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OSHA ramps up action on bloodborne risks in health care settings

Reach extends to clinics, nursing homes

Some health care employers are failing to take even the most basic steps to protect against bloodborne pathogen exposures, and the U.S. Occupational Safety and Health Administration is beginning to take notice.

In 85 inspections last year of doctors' offices, OSHA issued more than $235,000 in fines for violations of the Bloodborne Pathogen Standard. Hospitals are cited more often for violations of that standard than for any other violation. And OSHA has targeted bloodborne pathogen compliance in its National Emphasis Program on nursing homes. In 2012, 47 nursing homes received $132,000 in fines.

"We really are looking at these issues and we will cite people who are not complying," says **Dionne Williams**, MPH, director of OSHA's Office of Health Enforcement.

The number of OSHA inspections is small compared to the scope of the health care workforce. There are about 5,700 hospitals, 16,000 nursing homes and about 50,000 multi-physician offices in the United States. But

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when inspectors target health care, they often find that employers fail to adequately train employees or update their exposure control plans. In some cases, they aren't even providing safety-engineered devices.

The Pittsburgh area office of OSHA conducted 10 special inspections in a year-long local emphasis program on health care that ended in September 2012. Inspectors cited a hospital and an allergy clinic for failing to offer the hepatitis B vaccine to all employees at risk. An ambulatory surgery center and a doctor's office weren't using safety-engineered devices. Sharps containers were overfilled or unsafe, OSHA said.

"It's very difficult to believe that anyone running a hospital or a clinic would not have these [bloodborne pathogen] rules well-documented and have familiarity with them," says **Janine Jagger**, PhD, MPH, director of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville. "I think it's just a question of doing the easiest thing if no one is looking."

Jagger and other sharps safety experts have long expressed concern about compliance with the Bloodborne Pathogen Standard in non-hospital settings. "OSHA is well aware that there are risks that are not being properly addressed in doctors' offices and non-hospital facilities, and they're turning their attention in that direction," she says.

Risk without protection or follow-up

Inspections in Pittsburgh provide a window into some of the problems occurring in health care facilities.

Jefferson Allergy & Family Associates, OSHA noted, "completely lacked an Exposure Control Program and no employee had been offered the hepatitis B vaccination. One worker had received a needlestick injury and she had been expected to pay for her own post-exposure evaluation and follow-up."

OSHA also cited the allergy clinic for using open buckets to dispose of sharps. "[O]nce every few days an employee would gather all of these open buckets of sharps and manually pour the used needles into a larger, approved sharps disposal container," OSHA said in a summary report.

A supervising physician at the clinic said the citations mischaracterized the practices at the clinic. The employees had all previously received the hepatitis B vaccine and the employee with the needlestick had not followed instructions about how to receive post-exposure follow-up. But the physician said the clinic is now working with a consultant to improve training, the Exposure Control Plan, documentation and other practices.

In Conemaugh Memorial Medical Center, a regional hospital in Johnstown, PA, OSHA inspectors found overfilled sharps containers and employees who had not been offered hepatitis B vaccination or provided annual bloodborne pathogen training.

"Problems were found in the soiled linen area, where employees emptied a suction canister of blood," OSHA said. "No procedures had been

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

Editorial Questions

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

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developed for the emptying and cleaning of this canister, and employees were subsequently not wearing appropriate PPE and gross contamination of the work area was allowed to accumulate."

Conemaugh has since created a SafetyNet Committee to reduce bloodborne pathogen hazards and has implemented new bloodborne pathogen training.

Other OSHA regions also have focused on bloodborne pathogen concerns. Region 2 issued a news release after citing Health East Ambulatory Surgery Center in Englewood, NJ, for failing to provide post-exposure counseling and prophylaxis after a needlestick. The surgery center contested the citations and reached a settlement with OSHA.

"The alleged written policy violations were self-corrected by Health East on our own initiative during the investigative process and long before OSHA issued its proposed penalties," a spokesperson said in an emailed statement. In fact, Health East is now pursuing the rigorous process of becoming a Voluntary Protection Program (VPP) site, she said.

National tracking is lacking

More than 10 years after the Needlestick Safety and Prevention Act, why are needlesticks still occurring? That question is best answered by surveillance, but national data have been lacking. The Centers for Disease Control and Prevention included a bloodborne pathogen module on its National Healthcare Safety Network (NHSN) but has not reported any data.

