



Hospital Employee Health®

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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Hospital flu shot rates entering the public realm

CMS reporting in 2013, public access in 2014

Your influenza vaccination campaign is coming into the public spotlight, and that means more pressure than ever on the logistics of administering and tracking those vaccinations.

Think of this first season of reporting as a test. The Center for Medicare & Medicaid Services (CMS) will not publicly report the health care worker flu vaccination rates until 2014.

But as of January 1, CMS is requiring hospitals to report the vaccination rates of employees, licensed independent practitioners (non-employee physicians, advance practice nurses and physician assistants) and adult students, trainees and volunteers who are at least 18 years old. (The Joint Commission recommends tracking vaccinations among all contracted workers, but that is not being reported by CMS.)

For many hospitals, calculating the numerator is the easy part. You must count and report the number of individuals who received the vaccine, said they received it elsewhere, declined the vaccine, or who have a medical contraindication of either a severe egg allergy or a history of Guillain-Barre Syndrome within six weeks of a previous influenza vaccination. There is also a category for “unknown.” (*See frequently asked questions, p.135*)

However, the denominator is causing some headaches. CMS asks you to include all individuals (employees, licensed independent practitioners, etc.) who were in your hospital for at least 30 days between October 1 and March 31. The measure counts a “day” as any part of a day in your facility. (You cannot use data on fulltime equivalent employees.)

Some hospitals plan to count their non-employees in the most liberal way.

“Most places cannot determine how many days their non-employed physicians and other licensed independent providers actually spend in the facility,” says Melanie Swift, MD, FACOEM, director of the



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Vanderbilt Occupational Health Clinic in Nashville. “The safest course of action is probably to assume everyone with access and credentials to be in the facility are spending 30 or more days there.”

How to count on NHSN

Although for this first year the reporting begins on January 1, you can begin counting from October. The reporting occurs through the National Healthcare Safety Network (NHSN), a surveillance system maintained by the Centers

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for Disease Control and Prevention.

You can report monthly cumulative totals through NHSN, but CMS will receive the data only once — on May 13, 2013.

Some hospitals are struggling with the logistics of tracking non-employees. Harbor-UCLA Medical Center in Los Angeles can expect to report a high vaccination rate, no matter how it is counted. With a policy that requires those not receiving the flu vaccine to wear a mask during the flu season, Harbor-UCLA vaccinated 89% of employees last year and expects to reach 90% or above this year.

But gathering the data for the denominator will be a challenge, says **Erika Sweet, RN, MSN, NP**, with Harbor-UCLA Employee Health Services.

“Medical students may come in for two weeks rotation, they’re off for two weeks, then they come back for another two weeks. We have residents that do the same,” she says. They also have students cycling into the hospital from nursing schools and other programs. “The non-employee category is very difficult because nobody except their instructor knows exactly what time period they’re going to be here during any specific rotation.”

Some employee health professionals plan to count employees and non-employees who have spent even a day in the hospital, despite the 30-day instruction. **Bruce Cunha, RN, MS, COHN-S**, manager of employee health and safety at the Marshfield (WI) Clinic, notes that hospitals have various types of providers who rotate through or who work in temporary positions. “The best they’re going to get out of this is some kind of general ballpark figure,” he says.

And some employee health professionals wonder why they shouldn’t count people who worked fewer than 30 days during the flu season. “Should it matter how many days they’re in your hospital if they’re not vaccinated? Aren’t they just as much of a risk on any one day they’re there?” says Cunha.

Measure may be tweaked

Comments from employee health professionals actually might prompt some minor changes in the measure for future reporting.

“We realize that facilities may have feedback on some issues and difficulties they encounter in meeting the reporting guidelines during this

FAQs on tracking flu vaccination rate

The Centers for Disease Control and Prevention answers to common questions on reporting health care worker influenza vaccination rates include the following:

The HCP Influenza Vaccination Summary Form in NHSN defines the influenza season as July 1 to June 30. Does this mean that my facility is required to report on twelve months of data when we do not vaccinate for all twelve months?

