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IN THIS ISSUE

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AHC Media

Hospital shooting incident highlights toll of everyday violence in healthcare

Apt held Molotov cocktails, rambling notes, pile of pills

It is an all-too-familiar scenario: A mentally ill young man has grievances and a determination to get attention or revenge, or perhaps to carry out a twisted, spectacular suicide. He enters a building and begins shooting, wounding or killing whoever happens to be in his range. Then he dies in a gun battle with police or security officers.

That is essentially what happened on March 8, 2012, at Western Psychiatric Institute and Clinic in Pittsburgh. The case spawned lawsuits, investigations and hospital renovations — and a cautionary tale for other hospitals seeking to minimize the worst kind of workplace violence.

At the same time, the Western Psych shooting also highlights the toll of everyday violence in hospitals, particularly in psychiatric facilities or emergency departments. In 2011, psychiatric and substance abuse hospitals had a rate of violent assaults on staff that was 32 times higher than the average for all industries.

Special Report: Facing down the threat of hospital violence

Navy Yard. Newtown, CT. Aurora, CO. In these mass shooting incidents, the shooter had a history of mental illness. For hospitals, it's all in a day's work to treat patients who may be confused, agitated, or suffering from a psychosis. In this special issue, *Hospital Employee Health* examines a shooting incident at Western Psychiatric Institute in Pittsburgh. We provide resources on training health care workers and implementing violence-prevention practices. We also highlight another risk factor: Domestic violence that spills over into the workplace.

Also inside: Are you ready for OSHA's Haz Comm standard? By December 1, all employees must be trained on the new labeling and safety data sheet requirements. (*See page p. 126.*) ■

Those were incidents that led to days away from work; minor physical assaults and verbal abuse are even more common.

"There's a crisis mentality when people come into a hospital," says **Lisa Pryse**, CHPA, CPP, president and chief of company police of ODS Healthcare Security Solutions in Richmond, VA and Raleigh, NC, and president of the International Association of Healthcare Security and Safety. "It's a microcosm of a city with the potential for violence all the time."

The ultimate act of violence — the "active shooter" — may seem as unpredictable as a lightning strike. But there are conditions that make lightning more likely, or more dangerous, and we take precautions, notes Pryse. Similarly, hospitals can work to avoid and protect against workplace violence, from minor events to deadly ones, she says. (*See related story, p. 123.*)

"You've got to be as educated in human behavior as possible and have some [interventions] in place," she says.

It happened in minutes

On March 8, 2012, 30-year-old John Shick walked out of the rain and into the lobby of Western Psychiatric Institute, his tan-colored trench coat hiding the two semi-automatic handguns he carried and the fanny pack with extra ammunition.

At that moment, Michael Schaab, a 25-year-old geriatric therapist, was returning from a lunch break. Kathryn Leight, 64, sat at the reception desk talking on the telephone and Jeremy Byers, an unarmed security guard, stood nearby, as employees and visitors came in and out of the lobby.

Shick began shooting within 30 seconds of entering the hospital, the district attorney would later tell reporters. A bullet hit Schaab in the aorta, killing him instantly. Leight was shot in the chest and abdomen. He shot two other employees and a hospital visitor — one of them was trying to help Schaab — and then went into a stairwell that led to a second-floor entrance to the garage.

He didn't have an access card to open the door, so Shick returned to the first floor, where he was accosted by members of the University of Pittsburgh's Special Emergency Response Team. They shouted at him to stop, but Shick fired at the officers, hitting one in the chest. (The officer was wearing a bullet-proof vest, which deflected the bullet.)

Finally, one of the officers shot Shick three times, killing him and ending the shooting spree. The entire episode had lasted only minutes.

Investigators later found the makings of Molotov cocktail explosives and rambling notes in Shick's apartment, along with a pile of prescription pills and bottles for a wide variety of maladies.

The questions began literally as soon as the smoke cleared. Who was John Shick? He was a former graduate student at Duquesne University who had been dismissed from the program, and he had frequented doctors in the University of Pittsburgh Medical Center (UPMC) system but was not currently being treated at Western Psych. He had previously been involuntarily committed for psychiatric treatment in New York and Oregon.

What had triggered the shooting? Shick had stopped taking his medication for schizophrenia months before.

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In the weeks and months before the shooting, he displayed erratic and even threatening behavior and made irrational physical complaints and demands for specific medication and tests. Two physicians had inquired about seeking his involuntary psychiatric commitment, according to court documents.

