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AHC Media

Joint Commission gives hospitals a wake-up call on fatigue risks

But OSHA balks at adding more enforcement

Hospitals have been put on alert to recognize fatigue among health care workers as a risk to patient safety. But for now, hospitals won't face any regulatory consequences for failing to address it.

The U.S. Occupational Safety and Health Administration denied a petition to regulate the duty hours of medical residents, noting that the Accreditation Council for Graduate Medical Education (ACGME) has adopted stricter duty hour limits. Instead, OSHA administrator **David Michaels**, MD, MPH, said the agency will develop guidance on "coping with the effects of fatigue and sleep deprivation."

A Sentinel Event Alert from the Joint Commission indicates that the accrediting body is concerned about the impact of fatigue on patient safety. But while the alert offers suggestions on fatigue management, it doesn't direct health care employers to limit shift length. *(For Joint Commission suggestions, see box on p. 27.)*

"The purpose of the alert is really to educate and create awareness," says **Ana Pujols McKee**, MD, executive vice president and chief medical officer of the Joint Commission, which is based in Oakbrook Terrace, IL, noting that fatigue has not been widely addressed in hospitals.

The alert should begin a dialogue about fatigue, its impact and ways to mitigate it, McKee says. "We ask organizations to conduct their own assessments and look at their adverse events and analyze trends and patterns where fatigue might have been [an issue]," she says. "I anticipate there will be more discussion, more information and more opportunity to provide risk-reduction strategies."

Error rises with longer shifts

Long work hours and rotating shifts make physicians and nurses more prone to error. That fact is supported by a growing body of evidence — findings that are creating pressure for health care employers to limit shift length and overtime.

In 2004, an Institute of Medicine panel recommended state rules to restrict nurses to shifts of no more than 12 hours in a 24-hour period and a work week of no more than 60 hours in seven days.[1] While some states prohibit mandatory overtime for nurses, there are no limits on shift length or voluntary overtime.

Yet studies continue to show an impact on patient safety. In one study, 393 nurses kept track of their work hours and errors or near-errors for a four-week period. All of them worked at least one day of overtime, and about a third worked overtime every day they worked. More than a quarter (28.7%) reported working mandatory overtime at least once during that timeframe.[2]

The number of errors and near-errors rose with length of shift and was significantly higher for nurses working more than 40 hours or more than 50 hours a week.

"When a nurse worked 12.5 hours or longer, the nurse was three times more likely to report making an error than when they worked a shorter shift," says lead author **Ann E. Rogers** PhD, RN, FAAN, Edith F. Honeycutt Chair in Nursing and director of Graduate Studies at the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta. "We also found that nurses invariably worked much longer than scheduled. They got out on time once every five shifts they worked."

The Joint Commission advises hospitals to involve employees in designing work schedules that minimize fatigue. But many nurses actually prefer the 12-hour shifts, notes Rogers.

"Everybody likes 12-hours shifts because you have more days off, but what people don't realize is that they're fatigued the next day," she says. "People are very poor judges of their own alertness and fatigue. While others may recognize that they're tired, they may not."

While 12-hour shifts may be here to stay, at least for the foreseeable future, hospitals should create strict limits on overtime and overall work hours, Rogers advises. "Make sure the workload is such that [nurses] can leave at the end of the 12 hours. They should have no more than three consecutive 12-hour shifts," she says. "You're going to be so short on sleep that you're profoundly fatigued. This is even more critical for the night shift worker."

Can OSHA enforce ACGME rules?

Public Citizen, a consumer and health advocacy organization based in Washington, DC, is still hoping to influence OSHA to address fatigue in health care.

OSHA should use its existing authority to enforce the ACGME limits on medical resident duty hours and to address fatigue in health care, Public Citizen said in a letter to Michaels. OSHA could issue financial penalties under the general duty clause and provide medical residents with whistleblower protection, says **Sammy Almashat**, MD, MPH, staff researcher with Public Citizen's Health Research Group.

"If OSHA went in to hospitals [on an inspection], they could enforce violations of the ACGME

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Joint Commission keys to fight fatigue

In a recent Sentinel Event Alert, the Joint Commission accrediting organization offered suggestions for health care employers to "mitigate the risks of fatigue that result from extended work hours — and, therefore, protect patients from preventable adverse outcomes."