No. Although influenza may occur any time of the year, you should report data for the period specified in the NHSN protocol, which is from October 1 to March 31 for the denominator, including all vaccinations given during the influenza season in the numerator. The July 1 to June 30 time period is used by NHSN to clearly define the end of one influenza season and the beginning of the next influenza season. For the 2012-2013 influenza season, NHSN is allowing facilities to report data for only half of the influenza season to align with the CMS rule that requires acute care hospitals to report data beginning on January 1, 2013. For subsequent influenza seasons, data for the entire reporting period (October 1 to March 31) are required to be reported as specified in the NHSN protocol.

What types of nurses are counted as licensed independent practitioners?

All advanced practice nurses should be included in the licensed independent practitioner category. Advanced practice nurses include nurse practitioners, nurse midwives, clinical nurse specialists, and nurse anesthetists.

Would you count health care personnel (HCP) who are not working with patients for 30 days or more, but because of staff meetings, etc. are physically in the facility for 30 days or more?

Yes. Individuals who perform any work duty in the facility for 30 days or more from October 1 to March 31, are included in the count, regardless of clinical responsibility or patient contact.

My acute care hospital owns several outpatient provider practices that are physically separate from the main hospital campus. Employees of these clinics are on the hospital's payroll, so should we include them in our HCP influenza vaccination reporting?

No. These employees should not be counted in the vaccination reports since they do not physically work in the acute care hospital.

Many of our HCP also work at another facility in town. Must they be reported by every facility at which they work?

Yes. These reports describe vaccination rates among HCP working at a specific facility, so all eligible HCP must be counted by each facility where they work.

My hospital is part of a multi-hospital system that has one corporate payroll. Each hospital has its own NHSN number, so how should each hospital report its total number of HCP?

Each facility should report the total number of HCP who physically work in that facility. If a health-care worker (HCW) physically works in multiple facilities in the hospital system for 30 days or more from October 1 to March 31, this individual should be counted in the total number of HCP for each facility where he/she works.

Should I count an employee who starts at my facility after October 1, or leaves their position after October 1?

Yes. All employees, non-employee licensed independent practitioners, and non-employee students and volunteers aged 18 and older who physically work at the facility for 30 days or more from October 1 through March 31, regardless of exact stop and start dates, should be counted.

Should HCP who are employees of the healthcare system (e.g., university), but who are not hospital employees, be included?

Non-hospital employees should only be included if they are physically in the facility for 30 days or more from October 1 to March 31 and meet the criteria for either the licensed independent practitioner category or the adult students/trainees and volunteers category. They would not be in the employee category if they are not on the hospital's payroll.

Are other licensed contract workers/non-employees such as nurses, technicians, therapists, etc. reported?

Non-employee licensed or credentialed providers other than physicians, advanced practice nurses, and physician assistants are not required to be reported. ■

first year of reporting,” says **Megan Lindley**, MPH, epidemiologist with the CDC's National Center for Immunization & Respiratory Diseases in an email to HEH. “We will take all of

the input that is offered and will reevaluate the specifics of the protocol and measure after this first reporting period to see if there are changes we can make in order to improve the reporting

experience for users and the accuracy and reliability of the data.”

Some concessions have already been made to make it easier for facilities to comply. For example, employees and non-employees can report in writing (online or on paper) that they have received the flu vaccine outside the facility. They are not required to produce documentation.

Swift called that “the saving grace of the CMS measure ... so an electronic survey sent to all licensed independent practitioners is a viable way to ascertain their vaccination status.”

[Editor’s note: More information about the influenza immunization reporting criteria is available at <http://ow.ly/felo9> ■

One in three hospitals now mandating flu shots

Governor vetoes California bill

Health department rules are broadening the scope of mandatory influenza vaccination policies, even as critics assail the policies as punitive and not science-based.

Almost one in three (31%) of hospital-based health care workers now report that their employers require influenza vaccination.¹ Rhode Island, Colorado, and several local health departments in California require health care workers at hospitals, long-term care facilities, and ambulatory surgery centers to receive the influenza vaccine or wear a surgical mask during the flu season.

