30th ANNIVERSARY

Hospital Employee Health®

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

May 2012: Vol. 31, No. 5
Pages 49-60

IN THIS ISSUE

Financial Disclosure:
Editor **Michele Marill**, Executive Editor **Gary Evans**, and Consulting Editor **MaryAnn Gruden** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

OSHA: 'Right to Understand' means a duty to retrain

New Hazard Comm standard changes labeling

It's time to revamp your chemical safety training. An updated Hazard Communication Standard will change labels and safety data sheets on everything from cleaning products and sterilizing agents to hazardous drugs. And it requires employers to train workers on the new system before Dec. 1, 2013.

For hospitals, that means training a wide range of employees, including environmental service workers, nurses, laboratory workers, and maintenance workers. The new rule is designed to make safety information easier for them to understand.

In fact, the Occupational Safey and Health Administration is touting it as a "right to understand" standard — a move forward from the "right to know" about chemical hazards in the workplace.

"The 'right to know' has protected millions of workers in its time, but we realize we must do more," said Secretary of Labor **Hilda L. Solis** as she released the new standard. The standard "will reduce confusion in the workplace, especially for low wage and low literacy workers.

"That understanding is powerful and perhaps the single most effective tool to protect workers," she said.

The revisions bring hazard communication in line with international requirements — a Globally Harmonized System of Classification and Labeling of Chemicals. The standard involves new pictograms and "signal" words on labels as well as revised safety data sheets (SDSs). For example, irritants and dermal or respiratory sensitizers would be marked with a black exclamation point surrounded by a red diamond. *(See pictograms on p. 51.)*

The current Material Safety Data Sheets (MSDS) are simply too technical and difficult to read, said OSHA administrator **David Michaels**, MD, MPH.

"Over the years, it became clear the Hazard Communication Standard wasn't adequate," he said. "The move to pictograms we think is a huge step forward. It will help workers who don't speak English as their native language or have low literacy."

NOW AVAILABLE ONLINE! Go to www.ahcmedia.com.
Call (800) 688-2421 for details.

Update your inventory of chemicals

As a first step, hospitals should review their inventory of hazardous chemicals, said **Rick Cotter**, president of RT Cotter and Associates in Kingston, MA, a consulting firm that helps hospitals prepare for Joint Commission Environment of Care surveys. His related company, MSDS Direct, helps hospitals manage their hazardous material systems.

Both the current and revised OSHA standards require employers to keep a list of known hazardous chemicals. There is no specific timeline for updating the list; employers are expected to keep it up to date as new chemicals are brought into the workplace, says Cotter.

A typical 150-bed hospital could have 1,500 to 2,000 items on the inventory, he says. You can monitor your chemical inventory by conducting spot checks — pulling a chemical off the shelf, making sure it's on the inventory list and verifying that the safety data sheet is readily available.

It's a responsibility that shouldn't be left to department heads, who have other priorities, he says. "They don't have time. They're busy trying to manage patients," he said.

The new safety data sheets will have more detailed information, including sections on first aid, response to accidental release, exposure control, and proper handling and storage. They also will include the threshold value limits, or recommended exposure limits, of the American Conference of Government Industrial Hygienists, as well as any other established exposure limits.

Current material data safety sheets vary, said Cotter. "They were too technical in some places and not enough in other places," he says. "This is an excellent improvement in the formala so people really could understand."

To make sure you receive updated information on your products, Cotter suggested adding a statement to purchase orders requiring deliveries to be accompanied by safety data sheets.

The labels on hazardous products will be clear, with one of eight pictograms conveying the type of hazard. They will contain signal words: "Warning" for a less severe hazard and "Danger" for a more severe hazard. Labels also must contain a brief description of the hazard and the precautions that should be taken.

"The key date is 2016, when all employers that use or store chemicals must make sure their labeling of secondary containers complies with OSHA 2012 — what's now called the 'Right to Understand' rule," said **Pamela Dembski Hart**, CHSP, BS, MT (ASCP), principal with Healthcare Accreditation Resources in Boston.

Teach employees about labels, safety

Manufacturers, importers and distributors have until 2015 to transition to the new labeling requirements, but employers have less than two years to re-train their workers.

Hospitals could conduct the training during other annual mandatory competency testing, or make it part of a safety fair, says Cotter. Or they might want to act

Hospital Employee Health® (ISSN 0744-6470), including The Joint Commission Update for Infection Control, is published monthly by AHC Media, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Employee Health®, P.O. Box 105109, Atlanta, GA 30348.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: customerservice@ahcmedia.com. Web site: www.ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Senior Vice President/Group Publisher: **Donald R. Johnston**
Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).
Executive Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

Copyright © 2012 by AHC Media LLC. Hospital Employee Health® is a trademark of AHC Media LLC. The trademark Hospital Employee Health® is used herein under license. All rights reserved.

Editorial Questions

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

AHC Media

HCS Pictograms and Hazards

more quickly with a special training program to teach employees how to decipher the new labels and what to expect from safety data sheets.

The new training may raise awareness of longstanding hazards. For example, employees don't always recognize the potential dangers from exposure to hazardous drugs, said **Thomas Connor**, PhD, a research biologist with the National Institute for Occupational Safety and Health (NIOSH) in Cincinnati and an expert on hazardous drugs.

"These are drugs, they help people, but they're still toxic chemicals," he said. "Over the years, it's been difficult to get that point across."

The Hazard Communication standard does not apply to drugs that are given in solid form to patients without being altered, such as pills or tablets. But it does apply to drugs that pose a risk of exposure when they're handled, mixed, or administered.

The standardized format of the safety data sheets will be helpful, said Connor: "Anything that brings attention to the hazards would be good for the workers."

[*Editor's note: The Hazard Communication Standard is available at* www.osha.gov/dsg/hazcom/index.html.] ■

Manage fatigue to boost safety

ACOEM: Staffing, education path to culture change

It will take a culture shift for doctors, nurses and other health care workers to consider fatigue as a major factor in patient and employee safety. But that moment may be a step closer with new guidance on fatigue management in the workplace.

The American College of Occupational and Environmental Medicine (ACOEM) issued detailed guid-

Educate employees on fatigue

According to the guidance on Fatigue Risk Management in the Workplace, employees and managers should be educated on:

The hazards of working while fatigued and the benefits of being well rested.