1. Assess your organization for fatigue-related risks. This includes an assessment of off-shift hours and consecutive shift work, and a review of staffing and other relevant policies to ensure they address extended work shifts and hours.

2. Since patient hand-offs are a time of high-risk — especially for fatigued staff — assess your organization's hand-off processes and procedures to ensure that they adequately protect patients.

3. Invite staff input into designing work schedules to minimize the potential for fatigue.

4. Create and implement a fatigue management plan that includes scientific strategies for fighting fatigue. These strategies can include:

- engaging in conversations with others (not just listening and nodding);
- doing something that involves physical action (even if it is just stretching);
- strategic caffeine consumption (don't use caffeine when you're already alert and avoid caffeine near bedtime);
- taking short naps (less than 45 minutes).

These strategies are derived from studies conducted by the National Aeronautics and Space Administration (NASA), which state that people can maximize their success by trying different combinations of countermeasures to find what works for them. The NASA studies stress that the only way to counteract the severe consequences of sleepiness is to sleep.

Strategies for determining shift durations and using caffeine to combat fatigue can be found in chapter 40 of "Patient Safety and Quality: An Evidence-Based Handbook for Nurses" (http://1.usa.gov/TdWd7).

5. Educate staff about sleep hygiene and the effects of fatigue on patient safety. Sleep hygiene includes getting enough sleep and taking naps, practicing good sleep habits (for example, engaging in a relaxing pre-sleep routine, such as yoga or reading), and avoiding food, alcohol or stimulants (such as caffeine) that can impact sleep.

6. Provide opportunities for staff to express concerns about fatigue. Support staff when appropriate concerns about fatigue are raised and take action to address those concerns.

7. Encourage teamwork as a strategy to support staff who work extended work shifts or hours and to protect patients from potential harm. For example, use a system of independent second checks for critical tasks or complex patients.

8. Consider fatigue as a potentially contributing factor when reviewing all adverse events.

For organizations with a current policy that allows for sleep breaks for staff defined as essential by the organization:

9. Assess the environment provided for sleep breaks to ensure that it fully protects sleep. Fully protecting sleep requires the provision of basic measures to ensure good quality sleep, including providing uninterrupted coverage of all responsibilities (including carrying pagers and phones, and coverage of both admissions and all continuing care by another provider), and providing a cool, dark, quiet, comfortable room, and, if necessary, use of eye mask and ear plugs.

[Editor's note: The Joint Commission alert is available at http://bit.ly/xohRAz.] ■

rules that already exist," he says.

Public Citizen had asked for rulemaking on work hours, but the rulemaking process has been notoriously slow and politically delicate for OSHA. In his response, Michaels noted, "OSHA's decision comes at a time when the agency faces significant challenges. Unfortunately, OSHA must prioritize limited resources and cannot move forward on every rulemaking request."

Federal rules currently set work limits for some other safety sensitive industries, such as trucking, nuclear power and airlines. But for now, health care employers are being urged to monitor themselves.

Some chief nursing officers have banned double shifts (16 hours), says Rogers. Chief nursing officers also may monitor time cards to make sure nurses aren't working excessive amounts of overtime, she says.

Employees also need to understand the safety risks and make sure that they get enough sleep, says McKee. After all, work isn't the only reason

that health care workers may fail to get adequate sleep.

"There is some responsibility and accountability on the part of the health care worker to come to work rested. That can't be regulated or mandated," she says. "It's something each individual has to be accountable for [as part of] the professionalism that we all have."

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Is it a mandate — or just a requirement?

Federal recs leave flexibility on flu shots

A federal advisory panel gave a boost to policies that require health care workers to receive the flu vaccine but stopped short of endorsing the strongest mandates. If health care employers can't achieve an influenza vaccination goal of 90% "in an efficient and timely manner," then they should "strongly consider an employer requirement," a subgroup of the National Vaccine Advisory Committee (NVAC) said.

Overriding objections by the nation's leading occupational health agency, NVAC approved the recommendation and sent it to the Department of Health and Human Services (HHS) for final approval. HHS approval would raise several implications, but certainly it would give hospitals considering mandatory vaccination policies a top-level federal recommendation to proceed.

