

Hospital Employee Health®

THE TRUSTED SOURCE FOR EMPLOYEE HEALTH PROFESSIONALS FOR MORE THAN 30 YEARS

July 2014: Vol. 33, No. 7
Pages 73-84

IN THIS ISSUE

- **MERS meets match:** U.S. hospitals responded to the first suspected MERS cases with good communication and strict adherence to infection control guidelines..... cover
- **An ACA lift?** Safe patient handling may get a boost from policies that end reimbursement for pressure ulcers and patient falls..... 76
- **Addiction issues:** HCWs are similar to general population when it comes to substance abuse 77
- **Tell-tale signs of drug diversion:** Behavior changes, seeking late shift work, gravitates to patients on pain meds 79
- **Treatment over punishment:** HCWs with substance abuse problems need treatment and care to overcome addiction..... 79
- **Every breath you take:** Has been a struggle with many respirators but new design on way at VA. 80
- **Wordsmiths:** Standardized language critical for employee health's electronic health records. . 81

Financial Disclosure: Editors Michele Marill and Melinda Young, Executive Editor Gary Evans, and Consulting Editors/Nurse Planners Kay Ball and MaryAnn Gruden report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Communication critical in tracking down HCWs exposed to MERS

Screening and isolation practices should be 'hard-wired' into triage

With health care workers in the bull's eye of Middle East Respiratory Syndrome (MERS), hospitals preparedness was recently tested by the first two U.S. cases in Indiana and Florida. The real-world situation revealed one critical element of a response plan: Communication.

The second U.S. MERS patient was a health care worker working and living in Saudi Arabia who was visiting Orlando, FL. In the hours before MERS was suspected, some employees in the emergency department at Dr. P. Phillips Hospital, where he sought treatment, had unprotected exposures.

With the help of nurse managers, the hospital quickly identified those exposed employees, says Ken Michaels, MD, MPH, medical director of occupational health at Orlando Health, the parent health system. Two physicians and 14 employees at Dr. P. Phillips Hospital were placed on home isolation for 14 days. Another six employees and one physician at Orlando Regional Medical Center were furloughed after it was discovered they were exposed when the patient accompanied a friend to the radiology department there.

Daily phone calls to exposed employees helped assuage fears, and use of a mobile occupational health clinic at the hospital made testing quick and convenient, Michaels says.

"We wanted to make sure they had an avenue to ask questions, to be heard," says Michaels, who personally called each furloughed employee every day to ask about any symptoms and to respond to any concerns. "I really think that made a tremendous difference. It was very reassuring for them."

Two Orlando employees developed respiratory symptoms shortly after the exposure, but they tested negative for MERS. The symptoms were coincidental, Michaels says. The median incubation period for MERS is five days, and the range is two to 13 days, CDC reports.

Fifty-three health care workers had been placed on home isolation in Indiana after the first MERS case was identified at Community Hospital in Munster, involving a patient who also had been working at a hospital in Saudi Arabia. Worldwide, about 20% of all MERS cases are among health



NOW AVAILABLE ONLINE! Go to www.ahcmedia.com.
Call (800) 688-2421 for details.

care workers, according to the Centers for Disease Control and Prevention.

Raise the index of suspicion

For the hospitals in Indiana and Florida, MERS underscored the importance of infection control basics, says Michaels. Health care workers wore fit-tested N95s, goggles, gowns and gloves when caring for the MERS patients in negative-pressure rooms. CDC has recommended standard, contact and airborne precautions for suspected or con-

Hospital Employee Health® (ISSN 0744-6470), including The Joint Commission Update for Infection Control, is published monthly by AHC Media, LLC One Atlanta Plaza, 950 East Paces Ferry NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
Web: www.ahcmedia.com

POSTMASTER: Send address changes to
Hospital Employee Health®, P.O. Box 550669,
Atlanta, GA 30355.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. E-mail: customerservice@ahcmedia.com. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

Subscription rates: U.S.A., **Print**: 1 year (12 issues) with free Nursing Contact Hours, \$499. Add \$19.99 for shipping & handling. **Online only, single user**: 1 year with free Nursing Contact Hours, \$449. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Back issues, when available, are \$78 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media. Address: P.O. Box 550669, Atlanta, GA 30355. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcmedia.com>.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).

Executive Editor: **Gary Evans**, (706) 310-1754,

(gary.evans@ahcmedia.com).

Production Editor: **Kristen Ramsey**.

Continuing Education and Editorial Director: **Lee Landenberger**.

Copyright © 2014 by AHC Media LLC. Hospital Employee Health® is a trademark of AHC Media LLC. The trademark Hospital Employee Health® is used herein under license. All rights reserved.

Editorial Questions

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

AHC Media

firmed MERS patients. (See *MERS checklist*, p.75.)

Most importantly, CDC advised health care providers to ask patients with respiratory symptoms and fever about any travel to the Arabian Peninsula or contact with people who have traveled there.

Five airports in the United States receive 75% of the air travelers from Saudi Arabia; about 100,000 people were expected to fly through Washington, DC, New York, Los Angeles, Atlanta, and Chicago in May and June 2014 alone. But as the first U.S. cases demonstrate, the travelers continue on to many other communities. The Orlando patient had taken four flights from Saudi Arabia.

“While certain cities might appear at higher risk to receive travelers from the Arabian Peninsula, all health care facilities around the United States need to be aware that they could receive an unexpected traveler from the Arabian peninsula and they need to be prepared [to respond],” says **David Kuhar**, MD, medical officer with CDC’s Division of Healthcare Quality Promotion.

After the first U.S. case and amid a rise in cases in Saudi Arabia, CDC issued a health advisory urging health care providers “to increase their index of suspicion to consider MERS-CoV infection in travelers from the Arabian Peninsula and neighboring countries.”

“It’s very important for people to be aware of the possibility of encountering people who are infected with this disease,” says Kuhar.

