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OSHA proposes quarterly electronic reporting with more transparency

Individual employer data would be online

In a major move toward greater transparency in injury and illness reporting, the U.S. Occupational Safety and Health Administration has proposed a rule that would require large employers to send their information to the agency electronically every quarter.

The regular public reporting will encourage employers to find and fix hazards, said OSHA administrator **David Michaels**, MD, MPH. OSHA also will use the information to identify employers with higher injury rates, he said in a telephone press conference.

"For the most part, the information in the [OSHA] logs never leaves the workplace," he says. "We propose to change that so these logs can play a greater role in preventing injuries and illnesses."

Some employer groups reacted with skepticism or opposition to the plan to collect information quarterly and make it available in a searchable database. Recordkeeping would transform from an internal mechanism to identify hazards to an external publication of safety performance, says **Brad Hammock**, leader of the Workplace Safety and Health practice group at Jackson Lewis law firm in Washington, DC.

"You want to drive injury reporting as much as possible [to identify hazards]," says Hammock. With such a rule, "are you setting up a system where you're actually dis-incentivizing reporting, which makes it more difficult for you as an employer to know where all your injuries are occurring?"

For safety professionals, a more accurate and timely database of injury and illness data provides more opportunities for comparison. "Once implemented, this initiative will enable employers to compare their safety records to those at similar facilities," **Stephen Burt**, president of Health Care Compliance Resources, an affiliate of Woods Rogers Consulting in Roanoke, VA, says in a white paper released after the proposed rule. "In addition, prospective employees will know which employers have better safety records, helping those employers compete for the most desirable workers.

Identifying top safety performers?

Currently, the U.S. Bureau of Labor Statistics surveys about 80,000 employers each year to gather information on occupational injuries and illnesses. There is a lag of about a year before data for a calendar year is released. The Bureau of Labor Statistics will continue conducting surveys, Michaels said. OSHA will use the reported data to target enforcement, but also to shape compliance and outreach programs, Michaels said. And just the public reporting itself will shape behavior, he said.

"Employers want to be seen as the top performers in their industry," he said. "We believe responsible employers want to be recognized as leaders in safety."

OSHA said it does not expect the proposed rule to be a burden for large employers – defined as those with 250 or more employees – because most of those employers already collect the OSHA 300 log information electronically. Smaller employers (with 20 or more employees) in designated industries would be required to submit information from the summary form (OSHA 300A) annually. Hospitals, nursing homes and home health care are among the designated industries.

OSHA is seeking comment on whether and how to phase in the shift to electronic reporting, how reporting should occur for employers with multiple establishments or facilities, and what impact the change may have. (*See editor's note below.*)

Federal agencies are the test case

While OSHA's proposal would radically change the way employers report injuries and illnesses, it isn't completely unexpected. The agency had included the item on its regulatory agenda and had already taken steps toward reworking the nation's injury and illness recordkeeping.

As of January 1, 2014, OSHA is requiring all federal employers (including hospitals) to submit their injury and illness data to the U.S. Bureau of Labor Statistics every year. Some saw this as a first step toward broader reporting requirements from all employers.

"Everybody's reading between the lines. It's almost like a test program [for federal agencies]," Burt said of the new federal requirement.

OSHA could eventually move toward real-time injury and illness reporting, perhaps starting with high-hazard industries, says **Brad Harbaugh**, editor of the EH&S blog for MSDSonline, a safety compliance consulting firm. "OSHA is going to use that [recordkeeping information] to target their inspections," he says. "If they have more information about specific companies and industries [that have the greatest problems], those industries should expect to see more regulatory activity."

Flaws in recordkeeping have always been a prominent OSHA concern. In fact, Michaels highlighted the problem of underreporting even before he became assistant secretary for labor. He implemented a National Emphasis Program on recordkeeping from September 2010 to February 2012, including nursing homes among other high-hazard workplaces that were targeted for more intense scrutiny.

"When worker injuries and illnesses are underreported, it only serves to conceal hazards that,

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unabated, continue to endanger workers' health and safety," Michaels said in a 2012 speech.

Recordkeeping in the spotlight

Recordkeeping has long been in OSHA's sights. Failing to properly maintain OSHA 300 logs is one of the most frequently cited violations for hospitals. Employers can err by failing to place certain incidents on the log. They are required to record work-related injuries or illnesses within seven days of learning about the incident. Any medical treatment beyond first aid makes an incident recordable – and OSHA's list of first aid treatments is all-inclusive.