And, most importantly, could it have been prevented?

Addressing the aftermath

Lawsuits lay out their own answers in stark terms. Shooting victims assert that the University of Pittsburgh, through its physicians, facilities and crisis intervention program, should have initiated involuntary emergency evaluation and treatment of Shick and that Western Psych had inadequate security.

UPMC responded that Shick never made specific threats and hadn't presented a "clear and present danger to himself or others," requirements for involuntary commitment. (UPMC declined to comment for this article.)

Last year, the Occupational Safety and Health Administration cited two psychiatric hospitals for workplace violence under the "general duty clause," which requires employers to maintain a workplace free of serious, recognized hazards. In one of those cases, a patient attacked a doctor.

But Shick wasn't actually a patient at Western Psych. And after an investigation into the shooting and other assaults, OSHA declined to cite Western Psych.

The emphasis instead has been on making the psy-

Tips and strategies to prevent violence

Times of risk: Pt transfers, emergency response, mealtimes

An OSHA list of work practices to help prevent incidents of workplace violence in hospitals includes the following key points:

- Establish liaison with local police and state prosecutors. Report all incidents of violence. Give police physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep log books and reports of such incidents to help determine any necessary actions to prevent recurrences.
- Advise employees of company procedures for requesting police assistance or filing charges when assaulted and help them do so, if necessary.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers to deal with aggressive behavior. Follow written security procedures.
- Ensure that adequate and properly trained staff are available to restrain patients or clients, if necessary.
- Ensure that adequate and qualified staff are available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of "restricted visitors" for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses' stations and visitor sign-in areas.
- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Do not allow employees to enter seclusion rooms alone.
- Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.
- Establish a system — such as chart tags, log books or verbal census reports — to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed.
- Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions).
- Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.

For the complete list of prevention strategies and more information in other areas see: OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers: www.osha.gov/Publications/OSHA3148/osha3148.html. ■

chiatric facility safer. That began with recognition that everyday assaults create an inherently unsafe work environment, says **Jane Lipscomb**, PhD, RN, FAAN, professor in the University of Maryland School of Nursing and Medicine in Baltimore and an expert in workplace violence. OSHA hired Lipscomb to review workplace violence at Western Psych.

She found that incidents had recently increased, and that the facility had no policy or committee that specifically addressed worker safety or patient-on-staff violence.

"If Western Psych had done a real risk assessment that was focused on staff safety, things may have played out differently," Lipscomb says.

In fact, the union had previously complained that nurses were required to perform security wanding of patients and visitors on the floors. (There were no metal detectors in the lobby.)

"We had a very hard time, even immediately after the shooting, getting resonance on the fact that the day-to-day violence had to be taken very seriously," says **Zach Zobrist**, MA, executive vice president of SEIU Healthcare Pennsylvania. "It was viewed as part of working at Western Psych.

"What we've been saying as a union is that it's that kind of mentality that leads to more problems," he says. "You need to have the mindset that it does not have to be the norm, even to work in a psychiatric institute, that an employee should get kicked, punched, stabbed with an object, threatened. All of those things had happened on a day-to-day basis."

Becoming more secure

After the shooting, there was no shortage of recommendations for improvements. In a hazard alert letter, OSHA recommended the creation of a labor-management committee to track and review patient-on-staff violence. Western Psych improved communication about incidents of violence and beefed up security.

The Allegheny County district attorney commissioned a security assessment of Western Psych and recommended changes, including more video surveillance cameras, new barriers in the lobby, personal emergency buttons and other enhancements.

In fact, UPMC hired its own security consultants and began investing in better security. Among the changes: An armed security guard is stationed at Western Psych on all shifts, employees enter through a secure entrance with a card swipe, and metal detectors have been placed in UPMC emergency departments in Allegheny County.

"They're making large architectural changes to revamp the access to the building, the flow and the security operations," says Zobrist. "They included nurses in looking at the blue prints. We were able to include some questions that they hadn't thought about."

Better communication is essential, he says. "The most important thing is that there be workplace violence assessment and review that's done by an outside group and shared with frontline staff," he says.

OSHA issued workplace violence prevention guidelines specifically geared toward health care and social services in 2004, and those recommendations still serve as a template. (www.osha.gov/Publications/OSHA3148/osha3148.html) (*See box on p. 123.*)

Lessons from other shootings

Hospital security experts also have learned lessons from "active shooter" incidents around the country.

