" on a unit, says Nash.

That integration should occur even if a hospital uses a contractor for environmental services, says Nash. Those workers still have a commitment to doing the job correctly, she says. And the hospital still has a manager who oversees environmental services and can work closely with infection control and employee health, she says.

Green means less risk

Environmental services workers also must learn how to protect themselves from the chemicals they use to decontaminate the rooms. For example, Hunterdon has eliminated most trigger spray bottles, which can aerosolize the cleaning solutions. If a spray bottle is used, the workers spray it onto a rag rather than on the surface, Nash says.

SEIU is promoting the use of less toxic, "green" cleaners, which pose less health risk to the workers as well as others in the health care environment. But the environmental service workers need to understand how to properly use the products, such as how long they must stay on a surface before being wiped off, says Borwegen. "It's important that these workers be properly trained," he says.

Yet there are potential barriers. "These are some of the lowest paid workers in a health care facility," Borwegen says. "In many instances, they're contracted workers — they're not even employees of the hospital. They're predominantly an immigrant population. English may not be their first language."

It's important to use educational materials that have a lot of graphics and pictures, he says. Nash sometimes uses interpreter services, and she adjusts her training to accommodate those who have learning disabilities or literacy problems. For example, they may learn from observing and then demonstrate their competence, she says.

Monitoring quality of cleaning

At Hunterdon, there's an information loop from infection control to environmental services. In an environmental services audit, infection control swabs six surfaces in patient rooms to detect adenotriphosphate (ATP), an indicator of organic matter. They test different surfaces on different shifts in about 30 to 40 rooms a month.

"Right now, we are swabbing the overbed table control knob, blood pressure cuff, the arms on the patient chair, telephone, toilet seat in the bath-

room, and the light switch in the bathroom," says Nash.

The monitoring demonstrates the effectiveness of the environmental services staff. Infection control professionals often comment on the cleaning. "They'll stop and say, 'Thanks for doing such a great job.' That means more to my staff than anything in the world," says Nash.

And by teaming up, infection control and environmental services support each other. For example, Nash recently hired an employee for the night shift who cleans keyboards, computer mouses, telephones, medical record covers, and other such surfaces.

Of course, the users of those devices are expected to clean them regularly, as well, says Nash. The hospital provides germicidal wipes. "The culture [at our hospital] is that cleaning is everyone's responsibility," she says.

[Editor's note: More information about "Clean Spaces, Healthy Patients," including links to resources, is available at www.apic.org/cleanspaces.]

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3. Hayden MK, Bonten MJ, Blom DW, et al. Reduction in acquisition of vancomycin-resistant enterococcus after enforcement of routine environmental cleaning measures. *Clin Infect Dis 2006*; 42:1552-1560. ■

OSHA offers resource on lab safety

With a myriad of potential hazards, laboratories need a complex array of safety measures. They must develop a Chemical Hygiene Plan, detailing how they will minimize the risk of exposure to chemicals, monitor the workplace and respond to exposures. Beyond the Laboratory Standard, there are a number of other regulatory standards that impact labs, including respiratory protection, hazard communications, control of hazardous energy (lockout/tagout) and personal protective equipment.

The U.S. Occupational Safety and Health Administration has developed guidance documents and fact sheets to help employers comply with the standard and address the hazards.

The OSHA documents provide a useful review of laboratory safety, says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic. But he also notes that automated systems in labs have greatly reduced the potential for exposure.

OSHA's guidance is available at http://1.usa.gov/twJZjh ■

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

- Lessons from best practices in workplace safety
- Make the most of your SPH peer leaders
- Helping HCWs cope with stress
- Can you require Hepatitis B vaccination of HCWs?
- Overcoming language barriers in safety training

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 QUESTIONS

1. Business groups such as the National Federation of Independent Business have been critical of OSHA's proposed rule to add a column to the OSHA 300 log to record work-related musculoskeletal disorders because:
   A. those injuries don't currently have to be reported
   B. they didn't provide a definition of MSDs
   C. most MSDs aren't work-related
   D. they say OSHA underestimated the time and cost of the rule.

2. According to an analysis by Thomson Reuters Healthcare consulting business in Ann Arbor, MI, how do medical and prescription drug costs of hospital employees compare to other workers?
   A. They are lower.
   B. They are 10% higher.
   C. They are 20% higher.
   D. The costs are about the same.

3. What is the current guidance from the Centers for Disease Control and Prevention on the use of respirators with seasonal influenza?
   A. Only surgical masks, not respirators, are recommended.
   B. Respirators are used only in high-risk units, such as the ICU.
   C. Respirators should be used during aerosol-generating procedures.
   D. Respirators should be worn in all patient contact with seasonal flu.

4. In the new California safe patient handling law, who is responsible for "the observation and direction of patient lifts and mobilization"?
   A. Registered nurses
   B. Lift team members
   C. Nurse managers
   D. Ergonomists

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