Other concerns include:

Protecting whistleblowers: In March 2012, OSHA reminded inspectors that it is unlawful for employers to discipline workers who have been injured or who report an injury. OSHA also cautions against incentives that reward employees for not reporting injuries. (www.osha.gov/as/opa/whistleblowermemo.html) "They're looking very closely at those programs to see if they create a chilling [effect on] injury reporting," says Burt.

Need for immediate reporting: A final rule is pending for new OSHA recordkeeping requirements. Under the proposed rule, employers would be required to report all hospitalizations due to work-related injuries or illnesses within eight hours and all work-related amputations within 24 hours. OSHA currently only requires reporting of hospitalizations of three or more workers in the same incident and doesn't have a specific reporting rule for amputations.

The reporting rule is geared toward trauma and does not apply to hospitalizations from surgery related to previous injuries, says Hammock.

Statute of limitations: Last year, the U.S. Court of Appeals in the District of Columbia ruled that OSHA can only cite for recordkeeping violations that occurred in the past six months. OSHA contended that recordkeeping violations were ongoing, or continuous, and because the Occupational Safety and Health Act requires employers to maintain their injury records for at least five years, that was the functional statute of limitations for recordkeeping deficiencies. "That was a very significant, pro-employer decision," says Hammock.

In its 2013 regulatory agenda, OSHA indicated that it will issue a rule "to clarify that the duty to make and maintain accurate records of work-related injuries and illnesses is an ongoing obligation.

"The duty to make and maintain an accurate record of an injury or illness continues for as long as the employer must keep and make available records

First-aid only need not be reported

The U.S. Occupational Safety and Health Administration offers this list of treatments that are considered first aid. OSHA considers this a "complete list," so that any other treatments would be recordable.

-Using a non-prescription medication at non-prescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for recordkeeping purposes)

-Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment)

-Cleaning, flushing or soaking wounds on the surface of the skin

-Using wound coverings such as bandages, Band-Aids, gauze pads, etc., or using butterfly bandages or Steri-Strips. (Other wound closing devices such as sutures, staples, etc., are considered medical treatment)

-Using hot or cold therapy

-Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (Devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes).

-Using temporary immobilization devices while transporting an accident victim (such as splints, slings, neck collars, back boards, etc.).

-Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister

-Using eye patches

-Removing foreign bodies from the eye using only irrigation or a cotton swab

-Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means

-Using finger guards

-Using massages (Physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes)

-Drinking fluids for relief of heat stress ■

for the year in which the injury or illness occurred," OSHA said. "The duty does not expire if the employer fails to create the necessary records when first required to do so."

[*Editor's Note: The comment period on the OSHA proposed rule "Improve Tracking of Workplace Injuries and Illnesses" is open through Feb. 6, 2014. For a copy of the proposed rule and instructions on how to submit comments go to:* http://1.usa.gov/1agpyyx.] ■

Political turmoil a threat to OSHA mission

Agency preserves enforcement power

Federal budget cuts and a two-week shutdown didn't divert the U.S. Occupational Safety and Health Administration from its focus on enforcement. But as Congress moves forward with difficult budget debates amid the specter of an even deeper automatic cut known as the "sequester," the agency 's allies worry that diminished resources could undermine its mission of ensuring workplace safety and health.

Even before the current budget battles, OSHA had fewer inspectors than in 1981, although the number of workplaces has doubled in that timeframe,[1] according to a report by the Center for Effective Government, an advocacy and research group based in Washington, DC.

In 2011, for example, OSHA conducted 140 inspections in hospitals – 86 of them in response to employee complaints, 45 that targeted high-injury worksites, two due to fatalities and seven for other reasons. There are more than 5,000 hospitals in the United States.

"[OSHA's] ability to conduct inspections is very constrained, so it's no surprise that hospitals often don't see an OSHA inspector," says **Nick Schwellenbach**, senior fiscal policy analyst at the Center for Effective Government and co-author of the report. "Many industries that are hazardous don't receive the type of attention that they should."

With an additional 7.2% cut from the 2014 funding in another sequester, OSHA's budget would be $531 million, close to the same amount as in the last fiscal year of the Bush Administration, Schwellenbach notes.

"At some point it becomes the new normal at the agency," says **Celeste Monforton**, DrPH, MPH, a former OSHA official who is now a lecturer in the School of Public Health & Health Services at George Washington University in Washington, DC. "If you have another sequester and it is cut further, the new normal becomes quite troubling, when you think about how little presence OSHA has in workplaces."