"Probably one of the biggest things we learned from Virginia Tech [where a student killed 32 and injured 17 students and faculty in 2007] is the need to have an ongoing threat assessment team in your facility that meets regularly and often," says Pryse. Weekly or bi-weekly is a good goal, she says.

The team should be interdisciplinary, including representatives from human resources, risk management, security, legal, occupational health and other areas, as needed, she says. The minutes are kept confidential, unless they need to be shared for a specific purpose. The meetings are generally brief, lasting about 30 minutes to an hour.

The critical piece, says Pryse, is communication about potential threats. For example, someone may be agitated over a specific incident — such as the death of a loved one — and that anger may escalate when a medical bill or other communication from the hospital arrives. Resolving the billing issue and halting communication can remove a potential instigating factor, Pryse says.

A patient or visitor who exhibits repeated hostile or aggressive behavior may eventually be barred from the hospital, except in the case of a medical emergency. But before that happens, a staff person with a positive relationship with the patient can try to de-escalate situations, conveying both kindness and firmness about expected behavior, Pryse says. "It can be just as simple as having the right person have contact with that individual," she says.

Could the Western Psych shooting have been prevented? "It's impossible to judge whether anything could have been done to prevent this man from coming in and taking the life of this staff [member]," says Lipscomb.

But she and other experts in workplace violence

Free online course on violence prevention

NIOSH provides CEUs, resources for nurses

Training nurses about workplace violence has just become free and easy — with information literally at their fingertips. The National Institute for Occupational Safety and Health (NIOSH) has launched an online training program, complete with free continuing education units. (www.cdc.gov/niosh/topics/violence/training_nurses.html)

There has been an unmet demand for information about preventing workplace violence, says **Dan Hartley**, EdD, Workplace Violence Prevention Coordinator in NIOSH's Division of Safety Research in Morgantown, WV. Within 10 days of the release of the course, almost 300 people had completed it for CEUs, he says.

Although the health care industry has the highest rate of occupational injury from assaults that require days away from work, many nurses have never had any specialized training, he says.

"Health care professionals could go their entire career without having any workplace violence prevention training," he says.

The course describes risk factors for patient assaults as well as co-worker aggression, such as bullying. For example, it notes that people with a major mental disorder and/or substance abuse problem have a significantly greater likelihood of displaying violent behavior.

Nurses can gauge the potential risk of violence using assessment tools, NIOSH says. Sample tools are provided with the training.

Perhaps most importantly, the workplace violence course offers intervention strategies to help nurses prevent a situation from escalating to violence. Case studies illustrate appropriate ways to respond to different scenarios.

NIOSH also provides additional resources, including checklists and sample incident reports.

In the next couple of years, NIOSH plans to add content to the course, including specific modules for the emergency department, psychiatric units and nursing homes, Hartley says.

Employers can adapt the course to incorporate into their own employee training, adding hospital-specific policies and forms, says Hartley. ■

urge health care employers to take whatever steps they can to prevent all types of violence and to protect staff, patients and visitors if an incident occurs.

[*Editor's note: The description of the shooting was drawn from news reports in the Pittsburgh Post-Gazette and Tribune-Review and from court documents.*] ■

Violence spills from home to workplace

'Don't just wait for something bad to happen'

Domestic violence is not just a crisis in the home. It is a significant risk factor for workplace violence, as well.

Violence prevention experts are urging employers to screen for domestic violence and to have policies to address it. That is especially important in hospitals, where about 80% of employees are women, **Patricia Dawson**, RN, manager of occupational health clinics for Nationwide Mutual Insurance Co. in Columbus, OH, explained in a recent webinar sponsored by the American Association of Occupational Health Nurses.

"Domestic violence is a leading cause of injury to women in the U.S. and one of four women in the United States will be impacted by it in their lifetime," she said.

When women are killed at work, the incident is often linked to domestic violence. About two in five (39%) workplace homicides of women involve relatives or personal acquaintances, according to the U.S. Bureau of Labor Statistics.[1]

That presents a potential risk to patients, visitors and other employees. Domestic violence also impacts employers through medical claims and lost productivity, noted Dawson.

"There are some significant costs to employers, which include loss of days worked, absenteeism and presenteeism," she said. "For victims, [there is a] vicious cycle of not showing up at work. The victims may miss work due to health effects [of violence at home] or due to the controlling behaviors of their abusers."