“The intention behind it is [to address] the documented low immunization rate for health care workers,” says **Sherri Willis**, public information officer for the Alameda County Public Health Department. “In other words, health care workers are not getting the flu shot and we want to assure their protection and that they are not transmitting the virus to patients.”

Facilities that attain a vaccination rate of at least 90% are exempt from the masking policy in Alameda County. Colorado has adopted that same exception, allowing facilities that reach a rate of 75% by December 2013 and 90% in 2014 and beyond to continue voluntary programs.

In Rhode Island, the masking policy only applies in direct patient care when the state direc-

tor of health declares that flu is widespread.

Masking has become a major component of mandates. The California Medical Association sponsored a bill to require masking of health care workers who decline the flu vaccine. There isn’t any scientific evidence that masks reduce the nosocomial transmission of influenza, concedes **Ryan Spencer**, associate director of government relations for the CMA. “The mask was never regarded as being a substitute for the vaccine,” he says.

But it’s clear that health care workers don’t want to wear a mask. Masking policies increase compliance with vaccination, he says.

Politics of flu vaccine

The California bill illustrates some of the delicate political realities of an influenza vaccination mandate. Unions opposed the masking requirement as punitive, but when it was removed from the bill, the California Hospital Association withdrew its support.

The final bill required facilities to reach a 90% flu vaccination rate by 2015, but simply said that health care workers who don’t receive the vaccine “shall agree, in writing, to adhere to the most effective measures determined by the health facility in preventing health care workers from contracting and transmitting the influenza virus.”

Gov. **Jerry Brown** vetoed the bill, although he said he supports the Healthy People 2020 goal of reaching a 90% vaccination rate for health care workers. “This bill would move the date up to 2015 and make compliance mandatory, which are requirements I do not believe are reasonable,” he said in his veto statement. “I have confidence that local governments and health facilities are well equipped to make these decisions on their own.”

To combat the vaccine-or-mask mandates, unions took their message on the road in Pennsylvania. The union will work with hospitals to promote voluntary influenza vaccination, says **Bill Borwegen**, MPH, safety and health director of the Service Employees International Union (SEIU).

“We’re going to give a positive approach rather than an adversarial, coercive approach a try,” he says.

Masks can impair communication between patients and providers, Borwegen says. And because health care workers touch their face

to adjust or reuse the masks, they may actually increase the risk of transmitting influenza, he says.

In unionized hospitals, the union is also prepared to file grievances and legal challenges to stop mandates, he says.

Is evidence over-sold?

While vaccine-or-mask becomes a common policy, a critical article in an Australian journal added to the controversy.

Influenza vaccination of health care workers is an example of guidelines that use evidence that is of “inadequate quality or may be misused to underpin particular advocacy positions,” the authors state.²

They note a “paucity of evidence” that health care worker vaccination reduces nosocomial transmission in hospitals. The randomized controlled studies commonly cited occurred in long-term care facilities and might not be applicable to an acute-care setting, says the article by Jackie M. Street of the University of Adelaide and Toni N. Delany of Flinders University, both in South Australia.

“Despite the lack of evidence, guidelines in the countries examined are often underpinned by claims that such evidence exists,” they wrote.

Guidelines on health care worker flu vaccination also selectively use only research findings that bolster their recommendations, oversimplify issues and include “dead-end” citations that don’t actually contain relevant evidence, the authors said.

The paper supports the contentions of labor unions and other opponents of mandatory policies.

Although the Mayo Clinic in Rochester, MN, has reached a 90% vaccination rate through a voluntary program, **Bill Buchta**, MD, MPH, medical director of the Occupational Health Service, questions the rationale for the 90% rate. One commonly cited study showed elimination of nosocomial cases with a vaccination rate of 60%, he notes.

Mandatory vaccination has “taken on a life of its own. It’s become a political issue, a public policy issue,” he says. “It doesn’t matter anymore if there’s a scientific basis.”

Tom Talbot, MD, MPH, chief hospital epidemiologist at Vanderbilt University Medical Center in Nashville, counters that attaining the

highest quality evidence on the impact of health care worker vaccination isn’t really possible. Talbot says he identified about 50 published reports of outbreaks in health care facilities related to nosocomial transmission of influenza in the past four decades.