- The impact of chronic fatigue on personal relationships, mental/physical well-being, as well as general life satisfaction.
- Recognizing that although fatigue cannot be eliminated, it can be managed and minimized.
- Adequate quantity and quality of sleep as the key to managing fatigue.
- Basics of sleep physiology, circadian rhythms, and what is getting adequate sleep.
- Sleep hygiene — how to obtain adequate quantity and quality of sleep.
- Sleep disorders — why they matter, how to tell if one may have one, and what to do about it.
- The importance of diet, exercise, stress management, and management of other health conditions that affect fatigue, as well as information about how to address these issues.
- How to recognize fatigue in oneself or one's coworkers.
- Alertness strategies to be used while at work, such as appropriate use of caffeine, rest or exercise breaks, and social interactions.
- Advice on managing personal relationships for shift workers.

Source: American College of Occupational and Environmental Medicine ■

ance on establishing a fatigue management system and urged occupational medicine physicians to be involved in developing such programs.[1] "Well-rested, alert employees are critical to safe and productive operations," ACOEM declared.

ACOEM touts a "science-based, data-driven" system to reduce the risk of fatigue that puts responsibility on both employees and employers. That means adequate scheduling and staffing levels and treatment of sleep disorders.

"As part of a comprehensive fatigue risk management system, management provides for the opportunity for employees to get adequate sleep. Management also provides training that is designed to inform employees of the risks associated with inadequate sleep and what they can do to get an adequate quality and quantity of sleep," says **Steve Lerman**, MD, MPH, FACOEM, lead author of the guidance and occupational health manager at Exxon Mobil Corp.

The guidance document was drafted by sleep experts and occupational medicine physicians on ACOEM's Task Force on Fatigue Risk Management.

Fatigue management rules and interventions are commonplace in some sensitive industries, such as trucking, airlines, and nuclear power. The paradigm shift has been much slower in health care, says **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.

"Our culture doesn't value it," says Rogers, who has studied the impact of shift length on nursing errors. "You don't want to short-staff the unit and make your colleagues overburdened. Our culture values the workaholic, [and the idea] that you can get by without sleep, which is not true."

The ACOEM guidance provides powerful evidence, she says. "They supported this with data," she says.

HCWs need time off

Work hour limits and alertness strategies alone won't solve the problem of fatigue, although they are components of the solution. The ACOEM outlines elements of a fatigue risk management system. They include analyzing fatigue as a risk to patients and employees and considering the role of fatigue in incident investigations.

ACOEM urges employers not just to react to adverse events that are related to fatigue, but to be proactive and try to avoid them. "Excess fatigue is a known risk factor for errors leading to incidents," Lerman says.

A major issue: staffing levels that enable employees to have adequate time off and breaks during their work shifts. "One of the most important (but frequently overlooked) root causes of employee fatigue is an imbalance between workload and staffing levels," ACOEM says.

Managers tend to correct a staffing imbalance with overtime, which leads to fatigued workers and ultimately to absenteeism, the guidance says. A small portion of workers may volunteer for overtime, and they may become financially dependent on the extra

money.

Short-staffing may prevent nurses from taking breaks during their shifts, says Rogers. Many nurses in our data show they'll work through [their breaks], they may or may not get lunch, they'll eat on the unit," she says. "They're going to have trouble staying alert.

Meanwhile, employees may not even realize that they are fatigued or that their performance is suffering, says Rogers.

"We're really not good at assessing our level of fatigue and we're often in denial," she says. "We're all human beings. We're all going to be affected by sleep deprivation, and we're all going to be affected by working nights."

Lerman suggests conducting a workload-staffing analysis to make sure you have enough employees to cover the needed positions. "Management should take into account such factors as vacations, anticipated turn-over, illness absence and variations in workload to determine the right level of staffing for their organization," he says.

Sleep disorders lead to fatigue

What can you do about employees who are fatigued because they don't get enough sleep at night, either because of poor habits or sleep disorders?

Education about sleep hygiene, fatigue and alertness can change behavior, ACOEM says. Ideally, the education could occur in "natural work teams," where an instructor would customize the program for the unit, the guidance says. *(For a list of symptoms and education elements, see boxes on p.52 and at right. For information on a successful hospital-based intervention, see related article, right.)*

Meanwhile, more than 40 million Americans suffer from a sleep disorder, a leading cause of fatigue. Fatigue is also a symptom of depression and other conditions.

ACOEM recommends using a questionnaire to screen for sleep disorders. "There are a variety of validated questionnaires that can be used to detect excess daytime sleepiness, which may be the result of a sleep disorder," Lerman says.

A physical exam, a sleep diary and a mental health evaluation are other ways to assess sleep disorders.

It's hard to change longstanding behaviors, but there are signs that fatigue management is gaining recognition in health care. The Joint Commission accrediting body issued a Sentinel Event Alert on fatigue. *(See* HEH *March 2012, p. 25)* and the Accreditation Council for Graduate Medical Education issued stricter duty limits for first-year residents *(See* HEH *August 2012, p. 95.)*

"There is increasing awareness," says Rogers. "But we also need nurses and physicians and [others in health care] to alter the culture."

[Editor's note: A copy of the ACOEM Guidance Statement, "Fatigue Risk Management in the Workplace," is available at www.acoem.org.]

Know these signs of excessive fatigue

- Physical signs
- Yawning
- Drooping eyelids
- Rubbing of eyes
- Head dropping
- Microsleeps
- Digestive problems
- Mental signs
- Difficulty concentrating on tasks
- Lapses in attention
- Difficulty remembering tasks being performed
- Failing to communicate important information
- Failing to anticipate events or actions
- Accidentally doing the wrong thing
- Accidentally not doing the right thing
- Emotional signs
- More quiet or withdrawn than usual
- Lack of energy
- Lacking the motivation to perform the task well

Source: American College of Occupational and Environmental Medicine ■

REFERENCE

1. Lerman SE, Eskin E, Flower DJ, et al. ACOEM Guidance Statement: Fatigue risk management in the workplace. *Jrl Occ Environ Med* 2012; 54:231-258. ■

Managing fatigue reduces nurse errors

Sleepiness affects day, night shifts

Night shift nurses aren't the only ones fighting sleepiness during work. Even day shift nurses

suffer from sleep deprivation from getting too little sleep at night. A recent study in Michigan found that a comprehensive fatigue management program can improve alertness and prevent fatigue-related errors in nurses regardless of their shift.[1]

"Most people know we have a strong drive to sleep at night, but most people don't realize we have a strong drive to sleep in the afternoon [because of the circadian rhythm]," says **Linda Scott**, PhD, RN, NEA-BC, FAAN, a professor and associate dean at the Kirkhof College of Nursing of Grand Valley State University in Grand Rapids, MI. "If you could take a strategic nap during that time period, it would refresh you for the commute home or the rest of the afternoon."