What can occupational health professionals do about events that take place outside of work? They can provide awareness and referrals to the employee assistance program. A multi-disciplinary committee

should include domestic violence in threat assessment, and security personnel may need to become involved to provide a safety plan for the employee, said Dawson.

For example, arrival and departure times are often the most dangerous times for the employee, she said.

Free resources are available to employers through Workplaces Respond to Domestic and Sexual Violence: A National Resource Center, a program funded by the U.S. Department of Justice. (www.workplacesrespond.org.) Employers can download a model policy and posters that can be placed in a break area with information about the hospital's employee assistance program.

The website also provides fact sheets and information for employers, including a guide for supervisors. "It's important for employers to understand more about the dynamics of domestic violence and stalking and how that violence can impact the work environment," says **Maya Raghu**, senior attorney with Futures Without Violence in Washington, D.C., one of the groups in the Workplaces Respond project.

"Our approach is to encourage employers to be proactive about how domestic violence and stalking affect the workplace and not just wait for something bad to happen," she says.

[Editor's note: An archived version of the domestic violence webinar, as well as other occ health webinars, is available at www.aaohn.org.*]*

REFERENCE

1. Bureau of Labor Statistics, U.S. Department of Labor. Workplace homicides from shooting, January 2013. Available at www.bls.gov/iif/oshwc/cfoi/osar0016.htm. ■

Deadline looming for training on chem labels

OSHA may ramp up citations after Dec. 1

The deadline is looming for hospitals and other employers to complete new training requirements for chemical safety — or face the possibility of citations from the U.S. Occupational Safety and Health Administration.

By December 1, hospitals and other employers must train all their employees how to read and understand new labels and safety data sheets that are part of the Globally Harmonized System (GHS) for the labeling of chemicals.

This switch to an international system has been an important move for OSHA, as the United States joins more than 65 other countries in adopting the uniform labels and safety sheets. Hazard Communications is the third most frequently cited standard in hospitals — and in general industry.

"The concept of having a worldwide format is way, way overdue," says **Rick Cotter**, president of RT Cotter & Associates in Plymouth, MA, which provides "environment of care" consulting and safety data sheet management. "We're just going to go through the pain of making that transition over the next several years."

OSHA wants employees to be trained on the new pictograms, label wording and safety data sheets because manufacturers may gradually shift to the new system over the next couple of years. By June 1, 2015, manufacturers must fully comply with the new labeling and safety data sheets, and by June 1, 2016, employers must update their workplace labeling and hazard communications program and provide any new training, as necessary.

"Between now and [2015], employees and employers should expect it's going to be a bit of a mess," cautions **Brad Harbaugh**, editor of the EH&S blog for MSDSonline, which helps employers with chemical management and other safety compliance. "A lot of chemical manufacturers are making these changes a little at a time. The employer has to make sure they're compliant with the old [Hazard Communications] standard or the new one in some combination during this transition period."

Train before new chemicals arrive

Meeting the December training requirements is rather simple. (*See related story, p. 127.*) But full compliance with the Hazard Communications standard requires hospitals to keep up with new chemicals that employees handle, including hazardous drugs.

(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.)

Your hazard communications plan should indicate who is in charge of managing chemicals, how to train employees, where to store safety data sheets, and how to re-label containers if they are taken out of the original container, says Harbaugh.

This involves conducting a complete chemical inventory. "It's important that this includes any hazardous chemicals to which your employees are exposed, including paint and cleaning agents," he says.

OSHA requires employees to receive training before

any new chemical is introduced, so that means being proactive, Harbaugh says.

"Start with doing a physical inventory of the chemicals in your facility," he adds. "When was the last time you walked around and opened every closet and every door and knew the chemicals that are actually being used in your facility?"

Be aware that changes in chemical concentrations can create a new hazard in an old product. For example, **Stephen Burt**, president of Healthcare Compliance Resources in Roanoke, VA, recalls one incident in which a hospital switched a glutaraldehyde product from 2.7% to 4.9% concentration. An environmental services worker had an adverse reaction to the higher concentration, including respiratory and eye problems.

Because of the greater hazard with a higher concentration, employees needed to be retrained, Burt says.

Quiz employees on hazard info

An OSHA inspector may ask for your hazard communication plan. But to gauge compliance, he or she may also ask employees about the hazards associated with a chemical they work with or where they would find the safety data sheet.

"If employees are working with chemicals, OSHA assumes they've been trained on the chemicals and the hazards associated with them," Harbaugh says.