Not everyone sees OSHA as a toothless tiger. Employers still feel OSHA's shift toward more aggressive enforcement under the Obama Administration, says **Brad Hammock**, leader of the Workplace Safety and Health practice group at Jackson Lewis law firm in Washington, DC. "Since the sequester has occurred, and even during the government shutdown, the clients I work with did not notice any change in the vigor with which OSHA is operating," he says.

Shutdown led to delays

OSHA shifted its resources in the sequester, but some OSHA efforts lagged due to the two-week federal government shutdown in October. For example, OSHA delayed its roll-out of new tools to promote voluntary compliance with lower limits of hazardous chemicals. (*See related article on p. 138.*)

During the shutdown, only two inspectors continued working in each of the area offices, or about one-tenth of the inspection workforce. Regional administrators and assistant regional administrators also stayed on the job, but most enforcement activities were halted.

As OSHA ramped back up in late October, Michaels said OSHA is continuing to move forward on an Injury and Illness Prevention Program, which would require employers to maintain a program to identify, prioritize and address workplace hazards. *(See box on p. 137.)*

Yet safety advocates have become discouraged about the prospects of new regulations from OSHA. The agency's proposed silica rule, which sets new permissible exposure limits for respirable crystalline silica in shipyards and construction sites, was held up for more than two years in a review by the Office of Management and Budget. OSHA has estimated that the silica rule will save almost 700 lives and prevent 1,600 cases of silicosis a year.

That leads **Aaron Trippler**, director of government affairs for the American Industrial Hygiene Association, to wonder: Is this really the best way of doing business? "I just worry about the future of OSHA as an independent agency," he says. "They don't have enough political power."

The anti-regulatory rhetoric is harsh in Congress and makes it difficult for the agency to move forward on more than one rule at a time, says Monforton.

"You hear so much disdain for OSHA overregulating," she says. "Those arguments are very contrived and they're not based in fact."

Training and outreach take a hit

When OSHA preserved its enforcement budget in the last sequester, that came at the cost of some other activities. The agency cut back on training, outreach and compliance assistance, but that cannot be sustained, says Schwellenbach.

"The training is of special concern because OSHA, like many federal agencies, is facing a wave of retirements among their more experienced staff," he says. "They need to recruit new people and train new people. They can't defer training forever."

States that run their own occupational safety and health programs also have taken a hit with fewer federal dollars. They lost about $28 million in the 2013 sequester and stand to lose another $9 million in a second sequester. President Obama requested an increase in OSHA's FY 2014 budget.

In an investigation that predated the budget cuts, the Government Accountability Office found that the 22 states that have programs that cover both public and private sector workplaces have trouble recruiting, training and retaining inspectors.[2]

Meanwhile, the federal portion of state-plan funding has decreased over the years, according to a 2012 report by the Occupational Safety and Health State Plan Association.[3]

"We have some state plans that have done some remarkable work," says **Mark Catlin**, health and safety director for the Service Employees Interna-

Injury prevention basics: Identify, control hazards

The U.S. Occupational Safety and Health Administration has issued a fact sheet that outlines the basics of an injury and illness prevention program. According to OSHA, the major elements of an effective program include:

Management Leadership

• Establish clear safety and health goals for the program and define the actions needed to achieve those goals.

• Designate one or more individuals with overall responsibility for implementing and maintaining the program.

• Provide sufficient resources to ensure effective program implementation.

Worker Participation

• Consult with workers in developing and implementing the program and involve them in updating and evaluating the program.

• Include workers in workplace inspections and incident investigations.

• Encourage workers to report concerns, such as hazards, injuries, illnesses and near misses.

• Protect the rights of workers who participate in the program.

Hazard Identification and Assessment

• Identify, assess and document workplace hazards by soliciting input from workers, inspecting the workplace and reviewing available information on hazards.

• Investigate injuries and illnesses to identify hazards that may have caused them.

• Inform workers of the hazards in the workplace.

Hazard Prevention and Control

• Establish and implement a plan to prioritize and control hazards identified in the workplace.

• Provide interim controls to protect workers from any hazards that cannot be controlled immediately.

• Verify that all control measures are implemented and are effective.

• Discuss the hazard control plan with affected workers.

Education and Training

• Provide education and training to workers in a language and vocabulary they can understand to ensure that they know:

– Procedures for reporting injuries, illnesses and safety and health concerns.

– How to recognize hazards.

– Ways to eliminate, control or reduce hazards.