In the study, 47 nurses received education about fatigue, sleep and strategies to improve alertness. Schedules were adjusted so nurses could take breaks in which they were completely relieved by other nurses, and they had the opportunity to take strategic naps during their break or mealtime.

After the interventions, the nurses reported that their nighttime sleep duration had increased by 50 minutes. Their reported errors and near-errors decreased.

While fatigue management strategies have often been used in transportation and other 24-7 industries, this study "showed it was feasible to do this in health care," says Scott.

Nurses respond to sleep education

To combat fatigue, both nurses and managers had to change some assumptions about sleep and work. For example, some nurses believed they could handle a lack of sleep during the work week and make it up by sleeping more on their days off, says Scott.

"We found people who did not sleep in the 24 hours before work and then went to work and worked another 12 hours. Then they drove home, putting the public at risk on the road," she says.

Sleep duration improved immediately after the education sessions, Scott says.

Meanwhile, the managers agreed to avoid assigning overtime, which might make it more difficult for nurses to have enough time off between shifts to allow for adequate sleep. They made sure that staffing allowed for nurses to take breaks in which they were completely off duty, and they suspended policies that didn't allow people to sleep on the job.

Instead, the three study hospitals found space for nurses to take a nap. Even taking a complete break improved function, Scott says. "There is evidence that respite from the job will help you increase awareness. It allows you to refresh and refocus," she says.

Nurses used logbooks to track their sleep, drowsiness, errors, near-errors and other fatigue-related issues. In the 16-week study period, they reported 117 errors or near-errors. Those reports decreased with the fatigue management strategies, while errors that were discovered and prevented increased.

Sleep quality still a problem

Still, there were challenges. Nurses felt guilty about taking naps and some stopped during the study. Managers were supportive of the naps and other strategies, but sometimes had trouble finding adequate space, says Scott. For example, one hospital converted old physician call rooms for nap space, but nurses felt it was too far from their unit.

"It wasn't inconvenient to get to, but it was far enough from the unit that they felt uncomfortable," Scott says.

Almost all the nurses (92%) continued to report problems with their daily sleep quality. In fact, 18 of the 47 nurses reported severe daytime sleepiness even after the fatigue management intervention.

Health care employers should promote good sleep hygiene and implement fatigue management, Scott says. And employees need to understand that they should come to work well-rested, she says.

"As health care providers, we all have an accountability to go to work being fit for duty," she says. "As employers, we have an obligation to ensure that the work environment is safe for our customers."

Addressing fatigue in health care is one important part of a safe workplace, Scott says.

REFERENCE

1. Scott LD, Hofmeister N, Rogness N, et al. An interventional approach for patient and nurse safety. *Nursing Research* 2010; 59:250-258. ■

Experts make renewed push for safety

Sticks persist in OR, beyond hospital

In a "call to action," sharps safety experts are targeting gaps in needlestick prevention and seeking to

spur a new commitment to make improvements.

"Over the past 25 years, there's been such tremendous success in reducing health care workers' risk of bloodborne pathogens," says **Janine Jagger**, Ph.D., director of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville and a pioneer in sharps safety. "It's a question of finding gaps [in compliance] and trying to plug up those gaps."

Sharps safety experts identified the barriers at a conference on the 10th anniversary of the Needlestick Safety and Prevention Act in November 2010. The consensus statement offers some recommendations for making new progress in sharps safety:

1. Improve sharps safety in the surgical setting. Sharps injuries in the OR actually rose during the time that injuries from needles and syringes were declining dramatically. Surgeons have been reluctant to use blunt suture needles or safety scalpels, Jagger says. "It all comes down to getting surgeons on board. If they're not onboard nothing's going to happen," she says.

Still, hospitals and surgery centers should adopt policies that mandate safety. "Most of the injuries in the OR occur to the OR staff and not to the surgeon," says Jagger. "The surgical equipment that the surgeon chooses has the major effect on the risk of everyone else in the room."

Surgeons should work with nurses and other OR personnel "to develop sharps safety standards and practices that are consistently implemented and followed in all surgical environments," according to the consensus statement. The experts also called on OSHA to monitor compliance in ORs.

The American College of Surgeons has issued statements encouraging safer practices, including double-gloving, passing instruments in a neutral zone, and using blunt suture needles. The consensus statement gives OR personnel some additional leverage, says Jagger. "It gives them a new opportunity to raise the issue and to focus on its importance," she says.

2. Increase use of safety devices in non-hospital settings. The use of sharps safety devices is commonplace in hospitals, but not as consistent in non-hospital settings, such as clinics, physician offices and home health. In fact, the needlestick surveillance programs focus on hospitals; much less is known about compliance elsewhere. Market data from device manufacturers indicates less use of safety needles in non-hospital settings. The sharps safety experts recommended more research from the National Institute for Occupational Safety and Health and special enforcement programs from OSHA. "There's less compliance because there's less enforcement [in smaller settings]," Jagger says.

3. Ensure that frontline workers are involved in selection of safety devices. The Bloodborne Pathogen Standard requires employers to solicit the input from frontline workers when they select sharps safety devices. Yet it is hard to keep tabs on the compliance with this provision. The experts note that it is "not consistently" followed. "At a time when the pressure to reduce healthcare costs is intense, it is important to keep these user-oriented questions at the forefront of device selection," the experts said in the consensus statement.

4. Continue innovation in safety design. When needle safety became law in the United States, device manufacturers responded quickly and developed more effective and innovative designs. "It's really quite amazing. The technology they've brought forward is really good technology," says Jagger. But even 11 years after the revised Bloodborne Pathogen Standard was released, there are devices for which there is no safety version. "I think that as we bring new information forward about gaps we have, the medical device industry is likely to respond very well again," she says.

5. Enhance education and training. Teaching hospitals have higher needlestick rates than non-teaching hospitals. That indicates a need to improve training, the safety experts said. Failure to activate a safety device also may reflect a lack of training in how to use the device. The Bloodborne Pathogen Standard requires annual training that includes "an opportunity for interactive questions and answers with the person conducting the training session."