A possible case of MERS put Vanderbilt University Medical Center on alert and essentially served as a very realistic drill. A child with fever and respiratory symptoms who had recently been hospitalized in Saudi Arabia was transferred to Vanderbilt from another U.S. hospital just two days after the first U.S. case emerged in Indiana.

Employees caring for the patient used the recommended enhanced precautions, but Vanderbilt still planned to monitor their health twice daily. The Tennessee health department tested the patient’s samples within hours of admission and found them to be negative for MERS.

“Our plan ... was to have an electronic log using a survey tool that we would send to the participants every day for them to log their temperatures and symptoms and to remind them to call us should they develop any symptoms,” says **Melanie Swift**, MD, director of the Vanderbilt Occupational Health Clinic.

Vanderbilt had convened an emergency preparedness group when the number of MERS cases began to spike this spring in Saudi Arabia and the United Arab Emirates. The medical center updated protocols,

checked the stockpile of personal protective equipment, and added travel questions to the screening of patients.

Patients who come to the emergency department with a febrile respiratory illness are asked to wear a mask, Swift says. “It’s a good time to revisit those screening and early source isolation practices that really should be hard-wired in to how we triage patients anyway,” she says.

Hospital spread linked to poor IC

The MERS virus is similar to the SARS virus, another coronavirus that emerged suddenly in 2003. However, the mode of transmission of MERS is not

understood and it is not clear whether “super-spreading” may play a role in hospital outbreaks, as it did with SARS.

In all reported cases, there have been direct or indirect links with seven countries: Saudi Arabia, UAE, Qatar, Oman, Jordan, Kuwait, and Yemen, according to the CDC. Concerns about transmission were highlighted by the case of an Illinois man who was a business associate of the Indiana patient and initially seemed to test positive for MERS antibodies. Further testing showed that he had not been infected with MERS, the CDC said.

The spread of MERS in Saudi Arabian hospitals has been associated with inadequate infection control, says **Scott McNabb**, PhD, MS, research

CDC checklist for MERS preparedness

The Centers for Disease Control and Prevention provided this checklist to help health care facilities prepare for MERS-CoV. It corresponds with CDC guidance but doesn’t represent mandatory requirements, the agency said.

- Ensure facility infection control policies are consistent with the CDC guidance available at www.cdc.gov/coronavirus/mers/infection-prevention-control.html.
- Review procedures for rapidly implementing appropriate isolation and infection practices for potential MERS-CoV patients.
- Review policies and procedures for screening and work restrictions for exposed or ill health care personnel (HCP) including ensuring that HCP have ready access, including via telephone, to medical consultation.
- Review procedures for laboratory submission of specimens for MERS-CoV testing.
- Review plans for implementation of surge capacity procedures and crisis standards of care.
- Develop plans for visitor restriction if MERS-CoV is circulating in the community.
- Ensure that specific persons have been designated within the facility who are responsible for communication with public health officials and dissemination of information to other HCP at the facility.
- Confirm the local or state health department contact for reporting MERS-CoV cases and confirm reporting requirements.
- Assure ability to implement triage activities based on public health guidance including at the

facility and using remote (i.e., phone, internet-based) methods where appropriate to minimize demand on the health care system.

- Ensure that negative-pressure airborne infection isolation rooms are functioning correctly and are appropriately monitored for airflow and exhaust handling.
- Ensure that HCP who will provide patient-care have been medically cleared, fit-tested, and trained for respirator use.
- Provide education and refresher training to HCP regarding MERS-CoV diagnosis, how to obtain specimen testing, appropriate PPE use, triage procedures including patient placement, HCP sick leave policies, and how and to whom MERS-CoV cases should be reported, procedures to take following unprotected exposures (i.e., not wearing recommended PPE) to suspected MERS-CoV patients at the facility.
- Assess availability of personal protective equipment (PPE) and other infection control supplies (e.g., hand hygiene supplies) that would be used for both healthcare personnel (HCP) protection and source control for infected patients (e.g., facemask on the patient).
- Have contingency plans if the demand for PPE or other supplies exceeds supply.
- Assess effectiveness of environmental cleaning procedures (www.cdc.gov/HAI/toolkits/Evaluating-Environmental-Cleaning.html) and provide education/refresher training for cleaning staff.
- Monitor the situation at CDC’s MERS website at www.cdc.gov/coronavirus/mers/index.html. ■

professor with the Rollins School of Public Health at Emory University in Atlanta and a public health consultant and adjunct professor with the King Saud Bin Abdulaziz University for Health Sciences in Riyadh. Emory has a partnership with the Saudi Ministry of Health and is assisting with MERS investigations and infection control.

“In the hospitals where this has proliferated, there has not been the type of global best practices for hospital infection prevention and control,” McNabb says. “If all hospitals maintained the minimum standards, then I think we would be able to contain this.”

McNabb’s advice to US hospitals to prevent potential MERS exposures from an undiagnosed case: “Go back to the basics and look at exactly what the [CDC] recommendations are.” ■

Will ACA lead to lead to safer lifts?

Cost pressures hurt safe patient handling efforts

Safe patient handling may become an imperative in the nation’s hospitals — not because of any proposed legislation or regulation, but because of rising financial pressures related to both patient safety and workers’ compensation.

Patient falls and pressure ulcers are among the “never events” that insurers consider to be preventable — and that can be mitigated by safe patient handling and mobility. The Centers for Medicare and Medicaid Services (CMS) stopped Medicare reimbursement for “provider preventable conditions” in 2007, and the Affordable Care Act extended that policy to Medicaid. Many private insurers have followed suit.

Greater access to lift equipment leads to lower rates of pressure ulcers and patient falls in long-term care, recent research showed.¹ Cost-savings from safe lift programs produce a return on investment of one to three years in long-term care.² The benefits are similar in the acute care setting, safety experts say.

“You can’t afford not to [adopt safe patient handling],” says **Melissa McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore.