– Elements of the program.

– How to participate in the program.

• Conduct refresher education and training programs periodically.

Program Evaluation and Improvement

• Conduct a periodic review of the program to determine if it has been implemented as designed and is making progress towards achieving its goals.

• Modify the program, as necessary, to correct deficiencies.

• Continuously look for ways to improve the program.

[*Editor's note: Information on Injury and Illness Prevention Programs is available at* www.osha.gov/dsg/topics/safetyhealth/.] ■

tional Union. "Those states now will be getting less money."

Hope in the states?

In fact, states have been the catalyst for greater regulation of occupational health and safety. For example, California's needlestick prevention law became a model in 1998, as it required employers to provide safety-engineered devices. Other states followed suit, and in 2000, the federal Needlestick Safety and Prevention Act became law.

Currently, 10 states have laws that promote or require safe patient handling, and nine states have laws related to workplace violence prevention. California's Aerosol Transmissible Diseases standard was cited as a model when OSHA announced it would consider drafting an infectious diseases standard.

"The infectious diseases standard would be a groundbreaking standard to protect health care workers," Catlin says. It is listed on OSHA's 2013 regulatory agenda in the "pre-rule" stage, but OSHA has not issued a draft.

As state and federal regulators become further constrained by budget cuts and political pressure, Catlin encourages union locals to push for protections in their collective bargaining agreements. For example, unions have gained contract language establishing workplace violence prevention programs in hospitals.

Trippler of AIHA says he hopes states will continue to take the lead in improving occupational safety and health. As for federal OSHA, he sees diminished impact.

"When you look at the future, I think we have a weakened agency," he says. "OSHA used to be recognized worldwide for occupational safety and health, and I don't think it is anymore."

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OSHA: Employers must step up to chem hazards

Hospitals face issues with anti-cancer drugs

Federal regulators have failed to adequately protect workers from chemical hazards, so employers need to step up and do it on their own.

That was a message that came from **David Michaels**, MD, MPH, himself, the administrator of the U.S. Occupational Safety and Health Administration. OSHA has launched a website to provide resources on eliminating and substituting hazardous chemicals and to find lower recommended exposure limits for hundreds of chemicals. For example, California has adopted lower permissible exposure limits (PELs).

"Our workplace exposure limits are dangerously out of date," Michaels said in a teleconference. "New scientific and industrial data and developments in technology clearly indicate that in many instances these mandatory limits are not protective enough."

Most of the chemicals with PEL limits are used in industrial settings. But information on substitution and lowering exposure levels is important in efforts to promote safer, greener cleaning chemicals in hospitals, says **Seema Wadhwa**, LEED AP, director of the Healthier Hospital Initiative, a sustainability effort based in Reston, VA.

Thirteen hospital systems are sponsoring the Healthier Hospital Initiative, and promoting greener cleaning chemicals as a part of six "challenges," which also includes efforts to use less energy, serve healthier food and produce less waste.

"Nurses have the highest rate of work-related asthma," says Wadhwa. "Environmental service workers – housekeepers – have the second-highest. It's clearly a highly exposed workforce."

Healthier Hospitals Initiative also provides a toolkit and success stories of hospitals that have switched to "greener" chemicals. About 800 hospitals have joined the initiative.

However, substitution, elimination and even lowering exposure levels will not be possible for hundreds of hazardous chemicals used in hospitals. Anti-neoplastic drugs are designed to be toxic and must be prescribed based on the needs of the patient, notes **Thomas H. Connor**, PhD, research biologist with the National Institute for Occupational Safety and Health's Division of Applied Research and Technology and an expert on hazardous drugs and occupational safety.

"They're prescribed based on their mechanism of

action, so you're not going to look to something else," he says.

Employee training and use of personal protection equipment are important to reduce exposures, he says. NIOSH will release an updated list of hazardous chemicals in early 2014.

[*Editor's note: The OSHA chemical hazard resources are available at* www.osha.gov/dsg/safer_chemicals/index.html and www.osha.gov/dsg/annotated-pels/index.html. *Information on the Healthier Hospitals Initiative is available at* http://healthierhospitals.org/.] ■

Hand-washing is answer to infection threat

CDC warns of a 'post-antibiotic' era

In the direst terms, the Centers for Disease Control and Prevention is warning the nation of the growth in antibiotic-resistant organisms. In its first-ever Threat Report, the agency listed the organisms that pose the most urgent risk to the nation's health. Two of the three, Clostridium difficile and carbapenem-resistant Enterobacteriaceae (CRE), are found primarily in hospitals.