[Editor's note: The consensus statement, "Moving the Sharps Safety Agenda Forward in the United States," is available at www.healthsystem.virginia.edu/internet/epinet/.] ■

Norovirus outbreaks trigger unit closures

Organism tops list of outbreaks

Norovirus is the organism most likely to trigger a shutdown of units in your hospital. And according to a recent survey of infection preventionists, it is responsible for more outbreaks than some deadlier organisms, such as *Clostridium difficile* and *Staphylococcus aureus*.[1]

It poses a risk to patients and employees alike. "Norovirus is different from the other [health-care acquired] organisms because norovirus can affect employees, and in outbreaks many times does," says lead author **Emily Rhinehart**, RN, MPH, CIC, vice president and division manager of the health care division of Chartis Global Loss Prevention in Atlanta.

In fact, norovirus outbreaks were as likely to occur in behavioral health and rehabilitation units as medical/surgical units, another contrast to other organisms. In those units, patients are more mobile, and therefore more likely to contract or transmit the disease, Rhinehart notes. "They're walking around their environment and interacting with the environment and other patients and the employees are interacting with them," she says.

Last year, the Centers for Disease Control and Prevention issued an updated guideline on norovirus in health care settings, and the agency released a toolkit to help hospitals and other facilities cope with outbreaks. (*See box below.*)

Norovirus outbreaks are easy to identify because they are often dramatic, with sudden onset of nausea, vomiting and diarrhea. Norovirus "has a very short incubation time, it's very transmissible, and a lot of people can be infected in a short amount of time," says **Clifford McDonald**, MD, medical epidemiologist at CDC.

The virus is not associated with significant mortality. An unpublished analysis of death certificates found that *C difficile* was associated with about 14,000 deaths in a year compared with just 800 for norovirus, McDonald says.

Still, it presents significant challenges for both infection control and employee health professionals. Here are some issues to keep in mind:

• **Monitor employee absences.** If you see a pattern of digestive illness among employees, particularly in the same unit, that may be a clue about an outbreak. Being alert can help you detect norovirus and implement strategies to prevent its spread, says Rhinehart.

• **Don't penalize employees for being sick.** You want ill employees to stay home if they're sick – and during an outbreak, you might require some exposed employees to stay home for a two- or three-day incubation period. Make sure your policies don't penalize them for reporting symptoms or an exposure by requiring them to take time from a pool of paid time off. Some employers have used workers' compensation or even a contingency fund to cover those payments for ill or exposed employees to stay home, Rhinehart says.

• **Emphasize glove use and hand hygiene.** Alcohol gel may not be as effective against norovirus as handwashing. But while you can educate staff and encourage hand-washing, don't try to completely revamp your hand hygiene program, says McDonald. Alcohol gel has been extremely effective in combating other organisms, and studies show it improves compliance with hand hygiene, notes McDonald.

You should emphasize glove use and changing gloves between patients, he says. "Glove use is only as good as your practice of changing gloves between patients," he says. "If you don't change them between

Identifying a norovirus outbreak

In the absence of clinical laboratory diagnostics or if there's a delay in obtaining laboratory results, use Kaplan's clinical and epidemiologic criteria to identify a norovirus gastroenteritis outbreak:

1. Vomiting in more than half of symptomatic cases, and
2. Mean (or median) incubation period of 24 to 48 hours, and
3. Mean (or median) duration of illness of 12 to 60 hours, and
4. No bacterial pathogen isolated from stool culture

• Consider submitting stool specimens as early as possible during a suspected norovirus gastroenteritis outbreak and ideally from individuals during the acute phase of illness (within 2-3 days of onset).

• Specimens obtained from vomitus may be submitted for laboratory identification of norovirus when fecal specimens are unavailable. (Consult with your lab). Testing of vomitus as compared to fecal specimens may be less sensitive due to lower detectable viral concentrations.

• Routine collecting and processing of environmental swabs during a norovirus outbreak is not required.

Staff leave policy

• Exclude ill personnel from work for a minimum of 48 hours after the resolution of symptoms. Once personnel return to work, the importance of performing frequent hand hygiene should be reinforced.

• Establish protocols for staff cohorting in the event of an outbreak of norovirus. Ensure staff care for one patient cohort on their ward and do not move between patient cohorts (e.g., patient cohorts may include symptomatic, asymptomatic exposed, or asymptomatic unexposed patient groups).

• Exclude non-essential staff, students, and volunteers from working in areas experiencing outbreaks of norovirus.

Source: Centers for Disease Control and Prevention. A Norovirus Prevention Toolkit, available at www.cdc.gov/HAI/organisms/norovirus.html. ■

Be alert to rise in *C diff* cases

Infections from *Clostridium difficile* have skyrocketed, more than doubling from 2000 to 2009. While most cases (75%) originate in nursing homes, doctors' offices or other health care settings, many of those *C. diff* patients will end up in hospitals.[1] A hypervirulent, resistant strain of *C. diff* requires greater vigilance.

The Centers for Disease Control and Prevention is asking health care workers to be alert for signs of *C. diff* among patients. Patients usually have watery diarrhea but also may have fever, nausea, loss of appetite and abdominal pain and tenderness.

Employees are not at high risk for developing *C. diff*, which is highly associated with antibiotic use, says **Clifford McDonald**, MD, medical epidemiologist at CDC. However, they can help prevent the spread of the infection by wearing gloves and gowns while in patient rooms or during patient care, changing gloves between patients, and performing hand hygiene after removing gloves, he says.

Alcohol-based gels are not effective against *C. diff*, so in the case of an outbreak, CDC recommends using soap and water.

The usual hospital disinfectants are not effective against *C. diff* spores, which can persist on surfaces. CDC recommends cleaning with bleach or another EPA-approved, spore-killing disinfectant.

REFERENCE

1. Centers for Disease Control and Prevention. Vital Signs: Preventing *Clostridium difficile* infections. *MMWR* 2012; 61:157-162. ■

patients, you're doing nothing for patient safety." It is also important for employees to remove the gloves in a way that prevents contamination of their hands and to perform hand hygiene after removal.

Report outbreaks to the state health department. While hospitals had surveillance programs to detect health care acquired infections, the survey of infection preventionists found that only 52% of the outbreaks had been reported to an external agency, such as the local or state health department. Some hospitals might be reluctant to bring attention to their outbreak, or they might feel they don't need the help of public health authorities, says McDonald. Yet reporting allows for a greater awareness of the disease spread and may even warn nearby hospitals of a circulating organism, he says.

REFERENCE

1. Rhinehart E, Walker S, Murphy D, et al. Frequency of outbreak investigations in US hospitals: Results of a national survey of infection preventionists. *AJIC* 2012; 40:2-8. ■

Workers are hurt when patients fall

Trying to protect a patient from a fall may be one of the most dangerous things your employees do. They will put themselves at risk to cushion a patient. And often, that results in a serious musculoskeletal injury.