McDiarmid developed a “safe lift index” that measures the key components of a safe patient handling program: Lift equipment, training, enforcement

of safe lifting policies and support from directors of nursing. A higher safe lift index was associated with lower workers’ compensation costs. Increasing the availability of lifts by just one lift per 100 long-term care residents reduced costs by 11%.¹

“This is a win-win — good for patients and residents, good for workers, good for the bottom line,” says McDiarmid.

Hospitals struggle for SPH resources

Despite the cost-savings, implementing safe patient handling has been a challenge in a time of budget constraints.

Each year, ECRI Institute in Plymouth Meeting, PA, assists hospitals with their safe patient handling programs. Yet faced with other patient safety initiatives and cost pressures, hospitals may not devote the resources that are needed to achieve a sustained result, says **Robert P. Maliff**, director of Applied Solutions for ECRI. A budget for lift equipment competes with other priorities for capital expenses.

Hospital leadership needs to support safe patient handling as an integral part of an overall safety culture, with regular education and enforcement of lift policies, he says. Otherwise, lift equipment may be inadequate, the existing lifts may sit unused, and the hospital may need to re-start a safe patient handling program every few years, he says.

“It needs to be something that is incorporated into everyday practice,” Maliff says. “The real challenge is how to sustain a culture that encourages and rewards safe patient handling.”

Risk managers are natural partners for employee health professionals who want to improve the patient handling program, says **Maura Crossen-Luba**, MPH, CPH, an ECRI risk management analyst.

In a risk analysis, Crossen-Luba noted that manual handling can lead to pain or discomfort for patients, including skin tears and joint dislocation, in addition to high rates of musculoskeletal injury among workers. (An ECRI information sheet for nurses has been inserted in this issue.)

“Worker safety is very much related to patient safety,” she says.

No federal mandate in sight

Political momentum to require safe patient handling has sputtered, with most activity occurring in state legislatures.

Ten states currently require hospitals to have a comprehensive safe patient handling program. New York added the Safe Patient Handling Act to the state

budget language this year, requiring safe patient handling programs by Jan. 1, 2017. It was the first new state law since 2011. Legislation also was pending in Massachusetts and Vermont, but at presstime they had not moved forward.

“It’s going to be dependent on the states to keep moving forward and I think that will happen,” says Aaron Trippler, director of government affairs for the American Industrial Hygiene Association. “I think you will see additional states consider this issue and address it on their own.”

Meanwhile, the federal Nurse and Health Care Worker Protection Act of 2013 remains politically out of reach.

The American Nurses Association scheduled a Congressional briefing in May — a kind of unofficial hearing — and planned a lobbying day for nurses to meet with their representatives in June. The ANA issued inter-professional safe patient handling and movement standards last year, which were cited by the U.S. Occupational Safety and Health Administration in its “Worker Safety in Hospitals” web resources (www.osha.gov/dsg/hospitals/patient_handling.html).

“It’s definitely a marathon, not a sprint,” says Joe Mayer, associate director for federal government affairs at the ANA in Silver Spring, MD. “A lot of times you’re facing some uphill battles. It doesn’t mean you don’t keep fighting. It’s a long campaign and we’re in it for the long haul.”

Hospitals that fail to adopt to safe patient handling will eventually pay the price in higher workers’ compensation premiums, says Harry Shuford, PhD, practice leader and chief economist for the National Council on Compensation Insurance (NCCI) in Boca Raton, FL. Employers with a workers’ compensation claims experience that is worse than the industry average will see their premiums rise, he says.

Even low-cost injuries, such as back strain, may be the precursor to more significant claims, he cautions. “Minor injuries, if they continue on a repetitive basis, can ultimately become a very expensive injury,” he says.

Shuford predicts that safe patient handling will eventually become the accepted practice.

“It’s like so many things where there is new technology or new ways of doing things,” he says. “There are the early adopters. Then it begins to pick up until eventually it becomes an industry practice.”

REFERENCES

1. Restrepo TE, Schmid FA, Gucer PW, et al. Safe lifting programs at long-term care facilities and their impact on workers’ compensation costs. *J Occup Environ Med* 2013;55:27-35.
2. Lahiri S, Latif S, Punnett L and the ProCare Research

Team. An economic analysis of a safe resident handling program in nursing homes. *Am J Ind Med* 2013;56:469-478. ■

Myth busters: Drug abuse no different in HCWs

Watch for changes in behavior, absenteeism

Common wisdom suggests the drug-addicted doctor is different from the drug-addicted sales rep or homeless person. Along with other health care professionals, physicians begin using drugs later in life and for different reasons than the man or woman down the street, or so the health care community has theorized for decades.

It is an interesting theory, seemingly supported by decades of studies that showed physicians were more likely to abuse prescription drugs than people in non-health care professions. The trouble is that the theory is wrong: Researchers recently asked doctors and other health care professionals when they first used substances, including tobacco and alcohol.

They discovered to their surprise that initiation into substance use began long before they became doctors or even entered college.¹

“Health care professionals with addiction are just like everyone else,” says Lisa Merlo, PhD, MPE, assistant professor of psychiatry at the University of Florida in Gainesville. “They started off like any other teenager, wanting to try drugs to get high at a party or to participate in the general social scene, and they continued using because they were having fun.”

The fine line between abuse and addition is eventually crossed.

“They get addicted and experience withdrawal symptoms if they stop,” she says. “They find that drugs help with stress and the reasons for substance use continue through their careers.”

These findings suggest that hospital employee health programs could do more to identify workers with substance abuse problems and make inroads toward prevention.

Many health care workers identified with substance abuse problems are found because of drug diversion or problematic workplace behaviors, says Jay D. Harper, MD, MBA, MPH, employee health services medical director at the University of Pittsburgh Medical Center in Pittsburgh, PA. (*See related story, p. 79.*)

“Technology makes it easier to catch people diverting drugs,” Harper notes. “There’s a given range of people making mistakes, but if you see something going on outside the norm, then you have a suspicion.”