The best surveillance has come from Massachusetts, where all hospitals are required to report bloodborne pathogen exposures, and EPINet, a network based at the University of Virginia that collects data from 32 hospitals and health care facilities, many of them from South Carolina.

Those tracking systems point to lingering gaps in sharps injury prevention. In 2010, more needlesticks were linked to hypodermic needles than any other device, the Massachusetts data showed.

AOHP to track national needlestick trends

Employee health professionals who want more information about needlesticks are taking matters into their own hands. The Association for Occupational Health Professionals in Healthcare (AOHP) has begun to collect data in a national survey and will report the first results this fall at the AOHP conference in Orlando.

"We saw a gap in the knowledge," says **Linda Good**, PhD, RN, COHN-S, director of Employee Health Services for Scripps Health in La Jolla, CA, and chair of the AOHP Research Committee. "With our AOHP membership spanning the United States, we had an opportunity to collect data from our members and come up with some good numbers."

Expo-S.T.O.P, or Exposure Survey of Trends in Occupational Practice, could eventually gather data on other health care hazards, such as patient handling injuries, says executive president **Dee Tyler**, RN, COHN-S, FAAOHN, who is director of Medical Management for Coverys Insurance Services in Lansing, MI.

About 115 occupational health professionals have participated in the survey so far, providing information about needlesticks and mucocutaneous exposures. They also report some hospital characteristics, such as bed size, average daily inpatient census, number of employees, and whether it is a teaching or non-teaching hospital.

While hospitals track their own needlesticks, they also like to know how they compare to similar hospitals, Good says. AOHP also plans to share information about best practices. "The membership has expressed a lot of interest in what we find," she says.

Bloodborne pathogen exposure is one of five "health and safety initiatives" that AOHP targeted in its recent public policy statement. AOHP also is advocating for: "evidence-based best practices" on influenza vaccination of health care workers; safe patient handling "regulations, legislation, education, training, research and prevention activities;" "increased research, training and education" on respiratory protection; and comprehensive workplace violence prevention programs.

The priorities will guide AOHP's strategies as it designs education programs and collaborates with other organizations, says Tyler. ■

About one-fourth of those hypodermic needles (24%) lacked safety features.

Suture needles cause almost one in five (18.6%) sharps injuries, according to 2011 EPINet data, which reveals the continuing risk in operating rooms.

National information would help employee health professionals target their sharps injury prevention and provide some benchmarks, says **Linda Good**, PhD, RN, COHN-S, director of Employee Health Services for Scripps Health in La Jolla, CA.

The Association of Occupational Health Professionals in Healthcare (AOHP) is collecting sharps injury information from members to provide some basic data while they wait for a national reporting system, says Good, who is chair of the AOHP Research Committee. (*See related article on p. 63.*)

"If we can identify some best practices, we can share those with our membership and the community at large to try to make a safer workplace," she says.

Employers are required to update their Exposure Control Plan annually, including a review of new safety technology. But they also should be reviewing procedures to look for ways to redesign them for safety, says Jagger.

"The elimination of a sharp, whenever possible, is always the Number 1 goal," she says.

Health care facilities need to recognize the inextricable link between patient safety and worker safety, says Williams. "Health care workers in general have a very high regard for patient care," she says. "Their own protection also is a benefit to their patients."

Employers who need some help with compliance should contact their area OSHA office for free consultation — a program that won't trigger enforcement action, Williams says. ■

OSHA enforcement despite sequester

Cuts to travel, bonuses but no furloughs

The federal budget sequestration may have led to delayed flights and canceled White House tours, but by mid-April, the belt-tightening had not had an obvious impact on the main function of the U.S. Occupational Safety and Health Administration — enforcement.

OSHA canceled all non-essential travel, new hiring, and performance bonuses, but has managed to keep its priority on enforcement, according to occupational health and safety experts.

"This is a democratic administration. If there's one thing they've wanted to do, it's more enforcement," says **Aaron Trippler**, director of government affairs for the American Industrial Hygiene Association in Washington, DC.

"If you're going to see cuts, I think it will be on the compliance assistance side," he says. "They may cut back on training. I don't think they're going to cut back on enforcement at all."

An OSHA letter to employees indicated that the agency will avoid furloughs, according to reports: "While there is little to call 'good news' with respect to the sequester, I am pleased to say that by reprogramming funds we have been able to identify sufficient reductions — while still being able to support our priorities and mission — to take the required budget reductions without furloughing OSHA staff," said an excerpt of the letter published on the online site of the magazine, Government Executive.