“You can’t ethically take a cohort of health care workers and not vaccinate them. We can’t do that study,” says Talbot, who is chair of the Task Force for Healthcare Personnel Influenza Vaccination of the Society for Healthcare Epidemiologists of America. “If you need that study, then you’re never going to support a mandatory policy.”

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Long-term care lags in HCW flu shots

Only half report getting flu vaccine

About one-third of health care workers fail to get their annual flu shot. But look behind those numbers and you’ll find the true disparity: Barely more than half of long-term care workers received the flu vaccine last year, while the rate for hospital employees reached an all-time high of 77%.

Yet by far, the focus of influenza vaccination efforts has fallen on the acute care sector. The Centers for Medicare & Medicaid Services (CMS) is requiring public reporting of flu vaccination rates for hospitals, but not for long-term care facilities.

While infection preventionists stress the need for better vaccination rates in long-term care, they acknowledge the challenges. “The resources and the manpower to address the safety issue are broader in an acute care facility” compared with long-term care facilities, notes **Tom Talbot**, MD, MPH, chief hospital epidemiologist at Vanderbilt University Medical Center in Nashville and chair of the Task Force for Healthcare Personnel Influenza

enza Vaccination of the Society for Healthcare Epidemiologists of America.

The Joint Commission accrediting body is requiring long-term care to track vaccination rates and to seek improvements to a 2020 goal of 90%. And some state and local health department regulations include long-term care in requirements for employees to get the vaccine or wear a mask during the flu season.

“If a regulating organization or new law mandates vaccinations then we will certainly comply,” says **Peggy Connorton**, manager of Long-term Care Trend Tracker of the American Health Care Association, noting that the organization encourages flu vaccination.

Long-term care can take a page from the playbook of acute care, suggests Talbot, by building strong leadership support and a vaccination infrastructure. At the core, all health care facilities should make sure the vaccine is accessible and free, promote its importance, and emphasize the leadership support, he says.

Nurses’ aides decline vaccine

Who gets the flu vaccine, who doesn’t, and why? Those are questions that public health authorities have struggled to understand.

The clearest picture comes from an Internet-based survey conducted for the Centers for Disease Control and Prevention. Physicians reported the highest vaccination rates – of about 86%. Hospital-based nurses were not far behind at 78%. Some 72% of nurses in long-term care reported having received their flu vaccine.¹

Yet vaccination rates diverged for other health care workers. In hospitals, 76% of them reported having the flu vaccine. But in long-term care, only 50% of these other health care workers received the vaccine. They are comprised largely of nurses’ aides – daily caregivers of elderly residents. And in the survey, these non-physician, non-nurse workers represented 82% of the respondents from long-term care.

“The real concern is that long term care facilities have not received enough attention, especially among their workers other than physicians and nurses,” says **Gary L. Euler**, DrPH, epidemiologist with the Assessment Branch of CDC’s Immunization Services Division.

A mild flu season last year may have contributed to the dip in vaccination by long-term care workers, says Euler. He stresses the importance

of providing education about the flu vaccine.

But the survey also suggests that long-term care employers need to work harder on their flu vaccine efforts. About 84% of health care workers in non-hospital settings reported that their employers did not promote vaccination, such as through incentives, special events or invitations.

“There may have been some type of promotion that they didn’t know about,” says Euler. “At least to that person, the effect would be the same as having no promotion.”

Cost, education are issues

Education could help dispel some notions about influenza vaccination. The most common reason health care workers declined vaccination: they believed they did not need it. They also expressed concern about the effectiveness of the vaccine and about side effects.

In particular, non-clinical personnel need “a clear message that’s tailored to them,” says Euler.

Other surveys also demonstrate the challenges in non-hospital settings. Cost and access remain a barrier for many non-hospital employees, according to a survey of 3,188 health care workers by researchers at Saint Louis University in Missouri. Non-hospital workers also were more likely than hospital workers to have a fear of vaccine side effects.²

While the Internet-based survey for CDC provides an important snapshot of last year’s flu season, it has some limitations.