Behavior that should raise red flags includes employees having financial problems, missing work more frequently, or showing up for work but not being fully mentally present, he explains.

“An employee could go into a rage or just not act like themselves,” he says. “Falling asleep at work is another sign.”

Patient safety at risk

With patient safety at risk, health systems need efficient ways to screen for substance abuse problems. The small percentage of health care workers identified through current practices might be the tip of the proverbial iceberg.

Data show that health care employees have a substance use rate that is similar to the general population, which means roughly one in 10 has a substance abuse problem, says **John Furman**, PhD, MSN, executive director of Washington Health Professional Services in Olympia, WA.

“Health professionals have a higher rate of prescription drug misuse, but the general rate is the same,” Furman adds. “The American Nurses Association estimates that 6 to 8 percent of nurses at some time in their career misuse substances to the extent that their practice may be impaired.”

Programs like Washington Health Professional Services that offer follow-up care to these individuals are referred a tiny portion of the estimated workers with the problem, Furman says. “We have about 525 active clients — who are mostly nurses — at any given time, and we average 700 clients a year,” he says.”

There are some 100,000 nurses in Washington, meaning there may be as many as 10,000 who are misusing substances like alcohol or other drugs, he notes. Complicating the issue, marijuana is legal now in Washington, so it’s handled the same way as alcohol in terms of substance abuse, Furman says.

Physicians and HC professionals who misuse prescription medications often started taking pain killers legally because of chronic pain or some medical problem. Like non-health care addicts, however, they abused other substances before prescription drugs.

“We found initial use was like any other teenager: their friends were doing it or they were curious,” Merlo explains.

“Some 80 to 90 percent of the [addicted]

health care professionals started substance use before they went to college,” she adds. “We were not seeing a different pattern from the general population.”

Merlo and co-investigators recruited participants from attendees at a conference for health care workers in recovery, asking them to complete a questionnaire. They found that more than 60% of participants first smoked tobacco before they were high school graduates. Also, their average age of first drinking alcohol was 16 years and they were drinking regularly by the time they were 21. Marijuana was the third drug tried for most participants, followed by cocaine.¹

One major statistical difference between health care workers who abuse substances and other people with addictions is that the long-term recovery rate is much greater for medical employees, Merlo notes.

“We know that physicians who participate in monitoring programs do really well, with 80 percent of them having five years of abstinence,” she says. “This is in comparison to individuals in the general population who may go to rehab and don’t have follow-up care; their relapse rates are extremely high — even one year after treatment you’re lucky to have half of them who are clean and sober.”

Merlo attributes this difference to hospitals having better after-care programs than those available to the general public.

“Why don’t we provide everyone with addiction access to the same treatment? We know it works,” Merlo says.

Specifically, Merlo refers to hospital health programs that require random drug and alcohol testing for a five-year follow-up period.

Washington Health Professionals Services provides a follow-up substance use program as an alternative to discipline for HC professionals, Furman says. When nurses are identified with a substance abuse disorder and there has been no patient harm, they are often given the option of going into such programs, he explains.

“We provide substance abuse monitoring services,” he says. “Substance abuse disorder is considered by our legislature and department of health as a chronic illness, like diabetes or cardiovascular disease.”

REFERENCE

1. Merlo LJ, Trejo-Lopez J, Conwell T, et al. Patterns of substance use initiation among healthcare professionals in recovery. *Am J Addict* 2013;22:605-612. ■

Controlling risks of HCW drug diversion

'It's happening much more than it used to'

Hospitals increasingly are teaching managers to look for signs of drug abuse among employees, focusing on subtle clues like talk of financial problems or more blatant signs, such as arriving to work late or failing to show up as scheduled.

Once there is suspicion of a problem, managers can refer the employee for a drug and alcohol screening test.

The biggest trigger for screening a health care worker for substance abuse is suspicion of drug diversion, says **Jay D. Harper, MD, MBA, MPH**, employee health services medical director at the University of Pittsburgh Medical Center.

"Drug diversion is the trigger that gets a lot of attention and is happening much more than it used to," Harper says.

Hospitals increasingly are having employees drug-tested when there are problems of miscounted medications, not following procedures, and not being able to say what happened to missing medications, Harper says.

Here are a few suggestions for how to screen for drug diversion and handle the problem:

Require a blood-borne pathogen test: "When we do fitness for duty testing, we do blood-borne pathogen testing, checking for HIV, hepatitis B and C, because with diversion there have been cases where health care workers have been taking syringes and injecting themselves, and then giving them to a patient," Harper explains. This practice may result in patients becoming infected, especially with hepatitis C, he adds.

If the employee who is suspected of drug diversion tests positive for hepatitis C that matches the infected patient, then hospital officials have confirmation of drug diversion.

Involve other departments when diversion is suspected: Ask a human resources representative and the employee's manager to be present as witnesses. The decision about requiring a blood-borne pathogen test should be made by HR and the manager — not employee health, Harper notes.

"The person suspected of diversion should always be accompanied by another person to employee health," he explains. "We'll do the testing and make sure the employee has transportation to return home."

Results can be given over the telephone by the employee health director.

Keep employee assistance in the loop: Whenever there's a fitness for duty test, it's a mandatory referral to the hospital's employee assistance program (EAP), Harper says.

Employees with substance use problems sometimes need medical and other help.

"EAP reports whether the person is complying or not with their recommendations," he says. "I get involved if the employee's drug test comes back negative, but the person still has behavior problems at work — maybe there's a medical reason."

The hospital's EAP also can take care of making arrangements for narcotics anonymous or alcoholics anonymous.

"I'll talk to the employee, and EAP will talk to them, so if there's an issue other than drugs where they need help, we'll figure it out," Harper says.