The Obama Administration had previously warned that sequestration could lead to a reduction of 1,200 inspections. "The Occupational Safety and Health Administration (OSHA) could have to pull its inspectors off the job for some period of time … which would leave workers unprotected and could lead to an increase in worker fatality and injury rates," the White House said in a February "Fact Sheet: Examples of How the Sequester Would Impact Middle Class Families, Jobs and Economic Security."

In fact, OSHA could use the sequester as a rationale for re-directing money away from compliance assistance toward enforcement, suggests **Bill Borwegen**, MPH, safety and health director of the Service Employees International Union (SEIU).

"This really should be an opportunity for them to review the amount of money they allocate to providing assistance to some of the largest, more profitable companies with the best safety records — [such as] all of their VPP [Voluntary Protection Program] programs," he says. "They need to spend more of their time and energy — and they would have much more impact — if they went after workplaces that receive few OSHA inspections, which includes a huge percentage of the health care industry."

President Obama's proposed budget for FY 2014 would give OSHA $507.5 million, a slight increase. It would provide an increase in standards development and whistleblower funds and

a decrease in technical support and compliance assistance.

The budget includes a reorganization of OSHA's regional offices to save $1.3 million. The plan would combine Regions 1 (Boston) and 2 (New York); Regions 7 (Kansas City) and 8 (Denver) and Regions (San Francisco) and 10 (Seattle).

The House and Senate have very different budget resolutions, with differing perspectives on revenue increases and budget cuts. A stalemate could mean another sequester in the fall for FY 2014 of $109 billion. ■

Two views on a ban: Smokers need not apply?

Hospitals vary in approach to smoking HCWs

Are you helping smokers by banning them from your staff? Are you serving as a model of health by taking a tough stand — or by promoting wellness and accepting that some employees will continue to smoke?

Recent opinion pieces in the *New England Journal of Medicine* weighed in on this controversial topic. Medical ethicists at the University of Pennsylvania and McGill University in Montreal argue that policies against hiring smokers, and even financial penalties for smokers, are unethical.[1] "It is callous — and contradictory — for health care institutions devoted to caring for patients regardless of the causes of their illness to refuse to employ smokers," the authors said. "Just as they should treat people regardless of their degree of responsibility for their own ill health, they should not discriminate against qualified job candidates on the basis of health-related behavior."

Behavioral economists and the chief executive of the University of Pennsylvania Health System argue that the hiring ban helps smokers overcome the short-term discomfort of quitting and ultimately saves lives.[2] As of July 1, the University of Pennsylvania will hire only non-smokers. (While some employers test for nicotine, the University of Pennsylvania asks new hires to self-report their smoking status.)

"In many surveys, about 70% of smokers say they want to quit, but only 2% to 3% succeed each year," the authors said. "One reason for this huge gap is that smoking cessation has immediate costs in the form of nicotine withdrawal (i.e., the symptoms of withdrawal and the costs of anti-smoking treatments), but its benefits in terms of improved health are considerably delayed. Thus, although some people may see anti-tobacco hiring policies as adding economic injury to physical injury, we would argue that such policies also make the benefits of smoking cessation more immediate and so help to counterbalance the immediate costs of quitting."

A growing number of hospitals have implemented a ban on hiring smokers, although the practice is prohibited by law in 29 states and the District of Columbia. To explore both sides of this issue, *HEH* is presenting the experiences of two hospitals that have taken different approaches.

A workforce of wellness – and no smoking

For the Cleveland Clinic in Ohio, not hiring smokers is more than a policy decision. It's part of the health system's culture, says **Paul Terpeluk**, DO, medical director of employee health.

"Our belief is that health care workers and health care institutions have a different responsibility than non-health care institutions," he says. "Their workers need to emulate and model healthy behaviors because they're caring for people, they're caring for the sick."

The push for a truly smoke-free hospital campus began in 2005, when cardiothoracic surgeon Toby Cosgrove, MD, became CEO. The Cleveland Clinic offered free smoking cessation classes to employees — and to the community. In 2007, it became one of the first hospitals in the country to stop hiring smokers.

All new hires are tested for cotinine, a metabolite of nicotine. If they test positive, they can reapply for the position in 90 days (and re-test). "We encourage them to reapply if the job is available, and we would encourage them to actually stop smoking," says Terpeluk.