Some 2,518 health care workers responded to the survey through Medscape or SurveySpot, and the responses were weighted to reflect the demographic makeup of the health care workforce. However, the respondents were not a random sample, and the method differs from the panel sample used in the prior year’s survey.

The National Health Interview Survey, which includes in-person interviews, will be available in June 2013, Euler says.

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CDC: Flexibility will remain on HBV

Options for testing young HCWs

Flexibility will be the guiding principle in upcoming recommendations on health care workers who were vaccinated against hepatitis B as infants.

Instead of directing hospitals to test all young health care workers for antibodies to hepatitis B surface antigen, the Centers for Disease Control and Prevention will present two approaches, medical epidemiologist Sara Schillie, MD, MPH, MBA, told the Advisory Committee on Immunization Practices (ACIP).

“There’s not a right or a wrong approach,” she told *HEH*.

Universal HBV vaccination of infants is a public health success — and a new challenge for health care employers. Health care workers who were vaccinated against hepatitis B as infants were never tested for an antibody response.

CDC currently recommends a three-dose series of HBV vaccine for health care workers. More than 90% of health care workers respond to the full series. Many non-responders show an immune response to an additional one to three vaccinations, but a small portion (about 5%) of health care workers will remain non-responders.¹

If non-responders have a bloodborne pathogen exposure and the source patient is positive for hepatitis B surface antigen, the exposed health care worker should receive hepatitis B immune globulin and additional vaccination, the CDC says.

For new hires who were vaccinated as infants, employers can take a pre-exposure or post-exposure approach, according to proposed recommendations discussed by ACIP.

In the pre-exposure approach, trainees or newly hired workers who were vaccinated as infants would be tested for HBV antibodies. If they have a level of at least 10 mIU/ml, they are considered protected and do not need further vaccination or testing. Those with lower levels of HBV surface antibodies would receive a single dose, and be re-tested, and if necessary receive two more doses.

As with current guidelines, health care workers who failed to respond sufficiently to the vaccine would be considered non-responders.

A post-exposure approach would involve test-

ing the health care worker for antibodies at the same time that the source patient is tested for hepatitis B surface antigen. Health care workers with a low level of antibodies would receive the hepatitis B vaccine as well as HBV immune globulin.

There are a number of issues to consider, notes Schillie:

- Trainees have a higher risk of bloodborne pathogen exposure than other health care workers. About 54% of needlesticks are unreported. So it would make sense to test trainees upon hire, says Schillie.

- Some facilities, such as long-term care centers, have a high turnover of staff. Testing those employees may be logistically challenging and expensive, she says. “It might be more practical for them to use a post-exposure approach,” she says.

- HBV vaccination of infants will eventually reduce the population of source patients who are hepatitis B surface antigen positive. The prevalence of hepatitis B in the community and among source patients may influence the decision to do routine, pre-exposure testing versus post-exposure testing.

Currently, 72% of health care facilities conduct pre-exposure testing of health care workers who were vaccinated as infants, and 20% take a post-exposure approach. About 7% give employees a challenge dose of vaccine and then test for antibodies.

“It’s optimal that institutions have an option to define their own approach,” says William Schaffner, MD, chair of the Department of Preventive Medicine at Vanderbilt University in Nashville, TN, and past president of the National Foundation for Infectious Diseases.

Meanwhile, there’s still work to be done to vaccinate older health care workers, Schaffner notes.

The U.S. Occupational Safety and Health Administration (OSHA) requires employers to offer the hepatitis B vaccine at no cost to employees. From 2005 to 2010, there were 203 cases of acute hepatitis B among health care workers that were reported to CDC. Only 19% of them reported having been vaccinated.

“We’re still not vaccinating everyone,” Schaffner notes.

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Stand up for employee health

Sit-stand device reduces risks

The most dangerous thing some of your employees may do each day is just sitting at their desk. Sedentary behavior — long hours of sitting — can increase metabolic and cardiovascular risks, even in someone who gets regular exercise on most days.^{1,2}

For employees who work in call centers, data input, or other desk jobs, there might seem to be little recourse to spending much of the day in a desk chair. But a new study indicates that employees are willing to stand at their desk for part of the day, and the time spent standing can improve their health.