Offer last-chance agreements: "We give last-chance agreements where the employee is subject to random drug testing for three years," Harper says. "The person is tested frequently for six months and then less frequently, and it's totally random." ■

Providing treatment for addicted HCWs

Handle it like a chronic illness

Health care systems handle cases of employee substance abuse in a variety of ways from punitive measures to providing treatment and long follow-up care and monitoring.

Almost all states offer some type of treatment program for health care professionals, says **John Furman, PhD, MSN**, executive director of Washington Health Professional Services in Olympia, WA.

"We monitor the employees, and as long as they are successful at the program, they can return to practice as successful health professionals," he explains. "Our contracts are generally for five years. Research has shown that at least five years of rigorous monitoring provides the best chance of long-term recovery."

Hospitals should value the opportunity to help health care workers return to work because they are valuable resources, and treatment and monitoring preserve that resource and investment, Furman says.

"Nurses and some other health care professionals have about a 70 percent success rate when they're in a risk monitoring program for five years," he says.

“Physicians have a higher rate — about 85 percent.”

This alternative to the discipline route benefits everyone and is a fair way of handling employees with a problem that many public and health authorities now compare to a chronic illness like diabetes, Furman argues.

“Once an action is taken against a health care professional in Washington state, that action is a public record and is attached to their professional license forever,” he explains. “An alternative to discipline allows someone to voluntarily come into monitoring and avoid that formal action against their license.”

A health system’s top priority should be to protect the patients while safely returning the addicted professional back to practice, he adds.

Furman offers these suggestions for handling substance use problems:

Provide a culture of transparency: “Develop a culture where it’s okay to talk about substance issues,” he says. “And make it clear that the employer is concerned about that — not just about the diversion of medications — but also about the health and safety of their employees.”

Health systems should have clear policies and procedures regarding reporting suspected cases of medication misuse and for safety of employees and patients. They also should emphasize a non-punitive and treatment-oriented approach, he adds.

Educate employees and managers about substance use signs: Workplace education and messages about substance use are important.

Brochures and other information could highlight signs and symptoms of a substance use problem, including when an employee:

- changes his or her behavior;
- becomes more irritable and defensive;
- performs poorly and work practices deteriorate;
- starts to take more time off;
- has unexplained absences while on the unit;
- volunteers for overtime or night shifts in areas

with less supervision;

- volunteers to work with patients with excessive pain medication;

One of those changes probably doesn’t mean there’s a substance use problem, but a pattern should trigger concern, Furman says.

Emphasize treatment over punishment: Again, the goal should be to help the nurse return to health so she can return to work and productivity, he says. Hiring and training new employees is expensive. While helping an employee recover from substance use also is costly, much of the cost is borne by the employee, Furman says.

“The basic costs for initial evaluation and treat-

ment can range from \$5,000 to \$50,000 in some high-end facilities. Then there are ongoing costs — random urine drug screens at \$75 to \$100 each,” he says.

Most programs require the employee to participate in a self-help group like Alcoholics Anonymous or Narcotics Anonymous.

Providing employees with the option of going through a treatment and monitoring program — where they attend regular meetings and are monitored for substance use over a long period — is also a way to encourage employees to self-report, Furman adds.

“A nurse might come in and report to the manager that she has an alcohol problem,” he says. ■

Hold the salt: Hospitals seek sodium reduction

Cafeteria strategies are healthy, not costly

In patient rooms, doctors are prescribing a low-sodium diet to improve health. But in hospital cafeterias, employees and visitors may be loading up on salty and processed food.

The average American consumes 3,400 mg of sodium every day, although current dietary guidelines recommend no more than 2,300 mg — and even less for older people, African-Americans, and those with chronic diseases such as high blood pressure and diabetes.

Small and rural hospitals in Illinois successfully targeted sodium reduction with a range of inexpensive strategies. They gathered a multi-disciplinary work group and designed ways to promote healthier eating.

Changing the food environment has a broad impact, says **Nancy Amerson, MPH**, chronic disease epidemiologist with the Illinois Department of Public Health, which sponsored the project with the Illinois Hospital Association. “It affects the whole community that utilizes the hospital,” she says.

Nine participating hospitals received \$5,000 grants to implement new strategies to reduce sodium consumption during a four-month study period. “The hospitals educated employees, patients, and the community overall about the effects of sodium,” says **Abby Radcliffe, MA**, manager of member program development at the Illinois Hospital Association in Naperville.

Sodium-reduction strategies included:

- Providing alternatives to salt for flavoring food.

Most of the hospitals removed salt shakers from cafeteria tables, although cafeteria customers could request it, says Radcliffe. Many replaced the salt with a seasoning such as Mrs. Dash. One hospital offered a seasoning blend day in which employees could use herbs and spices to make their own seasoning — and learn about sodium reduction.

- Promoting more information about nutritional content and sodium. Some hospitals used table tents to provide information about sodium reduction. One hospital had a vending machine with a touch screen that offered nutritional information. Another hospital used new employee orientation as an opportunity to point out healthier options in the cafeteria. One hospital even held cooking demonstrations for patients on a low-sodium diet.

- Offering healthier menu items. One hospital switched to lower-sodium items, such as from regular bacon to turkey bacon. Others created new recipes with lower sodium levels for the cafeteria menu.

- Making healthier choices more convenient. Some hospitals placed fruit or other healthy items in a convenient place, such as near the cash register.

“Just those little things can make a big difference,” says Radcliffe.

The grants helped the hospitals implement changes, but cost is not a barrier to implementing strategies, says Amerson. “You don’t need money to do a lot of the different interventions that the CDC recommends,” she says.

[Editor’s note: More information on sodium reduction is available in “Under Pressure: Strategies for Sodium Reduction in the Hospital Environment,” published by the Centers for Disease Control and Prevention and available at www.cdc.gov/salt/pdfs/sodium_reduction_in_hospitals.pdf.] ■

VHA leading the way to respirator comfort

Prototype trials start this summer

After years of development, the Veterans Health Administration (VHA) has created a respiratory protection device prototype that is expected to improve health care workers’ comfort and tolerance when wearing these devices.