Though it is left to individual facilities to define their policy parameters for exemptions (religious objections, etc.), NVAC rejected the strong objections expressed by the Occupational Safety and Health Administration (OSHA). However, with the support of all the major infectious disease and infection control groups behind it, NVAC voted 12-2 (1 abstention) to green light the recommendation and four others. *(See related story, p. 29)*

The recommendation appears to be intentionally vague in its timeframe and its definition of "employer requirement." Some employers allow exemptions for philosophical or "personal belief" objections and some do not. Some have consequences for failing to receive the vaccine, such as mask-wearing during patient care or even termination, and some have no consequences.

"It should be a decision made by an employer and facility," **Christine Nevin-Woods**, DO, MPH, executive director of the Pueblo City-County Health Department in Colorado and co-chair of the Health Care Personnel Influenza Vaccination workgroup, said in a webinar presentation. "This maintains flexibility for employers to make policies based on local resources and patient safety [concerns]."

Occupational health professionals welcomed that flexibility. "At first blush, it may seem to people that if you can't get to 90% you should mandate flu vaccine. That's really not what it says if you read it closely," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic and a member of the workgroup.

"The definition for employer requirement that the group created is pretty broad and allows the employer to determine what their requirement and consequences are going to be. I think that flexibility is absolutely crucial," she says.

"There are places where a mandatory vaccine program can work. That's fine for those places. There are places that have different organizational cultures and different organizational structures where that's just not feasible at all. There are variable levels of desire to mandate a vaccine, given the limitations of the current vaccine," she says.

OSHA: HCWs shouldn't face termination

Yet the recommendation for an employer requirement — and even the pressure to meet a goal of 90% vaccination — remains controversial.

OSHA urged NVAC to withdraw the recommendation for an employer requirement because it did not state that health care workers should not be terminated for failing to receive the vaccine.

"OSHA believes that there must be a very high burden of proof that mandatory-taking programs are not just desirable, but also necessary to protect the public health before the government promotes such a controversial policy that may result in employment termination," the agency's deputy assistant secretary, **Jordan Barab**, said in written comments. "At this time, OSHA believes there is insufficient evidence for the federal government to promote mandatory influenza vaccination programs that may result in employment termina-

tion."

OSHA suggested that employers should be mandated to offer the vaccination as well as influenza education.

Unions that represent nurses and other health care workers also decried the recommendations that they said would become a defacto rule, turning a Healthy People 2020 goal for 90% influenza vaccination of health care workers into a requirement.

"They're trying to take a goal and turn it into rulemaking, outside of the federal practice and procedure," says **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union (SEIU) in Washington, DC.

The Joint Commission accrediting body has already incorporated the 90% goal in its infection control standard, requiring hospitals and other health care facilities to create plans that are "consistent with achieving" that goal.

What's in a requirement?

It's not clear how much impact the NVAC recommendation on employer requirements may ultimately have. Hospitals with widely varying policies could all claim to have an "employer

Striving for 90%: HHS seeks a rate hike

A working group of the National Vaccine Advisory Group, which advises the Assistant Secretary for Health in the U.S. Department of Health and Human Services (HHS), developed the following recommendations to improve influenza vaccination of health care workers. They were all recently approved by the full committee and are now under consideration for adoption by the HHS.

Recommendation 1: The [working group] recommends that health care employers and facilities establish comprehensive influenza infection prevention programs as recommended by the CDC as an essential step for all health care employers and facilities to achieve the Healthy People 2020 influenza vaccine coverage goal of 90%. The [working group] recommends that the ASH strongly urge all HCE and facilities to adopt these recommendations.

Recommendation 2: [The working group] recommends that health care employers and facilities integrate influenza vaccination programs into their existing infection prevention programs or occupational health programs. [The working group] also recommends that the Assistant Secretary of Health assure that this recommendation is implemented in HHS facilities and services (including the Public Health Service, HHS staff and Federally Qualified Health Centers) and strongly urges all health care employers and facilities to do the same.

Recommendation 3: The [working group] recommends that the ASH encourage CDC and the Centers for Medicare and Medicaid Services (CMS) to continue efforts to standardize the methodology used to measure HCP influenza vaccination rates across settings linking vaccine coverage levels and quality improvement activities. The Assistant Secretary of Health should also work with CMS to implement incentives, penalties, or requirements that facilitate adoption of this recommendation.