Few smokers actually apply for jobs at the Cleveland Clinic. The hospital system hires about 4,000 to 5,000 employees a year and only about 1% test positive, Terpeluk says.

"People who chose to apply here either quit smoking, or if they're smokers they chose not to apply," he says.

The point is not to discriminate, he says. Smoking cessation is part of a vigorous wellness program that includes chronic disease management, health promotion activities and a healthy environment, he says. There are no sugared drinks or trans fats in the hospital's cafeteria. A Healthy Choice program offers discounts on insurance

premiums if employees take steps to improve their health, including smoking cessation, weight management and physical activity.

"We're trying to fit this into an overall strategy that tries to convince people to do the right thing for themselves," Terpeluk says. "It's actually a good place to work because we encourage people to take care of themselves and we give them the tools to do that. Smoking is just one small part of that."

As with many hospitals, the Cleveland Clinic is a tobacco-free zone, which means that employees, visitors, vendors and patients cannot smoke or use other tobacco products on the grounds.

Having healthier workers brings lower medical claims. But it also is better for patients, who don't want to smell the residue on smokers, he contends.

The policy hasn't hurt the Cleveland Clinic's ability to recruit quality staff, including nurses, he says. "People actually think it's a good idea to work for an institution that cares that much [about their health]," he says.

Terpeluk says he doesn't know how many current employees are smokers, but he suspects the number is small and getting smaller.

"Essentially, you're promoting a healthier workforce by not hiring smokers," he says. "We offer free smoking cessation program. Over time because of attrition and turnover, you'll eventually move toward a zero prevalence rate."

Smoking declines through wellness

At Vanderbilt University, smoking is not allowed — but smokers are. The hospital system has a tobacco-free campus and uses incentives to reduce smoking among employees.

The strategy has been successful. "In 2003, when started our current wellness program, we had [a smoking rate among employees of] about 12% percent. Now we're down to 6.4%," says **Mary Yarbrough**, MD, MPH, executive director of Occupational Health and Wellness.

For employees who have participated in the wellness program each year, the smoking rate is just 4.2%, she says.

The Go for the Gold wellness program gives employees a financial incentive (a discount on insurance premiums) for participating in a health risk assessment. They receive additional incentives for maintaining a Wellness Actions Log with improvement goals and viewing a Game Plan for Your Health video on ways to improve health.

Employees with identified health risks, including smoking, receive follow up. "Smokers would be invited to come to the occupational health clinic where we would explain all the ways to quit smoking," Yarbrough says. "A health coach follows up with them if they choose to participate with that."

About 80% of employees participate in the wellness program, she says. Those who don't participate are disproportionately young medical residents or older faculty members and, as a group, the non-participants don't have higher-than-average medical costs, she says.

Yarbrough says she prefers a positive, voluntary approach to reducing smoking among employees. "To me, it is a social problem we're trying to overcome," she says. "But there are many problems and things people could do to be healthy. Exercising, diet, mental health. How do we pick out one thing to penalize and say we won't hire? People who don't sleep 8 hours a day, should we not hire them?"

Wellness interventions take a holistic approach and try to inspire an intrinsic desire to change, she says. "We don't just want people who don't smoke or who exercise, we want people who are productive, healthy and happy," she says.

Yarbrough recalls an experience that resonates from her own medical training, when she was on rounds with a teaching physician and a group of residents and students. A patient's medical problems were related to alcohol. "Somebody was presenting the case and they were being a little bit non-flattering to the patient," she says. "He said, 'If you want to be a judge, go into law. If you want to be healer, go into medicine.'"

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Hospital's safety goal: No more injuries

Strategy includes transparency, reporting

Forget about modest goals and incremental progress. Cincinnati Children's Hospital Medical Center wants to cut its rate of employee injury in half by June 2015. And it already has an injury

rate that is just one-third of the average rate for hospitals.

You can see their monthly stats on a chart they post on a quality website, where they explain the goal: At Cincinnati Children's, we are working to make our institution the safest it can be for our employees. We do this not just because we value our staff, but also because we know that employee and patient safety are inextricably linked. We must address the two as one system — you cannot achieve one without the other.

Or, to put it another way: "In order to care for others, you have to feel safe in taking care of yourself," says **Terri Thrasher**, the hospital's senior director of human resources and professional services.