"Without urgent action now, more patients will be thrust back to a time before we had effective drugs," said CDC director **Thomas Friedan**, MD, MPH. "We talk about a pre-antibiotic era and an antibiotic era. If we're not careful, we will soon be in a post-antibiotic era. And, in fact, for some patients and some microbes, we are already there."

Hand-washing is an important strategy for reducing hospital-acquired infections. So in this issue of HEH, we are providing two case studies of hospitals that have significantly improved hand hygiene through education, monitoring and feedback.

Employee health professionals can play an important role in raising awareness about the importance of hand hygiene when they have other interactions with employees, says **Amy Delp**, RN, MSN, administrator of the Center for Quality at MetroHealth Medical Center in Cleveland, OH.

"Reinforcing flu vaccination, good hand hygiene and cough etiquette emphasizes how important [precautions are] in keeping our workforce and our patients healthy," she says. "[Each encounter] is an opportunity to script a message" to reduce the risk of transmission.

Wash In, Wash Out

The message at MetroHealth is simple and ubiquitous: Wash in, Wash out. Wash when you enter a patient's room, wash when you leave. Every employee learned how and why they should use hand sanitizer or soap and water. "It was required education for every employee in the hospital," says Delp.

For two months, employees of all levels attended one of the dozens of 20-minute sessions held to explain the basics of hand hygiene. Delp and her colleagues created the educational module with free tools from The Joint Commission and the Centers for Disease Control and Prevention. One photograph showed the fluorescence of Glo Germ, illustrating that organisms may be present on high-touch surfaces, such as door knobs, bed rails, and even ATM keypads.

MetroHealth then launched an ongoing system of hand hygiene observers, usually specially trained part-time employees. On the units, "Just-In-Time Coaches" serve as champions of hand hygiene, reminding co-workers when they see any gaps in practice.

The "Wash In, Wash Out" program began in 2011, after the hospital detected an increase in multi-drug resistant acetinobacter. At the time, hand hygiene compliance was only about 50%. In the first month of the program, compliance rose to 89% and has since hovered between 92% and 98%.

The program and other infection control initiatives led to a significant reduction in common nosocomial infections, including central line-associated bloodstream infections in the ICU, ventilator-associated pneumonia , and catheter-associated urinary tract infections.

The hospital continues to promote hand hygiene awareness by recognizing units that achieve 100% compliance.

"It is rare for us to have a nosocomial drug-resistant organism," says Delp. "As soon as one pops up, we're monitoring it and investigating it. The program has been extremely successful."

Spread the word, not germs

Hand hygiene isn't a campaign. It's a part of safety culture, says **Bonnie Colaianne**, RN, MSN, CNL, CIC, corporate infection prevention coordinator at the University of Pittsburgh Medical Center system. The goal of a sustained program is to make hand hygiene as automatic as putting on a seat belt every time you get in a car, she says.

"Historically, hand hygiene campaigns have been a one-day event or a one-week event. We're sustaining this over three years," she says. "It takes a long time

to change culture."

UPMC began with a staff survey to learn how the staff perceived hand hygiene and what they thought would lead to improvements. The responses helped guide the program, says Colaianne. For example, some employees expressed concern about access to hand sanitizer, so UPMC added additional hand hygiene stations.

Each UPMC facility could shape its own initiatives, but they interact through a multi-disciplinary task force that includes administrators of various departments, such as housekeeping, dietary, and even volunteers. They initially held conference calls every week, then less frequently, to monitor progress.

While UPMC facilities tailor the program to their own needs, they all use "secret shoppers" – people who record hand hygiene observations on the units. Infection preventionists also monitor hand hygiene.

Meanwhile, the messaging is ubiquitous, on full-size elevator-door stickers, table tents in the cafeteria, digital message boards, posters: "Spread the word, not the germs – Clean your hands."

The sustained focus has paid off. UPMC's 13 acute care facilities saw an overall increase of 25% in hand hygiene compliance, and some facilities reached 100%.

Employee Health helps promote the message, particularly among new employees," Colaianne says. "They can be a key advocate and set an example," she says. ■

WHO Five Moments for Hand Hygiene

In its evidence-based program, the World Health Organization developed these five "moments" for health care workers to perform hand hygiene:

1. Before touching a patient. WHEN? Clean your hands before touching a patient when approaching him/her. WHY? To protect the patient against harmful germs carried on your hands.

