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NIOSH: Health care workers lack training, awareness of chemical risks

Survey shows big gaps for surgical smoke, antibiotics

Health care workers exposed to hazardous chemicals in the workplace often lack training or awareness of safety measures, according to the largest-ever federally sponsored survey on health and safety practices in health care.¹

Gaps were found for all types of chemical hazards, as many respondents reported that their safety training occurred more than a year before. About 11,000 health care workers completed a web-based survey with modules addressing various chemical exposures in the study conducted by the National Institute for Occupational Safety and Health (NIOSH).

About half (48%) of health care workers who administer aerosolized antibiotics said they never received safety training. Employee health professionals should be aware that secondary exposure to some aerosolized antimicrobial drugs may lead to adverse effects in health care workers. For example, inhalation of certain aerosolized antibiotics (e.g., pentamidine and colistin) can lead to decreased pulmonary function and acute respiratory symptoms in exposed health care workers.²

Only one-third (32%) of workers exposed to surgical smoke said their employers had safety procedures in place.

Even some HCWs who compound antineoplastic agents in a health care pharmacy — a high-risk activity — reported a lack of awareness of safety. “One in 10 workers didn’t know if [their employer] had procedures for minimizing exposure to the chemicals,” says Andrea Steege, PhD, MPH, a study co-author and epidemiologist with NIOSH’s Division of Surveillance, Hazard Evaluations and Field Studies.

Steege notes that the surveys were sent to members of 21 professional organizations — which provide information and resources on safe work practices.

“This is probably the best case scenario for what is out there,” she says of the awareness of chemical hazards. “It’s important to make sure everybody has training, knows what they’re exposed to and knows how to avoid that exposure — or to minimize it to the highest extent possible.”



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The findings may spur more action to improve awareness of hazardous chemicals in health care. NIOSH will release a new list of hazardous drugs this summer, with separate information for antineoplastic (chemotherapy) agents and other hazards, says **Thomas H. Connor**, PhD, research biologist with the NIOSH's Division of Applied Research and Technology and an expert on hazardous drugs and occupational safety.

"We've gotten feedback from the end users that they needed more guidance, so we've tried to accommodate with these updates and changes," he says.

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NIOSH also is updating its alert on hazardous drugs, he says.

The survey found a high level of awareness about antineoplastic agents. Some 94% of health care workers who administer the drugs said they were aware of their employer's safety procedures for minimizing exposures.

Compounding drugs without training?

But one-third of those administering antineoplastic drugs and 42% of those compounding them had not been trained in the past year, the survey found.

"We recommend that people get training at least every year," says Connor, who notes that new drugs and technologies are constantly emerging.

In contrast, only 25% of health care workers exposed to surgical smoke reported receiving training in the past year to reduce exposure. The Association of periOperative Registered Nurses (AORN) has worked for years to raise awareness of the hazards of surgical smoke and offers a free toolkit that includes an educational PowerPoint presentation (www.aorn.org/Clinical_Practice/ToolKits/Tool_Kits.aspx).

New technology may bring more protections, says **Mary Ogg**, MSN, RN, CNOR, a perioperative nursing specialist at AORN in Denver. Newer smoke evacuators are much quieter, and some are even incorporated in the surgical booms popular in minimally invasive surgery, she says.

Meanwhile, hospitals should be aware that the Hazard Communications Standard of the Occupational Safety and Health Administration requires training of workers who are exposed to hazardous chemicals, Ogg says.

And employee health professionals should be alert to symptoms of smoke exposure, she says. "The effects of surgical smoke are cumulative. If you have an employee with chronic headaches or asthma coming from the operating room, that might be an indication that they're exposed to something in the OR," she says.

More research needed

Chemical risks and safety solutions are constantly evolving, and that may have been reflected in some of the responses to the NIOSH survey.

For example, little is known about the long-term effects of aerosolized antibiotics that are present when a patient exhales after using a nebulizer, says **Shawna Strickland**, PhD, RRT-NPS, FAARC, associate executive director of education for the American Association for Respiratory Care in Irving, TX.

“We’re seeing a higher use of aerosolized antibiotics because they’re so much more effective for lung diseases,” but the risk differs depending on the mechanism of delivery, she says. With breath actuated nebulizers, few particles are released when the patient exhales, she says.

More research is needed on the hazards of aerosolized antibiotics and how to minimize them, she adds.

Waste anesthetic gases are typically well-controlled in the operating room. But health care workers outside the operating room may need more training and protections, says Ogg. “In the recovery room and PACU, those nurses are being exposed to waste anesthetic gases [exhaled by patients], but there aren’t any scavenger systems in that area,” she says.

NIOSH issued an informational document on waste anesthetic gases in 2007 (www.cdc.gov/niosh/docs/2007-151/pdfs/2007-151.pdf).

Any employees who are working with hazardous chemicals, even on an occasional basis, should be aware of safety issues, Steege says.

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Top OSHA hospital citation: Bloodborne pathogens

Inspections still less than other industries

Thirteen years after the Needlestick Safety and Prevention Act required health care employers to use safer sharps devices, hospitals were more frequently cited for violations of the Bloodborne Pathogens Standard than any other occupational health and safety regulation.

Yet even as the Occupational Safety and Health Administration placed greater emphasis on enforcement nationally, inspections remain a rarity at hospitals, according to a data review by *HEH*. About 4% of hospitals had an OSHA inspection that resulted in a citation in Fiscal Year 2013. Hospitals received only .2% of all federal OSHA citations and .7% of

all state OSHA citations. About one in eight American workers are in the health care industry, including about 4.8 million in hospitals.

Several of the top 10 most cited standards for hospitals were industrial, involving issues such as electrical safety. The “general duty” clause, which requires employers to provide a workplace free of serious hazards, was cited only five times. None of those involved musculoskeletal disorders from patient handling, the single greatest hazard in health care, according to injury statistics. (*See related story, p. 64.*)

Without a standard, it is much more difficult for inspectors to cite employers, even when there is a known hazard, OSHA officials said in an emailed response to *HEH*. “OSHA issues fewer General Duty Clause citations because they require that the agency meet a higher burden of proof than when citing standards for specific hazards,” they said.