The VHA has more than 300,000 employees, and the vast majority of them take care of veter-

ans in medical centers around the country, says **Lewis Radonovich**, MD, director of the national center for occupational health and infection control at the VHA in Washington, DC, and Gainesville, FL.

“Employees are required to wear respiratory protection devices at various times in their work and we want to make sure they have access to the most comfortable devices,” he adds.

The VHA is starting a clinical study of the prototype this summer, with the investigation expected to be completed by June 2015.

Project BREATHE (Better Respiratory Equipment using Advanced Technologies for Healthcare Employees) started six years ago.

“BREATHE is an effort to bring a new respirator to the U.S. health care market, specifically for health care workers,” Radonovich says. “We have been bringing health care workers into the study so they could inform the future design.”

The VHA is working with NIOSH’s National Personal Protective Technology Laboratory in Pittsburgh on the project, and they’ve engaged two private partners: 3M Corporation and Scott Safety.

“Our hope is that there will be at least one prototype on the U.S. market in a couple of years — devices that are more comfortable for employees,” Radonovich says.

Investigators will measure how well the prototype is tolerated by health care workers in a simulated provider-patient situation. A new measurement tool was created to more accurately assess health care workers’ tolerance for wearing filtering face-piece respirators, says **Sherri LaVela**, PhD, MPH, senior research health scientist at the VHA and Hines (IL) VA Hospital.

“We developed a survey from scratch,” she says. “We talked with health care staff and addressed the constructs that would need to be addressed in a survey or measuring instrument to get at the concept of comfort and tolerability.”

Researchers met with three focus groups, audiotaped the sessions, and transcribed them to do a qualitative analysis and come up with common themes. The result was a tool they call the R-comfi, which stands for Respirator Comfort-wearing Experience and Function Instrument, LaVela explains.

“We wanted something easy to remember and hoped they’d start calling it the ‘comfi,’ as in, ‘Hey, use a comfi tool,’” she adds.

As part of the project, health care workers at two VA hospitals were fit-tested for the com-

monly-used N95 respirator to assess their comfort and tolerability.¹ The study found that 53% of health care providers could tolerate a fit-tested respirator for 20 minutes or less. A greater proportion of male providers could tolerate wearing the respirator for more than 20 minutes than could female providers.

“Despite being the most commonly used respiratory device in the U.S. market, the tolerability and comfort level was strikingly poor among health care workers in our survey,” Radonovich says.

The most commonly cited areas of discomfort were:

- tightness of straps (36%);
- lack of fresh air (34%);
- overall tightness (31%);
- facial warmth/heat (29%).

“A lot of the female workers also complained about how the equipment interfered with their make-up or putting on chap stick,” LaVela says. “They were having dry lips.”

When the respirator prototype is used in a lab-simulated setting during the trials, researchers will measure comfort and tolerability as health care workers perform patient care tasks on volunteer patients or staff members, LaVela says.

“We need to compare the comfort levels among employees in a scientifically rigorous way,” Radonovich says. “This tool Sherri’s group created is important because we can be confident that it will measure what we want it to measure and distill it down to a basic level.”

Previous tools would record different results based on personal perceptions of what the rating numbers meant. So two people could be equally uncomfortable but one would rate the discomfort level an eight and another would rate it a two, he notes.

R-comfi eliminates much of the personal subjectivity by observing health care workers’ actions while wearing a respiratory protection device.

“[For example], we counted how many times people were tugging at it and pulling on it,” LaVela says.

REFERENCE

1. LaVela S, Locatelli S, Kostovich C, et al. Discomfort factors and tolerance times for health care providers wearing fit-tested filtering face-piece respirators. Abstract ## IDWeek conference, San Francisco, CA: Oct. 3-6, 2013. ■

Standardized EHR language needed

Goal is to analyze data, trends

Standardized language in health care is not yet universal, which can cause problems when implementing electronic health records (EHRs) in an employee health setting.

There are a dozen different standards just for nursing, says **Karen A. Monsen**, PhD, RN, co-director of the Center for Nursing Informatics at the University of Minnesota in Minneapolis, MN.

One of the key benefits of an EHR is how easily it can be used to analyze data and trends. From an occupational health perspective, this could inform decisions about vaccinations and wellness campaigns. But to pull out the best data one needs standardized terms. For example, it’s not as useful if information about tuberculosis vaccinations is labeled three or four different ways.

“How can we optimize our best practices?” Monsen asks. “How can we use standards for documentation and how can we get data to show us if we’ve made a difference?”

The answer is to use standardized language in all electronic documentation, she says.

“That in turn generates good structured data you can use for program evaluation,” Monsen adds.

If all hospitals were to agree to standardized language there could be many more benchmarking possibilities.

One area of study might be hearing loss prevention in the workplace, says **Madeleine Kerr**, PhD, RN, an associate professor at the University of Minnesota. Even with electronic health records for collecting hearing loss data, it’s difficult to understand on a national level whether prevention programs are working because the databases are not using standardized metrics, Kerr explains. Agreeing on standards is the challenge.

“Every discipline has its own idea of what standards are important and what needs to be used,” Monsen says.

“Using standards forces us to give up our fondness for the English language and how we can capture all nuances of diagnosis or patient concern,” she explains. “For instance, using the patient’s own words — we have to give up some of this when we use standards.”

Standardized language for EHRs requires classifications into small buckets. It also requires training,

teaching staff how to use the standardized terms, Monsen adds.

“That is challenging; people don’t really like it, and we have to show them why it’s important to go to the trouble to learn the standard,” she says.

When occupational health departments switch to electronic health records staff will have to learn to document with checkboxes instead of descriptive words.

“It’s about health care quality, but sometimes it’s hard for people to see that because the health records have become such a big part of our health care day,” Monsen notes.