Recommendation 4: For those health care employers and facilities that have implemented Recommendations 1, 2 and 3 above and cannot achieve and maintain the Healthy People 2020 goal of 90% influenza vaccination coverage of health care personnel in an efficient and timely manner, the [working group] recommends that health care employers and facilities strongly consider an employer requirement for influenza immunization. [The working group] also recommends that the Assistant Secretary for Health assure that this recommendation is implemented in HHS facilities and services (including the Public Health Service, HHS staff and Federally Qualified Health Centers) and urge all other health care employers and facilities to do the same.

Recommendation 5: [The working group] recommends that the Assistant Secretary for Health encourage ongoing efforts to develop new and improved influenza vaccines and vaccine technologies including support for research, development, and licensure of influenza vaccines with improved immunogenicity and duration of immunity, as well as steps that improve the immunogenicity and rapid production of existing influenza vaccines. ■

requirement."

For example, the Mayo Clinic in Rochester, MN, attained an 88% vaccination rate by early January. Mayo has mandatory compliance – but not mandatory vaccination. Employees must receive their vaccine or view an education module and electronically sign a declination statement by the end of January.

"They were sufficiently vague, and I think appropriately so, to allow each institution to determine what they consider to be a requirement," says **Bill Buchta**, MD, MPH, medical director of Mayo's Occupational Health Service. "I don't think we can be nationally prescriptive on that."

A survey of 808 hospitals found that 55% of those with consequences for failing to get the flu vaccine allowed personal belief exemptions. Hospitals that allowed non-medical exemptions had increases in their vaccination rates that were similar to hospitals that allowed only medical exemptions, the study found.[1]

By mid-November, about 78% of hospital employees had received the flu vaccine, according to a survey sponsored by the Centers for Disease Control and Prevention. Rates were much lower at long-term care facilities, reaching only 45%.

The NVAC recommendations may help promote influenza vaccination programs in nursing homes, says **Jennifer Hilliard**, MMH, JD, public policy attorney with LeadingAge, an organization of non-profit long-term care facilities. A member of the NVAC workgroup, Hilliard does not support mandates.

"If employers take this responsibility seriously, then persistent and effective education will produce results," she says.

She notes that long-term care facilities have difficulty retaining good employees, even in a difficult economy. A mandate that involved terminating employees who don't receive the vaccine would be especially troubling to some foreign-born workers, such as those from west Africa, she says. "They don't trust anything the government pushes because in their country there were nefarious purposes when the government was pushing something like that," she says.

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It's a record: 12,850 flu shots in 8 hours

'Flulapalooza' tests mass shot plan

Each fall, hospitals seek to vaccinate as many health care workers as possible against influenza. But what if you tried to vaccinate as many as possible in one day?

That ambitious goal won a Guinness Book of World Records spot for Vanderbilt University in Nashville, TN, as well as some valuable lessons for emergency response and vaccine promotion. The tally: 12,850 students, faculty, staff and medical center employees in eight hours.

"Our primary goal was to test our mass vaccination plan, which we have in place for pandemics and other biologic emergencies," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic. "We wanted to really learn what our capacity is, what our logistical needs would be."

The plan relied on speed — quick set-up and the ability to move people through quickly while accommodating a high volume. "Flulapalooza" also had a marketing appeal. Students and employees alike rallied behind the quest to attain a world record. (Kaiser Permanente held the previous record of 6,215 vaccinations in eight hours.)

"We also wanted to generate enthusiasm for the flu vaccine," says Swift. "It was a morale-building kick-off for our flu vaccine this year."

Here are some of the lessons learned:

Use electronic documentation. Vanderbilt documented the vaccinations by swiping the magnetic strip of the employees' and students' ID badges. "Having the infrastructure in place so you can document electronically really helps efficiency," says Swift. "The documentation could have been an incredible nightmare. It was smooth as silk."

Buy pre-filled syringes. When you're conducting a mass vaccination, even seconds count. Vanderbilt had 44 nursing stations manned by more than 100 nurses and pharmacists throughout the day. They all used the same lot number for the vaccines — which also made documentation easier.