Fall prevention and safe patient handling are interconnected — they are both important to protect patients and health care workers, says **Stephanie Radawiec**, PT, DPT, MHS, MBA, a clinical consultant with Diligent Services, a division of the equipment manufacturer Arjo Huntleigh in Addison, IL. Radawiec spoke on fall prevention at the recent Safe Patient Handling and Movement Conference in Orlando, FL.

About one-quarter to one-half of MSD injuries occur while the worker is trying to prevent or cushion a patient fall, Radawiec says, based on her work with health care clients. "It can impact any body part. Frequently, you'll see a rotator cuff tear, cervical strain, and even knee injuries. What really puts the caregiver at risk is that it is a sudden change of the amount of assistance the caregiver is providing. It is not necessarily a balanced load."

A patient fall is typically described as "unexpected," but nurses should know if a patient is at risk for falls. Patients should always be evaluated for fall risk, just as they should be assessed for mobility and patient handling needs, she says. "If the person is determined to be at risk for falls, they should be considered for a piece of safe patient handling equipment to protect both the patient and the caregiver," she says.

Lifts help ambulation

There are a variety of reasons that a patient may be at risk of falling. They may be disoriented or very fatigued after blood loss in surgery. They may have urinary frequency and feel the need to get out of bed often. They may have poor vision, vertigo or muscle weakness.

The Morse Fall Scale provides a numerical score

that helps nurses assess the patient's risk. They may respond by making sure the room is clutter-free, lowering the height of the bed and installing a bed alarm.

But patient handling equipment also provides important protection. A sit-to-stand lift helps patients who need assistance getting out of a chair. Patients who are weak or who become fatigued even after sitting may need a full lift to safely transfer, Radawiec says.

There's an emphasis on getting patients out of bed to prevent complications and hasten recovery. "It's not a choice. You have to get that patient up even if they're at high risk of falls," she says.

Ceiling lifts have ambulation slings that allow the patient to walk on their own but provide protection from a fall. There are also special slings that will accommodate orthopedic patients.

Gait belts are not an effective tool to prevent patient falls, says Radawiec. In fact, health care workers may be injured as they grab the belt and try to block the patient's fall. "It ends up being a tool to protect the patient but not the caregiver," she says.

The hospital's fall prevention committee should include an employee health nurse, and an analysis of incidents should look at injuries to employees as well as patients, she advises.

Educate patient about lifts

When you choose new patient handling equipment, think about how it will impact both the patient and the worker, advises **Kimberly Falco**, MSN, RN, a safe patient handling expert in Las Vegas, NV. New lift devices are now being designed to assist patients with early mobility, she says. They have clips or holders for IV poles and oxygen tanks.

But before you buy, make sure you seek staff input. "It is absolutely imperative that the end user is involved and participating in any type of equipment purchase," she says. Evaluate the equipment you currently have to see how it can support patient ambulation.

It's also important to educate the patient about how patient handling equipment will support them as they regain their mobility, she says. "The patient needs to

Fast Facts: How to prevent MSDs

A work-related musculoskeletal disorder is an injury of the muscles, tendons, ligaments, nerves, joints, cartilage, bones, or blood vessels in the arms, legs, head, neck, or back that is caused or aggravated by work tasks such as lifting, pushing, and pulling. Symptoms include pain, stiffness, swelling, numbness, and tingling.

Lifting and moving clients create a high risk for back injury and other musculoskeletal disorders for home healthcare workers.

Employers should:

• Develop policies to ensure all care plans determine whether ergonomic assistive devices are needed.

• Provide ergonomic assistive devices (such as slide boards or gait belts) when needed.

• Provide training on assistive ergonomic devices, their uses, the clinical situation requiring them, and how to order them in the plan of care.

• Develop policies to assess the caregiver's competence with the assistive devices once he or she has been trained and is using them.

Employees should:

• Participate in ergonomic training.

• Use ergonomic assistive devices if available.

— Products such as slip sheets, slide boards, rollers, slings, belts, and mechanical or electronic hoists (to lift the client) have been designed to help healthcare workers and clients.

—Equipment such as adjustable beds, raised toilet seats, shower chairs, and grab bars are also helpful for reducing risk factors for musculoskeletal injuries. These types of equipment can allow the client to help during transfer.

• Use proper body mechanics. Even when assistive devices are used during client care, some amount of physical exertion may still be necessary.

— Move along the side of the client's bed instead of reaching while performing tasks at the bedside.

— When manually moving the client, stand as close as possible to the client without twisting your back, keeping your knees bent and feet apart. To avoid twisting the spine, make sure one foot is in the direction of the move. Using gentle rocking motions can also reduce exertion.

— Pulling a client up in bed is easier when the head of the bed is flat or down. Raising the client's knees and encouraging the client to push (if possible) can also help.

— Apply anti-embolism stockings by pushing them on while you are standing at the foot of the bed. You can use less force in this position than standing at the side of the bed.

• Notify your employer promptly of any injury in the workplace.

Source: National Institute for Occupational Safety and Health, 2012. ■

understand why we're using equipment," she says.

The equipment may make the patient feel secure and less likely to fall. In one case, a patient who hadn't walked in seven years was able to walk again with a use of a ceiling lift and an ambulation sling, Falco says.

"With some simple equipment and safety measures, you may never have to perform a rescue [of a falling patient]," she says. "It's so much more beneficial to be preventative than to react to an injury after it occurs."

[Editor's note: Resources for a fall prevention program are available from the VA at www.visn8.va.gov/visn8/patientsafetycenter/fallsTeam/default.asp.] ■

NIOSH: Boost safety in home health

Fast Fact cards give tips to workers

Home health care is one of the fastest-growing segments of the health care workforce. It is expected to grow at twice the rate of the rate of health care as a whole, according to federal labor projections. But will the safety of home health workers increase, as well?

The National Institute for Occupational Safety and Health is reaching out to these workers with "Fast Facts" cards for home health workers, to help them identify common hazards and protections. The cards include advice on preventing needlesticks, car accidents, musculoskeletal injuries, and latex allergies and coping with the risk of violence or unsafe conditions.

"The Fast Fact cards are designed to raise the awareness of the employer and employee so they can put [prevention steps] in the plan of care for the client," says **Laura Hodson**, CIH, an industrial hygienist in NIOSH's education and information division in Cincinnati.