Another barrier that arises when implementing EHRs and standardizing language is making sure information is easily accessible.

“It’s a workflow issue,” Monsen says. “We have the technology and want to manage it, so the next generation of this is to make it much more accessible and usable.”

A responsive implementation stage is crucial to the EHR success, Kerr notes.

“I think the key is to have this standardized, common language embedded in these electronic systems in a way that health providers can use it,” she says. “Early in the process, work with your information technology department to design it, and have end users — not just at the executive level, but people on the ground — involved from the very beginning.”

Monsen’s experience implementing EHR was in the 1990s. She was a manager of nurses who had to begin using electronic health records. She saw initial resistance, but soon the EHR use changed how nurses communicated about patient care and it made staff meetings much more efficient and effective, she recalls.

“We standardized our care plans, personalizing them for each individual, and we used that as the basis of our care,” Monsen says. “Soon we were able to demonstrate our outcomes and increase funding of our program.”

While using EHR in a general health care setting is different from using it in a hospital employee health setting, similar benefits could occur, she notes.

“With this kind of health record we could show whether we have a hearing problem or diabetes, overweight issues, substance use,” Monsen says. “We can incorporate all of this into a holistic assessment using a standard tool, and it supports employees in different ways than if we just made a checkmark on a form to show they had their hearing checked.” ■

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

- First public reporting nears for flu vaccination rates
- MERS puts spotlight on respiratory protection
- Are HCW clothes adding to infection risk?
- Measure ROI of employee wellness programs
- Measles resurges: Are you ready?
- Employee health issues and international staff

CNE QUESTIONS

1. According to the Centers for Disease Control and Prevention, what is the range of the incubation period for Middle East Respiratory Syndrome (MERS)?
 - A. 1 to 5 days
 - B. 1 to 14 days
 - C. 2 to 13 days
 - D. 5 to 10 days
2. The 10th (and latest) state to adopt a requirement for a comprehensive safe patient handling program is:
 - A. Massachusetts
 - B. Vermont
 - C. New Hampshire
 - D. New York
3. Which of the following is a sign that an employee might have a substance abuse problem?
 - A. Changes in behavior and irritability
 - B. Poor performance and unexplained absences
 - C. Volunteering for overtime and night shifts
 - D. All of the above
4. Which of the following is not one of the most commonly cited areas of discomfort for health care workers wearing face-piece respiratory devices?
 - A. Tightness of straps
 - B. Lack of fresh air
 - C. Anesthetic odor
 - D. Facial warmth/heat

EDITORIAL ADVISORY BOARD

Consulting Editors:

Kay Ball

PhD, RN, CNOR, FAAN Associate Professor, Nursing
Otterbein University
Westerville, OH

MaryAnn Gruden

MSN, CRNP, NP-C, COHN-S/CM
Association Community Liaison
Association of Occupational Health
Professionals in Healthcare
Manager Employee Health Services
Allegheny General Hospital
West Penn Allegheny Health System
Western Pennsylvania Hospital
Pittsburgh

William G. Buchta, MD, MPH
Medical Director, Employee
Occupational Health Service
Mayo Clinic
Rochester, MN

Cynthia Fine, RN, MSN, CIC
Infection Control/
Employee Health
San Ramon (CA) Regional Medical Center

June Fisher, MD
Director
Training for Development of
Innovative Control Technology
The Trauma Foundation
San Francisco General Hospital

Guy Fragala, PhD, PE, CSP
Consultant/
Health Care Safety
Environmental Health
and Engineering
Newton, MA

Janine Jagger, PhD, MPH
Director

International Health Care Worker
Safety Center
Becton Dickinson Professor of
Health Care Worker Safety
University of Virginia
Health Sciences Center
Charlottesville

Gabor Lantos

MD, PEng, MBA

President
Occupational Health
Management Services
Toronto

JoAnn Shea

MSN, ARNP

Director
Employee Health & Wellness
Tampa (FL) General Hospital

Dee Tyler

RN, COHN-S, FAAOHN
Director, Medical Management
Coverys Insurance Services
Executive President, Association
of Occupational Health
Professionals in Healthcare

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance

Phone: (800) 688-2421, ext. 5511

Fax: (800) 284-3291

Email: stephen.vance@ahcmedia.com

To obtain information and pricing on group discounts, multiple copies, site-licenses, or electronic distribution please contact:

Tria Kreutzer

Phone: (800) 688-2421, ext. 5482

Fax: (800) 284-3291

Email: tria.kreutzer@ahcmedia.com

Address: AHC Media LLC
One Atlanta Plaza
950 East Paces Ferry NE, Ste. 2850
Atlanta, GA 30326 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission

Email: info@copyright.com

Website: www.copyright.com

Phone: (978) 750-8400

Fax: (978) 646-8600

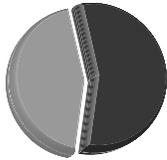
Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

Nurses: Protect Yourself and Your Patients—Use a Lift

Registered nurses are listed as one of the top 5 occupations with the highest number of musculoskeletal disorders requiring days away from work.^{1,2}

More than 1.5X as high as the average for all occupations

Over 11,000 musculoskeletal injuries in nurses occurred in 2011, with an incidence rate of 58.2 per 10,000 full-time workers and a median of 8 days away from work.^{1,2}



56% of surveyed nurses experienced musculoskeletal pain caused or made worse by the job.³

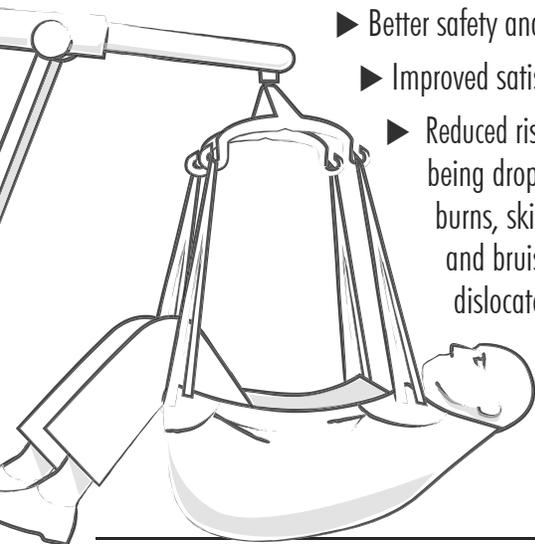
The consequences of musculoskeletal injuries⁴