"I really believe in that. Until you embrace safety as just one thought, the way that you approach everything, you're going to continue to experience problems in your patient safety journey," she says.

When employers set goals for low injury rates, there's always a concern that employees will just stop reporting their injuries. But Cincinnati Children's actually provides a job performance incentive for employees to report more injuries, incidents and near-misses.

"We're looking for a 30% increase in reported patient safety incidents and a 25% increase in employee incidents," says Thrasher. "We want more reports. In order to understand our situation well, you have to report."

Cincinnati Children's also uses outside benchmarks — but not from other hospitals. "We really don't use health care as our benchmark," says **Stephen Muething**, MD, vice president for safety. "Once we woke up to how far behind health care is in this work, we have been using other industries as our benchmark."

For example, Cincinnati Children's benchmarks against Alcoa, the aluminum manufacturer which set a goal of eliminating employee injuries. **Paul O'Neill**, former chairman and CEO of Alcoa, set a "no excuses" attitude. "It doesn't cost more money to investigate things gone wrong in real time and do something about them. It has to be a part of the culture," he said in a recent webinar on the emotional and physical health of the health care workforce. (*See related article on p. 68.*)

Starting the day with safety

As with most hospitals, Cincinnati Children's initially placed a strong focus on patient safety. A new CEO reviewed the program and asked, "Why aren't you making employee safety equal to patient safety?" says Thrasher. "Even though we had it on the [quality] dashboard and we had improvement efforts, it did not carry that same kind of weight."

Today, safety efforts address both patient and employee safety. Cincinnati Children's also took a cue from military operations, which hold briefings to review their activities and progress and conduct "situational awareness."

Every morning at 8:35 a.m., department heads and leaders of the clinical areas gather on a conference call for an operational briefing. Their mission: to report what went wrong the day before, what they're going to do about it, what potential issues they might face today, and what they're working on fixing.

For example, if they're short-staffed or if they are introducing a new piece of equipment, they anticipate problems and brainstorm solutions, says Muething. They might even talk about children in the mental health area who at risk of harming themselves or employees and how they can respond.

"We use that information to plan the shift. It's been a huge change for us and it's resulted in some significant reductions in harm," he says.

The hospital has an online reporting system and a call line for employees to report incidents and "potential harm." For example, if someone sees a spill or water on the floor, they can use the reporting system to get response from environmental services — and prevent a slip or fall, says Thrasher.

Small steps to a big goal

The hospital's safety goals are impressive, but it takes many small steps to get there, Thrasher and Muething say.

For example, employees working with severely autistic children or other children in the mental health unit sometimes suffered from bites or other injuries. The hospital undertook "very focused improvement work in trying to understand how these injuries are occurring and what we have to do to prevent them," says Thrasher.

Employees learned about triggers of aggressive behavior and how to diffuse them. They also have access to personal protective equipment, including Kevlar gloves, sleeves and collars. "I think they really appreciate the fact that we care enough to try to help them be safer," says Thrasher.

Cincinnati Children's reviewed the techniques used in lifting and patient handling, and purchased

additional equipment. The hospital evaluated office work stations and improved the ergonomics. Maintenance workers regularly look for irregularities in sidewalks, steps or curves and correct them to prevent falls.

Preventing needlesticks has been a challenge. The hospital is continually reviewing its devices. Some incidents occurred because the patient suddenly moved. So nurses received additional training on "how to appropriately engage a safety device as well as how to securely and safely hold a patient in order to have the best success in terms of giving an injection," Thrasher says.

Except in an emergency, nurses who need help holding a patient are told to wait for assistance before giving injections.

Even as those efforts succeed in reducing injuries, the hospital continues to look for new prevention strategies. "It's a forever journey," says Muething. "We believe as soon as you start getting comfortable, you are going backwards. We believe being a high-reliability organization is constantly and forever being uncomfortable." ■

Work safety: Freedom from harm, disrespect

'These are not sentimental notions.'

Seeking joy and meaning in work might seem like a stretch for a workforce that tops other sectors for back strain, workplace violence and stress-related disorders. But creating a workplace that is respectful and engaging also results in improved patient and worker safety, a roundtable of experts in patient and worker safety recently concluded.