Provide just-in-time training. Many of the vaccinators were nurse managers. Others were nursing or pharmacy students. It was important to provide some basic information about how the clinic would flow and what to do if they needed help, says Swift.

Schedule two-hour shifts. The core team of employee health and student health nurses worked 10 to 12 hours in Flulapalooza. "We learned that fatigue becomes an issue in an event of this duration," she says. "Had we needed to continue this — if it was a real [emergency] event — we could not have had such long shifts." The vaccinators were standing throughout their shift. Scheduling short shifts also would eliminate the need to schedule breaks. "The logistics of managing breaks on a scale like that is pretty challenging," she says.

Use a script. Vanderbilt provided vaccine information in the lobby before employees and students entered the vaccination area. Two physicians were on hand to answer questions. As they walked through the line toward the vaccination stations, the vaccine recipients were reminded to roll up their sleeves. The nurses and pharmacists followed a script, asking about egg allergy, previous Guillian-Barre Syndrome, or any other serious reactions after flu vaccine. The actual time spent at the vaccination station ranged from 20 seconds to more than 200 seconds.

Keep on vaccinating. At the end of eight hours, vaccinations didn't stop. Although they weren't part of the record-breaker, students and employees continued to receive vaccines for a couple more hours, bringing the Flulapalooza total to about 14,000. Of those, 8,585 were medical center employees. But that was still just a fraction of the 25,000 medical center employees. Many employees were not able to leave their shifts to participate in the Flulapalooza, so Vanderbilt geared up for its usual vaccine carts. A couple of days later, the medical center's annual flu vaccine campaign began. With a theme of "Stayin' Alive," they had a disco ball, fog machine and disco music in the flu tents in the medical center's central plaza. ■

First-in-nation rule targets hazardous drugs

Washington relies on 'tiered approach'

Washington became the first state to issue a rule to protect health care workers who handle hazardous drugs — a move that proponents hope will prompt other states to take similar action.

It is a watershed moment for the protection of health care workers from substances that pose cancer and reproductive risks, says **Melissa A. McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore. "These drugs are some of the most hazardous families of chemicals in health care," she says. "It's a long time in coming."

The dangers of working with toxic pharmaceuticals were brought to life in a series by InvestigateWest, a group of independent investigative journalists who publish online. They told the stories of pharmacists, a nurse and a veterinarian who developed cancer from working with chemotherapeutic agents. The articles prompted the Washington legislature to pass a law requiring a rule on hazardous drugs.

Although safety practices have evolved since those health care workers were mixing and administering drugs with virtually no protection, workers are still being exposed, says McDiarmid. In a study[1] of 109 health care workers, McDiarmid and colleagues in North Carolina and Texas found a 20% increase in chromosomal abnormalities in workers with a moderate level of drug handling (100 or more chemotherapeutic drug-handling events in a six-week period). Those with the highest level of exposure (500 drug-handling events) had a 2.5-fold increase in chromosomal abnormalities.

The "signature" chromosomal abnormalities found in oncology workers were the same as those observed in patients treated with these drugs, McDiarmid notes. Smokers and workers with previous treatment with chemotherapy, radiation, or genotoxic drugs were excluded from the study.

"There aren't many industries that are allowed to have human carcinogens as a regular part of their mission," McDiarmid says. "Our mission is important and these drugs are lifesaving to our patients. But we have to figure out a way [to provide the chemotherapy] and not mortgage the health of our workers in the process."

States may eventually lead the way to national protections, she says.

Not all hazards are equal

The Washington rule, which was issued in January and will become effective beginning in 2014, is based on a 2004 alert and 2010 update from the National Institute for Occupational Safety and Health (NIOSH). NIOSH has identified 157 hazardous drugs and outlined measures that should be taken to prevent exposure (http://1.usa.gov/AuX1NS)

The Washington Department of Labor & Indus-

tries (L&I) uses the NIOSH framework but allows health care facilities to take a "tiered approach," with different levels of precautions based on a hazard assessment. Retail pharmacies had argued that if all drugs on the list were treated in the same manner, they couldn't even dispense pre-packaged oral contraceptives without special safety equipment.