- ▶ Chronic pain
- ▶ Disability
- ▶ Inability to work
- ▶ May be less productive
- ▶ More susceptible to additional injury

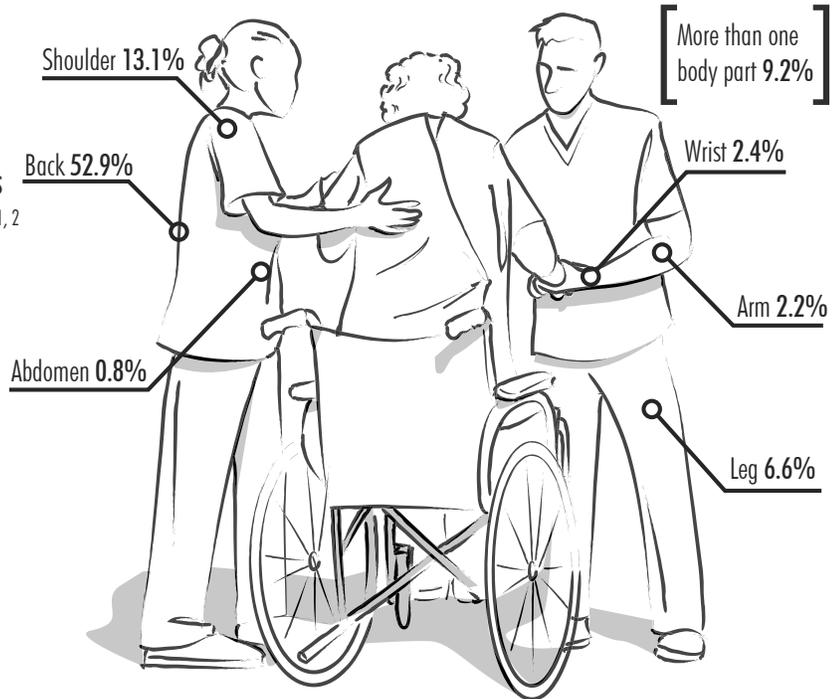


Use of lift equipment can decrease injuries. Patients can also benefit from lifting equipment, through:³

- ▶ Better safety and comfort
- ▶ Improved satisfaction
- ▶ Reduced risk of falling, being dropped, friction burns, skin tears and bruising, and dislocated limbs



The body parts most frequently injured are the back and shoulders.^{2,3}



Musculoskeletal injuries in healthcare are often related to repeated manual patient handling activities, such as transferring and repositioning patients, and working in awkward positions.⁴

High-risk tasks include:⁴

- ▶ Transfers: from toilet to chair; from chair to bed; from bathtub to chair
- ▶ Repositioning: from side to side in bed; a patient in a chair
- ▶ Lifting a patient in bed
- ▶ Making the bed with the patient in it

Even though 2/3 of nurses indicated that patient lifts are available at their facility, less than 1/3 use them frequently.³



Maximum weight for manually moving or handling any patient is 35 lb. Protect yourself—and your patients—from pain and injury by using lifting equipment.⁵

¹ Bureau of Labor Statistics. U.S. Department of Labor. Economic news release: table 18 [online]. 2012 Nov 8 [cited 2013 Aug 2]. <http://www.bls.gov/news.release/osh2.t18.htm>
² Bureau of Labor Statistics. U.S. Department of Labor. Economic news release: nonfatal occupational injuries and illnesses requiring days away from work, 2011 [online]. 2012 Nov 8 [cited 2013 Aug 2]. <http://www.bls.gov/news.release/osh2.nr0.htm>

³ Massachusetts Nurses Association. Safe patient handling toolkit [online]. 2011 [cited 2013 Aug 9]. http://www.massnurses.org/files/file/Health-and-Safety/Articles/Safe_Patient_Handling/Safe_Patient_Handling_booklet_2011.pdf

⁴ Occupational Safety & Health Administration. U.S. Department of Labor. Safe patient handling [online]. [cited 2013 Aug 2]. <https://www.osha.gov/SLTC/healthcarefacilities/safepatienthandling.html>

⁵ Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. CDC congressional testimony: safe patient handling lifting standards for safer American workforce [online]. 2010 May 11 [cited 2013 Aug 5]. <http://www.cdc.gov/washington/testimony/2010/20100511.htm>

Dear *Hospital Employee Health* Subscriber:

Here's a change we know you'll like: From now on, you can earn continuing education credit for each individual issue.

No more having to wait until the end of a 6-month semester or calendar year to earn your continuing education credits or to get your credit letter.

Starting now, you can earn up to 1.25 nursing contact hours *for* each issue of *Hospital Employee Health* and up to 15 total annually.

Here's how to earn your credits:

1. Read and study the activity, using the provided references for further research.
2. Log on to cmecity.com to take a post-test. First-time users must register on the site using the 8-digit subscriber number printed on your mailing label, invoice or renewal notice.
3. Pass the post-test with a score of 100%; you will be allowed to answer the questions as many times as needed to pass.
4. Complete and submit an evaluation form.
5. Once the evaluation is received, a credit letter is emailed to you instantly.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. Our fax is (800) 284-3291 or outside the U.S. at (404) 262-5560. We are also available at customerservice@ahcmedia.com.

Thank you for your trust.

Sincerely,

A handwritten signature in black ink, appearing to read 'Lee Landenberger', with a stylized flourish at the end.

Lee Landenberger
Continuing Education & Editorial Director