Instead, OSHA has focused on raising awareness of hazards in health care, while using emphasis programs to target specific issues. Currently, OSHA has a National Emphasis Program for nursing homes. In Fiscal Year 2013, 150 nursing homes were issued fines of more than \$410,000 for alleged violations of the Bloodborne Pathogen Standard. Overall, health care employers were fined more than \$1 million for Bloodborne Pathogen violations.

Hospitals could find themselves facing tougher inspections, as well, says Tressi Cordaro, JD, an occupational safety and health attorney with Jackson Lewis in Washington, DC. The Obama administration has placed a greater emphasis on enforcement than compliance assistance, she says.

OSHA has issued more citations with higher penalty amounts — and it is easier for employees to file complaints, she says. “Employees are much more aware of their ability to file anonymous complaints,” she says.

BBP cited in one-third of inspections

Bloodborne pathogen compliance is a continuing focus for OSHA. In 2014, Missouri began randomly selecting hospitals for inspection in a local emphasis program on bloodborne pathogens.

The Kansas City region is seeking to increase health inspections, those that address hazards that cause illness, says Dee Cantu, assistant regional administrator for enforcement programs in OSHA’s Region 7.

“Our hope and our goal is that all employers who are covered by the [local emphasis program] will take the necessary steps to get out ahead of OSHA and protect their employees,” she says.

OSHA citations: A duty to address serious hazards

The Occupational Safety and Health Administration issued five “general duty” clause citations against hospitals in Fiscal Year 2013, based on a provision of the Occupational Safety and Health Act that requires employers to provide a workplace “free from recognized hazards that are causing or are likely to cause death or serious physical harm.”

1. Nationwide Children’s Hospital, Columbus, OH. A fence around a construction project blocked about 200 feet of sidewalk, and there were no signs directing pedestrians to the sidewalk on the opposite side of the street. Employees were exposed to the risk of being struck by traffic while walking in the street around the construction zone.

2. St. Mary’s Good Samaritan, Mount Vernon, IL. Employees were operating lift gates behind box trucks that were not secured by parking brakes, wheel chocks or other methods. They were exposed to the hazard of being caught in-between or crushed by the trucks.

3. Armstrong County Memorial Hospital, Kittanning, PA. OSHA cited the employer for exposing employees in the behavioral health unit to the hazard of workplace assault. The inspection was triggered by a complaint. The hospital contested the citation and said in a statement that it already has put measures in place to reduce the risk of workplace violence.

4. Emerson Hospital, Concord, MA. Two employees “were exposed to the hazard of falling while using a step ladder in a closed position.”

5. New York Presbyterian Hospital, New York, NY. Wipe samples indicated that work surfaces at a data entry station next to a biological safety cabinet were contaminated with Ifosfamide, an anti-neoplastic drug. The hazard of dermal contact “may lead to the development of cancer, impaired fertility, and organ damage,” OSHA said. ■

About one-third of all hospital inspections by federal OSHA resulted in bloodborne pathogen citations in Fiscal Year 2013. The most common problems: Failure to update the exposure control plan each year, including a review of new devices or procedures, and

failure to include frontline workers in the evaluation of devices or update of the plan.

The operating room is an area of concern, as surgeons remain reluctant to use blunt suture needles and safety scalpels. The third most commonly cited portion of the Bloodborne Pathogen standard involves the failure to use engineering controls “to eliminate or minimize employee exposure.”

Some sharps devices still are not available with safety features, and the development of new sharps safety technology has slowed, says **Raylene Ballard, MS, MT(ASCP)** senior project officer at ECRI, a non-profit health care research and information organization based in Plymouth Meeting, PA.

“At least annually, you need to review devices that have the potential for a sharps injury and see if there’s anything currently available [to prevent injury],” she says. “If there’s nothing currently available, you need to [document the review].”

Don’t forget about non-clinical hazards

OSHA does not have the authority to scrutinize other, non-bloodborne infectious disease risks — and it has no standard related to many hazards that are unique to health care. But hospitals must still comply with safety regulations that include hazard communications (safety information related to hazardous chemicals), recordkeeping and the control of hazards related to servicing equipment.

“Employers should be aware that patient care areas are not the only places within hospitals where safety and health hazards may exist,” OSHA officials said. “OSHA encourages hospital employers to take a broad view when looking at safety and health issues to ensure that they are assessing hazards in each and every department of the facility. Areas such as machine shops, pharmacies, waste disposal operations, central supply departments and housekeeping are among those that should be included in the overall assessment of safety hazards.”

Meanwhile, OSHA continues to pursue new standards that would impact health care. In January 2014, OSHA stated that an infectious disease standard that would cover pathogens “transmitted through a variety of transmission routes” is in the pre-rule stage.

“OSHA is concerned about the ability of employees to continue to provide health care and other critical services without unreasonably jeopardizing their health. OSHA is considering the need for a standard to ensure that employers establish a comprehensive infection control program and control measures to protect employees from infectious disease exposures to pathogens that can cause significant disease,” the

agency said in the semi-annual regulatory agenda.

OSHA also plans to issue a proposed Injury and Illness Prevention Program rule by this fall, according to the agenda. That rule would require employers to assess the workplace for hazards and have a program to reduce the hazards.

To become more effective, the agency needs more legislative authority and financial resources, asserts **Keith Wrightson**, worker safety and health advocate with Public Citizen, an advocacy organization in Washington, DC. Wrightson co-authored a report last year called “Health Care Workers Unprotected,” which said that “OSHA has devoted relatively little effort to addressing the safety risks at health care.” (For more information, see HEH, September 2013, p. 97.)

A bill that would strengthen OSHA and raise its maximum penalties, called the Protecting America’s Workers Act, has been introduced in each session of Congress since 2007 but has withered on the vine.