"We recognize and acknowledge that all the drugs on the NIOSH list are not equally hazardous," says **Michael Silverstein**, MD, MPH, assistant director of the Department of Labor & Industries. "There is relative toxicity that differs from drug to drug and the exposure circumstance is different. [This is] a tiered program that matches the precautions to the nature of the exposure and the risk."

L&I is setting up an advisory committee with employer and employee representatives to help guide the implementation. The agency also is setting up model programs. "If [employers] have a tiered program that is consistent with the model programs, they're going to be in compliance with the rule," Silverstein says.

The rule requires hazard assessment and training of employees. Echoing the successful Bloodborne Pathogens Standard, it requires an exposure control plan that must be updated annually with input from frontline employees. It requires the mixing, compounding or crushing of hazardous drugs to occur within a ventilated cabinet, double-gloving in higher risk activities, and other safe handling practices. Employers must have written spill response procedures and appropriate personal protective equipment.

One important element has been deferred. Because NIOSH is updating guidance on medical surveillance related to hazardous drugs, L&I decided to hold off on that issue and consider adding a new provision at a later date.

NIOSH will periodically update its list of hazardous drugs, which now totals 157. There also may be new methods of exposure control. Silverstein says the Washington rule was designed to allow flexibility. "We think we've written a rule that is going to be durable, at least in the foreseeable future," he says. "It's written in such a way that it could be adapted [to changes]."

[Editor's note: The Hazardous Drugs rule is available at http://1.usa.gov/xhEUrh.]

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WA limiting exposure to hazardous drugs

A new Washington state rule requires employers to minimize or eliminate exposure to hazardous drugs. The hazardous drugs control program must include:

- a written inventory of hazardous drugs in the workplace.
- a current hazard assessment for hazardous drugs for which there is reasonably anticipated occupational exposure.
- hazardous drugs policies and procedures including, but not limited to:
  - —engineering controls (equipment use and maintenance).
  - —personal protective equipment.
  - —safe handling practices (receiving and storage, labeling, preparing, administering, and disposing of hazardous drugs).
  - —cleaning, housekeeping, and waste handling.
  - —spill control.
  - —personnel issues (such as exposure of pregnant workers) and
  - —training.
- a standard or universal precautions approach to managing occupational exposure to hazardous drugs is recommended by NIOSH; however, due to the variety of factors that affect occupational exposure some health care facilities may find it more effective to institute precautions based on exposure risk. For example a tiered approach that effectively matches precautions to the nature of exposure may be used including, but not limited to, handling, storing, cleaning, preparing and engineering controls.
- an annual update of the written hazardous drugs control program and whenever changes that affect occupational exposure occur, such as introduction of a new hazardous drug, or a change in handling practices.
- input from employees who may be exposed ■

Dementia rises in aging workforce

Forgetfulness may be an early sign

The housekeeper had always done a thorough job cleaning patient rooms, but lately her work was haphazard. When a supervisor pointed out things she'd missed, she said, "Oh, I must have forgotten." Forgotten? How could you forget how to do a job you'd done every day for 30 years?

Memory loss is one early sign of dementia, and as it turned out, the employee was in the early stages of Alzheimer's Disease. It was, in some ways, a sign of the times. As the nation's workforce ages, mental impairment in the workplace is becoming a growing problem.

Hospitals increasingly are navigating concerns about their employees' well-being with the need to maintain patient safety and quality care. Deficits may seem to emerge at an earlier stage in people who have jobs that require a higher level of cognitive functioning, says **Gabor Lantos**, MD, PEng, MBA, an occupational medicine physician and president of Occupational Health Management Services in Toronto. "It becomes more apparent and critical," he says.

Typically, the performance issues that occur with early dementia are initially addressed with the usual disciplinary steps. It's up to frontline management to talk with the employee and consider contacting employee health, Lantos says.

"There's no harm in a supervisor sitting down with them and saying, 'I noticed you're working slower, you seem distracted, you're not your happy, usual self. Have you had a check-up lately?' It's all a question of how you approach it," he says.

Alzheimer's cases will skyrocket

That topic is more likely to arise than ever before. About 5.4 million Americans have Alzheimer's Disease, but that number is expected to increase to 16 million by 2050, according to the Alzheimer's Association. Two-thirds of those with Alzheimer's are women.