“Reducing sitting time has become a major focus for health promotion,” says **Nico P. Pronk**, PhD, Vice President and Health Science Officer, HealthPartners in Minneapolis. And it’s a major opportunity for employers, he says.

“In the last five decades in this country, most of the moderate-intensity type jobs have moved to sedentary type jobs. We’ve had a 50% reduction in moderate-intensity work,” he says. “That has a progressive impact on overall health. If you make this part of the workflow so people don’t have to think about it and it becomes a way that you view your work, it can have a major benefit.”

Pronk and colleagues tested a sit-stand device with 34 employees in the health promotion department. The Take-a-Stand Project, as it was dubbed, led to about 66 fewer minutes sitting each day (an improvement of 224%), less upper back and neck pain and improved mood.³

“People ended up feeling much better,” says Pronk. “We found significant improvements in fatigue, vigor, tension, self-esteem, confusion and total mood disturbance.”

Break up hours of sitting

The project tested devices produced by Ergotron of Eagan, MN, that fit into an existing desk. The worker can adjust the height of the monitor, keyboard and mouse.

Employees completed surveys before and after the intervention, and they received three random texts a day on prepaid cell phones to find

out if they were sitting, standing or walking. Twenty-three received the sit-stand devices and 10 remained at traditional desks as a comparison group.

It was a simple adjustment to raise the computer for a standing posture. Pronk stresses that employees weren’t expected to stand all day.

“They just need to break up these long hours (of sitting),” he says. “If you can stand up every 30 minutes to one hour and break up that prolonged sitting time, then you get the benefit.”

Standing produces more blood flow, he says. “Physiologically, when you stand you activate a lot of muscles to maintain your balance. Your muscles are relaxing and contracting to maintain that balance. You’re always moving slightly from side to side,” he says. “Compared to doing nothing, it’s a huge difference.”

While Pronk wasn’t able to demonstrate an impact on productivity in the study, feedback from employees indicated that they felt more capable. For example, employees made comments like, “When I stand up I feel like I’m more attentive to the issues of my clients.” That translates into a higher quality of interaction with our clients, which to me is a productivity issue,” he says.

Back to the future

After four weeks, the devices were removed, and Pronk and his colleagues continued to monitor sitting, standing and walking for another two weeks.

“Within a couple of days, when you take the device away, people are basically sitting all the time,” he says. “The complete yield of the intervention was gone almost instantaneously. We felt definitely it was the device that made this work.”

The study was small, so while the results are promising, Pronk plans to do further research. But HealthPartners saw enough evidence to purchase about 2,000 of the devices, which sell for about \$400 to \$500 each.

“We make it available to those who have sedentary types of jobs,” he says. “We’ve introduced it as part of our health and wellness suite of programs.” HealthPartners also integrates it into the health promotion programs of corporate clients.

Pronk himself uses a sit-stand device and spends much of his day standing. He says it has made him more active, even when he’s just talking on the phone.

“It’s going back to the future,” he says.

“Around the turn of the century, standing desks were quite popular.”

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New coronavirus prompts concern

No human-to-human transmission

When a coronavirus recently caused two cases of severe respiratory illness in Saudi Arabia and Qatar, it was hard not to think of the challenging and deadly experience with another coronavirus — Severe Acute Respiratory Syndrome, or SARS.

SARS emerged in China in 2003 and eventually led to 774 deaths in 26 countries. In all, more than 1,700 health care workers were known to be infected with SARS, or about one-fifth of all cases.¹

As a “lesson learned,” the Centers for Disease Control and Prevention noted: “Healthcare facilities were disproportionately affected by SARS-CoV, and healthcare workers were among the first and most severely affected groups in every large outbreak reported.”

A SARS Commission in Ontario criticized the lack of a safety culture in Canadian hospitals and emphasized the “precautionary principle” — that facilities should take “reasonable action to reduce risk” to health care workers even if there is still scientific uncertainty.