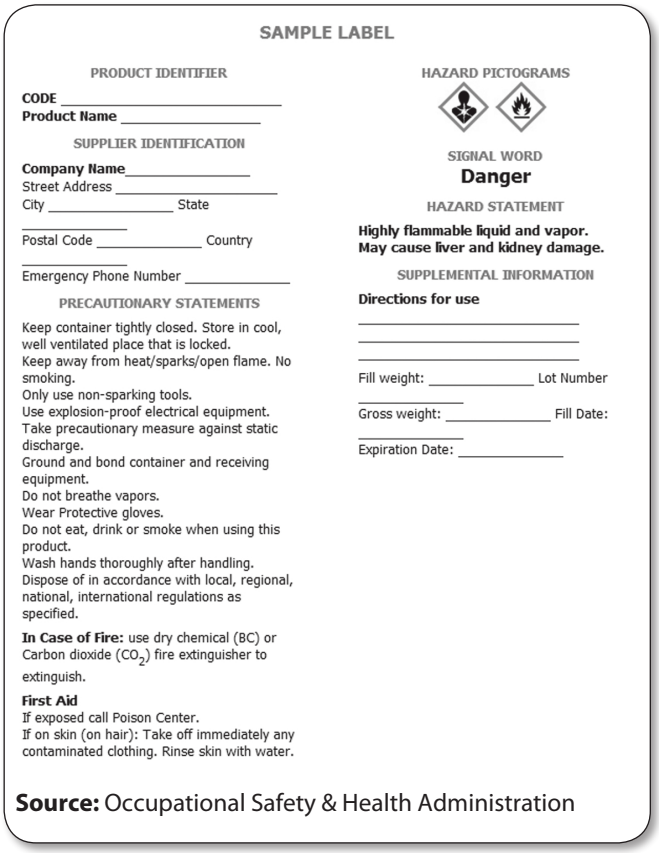
The labels on hazardous products will be clear, with one of eight pictograms conveying the type of hazard. They will contain signal words: "warning" for a less severe hazard and "danger" for a more severe hazard. Labels also must contain a brief description of the hazard and precautions that should be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

That will make it easy for even employees with limited English proficiency to readily identify hazards. But OSHA also makes it clear that employees must be trained in a way they can understand — which means they may need training in their native language.

Safety data sheets will likely be available in multiple languages, particularly since the GHS has been adopted by so many countries, including China, Japan, Korea and the European Union.

To monitor compliance, Burt suggests randomly asking employees about a hazardous chemical they work with.

"When I do my walk-around and risk assessment for hospitals, I ask everyone from physicians to environmental services employees," he says. "They have to know how to access that information. Otherwise it's a violation.



SAMPLE LABEL

PRODUCT IDENTIFIER

CODE _____
Product Name _____

SUPPLIER IDENTIFICATION

Company Name_____
Street Address _____
City _____ State _____
Postal Code _____ Country _____
Emergency Phone Number _____

PRECAUTIONARY STATEMENTS

Keep container tightly closed. Store in cool, well ventilated place that is locked.
Keep away from heat/sparks/open flame. No smoking.
Only use non-sparking tools.
Use explosion-proof electrical equipment.
Take precautionary measure against static discharge.
Ground and bond container and receiving equipment.
Do not breathe vapors.
Wear Protective gloves.
Do not eat, drink or smoke when using this product.
Wash hands thoroughly after handling.
Dispose of in accordance with local, regional, national, international regulations as specified.

In Case of Fire: use dry chemical (BC) or Carbon dioxide (CO_2) fire extinguisher to extinguish.

First Aid
If exposed call Poison Center.
If on skin (on hair): Take off immediately any contaminated clothing. Rinse skin with water.

HAZARD PICTOGRAMS

SIGNAL WORD
Danger

HAZARD STATEMENT

Highly flammable liquid and vapor.
May cause liver and kidney damage.

SUPPLEMENTAL INFORMATION

Directions for use

_____
_____
_____

Fill weight: _____ Lot Number _____
Gross weight: _____ Fill Date: _____
Expiration Date: _____

Source: Occupational Safety & Health Administration

"What would you do if you splashed this in your eye? Do they know what they're supposed to do? Where's the eyewash station? Has anyone trained you on this?"

With a heightened focus on hazard communications, OSHA inspectors are likely to be asking much the same thing.