While Alzheimer's Disease risk rises with age, about 200,000 people under 65 have "young onset," the Alzheimer's Association says. Dementia-like symptoms also may arise after a stroke or from other illnesses.

The first signs may include forgetfulness, difficulty concentrating, or frustration with tasks. At Henry Ford Macomb Hospitals in Clinton, MI, when the work of a long-time environmental services worker began to slip, supervisors suspected a medical problem. Broaching the issue was delicate, particularly because of the limits of the HIPAA privacy rule.

In this case, the employee suggested contacting her daughter. "We started partnering with the family to keep our employee working," says **Betty Kuschel-Rapaski**, RN, BSN, COHN-S, clinical manager of Employee Health Services. "We are trying to be very, very sensitive to our employees and their physical needs, dignity and respect."

The employee completed re-training and now uses a checklist to make sure she remembers all her necessary job tasks, Kuschel-Rapaski says.

Follow your HR policy

It's important to have a human resources policy to follow whenever a person's job performance suddenly begins to change, says **Curtis Chow**, NP, PA-C, COHN-S, employee health coordinator at Mercy Medical Center in Redding, CA. Such changes could be due to stress, such as a divorce, or substance use, such as prescription drugs, he notes.

"There needs to be a strong, interactive process that includes the responsibilities of the manager, human resources and the employee," he says.

While the discussions may begin informally – with a supervisor simply asking, "Are you feeling okay?" – the usual disciplinary steps should be followed for job performance problems. At the same time, there may be an evaluation by employee health and/or a referral to an employee assistance program, Chow says. *(For advice on accommodating early dementia, see box on p. 34.)*

The Americans With Disabilities Act (ADA) requires employers to accommodate a "known disability." If an employee doesn't ask for an accommodation, there's no obligation to provide one — "except where an individual's known disability impairs his or her ability to know of, or effectively communicate a need for, an accommodation that is obvious to the employer," according to the U.S. Equal Employment Opportunity Commission.[1]

"Raise the issue in a non-judgmental, non-discriminatory fashion, in a concerned fashion," advises Lantos.

Lantos recalls a case of a nurse who had been disciplined for deterioration in her job perfor-

mance. After 30 years of exemplary work, she suddenly began making errors. A brain scan revealed that she had had lacunar infarcts – tiny strokes. Instead of being terminated for poor job performance, the nurse went on long-term disability.

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1. U.S. Equal Employment Opportunity Commission. Americans With Disabilities Act: Questions and Answers. http://1.usa.gov/8jyopH. Updated on November 14, 2008. Accessed on January 15, 2012. ■

Young onset dementia: A guide for employers

This advice for employers provides suggestions for handling common problems faced by employees with early dementia. It was excerpted from a guide created by the Alzheimers & Dementia Alliance of Wisconsin. The full document is available at http://bit.ly/zb1GqP. The alliance also has documents on assistive technology and non-technological supports.

An employee with young onset dementia may become frustrated in his or her job.

What you can do:

Employers can address this understandable emotion in two ways. First, be aware of matching tasks with remaining abilities. Making use of the suggestions on this page will go a long way in alleviating frustration. Second, seek out a fellow employee who will "partner" with the person with dementia to provide an understanding ear and offer encouragement. In this way frustrating situations can be addressed before they interfere with work.

An employee with young onset dementia may begin to have problems with acquiring, storing and recalling information.

What you can do:

Employers can address this issue with the use of memory aids such as reminder notes, calendars, to do lists, and electronic memory aids such as electronic calendars to provide reminders to the worker, recording devices and other assistive technology.

The employee with young onset dementia may begin to have difficulty learning new things.

What you can do:

• Provide simple written instructions for the worker and offer increased or additional instruction.

• Use the employee's over-learned and over-remembered skills. Use the employee's long term memories-past experiences, habits and knowledge to aid functioning.

• Routine and structure will also help the employee with young onset dementia function at their highest possible level.

The employee with young onset dementia may have difficulty paying attention.

What you can do:

• Limit distractions. Try to limit noises and extraneous activity as much as possible to make it easier for the employee to focus on the task at hand. Ear plugs or headphones have been used by some employees with young onset dementia to help limit distractions.