"These are not sentimental notions," says **Julianne M. Morath**, RN, MS, Chief Quality and Safety Officer at Vanderbilt University Medical Center in Nashville, TN, and a member the Lucian Leape Institute of the National Patient Safety Foundation, which convened the roundtable. "Meaning is the sense of importance of an action. Joy is … the feeling of success and satisfaction as a result of the meaningful action. Workforce safety is the physical and psychological freedom from harm and disrespect.

"The costs of inaction of addressing the culture and conditions in which people are working in health care are significant," she says, citing high rates of burnout, turnover and medical errors in health care.

Through the Eyes of the Workforce: Creating Joy, Meaning and Safer Health Care offers seven recommendations for creating more effective organizations. Key strategies: Develop core values of respect, work to eliminate workplace harm, and create a high-reliability organization that constantly seeks improvement. (*See box, below.*)

"Organizations are either habitually excellent or they're not," said **Paul O'Neill**, former chairman and CEO of Alcoa and former U.S. Secretary of the Treasury, in a webinar on the report. He is also a member of the Lucian Leape Institute.

The Lucian Leape Institute report is the latest

The path to joy and meaning in HC

Through the Eyes of the Workforce, a new report from the Lucian Leape Institute of the National Patient Safety Foundation, offers these recommendations for improving the culture of safety at hospitals:

Strategy 1: Develop and embody shared core values of mutual respect and civility; transparency and truth telling; safety of all workers and patients; and alignment and accountability from the boardroom through the front lines.

Strategy 2: Adopt the explicit aim to eliminate harm to the workforce and to patients.

Strategy 3: Commit to creating a high-reliability organization (HRO) and demonstrate the discipline to achieve highly reliable performance. This will require creating a learning and improvement system and adopting evidence-based management skills for reliability.

Strategy 4: Create a learning and improvement system.

Strategy 5: Establish data capture, database, and performance metrics for accountability and improvement.

Strategy 6: Recognize and celebrate the work and accomplishments of the workforce, regularly and with high visibility.

Strategy 7: Support industry-wide research to design and conduct studies that will explore issues and conditions in health care that are harming our workforce and our patients. ■

to link quality patient care to worker safety. The Joint Commission recently issued a monograph detailing "high-reliability" organizations and the importance of an overall culture of safety. (*See HEH, January 2013, p.1.*)

The institute is known for actively promoting its findings and for getting the attention of hospital leadership on efforts to improve quality, says **Sandy Shea,** policy director of the Committee of Interns and Residents/SEIU Healthcare, which sponsored the report.

"It's potentially a game-changer," says Shea. "They really want to move the needle on reducing medical errors."

The report details the current risks to health care workers of physical and psychological harm, including high rates of musculoskeletal injuries, needlesticks, and emotional abuse and bullying. Yet it calls worker safety "a quality indicator for the culture of the organization — the culture that provides the critical context for achieving patient safety."

O'Neill, a powerful public speaker, already has projected his view that health care employers need to make a stronger commitment to preventing injuries.

"The injury rates for people in health and medical care are unbelievably high," he said. "I think it basically says, unfortunately, leadership in health and medical care organizations don't really believe the sentiment they espouse about people being our most important asset.

"I believe that workforce safety needs to be a pre-condition, never a priority. The word priority suggests that priorities could change," he said.

[*Editor's note: The report, Through the Eyes of the Workforce: Creating Joy, Meaning and Safer Health Care, is available at* www.npsf.org/about-us/lucian-leape-institute-at-npsf/lli-reports-and-statements/eyes-of-the-workforce/.] ■

'Clean' scrubs are teeming with germs

Don't ask HCWs to wash their own scrubs

It's time to rethink those dirty scrubs that hospital employees wear into the cafeteria, on the subway, in the grocery store, or home to their families. Evidence is mounting that home-laundered scrubs can spread infection.

Pathogens survive on the cloth, even after home washing, studies show.[1] "Hospital scrubs that people took home and laundered almost had as many opportunistic pathogens as the ones tested at the end of their shifts," says **Charles Gerba**, PhD, professor of environmental microbiology at the University of Arizona in Tucson, who compared hospital-laundered and home-laundered scrubs.