While some home health workers are skilled professionals, such as RNs, most are lower skilled aides who help patients with personal needs so they can continue to live independently. These workers are often not aware of the hazards or the ways they can protect themselves, says Hodson.

Meanwhile, they may have few resources. "In a hospital, if you have a patient that's heavy or obese, getting someone to help you readjust their position is a call away," says **Sherry Baron**, MD, medical officer in the NIOSH division of surveillance, hazard evaluations and field studies. "If you're doing a home visit, there may not be anyone else in the home."

The Fast Facts can be used in training, and employees can place them in the glove compartment of their cars for easy access. They may trigger some discussion about potential hazards and policies that employees can follow.

For example, if a home health worker is going to the home of an obese patient, what is the patient handling plan? Is a lift available? The patient may be eligible for some transfer equipment through Medicaid or Medicare but may not be aware of it, says Baron. (*For a sample Fast Fact card on MSD injuries, see box on p.58.*)

Continued on p. 60.

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

- CDC to track traumatic injury in HC
- Dangers of working the night shift
- Hazards of surgical smoke persist
- Reduce risk of violence from visitors, employees
- Update on post-exposure prophylaxis

Continued from p. 59.

Staying safe requires a partnership between the employer and employee, and between the home health worker and the patient, says Baron.

Some policies that protect workers also may reduce liability for the employer. For example, the health care employer can require employees who drive to wear a seat belt and may prohibit cellphone use while driving.

The employer shares in the responsibility for safe driving, says Baron. "Make sure the person has enough time between appointments so that the person can get there safety," she says.

[*Editor's note: The Fast Fact sheets are available at the NIOSH website at* www.cdc.gov/niosh/pubs/fact_date_desc_nopubnumbers.html.] ■

CNE QUESTIONS

1. According to Rick Cotter, president of RT Cotter and Associates in Kingston, MA, about how many chemicals are on an inventory of hazardous substances at the typical 150-bed hospital?
   A. 200-300
   B. 500-700
   C. 1000-1,200
   D. 1,500-2,000

2. According to the American College of Occupational and Environmental Medicine, employers should address fatigue with what type of program?
   A. Strategies such as caffeine and naps.
   B. Alertness tools such as better lighting and louder alarms.
   C. A system that includes adequate staffing, education and treatment of sleep disorders.
   D. Elimination of 12-hour shifts.

3. According to a survey of infection preventionists, what organism is responsible for the most outbreaks in hospitals?
   A. Norovirus
   B. *Clostridium difficile*
   C. *Staphylococcus aureus*
   D. Acinetobacter

4. According to Stephanie Radawiec, PT, DPT, MHS, MBA, a clinical consultant with Diligent Services, employees should not use gait belts as a fall prevention tool because:
   A. they often break when patients fall.
   B. they increase the risk of falling.
   C. they are responsible for the spread of disease.
   D. they can lead to employee injury when the employee tries to use them to stop a fall.

EDITORIAL ADVISORY BOARD

Consulting Editor
MaryAnn Gruden
MSN, CRNP, NP-C, COHN-S/CM
Association Community Liaison
Association of Occupational Health Professionals in Healthcare
Manager Employee Health Services
Allegheny General Hospital
West Penn Allegheny Health System
Western Pennsylvania Hospital
Pittsburgh

Kay Ball, RN, PhD, CNOR, FAAN
Perioperative Consultant/Educator, K&D Medical
Lewis Center, OH

William G. Buchta, MD, MPH
Medical Director, Employee Occupational Health Service
Mayo Clinic
Rochester, MN

Cynthia Fine, RN, MSN,CIC
Infection Control/Employee Health
San Ramon (CA) Regional Medical Center

June Fisher, MD
Director
Training for Development of Innovative Control Technology
The Trauma Foundation
San Francisco General Hospital

Guy Fragala, PhD, PE, CSP
Consultant/Health Care Safety Environmental Health and Engineering
Newton, MA

Janine Jagger, PhD, MPH
Director
International Health Care Worker Safety Center
Becton Dickinson Professor of Health Care Worker Safety
University of Virginia Health Sciences Center
Charlottesville

Gabor Lantos
MD, PEng, MBA
President
Occupational Health Management Services
Toronto

JoAnn Shea
MSN, ARNP
Director
Employee Health & Wellness
Tampa (FL) General Hospital

Sandra Domeracki Prickitt
RN, FNP, COHN-S
Employee Health Coordinator
Marin General Hospital/Novato (CA) Community Hospital
Executive President, Association of Occupational Health Professionals in Healthcare
San Rafael, CA

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance
Phone: (800) 688-2421, ext. 5511
Fax: (800) 284-3291
Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer
Phone: (800) 688-2421, ext. 5482
Fax: (800) 284-3291
Email: tria.kreutzer@ahcmedia.com
Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission
Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400
Fax: (978) 646-8600
Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

The Joint Commission Update for Infection Control

News you can use to stay in compliance

HAIs a high priority: Joint Commission gives infection prevention its own web portal

'We have both carrots and sticks.'

In yet another sign that infection control is becoming a national priority across a wide range of accreditors, regulators and state and federal agencies, the Joint Commission has created a new web portal to combine its full array of initiatives to prevent health care associated infections (HAIs).

"[We] have many moving parts that affect many aspects of health care," says **Jerod M. Loeb**, PhD executive vice president for healthcare quality evaluation at the Oakbrook Terrace, IL-based accrediting agency. "We have standards, performance measures, our center for transforming health care. The problem has been that they have all been located in silos."

The "HAI Portal" enterprise includes the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International. The goal of the HAI Portal is to provide an integrated "kiosk" of HAI resources — including those that are free and for purchase — in one web view that is accessible through any of the Joint Commission related websites. Yes, there are Joint Commission related products for sale on the site, but Loeb says that was not the primary driver of the

Key HAI topics on new JC portal

The Joint Commission Healthcare Associated Infection (HAI) portal lists resources under three headings:

HAI Topics

- General
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- Influenza
- Multi-Drug Resistant Organism (MDRO)
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia (VAP)

Infection Prevention and Control

- Environment of Care
- Hand Hygiene
- Patient Education
- Sentinel Event
- Staff Education
- Standards, National & International Patient Safety Goals
- Vaccination

HAIs by Setting

- Ambulatory Health Care (Includes Office-Based Surgery)
- Behavioral Health Care (Other than acute inpatient care)
- Critical Access Hospitals
- Home Care
- Hospitals
- Laboratory Services
- Long Term Care

The new Joint Commission Healthcare Associated Infection (HAI) portal can be accessed at http://www.jointcommission.org/hai.aspx. ■

project.