So when a novel coronavirus emerged this year, it immediately received global attention. The first known patient was a 60-year-old man from Saudi Arabia, who died in June. A 49-year-old man from Qatar was hospitalized in September with pulmonary and renal failure. There have been no cases of person-to-person or health

care-associated transmission.²

In Ontario hospitals, the information produced some alerts, says **Gabor Lantos, MD, P.Eng, MBA**, president of Occupational Health Management Services in Toronto and a consultant to hospitals.

Hospitals still struggle with issues such as respirator fit-testing, says Lantos, but preparedness has improved. “The awareness is definitely higher than it was 10 years ago, at all levels,” he says.

Although this coronavirus is a reminder of SARS, it is distinct from the virus that spread quickly in hospitals in Asia and Canada. “There are still only two cases so it doesn’t seem that it’s very communicable,” says Lantos. “When we had SARS, we had one index case, and within days we had people coming down with it.”

Lantos notes that “anybody presenting with a fever of 101 and coughing should be appropriately isolated, to the best available means,” until they have been fully evaluated. For respiratory hygiene, the CDC recommends providing a mask to the coughing patient, if possible, and separating the individual from other patients. Health care workers should wear a mask when in close contact with a coughing patient, CDC says.

The World Health Organization offers this definition for a “patient under investigation” for the new coronavirus:

- A person with an acute respiratory infection, which may include fever ($\geq 38^{\circ}\text{C}$, 100.4°F) and cough; AND
- suspicion of pulmonary parenchymal disease (e.g. pneumonia or Acute Respiratory Distress Syndrome (ARDS)) based on clinical or radiological evidence of consolidation; AND
- travel to or residence in an area where infection with novel coronavirus has recently been reported or where transmission could have occurred; AND
- not already explained by any other infection or etiology, including all clinically indicated tests for community-acquired pneumonia according to local management guidelines.

According to the CDC, anyone who develops an acute respiratory illness within 10 days of returning from Saudi Arabia or Qatar (beyond just passing through an airport) should consult a physician and mention the recent travel. Cases of patients who meet the WHO criteria should be reported immediately to CDC through state and local health departments.

Testing for this virus must occur through CDC. “[W]idely available diagnostic tests for coronaviruses are not suitable for detecting this new virus,” CDC says.

Based on its tests, CDC determined that this coronavirus is similar to coronaviruses found in bats but not to any coronavirus previously found in humans. “Treatment is supportive because no specific therapy has been shown to be effective,” CDC says.

[*Editor’s note: More information on the novel coronavirus is available at www.cdc.gov/coronavirus/ncv/.*]

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A culture of safety includes patients

Safety reduces inter-related risks

When you work to fix one problem in workplace safety, you may end up reducing other hazards to both workers and patients. Safe patient handling offers an example of this broad impact of injury prevention. While reducing musculoskeletal injuries, it also may reduce the risk of patient-on-health care worker violence as well as the risk of patient falls.

Look at it from the standpoint of both the patient and employee, says **Charlotte Lynch**, MS, CNS, RN, safe patient handling coordinator at the Dayton (OH) VA Medical Center. The nurse or aide may be fatigued and in pain from manual patient handling. The patient may be in pain, disoriented, confused or uncomfortable when someone comes to grasp them for a transfer.

“It’s almost like nurturing them when you move them with various kinds of slings,” she says. “They feel more secure and the pain is less. The staff can stand to the side, and they don’t have to envelope them in their arms.”

There are some important issues to keep in mind so you can leverage the benefits of your injury prevention program, workplace safety

experts say:

A culture of safety matters. A study of 198 nurses found a correlation between how they viewed the workplace climate and the level of workplace violence and aggression. If nurse managers and hospital policies reflected a concern about violence, there were fewer incidents.¹ “It’s important to determine what the culture is within a unit,” notes **Mary Matz**, MSPH, CPE, CSPHP, national program manager of Patient Care Ergonomics Office for the VA’s Public Health Occupational Health Strategic Health-care Group.

The Dayton VA recommends two caregivers help with patient transfers, if possible, even when using lift equipment. The VA also has a violence prevention program that includes training of staff and flagging the records of patients with a history of violence.