With limited resources, OSHA focuses largely on industries that have a greater potential for worker fatalities, says Wrightson. But other high-hazard workplaces, such as health care, should receive attention as well, he says.

“I understand [the focus on fatalities], but it’s equally important to give people good conditions so they can go to work and come home and care for their families,” he says. “In 20 years, if these folks can’t go to work, that spells disaster for our health care system.” ■

Despite safety gains, sharps discarded improperly

Survey’s findings ‘disturbing’

Sharps safety is widespread in U.S. hospitals, thanks in large part to the Needlestick Safety and Prevention Act in 2001. However, a recent study shows a persistent hazard: A high proportion of sharps are being discarded unsafely.¹

“It is disturbing that 39.9% of conventional needles were capped prior to discard, and 42.5% of all devices were discarded as a “naked” sharp,” the researchers concluded. “It is worrisome that 12 years after [the Needlestick Act], 64.3% of healthcare professionals placed themselves at risk by recapping or discarding naked needles.

The findings were revealed in a study of five health care facilities in central Florida, investigators audited sharps container contents.

“That 40% of all discarded sharps were naked is both surprising and disturbing, but it does need the caveat that it is a sampling from one region and from one state, and it is devoid of the clinical reasons why SED may not have been used,” says **Terry Grimmond**, FASM, BAgrSc, a consultant microbiologist and the study’s author, based in Hamilton, New Zealand.

“I haven’t met a hospital occupational health manager who did not have sharps injury reduction high on their agenda,” Grimmond says. “All are passionate in their endeavors to reduce sharps injuries. It is, however, a constant battle.”

The Association of Occupational Health Professionals in Health Care (AOHP) conducted a survey of members in 125 hospitals across the country and found little change in the number of needlesticks despite initial progress after the adoption of the needlestick safety law in 2001. (See HEH, February 2014, p.13.)

At an AOHP national meeting in September 2013, around 200 occupational health managers said more than 80% of needles at their facilities were safety engineered devices, which raises questions about the Florida survey, he says.

“It may be true that more than 80% of needlestick procedures have a safety engineered device available, but the survey indicates not all are being used, and some are used incorrectly,” Grimmond says. “Currently, I would think industry has developed safety engineered devices for more than 90% of sharps procedures.”

Hospitals should reinforce sharps safety through education and especially focus on interns and staff during periods of stress and heavy workloads. Some hospitals are moving away from the practice of “See one, do one, teach one,” in terms with safety devices, he says.

Instead, they will follow a training model that relies on helping staff practice until they can do it without risk. Then there is annual follow-up to see if there are any issues or need for additional practice and training, he adds.

“Education is vital and competency-based and repetitive education is very effective,” Grimmond says. “However, the literature is clear that stressed and/or overworked staff is at greater risk of sharps injury.”

“‘Overworked’ doesn’t just apply to the sharps users and handlers, it also applies to the occupational health department,” Grimmond notes. “Many are under-resourced to apply all the strategies they know work.”

U.S. hospitals may make needle safety devices

available for all procedures for which there are available commercial products, but clinical situations and provider preferences may trump safety in certain procedures. For instance, some surgical staff members are not comfortable using blunt suture needles for closures, despite strong evidence that using these can cut sharps injuries by half, Grimmond says.

Hospitals are prohibited by OSHA from rejecting safety devices solely on cost, but cost does appear to remain a factor, he adds.

“I know cost is still a factor in needle safety adoption or at least in the selection of perhaps a superior, more expensive [devices],” Grimmond says.

Hospitals that have the best possible practice in sharps safety go beyond mere OSHA compliance, he notes.

Best possible practices include moving from active needle safety devices to passive or semi-passive devices in specific procedures. Others include investigating every sharps injury immediately after it occurs and quickly determining the reason for the injury, Grimmond says.

“Other strategies are mandatory post-sharps injury re-education, a mandatory two-year review of a staff member’s competency, mandatory electronic education, and involving the injured person’s manager in the investigation,” he says.

It’s also important to provide transparency with sharps injury incidence via overt hospital-wide publication of the hospital’s record and to publicly praise departments for having zero sharps injuries for a month, quarter, and year, he adds.

“Other studies I have conducted confirm that sharps container-related [needlesticks] account for 5% — 10% in the U.S., and I am researching how we may improve sharps container design so as to eliminate containers as a source of [sharps injuries],” he says.

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Employee health benefits of electronic health records

More power to understand effective interventions

Increasing numbers of hospital employee health departments will move to electronic health

records (EHRs) in coming years as health systems see the need for “big data” to better inform population health decisions.

Occupational health use of EHR is the wave of the future, says **Madeleine Kerr**, PhD, RN, an associate professor at the University of Minnesota.

Arguments for switching to an EHR address how electronic files give hospital employee health departments the information model they need to holistically tackle population health issues.

“Once we have this big data — de-identified data from our individual health records — we’ll have so much more power to understand what is effective from interventions and which high risk groups we may be missing,” Kerr says.

Switching to EHR can reap benefits from a workflow perspective. For some, the benefits of having detailed information and real time trends at their fingertips outweigh some of the implementation, privacy, and staff buy-in issues.

“It’s wonderful,” says **Joanna Krasinski**, MSN, ANP-BC, COHN-S, director of occupational health services at Brigham and Women’s Hospital in Boston, MA.

Before Brigham and Women’s Hospital implemented the electronic health record for occupational health in the fall of 2013, everything was on paper, Krasinski says.

“For our clinic in a very large organization, our paper records needed to be kept off site, and we’d have records picked up and dropped off twice a day,” she says. “That burden of going back and forth and all of the storage is gone, and from that perspective it’s been a tremendous improvement.”

It’s also a big time-saver: when Krasinski needs to prepare for a Worker’s Compensation meeting, she can review a chart instantly with the electronic files.

The goal is to create an integrated record that captures the patient’s and service provider’s perspective, so that everybody can see the employee health needs, plan of care, and meaningful progress towards outcomes, says **Karen A. Monsen**, PhD, RN, FAAN, co-director of the Center for Nursing Informatics at the University of Minnesota in Minneapolis, MN.