• Limiting or eliminating work space clutter will also help the employee maintain focus.

• Choose tasks that fit the person's ability. They are more likely to gain and hold attention than those that are too complex or too simple.

• Frequent stopping and starting of a task may be difficult for an employee with young onset dementia. Try to avoid interruptions as much as possible.

The employee with young onset dementia may have difficulty starting, maintaining or stopping a task.

What you can do:

• Don't assume the worker is tired, lazy or uninterested.

• Encourage and assist the employee. Verbal or visual cues may also be helpful to signal to begin or end a task.

An employee with dementia may have problems with organization, judgment or reasoning. They may find it difficult to organize their time, set goals and follow plans.

What you can do:

• Help plan and organize daily activities. Consider a daily written schedule or check list for the employee.

• Maintain a structured routine in the day to help the employee maintain function. Keeping the same basic schedule can lessen confusion and frustration. ■

ANA: Most nurses work with MSD pain

Workplace safety, reporting improves

Despite the progress toward safe patient handling, about eight in 10 nurses still suffer from frequent musculoskeletal pain and six in 10 worry about having a disabling musculoskeletal injury, according to a 2011 online survey by the American Nurses Association in Silver Spring, MD.

"It's a wakeup call to see how concerned nurses are about developing a musculoskeletal disorder (MSD)," says **Jaime Murphy Dawson**, MPH, senior policy analyst at ANA's Center for Occupational and Environmental Health. "It's something that could end their careers."

Hospitals offer a safer workplace than a decade ago, with needle safety devices, powder-free gloves and other safety devices. Far fewer nurses worry about acquiring HIV or hepatitis from a needlestick or latex allergy compared to results of a similar survey a decade ago. Of the 4,614 nurses responding to the survey, almost two-thirds (62%) work in hospitals.

But even though two-thirds of nurses said they had access to patient handling devices, only one-third reported using them frequently. That finding points to a need for hospitals to make the devices more accessible and to provide more training in their use, Dawson says. Older nurses (ages 40 to 59) were more likely to report using the devices frequently.

The survey reflects a change in the makeup of the nursing workforce. Nurses have aged — 62% of the respondents are 50 or older. They are less likely to work overtime but more likely to work shifts of 10 hours or more, compared with respondents in 2001.

Yet their top health concern has remained the same: the impact of stress and overwork. "It's a culmination of the climate that nurses are working in today," says Dawson. ANA has launched a Healthy Nurse program to encourage stress management and healthy lifestyles, and the organization advocates for adequate staffing, she says.

Despite improvements in workplace safety, nurses are still sustaining about as many injuries as they reported a decade ago — 42% of nurses reported having been injured at least once in the past year compared to 40% in 2001. But nurses are much more likely to report injuries, with 81% saying they reported at least one injury. Only 24% of nurses surveyed in 2001 said they had reported an injury they sustained. ■

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 healthcare 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

- OSHA makes case for I2P2, injury prevention
- Safe patient handling in pediatric settings
- What OSHA has in store for HC employers
- 'Strategic naps' to reduce fatigue
- Reproductive risks for nurses

CNE QUESTIONS

1. According to a study of nursing errors and work hours, nurses who work shifts of 12.5 hours and longer reported:
   A. twice as many errors as nurses with shorter shifts
   B. three times as many errors as nurses with shorter shifts
   C. half as many errors as nurses with shorter shifts
   D. more near-errors but not more errors than nurses with shorter shifts.

2. According to a workgroup of the National Vaccine Advisory Committee, an employer requirement for influenza vaccination of health care workers should include:
   A. a religious belief exemption
   B. a personal belief exemption
   C. mask use by those declining a vaccine
   D. whatever exemptions or consequences an employer chooses

3. In its first-in-the-nation hazardous drugs rule, the Washington Department of Labor & Industries adopted a 'tiered approach' because:
   A. penalties differ based on the health care setting
   B. different health care settings comply with different rules
   C. not all hazardous drugs pose the same occupational risks
   D. precautions vary based on the quantity of drugs dispensed or administered.

4. According to the Alzheimer's Association, how many Americans currently have Alzheimer's Disease?
   A. 2.3 million
   B. 5.4 million
   C. 8 million
   D. 15 million