[Editor's note: More information on the GHS and new Hazard Communications standard is available at www.osha.gov/dsg/hazcom/.] ■

Training requirements for new labels, symbols

According to the Occupational Safety and Health Administration, at a minimum, these topics must be included in employee training by December 1, 2013:

Training on label elements:

Type of information the employee would expect to see on the new labels, including the

• **Product identifier**: how the hazardous chemical is identified. This can be (but is not limited to) the chemical name, code number or batch number. The manufacturer, importer or distributor can decide the appropriate product identifier. The same product iden-

tifier must be both on the label and in Section 1 of the SDS (Identification).

• **Signal word:** used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. There are only two signal words, "Danger" and "Warning." Within a specific hazard class, "Danger" is used for the more severe hazards and "Warning" is used for the less severe hazards. There will only be one signal word on the label no matter how many hazards a chemical may have. If one of the hazards warrants a "Danger" signal word and another warrants the signal word "Warning," then only "Danger" should appear on the label.

• **Pictogram:** OSHA's required pictograms must be in the shape of a square set at a point and include a black hazard symbol on a white background with a red frame sufficiently wide enough to be clearly visible. A square red frame set at a point without a hazard symbol is not a pictogram and is not permitted on the label. OSHA has designated eight pictograms under this standard for application to a hazard category.

• **Hazard statement(s):** describe the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard. For example: "Causes damage to kidneys through prolonged or repeated exposure when absorbed through the skin." All of the applicable hazard statements must appear on the label. Hazard statements may [have] classification categories, and chemical users should always see the same statement for the same hazards, no matter what the chemical is or who produces it.

• **Precautionary statement(s):** means a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling.

• **Name, address and phone number** of the chemical manufacturer, distributor, or importer.

Training on how to use labels in the workplace: For example,

• Explain how information on the label can be used to ensure proper storage of hazardous chemicals.

• Explain how the information on the label might be used to quickly locate information on first aid when needed by employees or emergency personnel.

Training to provide a general understanding of how the elements work together on a label: For example,

• Explain that where a chemical has multiple hazards, different pictograms are used to identify the various hazards. The employee should expect to see the appropriate pictogram for the corresponding hazard class.

• Explain that when there are similar precautionary statements, the one providing the most protective information will be included on the label.

Training on the format of the safety data sheet (SDS) must include information on:

The standardized 16-section format, including the type of information found in the various sections.

• For example, the employee should be instructed that with the new format, Section 8 (Exposure Controls/Personal Protection) will always contain information about exposure limits, engineering controls and ways to protect yourself, including personal protective equipment.

How the information on the label is related to the SDS

• For example, explain that the precautionary statements would be the same on the label and on the SDS.

Note: OSHA requires employers to present information in a manner and language that their employees can understand. If employers customarily need to communicate work instructions or other workplace information to employees in a language other than English, they will also need to provide safety and health training to employees in the same manner. Similarly, if the employee's vocabulary is limited, the training must account for that limitation. By the same token, if employees are not literate, telling them to read training materials will not satisfy the employer's training obligation.

SOURCE

Occupational Safety and Health Administration, www.osha.gov/Publications/OSHA3642.pdf. ■

Nursing homes lag badly on worker flu shots

Hospitals hit vaccine rate of 83%

Hospital employees recorded the highest-ever rates of influenza immunization in the past flu season, with 83% of hospital-based health care workers reporting they got the shot. But as public health authorities touted that success, they revealed a troubling statistic: Only 59% of health care workers in long-term care received the vaccine.[1]

That rate was actually worse than the rate of the 2010-2011 season, the year after the H1N1 pandemic, when an Internet-based survey indicated that 64% of health care workers in long-term care facilities received the vaccine.

The health care workers themselves aren't the only ones to blame. Half of them reported that their long-

term care employers did not offer free flu vaccines to workers.

"In the long-term care facilities, where the patients are the most vulnerable, they're the least likely to be offering vaccine or be offering it for free," said **Anne Schuchat**, MD, (RADM, USPHS), Assistant Surgeon General for the US Public Health Service and director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention. She spoke at a recent news conference sponsored by the National Foundation for Infectious Diseases (NFID).

Yet public health efforts have not always focused on health care workers in long-term care. The Centers for Medicare & Medicaid Services (CMS) requires hospitals to report influenza vaccination rates of health care workers, but long-term care facilities report the vaccination rates of residents.