The main reason to use EHRs is to access more detailed data and the possibility of creating decision support systems to easily and quickly identify populations at risk from any particular hazard, Kerr says.

“The reason behind decision support systems is to have built-in prompts for care providers and employees,” Kerr says. “There can be health mes-

sages to promote life style changes and to get new screening tests done.”

For example, an organization with wellness programs can track employees’ blood pressure and cholesterol levels on a population basis, while each individual worker could track his or her own progress on reaching health goals, Krasinski says.

“We will see from the information whether we need to do individual health counseling or implement new exercise programs,” she says. “I think this would be exciting for any facility.”

Data usefulness is dependent on how the system is created, Kerr notes.

Privacy, HIPAA concerns

The key is to use standardized, common language that is embedded in these electronic systems, Kerr adds. Chief concerns about implementing EHR for occupational health center around privacy and confidentiality. Health care worker list services recently have featured debates about electronic collection of employee health data. Critics point to the HIPAA Privacy Rule and the possibility of employees’ private information being breached by health care workers who are not involved in the worker’s medical treatment.

While breaches can occur, proponents of electronic records say standard security and confidentiality measures should provide adequate protection. For instance, the EHR at Brigham and Women’s Hospital is a closed system with a firewall that prevents unauthorized staff from accessing information, Krasinski says.

In addition, the occupational health department’s electronic medical record is a stand-alone system that is not interfaced with the hospital’s patient electronic medical record, Krasinski explains.

“The system is tested and monitored, and there have not been any breaches,” she says. “Through auditing and policies, you can make sure employees know they are not allowed to look through anybody’s medical records, including records for celebrities. I would reassure people that this is how the system is protected and how we make sure the right people are using it.”

Once employees are reassured of the system’s privacy, staff buy-in is more easily achieved. From Krasinski’s perspective, the initial organizational buy-in was the bigger challenge.

“It was a many-year endeavor,” she says. “We presented [to leadership] that having a completely paper medical record would not allow us to meet

standards, and we built our case around the efficiencies that would be gained,” Krasinski says.

“Having an electronic record helps with compliance: before we had a system that tracked blood borne pathogens exposure and another system with Workers Compensation cases, so you were constantly working in different systems.”

“The beauty of an EHR is it becomes a single system,” she adds.

It’s also useful from an individual employee’s perspective. The system has a patient portal where each employee can look up his or her own personal information and schedule appointments, she adds.

Although the employee health EHR is separate from the health system’s EHR, there should be interoperability between various electronic health systems, Krasinski says.

“A patient should be able to take that data and let it be read and used by another system,” she explains.

“Let’s say I’m getting medical care at Brigham, but I am seeing a specialist who is 10 states away, they’ll give me my medical record electronically so I can take it to that new specialist,” she says. “We built our system to be interoperable because the information is important and if the system is interoperable, then the information can be shared in a way that’s meaningful and helpful to the provider giving the care.”

Interoperability contributes to the goal of better informing treatment and screening, Monsen notes.

“We need to work towards a coordinated approach that has an information model supporting it,” she says. “Right now we have a lot of siloes, and we don’t see each other’s notes, and we don’t have a place where it all comes together.”

Ideally, there would be a patient-centered health record where the whole team can come together, she adds. ■

OSHA bulletin clarifies hospital responsibilities for temp workers

Hospitals, temp agencies share responsibility

Hospitals that hire temporary workers share responsibility for their safety with the temporary staffing agency, according to a recent bulletin

by the Occupational Safety & Health Agency (OSHA).

OSHA launched its Temporary Worker Initiative in April 2013 to address the growing numbers of temporary workers nationwide. It does not involve any new regulations, but emphasizes the joint responsibility shared by temporary staffing agencies and host employers, says **Tressi Cordaro, JD**, an occupational safety and health attorney with Jackson Lewis in Washington, DC.

“If you’re supervising on a day-to-day basis, you have always been required to record an injury or illness of a temporary worker,” she says.

Safety training should be addressed in the contract between the temp agency and the employer, she says.

But even if the temp agency provides training, the host employer still has a responsibility to ensure that the temporary worker knows how to safely use devices and equipment, the location of chemical safety data sheets, and what to do if an injury occurs, she says.

OSHA’s new guidance calls the temporary firm and its client joint employers of temporary workers. Both bear responsibility for safety and health protections, but in most cases the host employer should record the injuries and illnesses of temporary workers on the OSHA 300 log, says the March 2014 bulletin on “Injury and Illness Recordkeeping Requirements,” published online at https://www.osha.gov/temp_workers/OSHA_TWI_Bulletin.pdf. The bulletin is the first in a series of guidance documents issued under OSHA’s Temporary Worker Initiative.

Host employers are responsible for this recordkeeping if they supervise temporary workers on a day-to-day basis and when they control conditions that present hazards, the guidance says.

OSHA is taking a closer look at the balance of responsibility for temporary workers to ensure proper safety training is in place, says **Stephen A. Burt**, president of Healthcare Compliance Resources in Roanoke, VA.

“This recordkeeping [requirement] helps make hospitals responsible for all employees,” Burt explains. “If you are responsible for creating a hazard, then you are responsible for seeing that anybody on the site is trained and has hazard awareness.”

Staffing agencies typically are not able to provide adequate training, so this should be handled by the hospital, Burt notes.

It’s also the hospital’s responsibility to pro-

vide personal protective equipment to temporary workers, he says.

“If a temporary employee is injured at the hospital, the injury is reported on the hospital’s OSHA 300 log, not on the temporary agency’s log, Burt adds.

Host employers should communicate all information about injuries and illnesses with the staffing agency and establish notification procedures, OSHA states.

The OSHA bulletin does not address workers compensation claims and who pays for the injured employee’s treatment.

“The important part is determining who is responsible regarding worker’s compensation costs,” says **Dee Tyler, RN, COHN-S, FAOHN**, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP).