2. Before clean/aseptic procedures. WHEN? Clean your hands immediately before performing a clean/aseptic procedure. WHY? To protect the patient against harmful germs, including the patient's own, from entering his/her body.

3. After body fluid exposure/risk. WHEN? Clean your hands immediately after an exposure risk to body

fluids (and after glove removal). WHY? To protect yourself and the health-care environment from

harmful patient germs.

4. After touching a patient. WHEN? Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side. WHY? To protect yourself and the health-care environment from harmful patient germs.

5. After touching patient surroundings. WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.

WHY? To protect yourself and the health-care environment from harmful patient germs.

[*Editor's note: Hand hygiene tools are available from the World Health Organization at* www.who.int/gpsc/5may/en/ *and from the Centers for Disease Control and Prevention at* www.cdc.gov/handhygiene. ■

Injury prevention takes some heavy lifting

You'll have to work to maintain SPH success

Your safe patient handling program won't run on autopilot. For two or three years, you may celebrate the reduction in injuries, but the musculoskeletal disorder injuries will climb once again without continuous monitoring, safe patient handling experts say.

"Like any other program, it requires constant energy input and constant attention to detail," says **Margaret Arnold**, PT, CEES, CSPHP, coordinator of rehabilitation services at McLaren Bay Region in Bay City, MI, and champion of the safe patient handling program there.

There are obvious maintenance issues – torn slings that need replacing and batteries that must be constantly recharged. But occupational health and safety professionals also should be tracking injuries and reporting about successes and ongoing challenges to hospital leadership, she says.

The patient population is always changing – most likely, patients are heavier and older – while the nursing workforce is aging, says **Anna Kay Steadman**, OTR, CHSP, president and founder of Essential Ergonomics, a consulting firm based in Austin, TX. Technology needs shift, and new devices may become available to resolve long-standing problems.

Safe patient handling needs a champion, but your program can't rely on just one person who pushes it forward, she says. "You don't want your program to be gone when a person leaves," Steadman says.

Repositioning a major source of injury

When Vanderbilt University Medical Center launched its safe patient handling program in 2006, the hospital saw a dramatic reduction in injuries. But then after a couple of years, the improvement stalled and patient handling injuries remained at a new plateau. They even began to rise slightly.

Vanderbilt needed to dig beyond the facts of a particular incident to learning why injuries continued to occur, says **Mamie Williams**, MPH, MSN, FNP-BC, director of safe patient handling for the Vanderbilt Occupational Health Clinic. The key question: Why do nurses revert to manual lifting when an array of equipment is available?

Williams surveyed more than 100 previously injured nurses and found some clues. Almost half of the nurses hadn't felt that safe patient handling equipment was needed to perform the task that ultimately led to their injury. That at least in part reflected a failing in following protocol; many nurses reported they had not conducted a patient assessment of mobility and safe patient handling, as required by hospital policy.

Accessibility of equipment was not an issue. The majority of injuries involved repositioning, and the hospital has 8,000 pairs of friction-reducing sheets. There is a variety of other equipment available, including ceiling lifts in high-risk units.

The problem is deeper, says Williams. "This is truly a change in thinking for nurses and other caregivers," she says. "We have to do the hard work of getting a cultural change so it does become second nature for folks."

With some focused re-training, Williams and her colleagues emphasized that every patient needs to be assessed for patient-handling. "It's just like a vital sign," she says. "This becomes maybe the seventh or eighth vital sign that you assess for a patient's needs."

The hospital also boosted the training and support of safe patient handling "champions" on the units, who help encourage and train other caregivers. In another effective strategy, injured nurses are speaking at staff meetings and raising awareness about the risks of patient handling.

"Education is not the only fix, but it is a starting point," says Williams. It has helped to have a systematic way to learn about the caregiver's perspective, she says. "You definitely have to assess those caregivers on what's working, what's not working and why is it not working," she says.

Continue to make the case for SPH

In a time of tight budgets, safe patient handling competes with other hospital priorities, and that can be a challenge. It's hard to demonstrate what hasn't happened – the injuries that were prevented and would have been costly, says Arnold. But it is important to continually make the case that safe patient handling saves money.

"One of the reasons we continue to be successful is because we track our data – every single incident, no matter how small, on an ongoing basis," Arnold says. "It keeps up the awareness. We're always looking for opportunities to celebrate when we've had a success story and hold people accountable when the program gets off track."

At McLaren Bay, an interdisciplinary committee meets monthly for a status check on safe patient handling. The committee includes Arnold, a nurse manager, the employee health manager, inpatient rehabilitation manager or coordinator and two frontline staff.