"It was not built to be a marketing site," he says. "But just knowing a standard and knowing the elements by which a hospital might be surveyed doesn't give them all the other answers. So we have created a variety of tools and things that are available — many of which are free. If you are an accredited organization, for example, you can turn to our leading-practice library. If you have issues related to getting house staff to wash hands prior to central line insertion, for example, you can find dozens of things that other organizations that we accredit have identified as good solutions."

Other topics addressed on the site include, multidrug-resistant organisms, surgical site infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia. (*See box, p. 1.*) The portal also includes resources on influenza, staff education and vaccinations.

"HAIs are harmful for patients, costly for health care organizations and largely preventable," Loeb says.

Indeed, the Joint Commission has clearly separated itself from the old dogma of inevitable HAIs that reigned over health care epidemiology for decades.

"The mindset has changed radically," Loeb says. "This [new view of HAIs] is sort of a huge amalgam at the national level, and we have a very important responsibility as an accreditor. We have a pathway that can help organizations comply with best practices, and that is called the accreditation process."

The tightened focus on HAIs comes against the backdrop of unprecedented national activity on infection prevention.

"I think we were actually ahead of that curve with respect to the Joint Commission standards that have been on the books for years as well as our patient safety goals," he says. "Clearly it is a national issue, but we have been involved in this for a long, long time. I do think that the stakes have changed with respect to issues around incentive payment, value-based purchasing and hospital-acquired conditions. The national attention associated with anything about HAIs is high."

The long shadow of the CMS

Indeed, in the shadow of an increasingly active Center for Medicare and Medicaid Services (CMS) — the federal agency that gives it deeming authority to grant accreditation — the Joint Commission is not likely to become less aggressive in the survey process. (As we previously reported, the CMS will begin unannounced inspections of infection prevention and hospital employee health programs later this year.)

"We certainly have worked closely with them and we will continue to work closely with CMS as part of our deemed status relationship," Loeb says. "People and professional societies can preach it, but if nobody is validating whether [infection control] is done or not, things often don't change. We have an interesting perspective here because we have both carrots and sticks. This portal is, we believe, a large carrot."

Of course, what infection preventionists and other clinicians are hoping is that the multiple oversight groups and recommending bodies trend toward standardization and collaboration, unifying the rules and making the expectations crystal clear.

"At the national level there is an awful lot of collaboration going on," he says. "We hope that the easily accessible information on the HAI Portal will assist health care organizations, practitioners and caregivers to prevent HAIs in their organizations, practices and homes."

In that regard, while hospitals are expected to be the primary users, the Joint Commission designed the site to be accessible to a wide spectrum of health care settings and users.

"These are things infection preventionists, nursing home staff, health aides in a home health agency that we might accredit, all may want to know," he says. The HAI site may set the standard for similar web portals at the Joint Commission, Loeb adds.

"We decided to create a single door, a portal to get the [HAI] information that you might be seeking," he says.

However, in doing so, the Joint Commission was wary of creating a "menu" for standard compliance that could blunt critical thinking.

"If you open this portal and you are having a problem with a standard 'X,' you can utilize the tools," he says. "But we tried to be careful not to make this an artificial lock and key, forcing people to begin thinking they are doing 'X' because the Joint Commission says you have to comply with 'X.' We tried to get away from that mentality and mindset."

The Joint Commission HAI portal can be accessed at http://www.jointcommission.org/hai.aspx. ■

JC surveyors looked at IC 'everywhere'

Documentation, medications also key

One hospital's survey experience suggests Joint Commission surveyors will remain highly interested in infection control even if your health care associated infection (HAI) rate is low.

Such is the take-home lesson from the first Joint Commission survey for **Elizabeth Donnenwirth**, RN, accreditation/sharps safety specialist at Winchester Hospital in Winchester, MA. The week-long survey for the hospital, which has 189 licensed beds, was performed by two nurses, a physician, and a life safety specialist. Surveyors looked at the usual suspects: infection control, documentation, medication, and competencies, she says. Coming in December 2010, right under the wire for the changes coming in the life safety/environment of care surveys, she says, surveyors also focused on EOC issues such as clutter.

Unlike the Centers for Medicare & Medicaid Services' surveyors, who "start from the patient and work up," she says, The Joint Commission surveyors asked some patients questions, "but they didn't really focus on patient communication, not from the perspective of speaking to patients. They were very focused on communication in general."

She notes that the surveyors touched on every standard in the manual, but was still somewhat surprised at "the extent that they focused on infection control because we have extremely low infection rates."

As the time rolls on post-survey, she's hearing more and more from staff in particular areas. "Being the accreditation specialist, I was neither escort nor scribe. I was involved in one area with a question-and-answer session with the physician surveyors when they were already in the ED talking about something else, and I came to answer a question."

She says the hospital has an ambulatory care unit on site, but it's very small; the hospital itself is 100 years old. So there are a lot of offices off-site. Many of the endoscopy nurses visit the off-site clinic, going back and forth from the on-site to the off-site office. The surveyors watched the processes there, specifically surrounding cleaning the scopes for colonoscopies. Donnenwirth wasn't surprised that they went to the off-site clinic, as surveyors usually go to at least 50% of your off-site clinics, she says. The surveyor looked at the drying racks for the scopes and looked at the floor and said, "Oh good, no brown spots."

Staff "looked at him, and they were appalled that he would even think he would see that, and he said, 'Oh, you'd be surprised.'" Surveyors do seem to compare hospitals and have their own pet peeves, she says. "One of my personal things is hand hygiene and cleaning scopes and things like that. I also do sharps safety, so I'm really fussy about that kind of stuff. And these surveyors have their own [peeves]. One of the surveyors, the home care surveyor, was also a home care nurse so she did the home care survey. That's where she felt comfortable, and they had a good review even though she was tough with the questions. But she also came into the hospital and did a lot of infection control stuff and spoke to patients in isolation."

Surveyors surprised — in the right way

Overall, she says, surveyors were surprised by the size of the hospital and how well they were doing "because apparently a lot of smaller hospitals have more difficulty because you have one person wearing a lot of hats."

They emphasized documentation and policies, she says, and asked to see many files. They asked for an OR block time for a particular surgeon and spoke with her about how she schedules. Surveyors looked at physical and occupational therapy for the rehab perspective. "They asked, of course, in all the sessions, to see a lot of information straight out of the data," she says.