Hospitals and staffing agencies need to address how injuries are handled in their contracts, and they need a plan for action in the event of a temporary worker’s injury on the job, Tyler says.

From the hospital’s perspective, follow-up of temporary workers post-injury is complicated, she notes.

“We often have challenges getting our own employees back for follow-up, so it’ll be a challenge for the occupational health professional,” Tyler says.

Hospitals should at least notify the injured temporary worker and provide follow-up appointment information.

From the hospital’s perspective, the OSHA guidance offers a little clarity on an issue that they have dealt with for years. With both temporary workers and hospital volunteers, safety is an issue that needs to be addressed, Tyler says.

“A lot of health care facilities deal with this on an individual policy basis,” she explains. “Some offer volunteers and agency workers a significant amount of health care screening, such as the flu vaccine if they offer it to their employees.”

Other hospitals might refer temporary workers to the contracting agency or their personal physicians.

“OSHA’s bulletin makes it a little bit clearer for us about who would be responsible,” Tyler says. “It reminds us to clearly make sure we spell out who is responsible — whether it is with training or education or a workplace injury. It needs to be addressed in a contract so when an agency staff person is injured, people know how to respond and what is expected of them.” ■

Finding right staffing levels a challenge in employee health

Not too many years ago, the primary mission of employee health departments was to handle work-related injuries and job-related medical surveillance. Now the mission has expanded at many facilities to focus on overall health and well-being of the entire population of employees.

“The pendulum has swung 180 degrees,” says **Nicole Shaffer**, DNP, CRNP-BC, COHN-S, FAAOHN, director of occupational health and wellness at Pfizer in Lititz, PA.

The holistic focus to employee health also raises questions regarding whether a department should provide episodic care, ergonomics support, or safety education, Shaffer says. Another staffing factor is determined by the type of population the health system is serving, Shaffer notes.

“We look at the demographics,” she explains. “If the health care setting is in a lower-income area, then perhaps some of your staff doesn’t have access to the level of health care of a large research facility.”

In that situation, employees might need the onsite clinic for episodic care, handling things like a sore throat, Shaffer says. When assessing the resource and staffing needs of an onsite employee health clinic, a health system should collect data and look at various models, searching for a good fit with its mission and population.

Shaffer offers these suggestions:

Find out your hospital’s top five diagnoses: “Pull in the benefits group to find out what are your insurance incidence rates and the top five diagnoses of employees who use health insurance,” she says. “These could include cardiovascular, depression/mental health, musculoskeletal, and others.”

Also, check the workers compensation top diagnoses because this gives an indication of how complex the population is, Shaffer says.

For example, in manufacturing there might be medical surveillance due to exposure or material-handling injuries, and the staffing need might be higher. In an office environment, there might be only a couple of slip-and-fall injuries reported each year or some ergonomic problems, so the focus would be on wellness and could be handled with a lower staffing level, she says.

“In hospital care, we have patient handling and a

lot of musculoskeletal type of injuries from moving patients,” she says. “Also, there are biological exposures from needle sticks and body fluid exposure.”

Determine the type of care that is needed: While most hospitals have a separate occupational health clinic or service, some use an external service, Shaffer says.

“Most try to manage cases through case management, initial treatments, new hire exams, and blood exposure follow-up,” she says.

Research hospitals have more complex organizational models, she adds.

While the American Association of Occupational Health Nurses (AAOHN) created a model decades ago that called for one RN for every 300 employees in the health care setting, today it’s clear that level of staffing is not adequate, Shaffer says.

“That was a blanket statement, and now we’re looking at all other complexities and saying, ‘Is this site a simple site environment, or is it medium intensity, or a complex site?’” she explains.

Questions to ask to determine intensity level include:

How many injuries were there in the last year?

How many injuries required suturing, medical restrictions, prescription medications, and were OSHA reportable?

What does the occupational health clinic do? For instance, does it provide ongoing case management?

Will the clinic provide episodic care and not focus entirely on work-related health issues?

Preventive care, practice support

Other defining issues include preventive care and advanced practice support. Clinics could handle medical surveillance, pre-placement exams, as well as vaccination programs, health fairs, and health system-wide education.

“You can’t operate purely on an RN model,” Shaffer says. “You also need advanced practice support, whether it’s a few physician hours or a part-time nurse practitioner or physician’s assistant.”

Mid-level providers can do some of the roles that traditionally were done by RNs. Using an advanced practice model can provide better coverage and availability, she adds.

Make a case for providing ongoing case management and internal services, she recommends. Hospital health clinics traditionally have not done a great job at making sure they have a seat at the health system’s leadership table and educating leaders about the value they bring to the organization, Shaffer says.

“Their value includes decreased loss of productivity and understanding safety metrics,” she adds. “They need to talk strategic instead of tactical paths.”

There are some huge advantages to having an employee health clinic provide the ongoing case management and follow-up care, Shaffer notes.

For example, if an employee has injured his or her back on the job and sees a third party provider, a probable outcome is the clinician will tell them to stay off work for three weeks.

“A lot of studies show that the faster you can get someone back to work and meaningfully engaged in the workplace, they actually heal faster,” Shaffer says. “It’s a cost avoidance issue more than a cost generation, and that’s where having employees in case management in house helps.”

Facilities that are willing to provide health opportunity or episodic care by internal staff might help the health system keep down workers compensation and related costs and improve productivity.

If the injured employee receives treatment internally, which is easier than scheduling appointments with outside providers, then the worker is able to go back to work that same day, and it will prevent lost productivity, she notes.

Re-evaluate staffing needs regularly, she advises. Organizations with small, established health clinics, which might need additional staffing, should document their patient care hours and other services, Shaffer suggests.

“Keep track of the average week and jot it down: ‘17 phone calls lasting five minutes each,’” she says. “Find out how many patients you’ve seen in a day and take the averages to list out every function you perform and the amount of time it takes because that gives you a bigger picture.”