The risk isn't just hypothetical. Three cases of a deep sternal wound infection in patients who had coronary artery bypass surgery were linked to a single nurse anesthetist whose hands and scrubs were colonized with *Gordonia bronchialis*. An investigation indicated that the nurse's washing machine was the "likely environmental reservoir" for the organism. After the nurse got rid of the washing machine, her scrubs and hands were no longer colonized with the bacteria.[2]

That report underscores why it is important for hospitals to launder scrubs or provide disposable items, says **Lisa Spruce**, RN, DNP, ACNS, ACNP, ANP, CNOR, director of Evidence-Based Perioperative Practice for the Association of periOperative Registered Nurses (AORN) in Denver. AORN's practice guidelines call for hospital laundering of scrubs and note that "home laundering may not meet the specified measures necessary to achieve a reduction in antimicrobial levels in soiled surgical attire."[3]

As in the case of the nurse anesthetist, nurses often aren't aware of the potential contamination if the scrubs aren't visibly soiled, she says. "She was just re-infecting her clothes over and over again and infecting her patients," she says. "This was really a big eye-opener as to what types of organisms can survive on our scrubs."

Millions of bacteria survive

Getting rid of pathogens on hospital scrubs is more difficult than it would seem. In studies of laundry, Gerba found that about 95% of people wash their clothes in lukewarm or cold water. Only intense heat in the washer and dryer kills most organisms, he says.

"[Routine washing] is really designed to get rid of dirt, not bacteria. It only eliminates about 80% of bacteria during a wash. It sounds like a lot, but you're starting out with huge numbers," he says. "Some bacteria survive that washing over and over again."

A study of operating room scrubs found fungi

on almost all home-laundered scrubs (93%) and coliform bacteria on 44% of home-laundered scrubs — while hospital-laundered scrubs did not significantly differ from unused, new scrubs.[1]

Hospital laundries typically use bleach or a bleach substitute, which kills organisms, Gerba says. Drying clothes for at least 45 minutes also reduces the bacterial and viral load. AORN recommends the use of an accredited health care laundry facility to ensure consistency in the cleaning, says Spruce.

Many hospitals continue to rely on health care workers to wash their own scrubs, often due to cost concerns. The Centers for Disease Control and Prevention does not have a recommendation related to the laundering of hospital scrubs. But the issue may get increased scrutiny from infection control authorities, says **Irena L. Kenneley**, PhD, APRN-BC, CIC, assistant professor at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, OH, and chair of the Research Committee of the Association for Professionals in Infection Control and Epidemiology (APIC).

"We've proven that the organisms like MRSA can live for days on various surfaces, including the material that makes up our bed sheets and scrubs," she says. "It really does stand to reason that you should not wear these clothes anywhere but in the hospital."

You might want to think twice even about where health care workers wear the scrubs in the hospital.

"We find MRSA, C. diff and VRE and enterococci more often in the cafeteria than anywhere else," says Gerba. "I think it's because people are coming in there with dirty scrubs and no one disinfects the cafeteria like they do the patient rooms."

Using hydrogen peroxide on cafeteria surfaces such as tabletops would be effective in removing contamination, he says.

REFERENCES

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Green for Go: How to steer HCWs to healthy food

Cafeteria changes boost healthy choices

If you want employees to make healthier food choices in your cafeteria, keep it simple.

That is the strong message from the successful Choose Well, Eat Well program at Massachusetts General Hospital in Boston. The program uses red, yellow and green stickers to convey which foods are the healthiest. Placing healthier foods at eye level or in convenient locations also significantly improved the choices, according to a study of the program.[1]

"Our employees are very busy. When they go to the cafeteria they don't want to spend a lot of time looking at labels," says **Anne Thorndike**, MD, MPH, assistant professor of medicine at Harvard Medical School, who studied the program. "There are also impulsive purchases. We wanted to create a system that would be quickly understood and that didn't require people to do a lot of thinking."

The healthy food program began as a part of the hospital's Be Fit wellness program, which includes nutritional counseling. "You want your employees have every opportunity to be healthy while at work," says **Andrew Gottlieb**, NP, FNP-BC, director of Occupational Health Services at Mass General. "We want to take every opportunity we can to help people make the right choice."

Restaurants have used various methods to steer people toward the healthier menu options, from heart symbols for "heart-healthy" to calorie counts. Those are not always effective, says Thorndike. "We looked at what hadn't worked [in other studies] and needed to try something new," says Gottlieb.

People need an easy way to make the right choice, says Thorndike. "Sometimes people are either not knowledgeable about what the calories mean or they don't know how to put that into context," she says. "Sometimes people just don't notice it. It's just another number up there. That's why I like the colors. It's a very gut reaction you have toward seeing it."