As for infection prevention, she says, "everywhere they went, they looked at the infection control aspect of it." The surveyors asked about the solution that's put into the whirlpool bath to keep it free of bacteria and the processes involved. They asked a housekeeper how she prepares that solution and how she could ensure that it's the same every time. Donnewirth says that process has been standardized so that all that is needed is for a staff member to push a button and the solution is mixed perfectly.

"[I]t's pre-measured in this machine," she says. "And the company that supplies us with this comes every month to make sure that it's measuring exactly the right amount ... In some

hospitals, they have to measure it. So how do you know it's perfect?"

Joint Commission surveyors also looked at all the containers for labeling. Even the solution used to clean the tray and table area after scopes are cleaned has to be labeled, she says, because it's a "secondary container."

Overall, the hospital received kudos for staff working well together. Surveyors "could tell it wasn't put on for survey week. That [staff] truly did work well together. The communication, hand-offs, things like that, they were very impressed with." Surveyors also complimented nursing documentation and nursing patient care plans. "One of the things we were told they would focus on, and they did, was care plans. You look at the patient assessment and then [ask], 'Were those things that were identified put into the care plan?'" For example, if a patient is identified for falls risk, how is that implemented and checked on?

"So they drilled down to, 'OK, you identified these four things when the patient was admitted in the first 24-hour admission assessment. And now, how do you know that you're addressing them? And how do you know that it's resolved? And what happens when, OK that goal is done and you have a new goal? How do you identify a new goal?'... They were very impressed with that," she says.

In addition, the surveyors looked at legibility involving histories and physicals. "We did find some entries where timing was missing, so we did get hit on that," she says. Staff are "pretty good" with dating, she adds, but have not been so consistent with timing, specifically in certain areas. The hospital is only half-electronic. So timing may not be as good in some of the off-site clinics not yet on an electronic system but better in the hospital because of CPOE. The hospital also got cited for hospital clutter, certainly no uncommon finding.

"Some of the nursing units are larger than others in terms of room size," she says. Surveyors found in some hallways a couple of IV poles, a computer on wheels chart, and linen carts. Moving forward, she says, linen carts are going to be put inside patient rooms. Nursing and housekeeping, she says, are actually happy about the change, which will make their jobs easier.

She suggests asking any and all questions you may have for the surveyors while they're there. The more clarification you can get, the better, she says. ■

Gown use for isolation remains a judgment call

But consider high toll of HAIs

The question of gown use when entering patient isolation rooms is a recurrent one, so it is worth noting that this is the current thinking of the Joint Commission on the subject:

Joint Commission standard IC.01.05.01 EP 1 states: "When developing infection prevention and control activities, the organization uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus." The guideline that addresses contact precautions is published by the CDC's Healthcare Infection Control Practice Advisory Committee (HICPAC).

Recommendation V.B.3.b.i. from the HICPAC guideline states, "Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the patient-care environment."

Joint Commission surveyors will expect healthcare workers to wear a gown if their "clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient". The difficulty lies in "anticipating" when this may occur. For example, it is very probable that a nurses' aide preparing to perform a bed bath will have contact as described above, and therefore a gown would be expected. However, one of a large group of residents performing rounds with an attending physician would have a lower likelihood of clothing contamination.

Each organization may decide what guidance to provide to its healthcare workers within the parameters provided by HICPAC. However, The Joint Commission encourages organizations to consider the high morbidity and mortality of healthcare-associated infections in our nation when deciding what constitutes "anticipated contact" in each facility. Additionally, organizations may want to discourage non-essential personnel from entering the rooms of patients on isolation precautions. ■

Hospital Employee Health

2012 Reader Survey

In an effort to learn more about the professionals who read *HEH,* we are conducting this reader survey. The results will be used to enhance the content and format of *HEH.*

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by **July 1, 2012.**

In future issues of *HEH*, would you like to see more or less coverage of the following topics?

A. more coverage B. less coverage C. about the same amount

1. Joint Commission requirements	O A	O B	O C
2. OSHA requirements	O A	O B	O C
3. CDC guidelines	O A	O B	O C
4. Occupational exposures	O A	O B	O C
5. Ergonomic issues	O A	O B	O C
6. Immunization programs	O A	O B	O C
7. Record-keeping compliance	O A	O B	O C
8. Workers' compensation	O A	O B	O C
9. Latex allergies	O A	O B	O C
10. TB compliance regulations	O A	O B	O C

Please rate your level of satisfaction with the following items.
A. excellent B. good C. fair D. poor

11. quality of newsletter	O A	O B	O C	O D
12. article selections	O A	O B	O C	O D
13. timeliness	O A	O B	O C	O D
14. length of newsletter	O A	O B	O C	O D
15. overall value	O A	O B	O C	O D
16. customer service	O A	O B	O C	O D

17. On average, how many people read your copy of *HEH*?

O A. 1-3
O B. 4-6
O C. 7-9
O D. 10-15
O E. 16 or more

18. How would you rate your overall satisfaction with your job?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

19. How would you describe your satisfaction with your subscription to *HEH*?

O A. very satisfied
O B. somewhat satisfied
O C. somewhat dissatisfied
O D. very dissatisfied

20. What is your title?

O A. employee health director/manager/coordinator
O B. employee health nurse
O C. occupational health director/manager
O D. employee health/infection control manager
O E. other_____

21. How large is your hospital?

O A. fewer than 100 beds
O B. 100-200 beds
O C. 201-300 beds
O D. 301-500 beds
O E. more than 500 beds

22. *Hospital Employee Health* has been approved for 15 nursing contact hours using a 60-minute contact hour by the American Nurses Credentialing Center's Commission on Accreditation. If you participate in this CNE activity, how many hours do you spend in the activity each year? _____

23. Do you plan to renew your subscription to *HEH*?

O A. yes
O B. no If no, why not? _____

_____

24. What department do you report to?

- ○ A. Chief Financial Officer
- ○ B. Chief Medical Officer
- ○ C. Chief Operating Officer
- ○ D. Nursing

25. What is the highest degree that you hold?

- ○ A. ADN (2-year)
- ○ B. diploma (3-year)
- ○ C. bachelor's degree
- ○ D. master's degree
- ○ E. other_____

26. To what other publications or information sources about employee health do you subscribe?

27. Including *HEH*, which publication or information source do you find most useful, and why?

28. Which web site related to your position do you use most often?

29. Please list the top three challenges you face in your job today.

30. What do you like most about *HEH*?

31. What do you like least about *HEH*?

32. What are the top three things you would add to *HEH* to make it more valuable for your money?

Contact information