Remove the emotion from the assessment: “Sometimes it’s easy to catastrophize, saying, ‘I’m so overworked; my clinic has to be busier than anyone else,’” Shaffer says. “Then when you look at the numbers you find the clinic saw only four patients a day on average.” ■

Finally — HCWs will get a better respirator

Comfort, tolerability are NIOSH priorities

Memories are still fresh of the challenges of respiratory protection during pandemic flu: Inadequate supplies, stockpiles with the wrong size

or model, massive fit-testing. But good news is on the horizon. A better N95 respirator for the health care environment may be on the market within the year, and safety officials are developing new design criteria for a sleeker powered air-purifying respirator (PAPR) for health care workers.

The National Institute for Occupational Safety and Health (NIOSH) is testing prototypes of newly designed filtering facepiece respirators (N95s) with improved comfort and tolerability, says **Maryann D’Alessandro**, PhD, director of NIOSH’s National Personal Protective Technology Laboratory (NPPTL). Health care workers have complained about discomfort from prolonged use of respirators.

“It’s possible to have products with improved comfort by the end of the calendar year,” she says.

NIOSH also hopes to expedite the process of approving new respirators, which would make it easier to introduce new designs. “Hopefully, we can get a better process to get them into the market and into the hands of users,” says **Roland BerryAnn**, deputy director of the NPPTL.

In a Federal Register notice, NIOSH sought input on a proposal that would streamline the dual approval of NIOSH and the Food and Drug Administration, which clears respirators and surgical masks used in the surgical setting.

“How do we make the process as federally efficient as possible so you don’t have to have FDA clear every [new] respirator? That’s what we’re working toward,” says D’Alessandro.

Meanwhile, NIOSH is on a fast track to develop performance requirements for a PAPR designed for health care. The agency is sponsoring a workshop in Washington, DC, to gather feedback about health care needs. (*The workshop was tentatively set for August, but a date had not been finalized at presstime. More information is available at www.cdc.gov/niosh/npptl.*)

PAPRs currently must be able to run for at least four hours; 30 to 60 minutes may be sufficient for many health care uses, says D’Alessandro. The flow rate also may be decreased, which would allow for lighter, more efficient and less costly units, she says.

Many hospitals have begun to integrate reusable respirators into their respiratory protection programs because they do not require fit-testing. A survey of occupational health professionals found that about 10% of hospitals use elastomeric respirators and 30% use PAPRs. Almost all hospitals (90%) use filtering facepiece (N95) respirators, she says.

NIOSH is continuing to move forward on new fit criteria for N95s, called the “total inward leakage” rule. It would result in better-fitting respirators overall and more information on fit for buyers. Some N95 models have had low passing rates in fit-testing.

NIOSH is working with The Joint Commission and the Occupational Safety and Health Administration on documents that will provide information about best practices in respiratory protection.

And although pandemic concerns have diminished, NIOSH is researching the shelf life of N95s and how best to set expiration dates. Aging stockpiles may need to be replaced, says BerryAnn.

“The immediacy of need may have subsided, but there’s still a drive to have a viable solution [to building a stockpile of respirators],” he says. ■

CDC begins work on updated IC guidance

Current guideline dates to 1998

Sixteen years have passed since the Centers for Disease Control and Prevention issued the 1998 Guideline for Infection Control in Health Care Personnel. Occupational health professionals and infection preventionists may soon get the updated, user-friendly guidance they need.

A CDC work group is reviewing guidance related to various infectious diseases that has been released since 1998, as well as new issues that have emerged, says **David Kuhar, MD**, medical epidemiologist with CDC’s Division of Healthcare Quality Promotion.

“Many of the major principles are the same as they were in the previous guideline. Some things have clearly changed since 1998,” he says. For example, the guideline will refer to new recommendations on using blood tests for tuberculosis screening.

It’s too soon to know the scope of the updated document, but as with the 1998 guideline, it will address both patient-to-provider and provider-to-patient risks of transmission, Kuhar says. The guideline also may cover non-hospital settings, he says.

The update likely will be issued in 2015 or 2016, he says.

“We recognize that this is an important update ... It needs to come out in a timely fashion,” he 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. Scan the QR code below, or 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 emailed to you instantly. ■



CNE OBJECTIVES

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

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

COMING IN FUTURE MONTHS

- HCWs are the nation’s most stressed-out workers
- Does UV light pose a risk to HCWs?
- Impaired health care workers remains major problem
- A new push for a federal SPH law
- Developing standardized language in EHRs
- Partnerships can enhance case management services

CNE QUESTIONS

1. According to a survey by the National Institute for Occupational Safety and Health, what proportion of health care workers exposed to surgical smoke reported that their employers had safety procedures in place?
 - A. 25%
 - B. 32%
 - C. 42%
 - D. 55%
2. What provision of the Bloodborne Pathogen Standard is most commonly cited by the Occupational Safety and Health Administration in hospital inspections?
 - A. Failure to update the exposure control plan each year.
 - B. Failure to include frontline workers in the evaluation of devices or update of the plan.
 - C. Failure to use safety engineered sharps devices.
 - D. Failure to properly maintain the sharps injury log.
3. A recent study and audit of sharps disposal at five Florida health care facilities found that what percentage of sharps devices were discarded as "naked" sharps?
 - A. 28%
 - B. 35.1%
 - C. 42.5%
 - D. 59%
4. OSHA's new guidance regarding temporary workers states:
 - A. Temporary employment firms are responsible for all job safety training and recordkeeping
 - B. Host employers are responsible for recordkeeping if they supervise temporary workers on a day-to-day basis and when they control conditions that present hazards
 - C. Host employers must pay the Workers Compensation claims for temporary workers who are hurt at the host employer's facility
 - D. All of the above

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The Joint Commission Update for Infection Control

News you can use to stay in compliance

Joint Commission seeks 'high reliability' patient safety in collaboration with South Carolina hospitals

'We asked ourselves what is the next generation of this work?'

In an ambitious attempt to see if patient safety successes can go beyond individual units and even entire facilities, the Joint Commission Center for Transforming Healthcare is partnering with 20 hospitals in South Carolina.