First, nutritionists designed a food labeling system:

Green items ("choose often") contain fruits, vegetables, whole grains and/or lean proteins. Green foods contain a limited amount of calories and unhealthy fats. Green entrées have less than

500 calories and less than 5 grams of saturated fat. Green side items have less than 200 calories and less than 2 grams of saturated fat. Green beverages have less than 100 calories and less than 2 grams of saturated fat. (Bottled water, low-fat milk and diet drinks were marked green.)

Yellow items ("choose less often") may contain fruit, vegetables, whole grains and/or lean proteins. They may also contain additional calories or additional sources of unhealthy fat. Entrees may contain more than 500 calories or more than 5 grams of saturated fat, but usually not both. Side items may contain more than 200 calories or more than 2 grams of saturated fat, but usually not both. Beverages may contain more than 100 calories or more than 2 grams of saturated fat but usually not both. (Juices and sugar-sweetened drinks of less than 200 calories were labeled yellow.)

Red items ("There's a better choice") contain little or no fruits or vegetables, whole grains and/or lean proteins and contain additional calories and additional sources of unhealthy fats. Entrees contain more than 500 calories and more than 5 grams of saturated fat. Side items contain more than 200 calories and more than 2 grams of saturated fat. Beverages contain more than 200 calories and/or more than 2 grams of saturated fat. (Sugary drinks and sodas with more than 200 calories were red, as were whole milk dairy drinks of more than 100 calories and 5 grams of saturated fat.)

Thorndike and colleagues collected three months of baseline data, then made the change. Signs in the cafeteria explained the color coding, but the red-yellow-green was easily identifiable as similar to the traffic signals. "A lot of times people just don't know what they're getting and would make a different choice if they knew," she says.

The codes made an immediate difference. Consumption of red items declined by 9.4% and purchase of sodas declined by 23%.

"My first goal in this project, from a research perspective, was to demonstrate that these labels do make a difference. People are paying attention to them," says Thorndike. "It is impacting the way people are choosing."

Then the hospital added another intervention. Thorndike and her colleagues rearranged items. Healthier pre-made sandwiches were placed at eye level, and yellow and red versions were below or above eye level. Chips were moved lower. "They didn't have to do a lot of looking for what were healthier options," she says.

In the first intervention, bottle water sales actually declined slightly. The bottled water was in a refrigerated display off to the side. This time, "we put the water in every beverage refrigerator and we put baskets of water at each food station," says Thorndike. "It would be the first choice for someone to just grab a bottle of water."

The reorganization worked. Bottled water sales jumped by about 26%. Red items declined even further. With both interventions, all types of employees improved their healthy choices — regardless of education or ethnic background.

Labeling is just one way to encourage healthy habits, says Thorndike. But it is an important part of creating a healthy environment, she says.

REFERENCE

1. Thorndike AN, Sonnenberg L, Riis J et al. A 2-phase labeling and choice architecture intervention to improve healthy food and beverage choices. *Am J Public Health* 2012; 102:527-533. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

COMING IN FUTURE MONTHS

- The fight to save NIOSH
- Telemedicine for employee health?
- Overcoming depression's drag on productivity
- Hospitals react to PPD shortage
- Tracking sharps to lower injuries

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.

CNE QUESTIONS

1. What violations of the Bloodborne Pathogen Standard were identified in a special emphasis on health care by the Pittsburgh area office of the U.S. Occupational Safety and Health Administration?
   A. Collecting sharps in an open bucket.
   B. Failing to offer the hepatitis B vaccine to at-risk employees.
   C. Requiring employees to pay for their own post-exposure treatment.
   D. All of the above.

2. According to Paul Terpeluk, DO, medical director of employee health at the Cleveland Clinic in Ohio, which does not hire smokers, how many new hires who smoke are detected through testing?
   A. 15%
   B. 7%
   C. 1%
   D. Cleveland Clinic does not test new hires and asks for self-report.

3. To improve safety, Cincinnati Children's Hospital Medical Center has a performance incentive for employees with a goal of:
   A. reducing reported injuries by 30%
   B. reducing reported injuries by 15%
   C. reducing employee absenteeism by 10%
   D. increasing reporting of employee safety incidents by 25%.

4. According to a study of laundering of scrubs, what percentage of home-laundered scrubs still contained detectable coliform bacteria?
   A. 23%
   B. 34%
   C. 44%
   D. 93%