Arnold conducts a root cause analysis of every patient handling injury and near-miss, and the committee discusses problems that have been identified through that analysis or in facility rounds. Safe patient handling results also are shared with hospital leadership.

Every unit has one or two coaches, and those coaches meet quarterly for support and additional training. Safe patient handling is built into hospital policies, including manager responsibilities. For example, managers are expected to regularly check the battery-changing log to ensure that batteries are changed and re-charged during each shift. (That prevents the all-too-common problem of inoperable lifts.)

Equally important, Arnold makes sure to trumpet the continued success of the program. Before launching a comprehensive safe patient handling program in 2006, McLaren Bay had about 110 patient handling injuries a year. In the first eight months of 2013, there were only six such injuries, and only three of them were OSHA-recordable.

McLaren Bay calls its program Diligent, which is the name of the vendor they used but also illustrates the philosophy. At a Diligent celebration in the cafeteria lobby each year, Arnold displays the outcomes of the program. She asks for feedback from frontline staff, and everyone who responds is entered into a raffle for a prize.

Diligent also has a big cake to celebrate the anniversary of the program.

Link SPH to patient safety

Safe patient handling also gains relevance when it is connected with patient safety, Arnold says. She has

collaborated with teams seeking to reduce skin tears, pressure ulcers and patient falls.

"We use every opportunity that we can to raise awareness and integrate patient handling into other things we're doing," she says.

The Joint Commission and Centers for Medicare & Medicaid Services (CMS) are increasingly recognizing the connection between safe patient handling and patient safety, says Steadman. It is a part of the Environment of Care. "They're starting to ask the questions – 'Where is your safe patient handling program?'" she says.

The program needs constant updating, she says. "Unless you have a persistent, tenacious character about you, things can easily be lost along the way," she says.

Even after seven years of safe patient handling, there's more work to do, says Arnold. "The true success is when the use of equipment is just a part of what you do in everyday activity. It's not a separate program," she says. "We're not quite there yet." ■

Building a safety culture takes teamwork

TeamSTEPPS trains HCWs nationwide

Dig down to the root cause of medical error and you'll often find a lack of communication. Fixing that problem requires more than a checklist. It calls for a shift to a greater sense of teamwork.

That is the concept behind TeamSTEPPS, a program designed to build a culture of safety. While is it geared toward improving patient safety, it also boosts the work environment and employee satisfaction, says **Karyn Baum**, MD, MSEd, associate chair for clinical improvement at the University of Minnesota Department of Medicine in Minneapolis.

"This isn't something that is an overnight fix, but it can really be transformative for an organization and for the people who work there," says Baum, a hospitalist who directs one of six training centers for Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS).

Pilots in a cockpit have a systematic way of sharing duties and repeating back information, and they rely on clear communication to prevent accidents. The U.S. Military Healthcare System sought to emulate that model as it designed a teamwork curriculum in 2001 to reduce medical errors in a high-stress environment.

In 2003, the Department of Defense teamed up with the federal Agency for Healthcare Research and Quality to refine the program and make the curriculum widely available. Today, it is gaining traction in hospitals; about 25% of hospitals now use TeamSTEPPS, estimates **James B. Battles**, PhD, social science analyst with AHRQ in Rockville, MD.

"Poor teamwork is the largest contributing factor to adverse events, bar none," says Battles, who coordinates TeamSTEPPS at AHRQ. "In virtually every incident, if you strip back the contributing factors, you'll find poor communication and teamwork."

In fact, improving staff communication is one of the Joint Commission's National Patient Safety Goals for 2013.

Train the trainers

Every year, AHRQ trains about 700 "master trainers," who go back to their hospitals to train their coworkers. Battles suggests hospitals send a physician and a nurse or other clinician who is not a physician.

They may come from a unit that is struggling to work together. For example, hospitals have used Team STEPPS to improve patient handoffs, teamwork in the OR, and conflict resolution. "TeamSTEPPS is a tool amongst all the other tools in our quality improvement and patient safety arsenal," says Baum.

A study of 24 hospitals that adopted TeamSTEPPS and 13 control hospitals found that implementation of the tools led to higher scores on a measure of safety culture. The more fully they followed the program, including monitoring the implementation, the greater the boost in safety culture scores.[1]

TeamSTEPPS starts with some self-inspection, both in terms of the problems that will be addressed and the hospital's readiness for change. Hospital leadership must be completely supportive, Baum says.