"When we look at health care organizations around the country there is a lot of work being done to improve quality — a lot of places have established a particular [high quality] unit, a particular service," says **Mark R. Chassin, MD, FACP, MPP, MPH**, president of The Joint Commission (TJC). "What we don't see is entire hospitals, hospital systems, regions, functioning at very high levels of safety that is maintained over long periods of time. We don't see in health care the level of excellence and safety of commercial air travel — or even amusement parks."

The project with the South Carolina Hospital Association (SCHA) — the first of its kind for the TJC Center — includes 20 hospitals from seven health systems located throughout the state. CEOs and other executives from participating SCHA hospitals will meet regularly to collaborate on performance improvement projects and discuss strategies to move toward high reliability care. The specific interventions have not been announced yet, but medical errors and preventable infections are expected to be prime targets for reduction and even eradication.

"We will learn together how to move from a project-to-project approach to improvement to a transformative process that moves an entire organization from pockets of excellence — with

a lot of variation in quality — to one where it is equally maintained in every service for every patient every time," Chassin says. "That's the ultimate goal — a health care system where patients do not get harmed."

In the Joint Commission collaboration, improvements will be measured through safety culture survey assessments, evidence that activities have produced significant reductions in patient harm, and associated cost savings. In addition, the South Carolina hospitals will use a Web-based electronic tool designed by the TJC Center to identify critical high-reliability practices in health care and help hospitals assess their performance in these areas.

This "Targeted Solutions Tool" provides a step-by-step process to assist health care organizations in measuring performance, identifying barriers, and implementing the center's solutions. The TJC Center has developed targeted solutions for improving hand hygiene compliance, reducing the risk of wrong site surgery, and improving hand-off communications. Targeted solutions for surgical site infections, heart failure hospitalizations, safety culture, and patient falls will be added as these projects come on line. (See <http://www.centerfortransforminghealthcare.org/>)

Mistakes were made

"The primary job is always to deliver the right care for each patient every time," says **Thorn-ton Kirby, FACHE**, president and CEO of the SCHA. "Unfortunately the fact that medical care

is increasingly complex yields the fact that we still make mistakes. We don't like that mistakes are made, but they are still made. But South Carolina hospitals have been working really hard to improve the quality and safety of patient care over the last several years with really great results."

Indeed, South Carolina has not exactly been a laggard in quality improvement, as hospitals statewide are adopting a surgical safety checklist designed by author and surgeon **Atul Gawande**, MD, MPH, and colleagues at the Harvard University School of Public Health. (*See related story, this page*)

"The hospitals have been doing great work," Kirby says. "We asked ourselves what is the next generation of this work? Our conclusion is it's time to change the culture of hospitals so that we do not make mistakes. That is a tall order but that is why we are focused on this work."

Though zero infection goals have become commonplace in hospitals, some question whether health care delivery can ever achieve the efficiency of business and industry models. In an article lamenting the toxic safety cultures in too many hospitals, Chassin turned an old analogy on its head in conceding that sustaining high reliability in health care is harder than "rocket science."¹ Still, collaborations like the one in South Carolina signal the Joint Commission is in it for the long run.

"We know it's going to take a long time but we designed this so that each organization can take a hard look at itself – where it's strengths and weaknesses are — and learn from each other," Chassin says. "We fully expect that some places will be strong in one area and some in others."

Beyond the hospitals initially participating in the South Carolina project, the collaboration between the Center and SCHA is designed to improve safety and quality in health care organizations across the state. The lessons learned about identifying the underlying causes of specific breakdowns in care and creating targeted solutions will eventually be applied to other health care facilities nationally, according to the Joint Commission.

REFERENCE

1. Chassin, M. Improving The Quality Of Health Care: What's Taking So Long? *Health Aff* 2013;32:1761-1765 ■

South Carolina ORs adopt surgery checklist

Harvard comes to the Palmetto state

South Carolina hospitals are moving to the leading edge of the patient safety movement, collaborating with The Joint Commission on multiple projects and adopting a highly touted surgical safety checklist in every operating room in the state.

The 2015 Surgical Safety project is the brain child of author and surgeon, **Atul Gawande**, MD, who developed the checklist along with colleagues at the Harvard University School of Public Health. All 61 acute care hospitals in South Carolina have pledged to implement the checklist as a routine component of surgical care, according to the South Carolina Hospital Association. (*See checklist, p 3.*)

Project leaders estimate that even if the effort is only minimally successful, at least 500 lives will be saved annually along with \$28 million in health care costs.

Gawande led the World Health Organization's Safe Surgery Saves Lives Initiative, which resulted in development of a surgical checklist that has reduced surgery-related complications by more than one-third. Gawande documented his experience creating and testing the WHO Surgical Safety Checklist in his book "The Checklist Manifesto."

Key checkpoints on the surgical list include reviewing patient information and verifying the surgical site before the induction of anesthesia. The anesthesiologist shares patient-specific information with the rest of the surgical team, which goes down a checklist of patient risks and underscores that any team member can call for a "time out" if a break in protocol is observed.

The surgeon reiterates this safety factor, asking, "Does anybody have any concerns? If you see something that concerns you during this case, please speak up." In a debriefing following the procedure the surgical team discusses key concerns for patient recovery and management, with discussions centering on the question: "What could have been done to make this case safer or more efficient?"