“You can’t eliminate the risk, but you possibly can have the risk dealt with more efficiently and effectively,” says Lynch.

Take a comprehensive look at injuries. Too often, injury prevention focuses on an analysis of one incident without looking at the broader scope, says **Jane Lipscomb**, PhD, RN, FAAN, director of the Work and Health Research Center at the University of Maryland School of Nursing in Baltimore.

An injury and illness prevention program encourages employee health professionals to look for trends in injury reports. They also may see connections between different types of incidents. “We need to have a comprehensive program that looks across hazards,” she says.

Use ‘safety huddles’ to gain and share information. Lifts alone can’t solve a safety problem. To address patient handling concerns, the VA encourages units to have a “safety huddle,” a short staff meeting focused on a safety message or addressing an incident. They consider “what happened, what needed to happen and what we can make happen next time,” says Lynch. These huddles also could be used to discuss verbal or physical assault, address risk factors and raise awareness of violence prevention techniques, she says.

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Home care workers unaware of risks

Safety training, outreach needed

Here's a safety equation that doesn't compute well: A high risk of injury with a low awareness of hazards.

That is the profile of the non-clinical home health care worker, according to a recent study in Alameda County, CA. Surveys of 317 home health workers found that 60% (185) of them had been injured in the past year, but only five had reported the injury. Of the 51 workers who handled sharps, 30% had experienced a needlestick.

Yet they did not view their jobs as hazardous, says **Laura Stock**, MPH, associate director of the Labor Occupational Health Program at the University of California Berkeley School of Public Health, who presented the information at a recent conference of the American Public Health Association.

"People don't tend to think of their job as risky, even when they're getting injured," says Stock.

When the home health workers were asked about job hazards, they mentioned risks to their patients, she says. "They're not oriented to think about their own health and safety," she says.

It's important to provide health and safety training to workers in their native language, says Stock, who is developing a handbook on "Caring for Yourself While You Care for Others," and an awareness campaign. The research is supported by the National Institute for Occupational Safety and Health (NIOSH) in Cincinnati, which will help disseminate training materials.

Home care workers generally don't think of someone's home as a dangerous place. But there were toxic chemicals, heavy laundry, patient handling and sharps hazards, and even tobacco smoke, mold and animal bites.

"I think it's important for every workplace to have an explicit program in which they encourage people to report [injuries] and they make it clear there will be no reprisals," Stock says. "It's in the interest of every employer. They have the opportunity to eliminate hazards, thereby preventing future injuries from occurring."

The home health care workforce is among the fastest growing in the country, which makes outreach to this group of workers even more important, Stock says. ■

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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

- ANA creates new guidelines on safe patient handling
- Should we demand a better flu vaccine?
- A glimpse into the future of occ health regs
- How healthy is the healthcare workforce?
- Mining the link between patient and worker safety

CNE QUESTIONS

- In the upcoming requirement by the CMS to report influenza vaccination rates of health care personnel, should hospitals report the vaccination status of respiratory therapists who are contract workers?
 - Yes, hospitals must report on all contract workers.
 - Yes, hospitals must report on all clinical contract workers.
 - Yes, hospitals must report on all licensed independent practitioners.
 - No, hospitals only report on licensed independent practitioners who are physicians, advanced practice nurses and physician assistants.
- According to a CDC survey, approximately what proportion of hospital-based health care workers are required by their employers to receive the influenza vaccine?
 - One in three
 - One in four
 - One in five
 - One in ten
- According to proposed recommendations by the CDC, how should employers handle newly hired health care workers who were vaccinated for hepatitis B as infants but weren't tested for immune response?
 - Test for HBV surface antibodies and revaccinate if necessary.
 - Provide one shot of HBV vaccine and test for antibodies.
 - Test for antibodies only after an exposure.
 - Employers can choose which approach to take.
- A study at HealthPartners in Minneapolis found what effect of sit-stand devices on sedentary workers?
 - They aggravated workers' arthritis and back pain.
 - They reduced upper back and neck pain.
 - They increased worker fatigue.
 - They had no effect on worker health.

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