Some states have filled in the gaps. Rhode Island and New York currently require health care workers — hospital, long-term care and home care — to receive the flu vaccine or wear a mask while influenza is widespread in the state. A Colorado rule requires health care facilities, including nursing homes, to vaccinate 75% or more of their workers by December 31, 2013 (and 90% by Dec. 31, 2014) or adopt a vaccine-or-mask rule.

Nursing homes are aware of the importance of influenza immunization, says **Greg Crist**, senior vice president of the American Health Care Association in Washington, D.C., a federation of state associations that represent long-term and post-acute care facilities.

"The numbers aren't where we'd like to see them when it comes to immunizing our staff," he says.

Long-term care providers, which get about 80% of their funds from Medicare or Medicaid, have been struggling with reduced payments and rising costs, he says. They also face a challenge of high turnover of staff, he says.

Nonetheless, long-term care providers are adopting their own vaccine-or-mask policies to protect their residents, he says. "We understand just how vulnerable seniors are," he says.

In nursing homes, vaccination rates are lowest among the lowest paid workers. Some 85% of nurses in long-term care facilities reported having received the flu vaccine, but only 55% of nurses' aides and technicians said they were vaccinated, CDC reported.

Hospitals almost reach 2020 goal

Meanwhile, pressure on hospitals to boost vaccination rates has produced impressive results. CMS requires reporting of influenza immunization rates for employees, licensed clinical professionals, and volunteers/students/trainees, and those rates will be publicly reported in 2014. *(See related article in* HEH, *October 2013, p. 112.)*

Mandatory and vaccine-or-mask policies have become increasingly common in the nation's hospitals. Hospitals are now just shy of the Healthy People 2020 goal of vaccinating 90% of health care workers against influenza.

Physicians led the way, with a vaccination rate of 92%. About 87% of nurses and 80% of non-clinical personnel in hospitals reported receiving the vaccine.

About 2,000 health care workers participated in the Internet survey, which was conducted in April 2013.

Myths about influenza vaccination persist, despite yearly awareness campaigns, public health authorities say. Some health care workers believe the vaccine will give them the flu, and others believe they don't need a shot because they never get the flu, said **Richard S. Liebowitz**, MD, senior vice president and Chief Medical Officer of New York-Presbyterian Hospital in New York City, who spoke at the NFID press conference.

New York-Presbyterian allowed employees to decline vaccination but required them to first view a 25-minute video about influenza vaccination, he said. About 70% to 75% of the hospital's non-medical staff typically receives the vaccine, he said.

But for this flu season, the hospital will follow the new vaccine-or-mask rule of the New York State Department of Health. "I'm hoping that rather than [having] the stigma of wearing a mask, they will choose to do the right thing," he said.

REFERENCE

1. Centers for Disease Control and Prevention. Influenza vaccination coverage among health-care personnel — United States, 2012–13 influenza season. *MMWR* 2013; 62:781-786. ■

Be wary of MERS introductions

Super-spread pattern occurs in hospitals

Could a SARS-like outbreak be on the horizon? MERS-CoV (Middle Eastern respiratory syndrome coronavirus) has had limited transmission, but hospital-based outbreaks — and illnesses among Saudi Arabian health care workers — are reminiscent of the outbreaks of Severe Acute Respiratory Syndrome (SARS) that occurred 10 years ago.

One patient in a dialysis unit in Saudi Arabia, for example, spread MERS-CoV to seven other patients, which led to 12 other cases, including the infection of a health care worker.[1]

That pattern is "like the super-spreading events during SARS," says **Allison McGeer**, director of infection control at Mount Sinai Hospital in Toronto and an expert on SARS who has traveled to Saudi Arabia to help investigate MERS-CoV. She added, "It's not as dramatic as some of the super-spreading during SARS."

SARS culminated in 8,100 cases and 774 deaths, for a case fatality rate of about 10%. About a year after MERS-CoV was first detected in September 2012, there were 130 lab-confirmed cases and 58 deaths, or a case fatality rate of 45%. While urging greater surveillance and infection control, in September a World Health Organization panel of experts declined to call MERS-CoV a "Public Health Emergency of International Concern," a designation that leads to specific actions.

Still, hospitals in North America should be alert to MERS-CoV symptoms among patients with recent travel to the Middle East or contact with others who traveled there, she says. The symptoms include fever, cough, shortness of breath, and breathing difficulties, and could include gastrointestinal symptoms such as diarrhea. Patients have had pneumonia and some have had kidney failure, the World Health Organization reports.

Although no cases have yet been reported in North America, "these cases have been exported. We are at risk," says McGeer.