"It is about changing your culture," she says. "The leadership needs to be behind that. They're the ones who set the vision and the priorities."

One core aspect of TeamSTEPPS is briefings, which typically occur at the beginning and end of each shift. They are daily "huddles," and those huddles may occur as needed during the day, as well.

"'What are the issues we all need to be aware of and what's the game plan today?' It literally is a huddle," says Baum. "It could last as little as a minute or as long as 15 or 20 minutes."

There may be different configurations of teams, and they all need to have strong and clear communication. A group of caregivers – including the physician, nurse, nurses' aide, and other professional staff – may gather to discuss the care of a particular patient. An OR team would huddle before and after a procedure. A unit

huddle may be interdisciplinary – for example, including environmental services workers who need to be aware of any special disinfecting issues.

In fact, Battles encourages interdisciplinary rounding, instead of having physicians and nurses making separate rounds. "We had to break some old habits," he says.

Battles compares the model to a football game in which the coach briefs the players before they go on the field, but the players also huddle before they start a play.

There may be many analogies, but they share one commonality: teamwork works. "We know that it improves the care of the patient," says Battles. "The work environment in which people practice is also drastically improved."

[Editor's note: More information about TeamSTEPPS is available at http://teamstepps.ahrq.gov/.*]* ■

Follow the numbers to reduce injuries

Duke surveillance combines data sources

Do you know where your injuries are occurring? If you are just counting the incidents on your OSHA log, you may be missing some important information. Adding workers' compensation information and even health risk appraisals to your surveillance can help you identify safety concerns.

The Duke Health and Safety Surveillance System, created in 2001 to monitor health care workers in the Duke University Health System in Durham, NC, has identified groups of employees at the greatest risk of injury, says **John Dement**, PhD, CIH, a professor of occupational and environmental medicine at the university.

"We've used the workers comp data and other data sources to address a number of issues," he says.

"Data systems [often] collect information about events that happen but never put in it context," he says. "We've been able to look at rates by work location and job. It just gives you a richer set of information to define the problem and hopefully to design interventions to improve the situation."

For example, by linking workers' compensation and human resources information and examining the data over a seven-year period, Dement and his colleagues were able to determine the employees at highest risk of musculoskeletal injuries: nurses' aides, housekeepers and dietary staff. They also found smaller groups of employees with a higher-than-expected rate of injury: morgue technicians, patient transporters and skilled craft workers (maintenance workers).

Without the ability to dig deeper into the numbers, some of the high-risk occupations with fewer employees would not be identified, he says.

The system also can correlate personal health risk factors and workplace risks. For example, Duke is looking at the overall health burden of obesity, as it targets obesity in health promotion programs. Eventually, the surveillance system will reveal whether the health promotion was a successful intervention, Dement says. ■

CNE INSTRUCTIONS

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

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

CNE OBJECTIVES

After reading each issue of Hospital Employee Health, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
- cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.

CNE QUESTIONS

1. The U.S. Occupational Safety and Health Administration was able to maintain enforcement during the 2013 budget sequester because:
   A. the agency was exempt from cuts.
   B. more citations were issued per inspector.
   C. the agency shifted resources away from compliance.
   D. compliance made less enforcement necessary.

2. As of January 1, 2014, OSHA is requiring all federal agencies to submit their injury and illness data to the Bureau of Labor Statistics every year. Some safety experts say this is significant because:
   A. OSHA may eventually require routine reporting from private employers.
   B. the public sector has a higher rate of injury than the private sector.
   C. it's the first change in reporting rules in many years.
   D. it will lead to a shift enforcement priorities.

3. In the "Wash In, Wash Out" program at MetroHealth Medical Center in Cleveland, OH, which of the following has been a successful strategy for improving hand hygiene?
   A. fines for failing to comply.
   B. video monitors and disciplinary actions.
   C. education of all employees and frequent observations.
   D. patient-focused education.

4. At Vanderbilt University Medical Center in Nashville, TN, a survey of injured nurses revealed what issue in the patient handling program?
   A. lifts were not accessible.
   B. batteries had not been recharged.
   C. nurses were not using lifts with obese patients.
   D. nurses were not always conducting patient handling assessments, as required.

COMING IN FUTURE MONTHS

- Occ health benchmarks: How far are we from the goals?
- Addressing obesity in health care workers
- Trends in hospital workers' compensation
- States consider laws on violence prevention in hospitals
- Why onsite clinical care for employees makes sense