Editor's note: for more on the South Carolina surgical checklist program go to <http://www.safesurgery2015.org/> ■

Safe Surgery 2015: South Carolina Checklist Template

Before Induction of Anesthesia

Nurse and Anesthesia Provider Verify:

- Patient identification (name and DOB)
- Surgical site
- Surgical Procedure to be performed matches the consent
- Site marked
- Known allergies
- Patient Positioning
- The anesthesia safety check has been completed

Anesthesia Provider Shares Patient Specific Information with the Team:

- Anticipated airway or aspiration risk
- Risk of significant blood loss
 - Two IVs/central access and fluids planned
 - Type and crossmatch/screen
 - Blood availability
- Risk of hypothermia - operation >1h
 - Warmer in place
- Risk of venous thromboembolism
 - Boots and/or anticoagulants in place

Before Skin Incision

Entire Surgical Team:

- Is everyone ready to perform the time out?
 - Please state your name and role
-
- Patient's name
 - Surgical procedure to be performed
 - Surgical site
 - Essential imaging available
-
- Has antibiotic prophylaxis been given within the last 60 minutes?
 - Plan for redosing discussed

Briefing

Surgeon Shares:

- Operative Plan
- Possible difficulties
- Expected duration
- Anticipated blood loss
- Implants or special equipment needed

Anesthesia Provider Shares:

- Anesthetic plan
- Airway concerns
- Other concerns

Circulating Nurse and Scrub Tech Share:

- Sterility, including indicator results
- Equipment issues
- Other concerns

Surgeon says:

"Does anybody have any concerns? If you see something that concerns you during this case, please speak up."

Before Patient Leaves Room

Nurse reviews with Team:

- Instrument, sponge and needle counts are correct
- Name of the procedure performed
- Specimen labeling
 - Read back specimen labeling including patient's name

Debriefing

Entire Surgical Team Discusses:

- Equipment problems that need to be addressed.
- Key concerns for patient recovery and management
- What could have been done to make this case safer or more efficient



Version - 4-24-12

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Based on the WHO Surgical Safety Checklist, URL <http://www.who.int/patientsafety/safesurgery/en>. © World Health Organization 2008 All rights reserved.

TJC looking closely at endoscopy reprocessing

Joint Commission, other expert groups weighing in

With infections related to contaminated endoscopes a recurrent problem in health care, the Joint Commission and several other groups and associations are reiterating the importance of reprocessing procedures.

An emerging theme is safe practices in all settings and a desire for standardization of the guidelines issued by the different associations and expert groups. For example, the American Society for Gastrointestinal Endoscopy (ASGE) recently issued updated guidelines in part because the CMS and Joint Commission are taking a hard look at reprocessing practices.

"Over the past two years, surveyors have

called into question accepted practices at many accredited endoscopy units seeking reaccreditation," the ASGE states.¹ "Many of these issues relate to the Ambulatory Surgical Center Conditions for Coverage set forth by CMS and the lack of distinction between the sterile operating room and the endoscopy setting."

The Centers for Medicare and Medicaid Services Conditions has eliminated the distinction between a sterile operating room and a non-sterile procedure room, meaning GI endoscopy units are now held to the same standards as sterile operating rooms.

"We are doing flexible endoscope [procedures] in many different practice settings now, and in my opinion that is what the CMS and the Joint Commission surveyors are looking for — that you have standardization no matter where it is," says Rose Seavey MBA, BS, RN, CNOR, CRCST, CSPDT, president and CEO of Seavey Healthcare Consulting in Denver, CO.

Toward that end, the Association for the Advancement of Medical Instrumentation (AAMI) is working on a comprehensive guide to flexible endoscopes in health care facilities that may emerge as the gold standard for practice.

“So many guidelines are not that comprehensive, but this will be talking about the whole gamut of reprocessing,” Seavey says.

For its part, the Joint Commission recently issued some basic guidance on endoscope reprocessing that emphasized vigilance, warning that “the long term effects of poor processes and an unsafe environment are severe. Working in partnership with infection control and clinical staff, environment of care professionals should ensure that these critical tools remain safe, clean, and ready for use every time.”²

Recommending periodic environmental tours of reprocessing areas, the Joint Commission created a checklist that includes the following points:

- Is the reprocessing area sized appropriately in relation to the volume of equipment processed?
- Do staff put on personal protective equipment (PPE) before entering the area?
 - Are staff wearing suitable PPE?
 - Is there sufficient work space?
 - Are cleaning supplies, storage areas, and other critical items clearly labeled?
- Is there an appropriate hand washing station?
 - Is there an appropriate eyewash station?
 - Are “dirty” areas physically separated from “clean” ones?
 - Are there suitable storage areas for cleaned endoscopes? On visual inspection, do these areas look clean, free of debris and dry? If a cabinet serves as storage, does the cabinet have doors?
 - Are endoscope storage containers dry and located off the ground”?
 - What is the route from the processor to the cabinet? (The route should not cross through the soiled processing area.)

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2. Joint Commission. Tips for improving endoscope reprocessing and preventing the risk of infection. *Joint Commission Online* April 9, 2014: <http://bit.ly/1knPiNz> ■

TJC patient safety guide for CEOs, docs

Seeking to ‘motivate and energize’ leaders

Joint Commission Resources (JCR) has released a new, free guide to help hospital executives and physician leaders implement and sustain safe practices. Produced by the JCR Hospital Engagement Network (HEN), the guide is part of the federal Partnership for Patients initiative to improve the quality, safety and affordability of healthcare.

“Patient Safety Initiative: Hospital Executive and Physician Leadership Strategies,” is intended to help motivate and energize healthcare leaders to assess gaps in their organizational safety culture, engage key influencers for change, set goals for targeted improvement, implement proven safe practices, and reinforce key behaviors to ensure high-reliability performance improvement.

The document includes two sections:

Part I focuses on hospital executive leadership strategies and includes an Activation Toolkit with seven components: board engagement on patient safety; safety culture debriefing; safety leadership rounds; teamwork training and skill building; daily safety briefing; senior executive adopt a work unit; and known best practices of execution.

Part II focuses on physician leadership and includes an Activation Toolkit with seven components: physician communication at the bedside; physician involvement in unit-based huddles; physician leadership of unit-based patient safety meetings; harm-reduction rounding checklists and evidence-based guidelines; multidisciplinary teamwork training; physician leadership of post-adverse event debriefs; and managing challenging behavior.

Editor’s note: The patient safety guide is available for download at: <http://bit.ly/1rFPysn>

For more information on the JCR HEN, go to www.jcrinc.com/CMS-Hospital-Engagement-Network ■