The greatest challenge may be in detecting MERS-CoV in a contact or family member of someone who traveled to the Middle East, McGeer cautions. "What happens if it's the traveler's wife or the traveler's boyfriend or the traveler's mother? That's where we're more likely to get into trouble," she says. "That's where we got into trouble with SARS."

Echoes of SARS

An outbreak in the Al-Hasa region of Saudi Arabia, with 23 confirmed cases and 11 probable cases in four health care facilities reveals the SARS-like potential of MERS-CoV.

Patient A was admitted to the hospital with dizziness and profuse sweating. Four days later, he had developed a fever and pneumonia-like symptoms. He wasn't tested for MERS-CoV, but his son would later have a confirmed case.

Meanwhile, Patient C in the adjacent room developed fever three days later. Six new cases of MERS-CoV were linked to contact with him in the hemodialysis unit – including among three patients who were in adjacent beds. There was further secondary spread, including to two health care workers. (Patient C also was linked to a case in the intensive care unit.)

Most concerning, six new cases of confirmed or probable MERS-CoV occurred after heightened infection control. Those precautions included: "monitoring hand hygiene, implementing droplet and contact precautions for febrile patients, testing patients with fever for MERS-CoV, putting masks on all patients undergoing hemodialysis, not allowing patients with suspected MERS-CoV infection into the dialysis unit, enhancing environmental cleaning, and excluding visitors and nonessential staff."[1]

CDC: Use airborne precautions

Much is still not known about MERS-CoV — including how it is spread. In the report of the investigation of a hospital outbreak, the authors noted: "[W]e are unable to determine whether person-to-person transmission occurred through respiratory droplets or through direct or indirect contact and whether the virus was transmitted when the contact was more than 1 meter away from the case patient. Because some patients presented with gastrointestinal symptoms, and transmission appeared to occur between rooms on the ward, the current WHO recommendations for surveillance and control should be regarded as the minimum standards."

The Centers for Disease Control and Prevention recommends airborne infection isolation rooms for patients and N95s, gloves, gowns and goggles or face shields for health care workers entering a patient room. (www.cdc.gov/coronavirus/mers/infection-prevention-control.html) *(The World Health Organization recommends the use of a surgical mask except during aerosol-generating procedures, which then call for an N95.)*

Some cases of MERS-CoV are likely still occurring due to an animal vector, perhaps linked to camels, but as of September, researchers had not established the source.

In September, the World Health Organization reported four additional lab-confirmed cases of MERS-CoV. One, a 41-year-old female health care worker from Riyadh, Saudi Arabia, had no known exposure to a MERS patient or to animals likely to carry MERS. She died within a couple of weeks of onset of her illness.

A 30-year-old male health care worker at the same hospital became ill with severe pneumonia and was in

critical condition. Two other Saudis who had family members with MERS also became ill; one died and the other was in critical condition.

MERS-CoV cases have been detected in France, Germany, Italy, Jordan, Qatar, Saudi Arabia, Tunisia, the United Arab Emirates, and the United Kingdom. All cases either involved people who lived in or traveled to the Middle East or who had contact with people who had probable or lab-confirmed MERS-CoV. ■

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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

■ A better path to hand hygiene compliance

■ Prevent TB spread with better ventilation

■ Injuries among occupational therapists

■ Joint Commission monograph on best practices in respiratory protection

■ Job satisfaction linked to less worker injury

CNE QUESTIONS

1. According to **Lisa Pryse**, CHPA, CPT, president of ODS Healthcare Security Solutions in Durham, NC, what is an important ongoing measure to prevent "active shooter" incidents?
   A. A multi-disciplinary threat assessment team
   B. Bullet-proof partitions in emergency departments
   C. Arming of health care employees.
   D. All of the above

2. According to the U.S. Bureau of Labor Statistics, what percentage of workplace homicides of women involve relatives or personal acquaintances?
   A. 15%
   B. 23%
   C. 39%
   D. 45%

3. According to a survey of health care workers released by the Centers for Disease Control and Prevention, what percentage of hospital-based HCWs received the influenza vaccine in the 2012-2013 season?
   A. 59%
   B. 72%
   C. 83%
   D. 90%

4. A risk factor for MERS-CoV is:
   A. Travel to Europe or the Middle East
   B. Travel to the Middle East or contact with others who traveled there
   C. Previous infection with SARS
   D. Being of Middle Eastern origin or contact with someone of Middle Eastern origin

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