HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

NOVEMBER 2014 Vol. 33, No. 11; p. 121-133

INSIDE

AHC Media

CMS flu shot reporting raises thorny issue of vaccination status of docs, non-hospital employees

Immunization rates will be open to public scrutiny

Patients will soon be able to check the influenza vaccination rates of health care workers at the nation's hospitals through Hospitalcompare.gov, the website of the Centers for Medicare & Medicaid Services (CMS). That specter of public reporting has helped spur the rising rates of flu vaccination in hospitals, but it will also reveal the continuing problem of tracking the vaccination status of doctors, advanced practice nurses and physician assistants who are not hospital employees.

Only 62% of licensed independent professionals received their flu vaccine in the 2013-2014 flu season, according to the reports of 4,254 hospitals for the CMS quality measure – but that figure is skewed by significant underreporting. Vaccine status was unknown for about one-third (35%) of licensed independent professionals in the hospital reports.[1]

"They're a very mobile population. They're doing work at a number of facilities," says **Megan C. Lindley**, MPH, deputy associate director for science at the Immunization Services Division of the National Center for Immunization & Respiratory Diseases at the Centers for Disease Control and Prevention. "They're not necessarily at the facility all the time and they don't necessarily know when they're going to be at the facility."

> "ONLY 54% OF NURSES AIDES IN LONG-TERM FACILITIES REPORTED THEY RECEIVED THE FLU VACCINE IN 2013-2014.

When the measure was developed, hospitals expressed concerns about tracking non-employees. The criteria will

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.

HOSPITAL EMPLOYEE HEALTH

Hospital Employee Health®,
ISSN 0744-6470, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

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

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

EDITORIAL E-MAIL ADDRESS:
leslie.hamlin@ahcmedia.com.

SUBSCRIPTION PRICES:
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.

MULTIPLE COPIES: 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.)

ACCREDITATION: 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, (gary.evans@ahcmedia.com).
CONTINUING EDUCATION AND EDITORIAL DIRECTOR: Lee Landenberger

EDITORIAL QUESTIONS:
For questions or comments call **Michele Marill** at (404) 636-6021.

Strategies to track flu shots

Work with credentialing offices, sister facilities

Too many "unknowns" in your flu vaccination reporting can make it seem that your hospital's rate is lower than it really is. Hospitals shared successful strategies they used to track the vaccination status of licensed independent practitioners (physicians, advanced practice nurses and physician assistants) with the National Healthcare Safety Network of the Centers for Disease Control and Prevention (www.cdc.gov/nhsn/PDFs/HPS/General-Strategies-HCP-Groups.pdf).

Employee health professionals often worked with medical staff coordinators, credentialing offices, licensing boards, and sister facilities to track licensed professionals.

Other strategies included:

- Sent a letter along with a vaccination status survey and asked LIPs to return it to the credentialing office.
- Offered vaccination and/or collected vaccination status information during staff or department meetings, grand rounds, facility rounds, volunteer activities, and lunch.
- Organized clinics for LIPs to receive the flu vaccine and complete consent forms.
- Placed telephone calls to physicians' offices to obtain information for non-responding health providers.
- Asked the medical director to send a letter to non-responding health providers. ■

be reviewed in 2015, but licensed independent practitioners are likely to remain an important group because of their close patient contact, Lindley says.

"It continues to be a real balancing act between something that is feasible for hospitals and [a measure] that is comprehensive," she says.

Doctors and nurses report very high levels of influenza vaccination. In an Internet panel survey conducted for CDC, 92% of physicians, 91% of nurses and 90% of nurse practitioners and physician assistants said they received the vaccine in the 2013-2014 season.[2]

Health professionals were recruited for the survey through previous Internet panels and Medscape membership. CDC has been conducting Internet surveys to gain more rapid information on vaccination trends, says Lindley.

So are doctors and other licensed professionals receiving their vaccines but failing to provide documentation to all the facilities at which they work? Or does the Internet survey overstate their vaccination status?

"You've got motivated people who are taking time to complete the survey," says **Dee Tyler**, RN, COHN-S, FAAOHN, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP). "I suspect that's the correlation with such a high vaccination rate."

Employee health professionals often struggle to obtain physician participation with other initiatives, such as tuberculosis screening, she says.

CDC's National Healthcare Safety Network, which collects the data from

CMS, shows high compliance among those physicians, advance practice nurses and physician assistants who do report. Some 95% of licensed independent practitioners whose vaccine status was known had received the flu vaccine.

To track flu vaccination status, EHPs often work with the medical credentialing office or the medical staff office. Another option may be to tap into vaccine registries, says Tyler. Some states, such as Wisconsin, California, Georgia, Tennessee and Delaware, maintain registries of both child and adult immunizations that are available to health providers. (See related story, p.122.)

Hospitals hit Healthy People 2020 goal

While hospitals still struggle with vaccination of licensed independent practitioners, they have achieved high rates of employee vaccination – with or without a vaccine mandate.

Overall, 91% of hospital employees whose vaccine status was known had received the influenza immunization. That exceeds the Healthy People 2020 goal of 90% influenza immunization of health care workers.

More than half (58%) of health care workers in hospitals reported that their employers require the flu vaccine. Vaccine coverage was 80% among those who said their facilities offered free onsite vaccination for more than one day.

"We have seen voluntary vaccination programs that have had very high, successful vaccination rates," says **Mark Catlin**, health and safety director for Service Employees International Union (SEIU) in Washington, DC. "They make it easy for people to get vaccinated. They provide good education. They do the things that encourage people to get vaccinated."

Public reporting of vaccination rates gains the attention of hospital administrators, who make a stronger commitment to the efforts, says **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University in Nashville, TN, and past president of the National Foundation for Infectious Diseases.

"They provide more resources and encouragement to occupational health and infection control," he says. "They let everyone in the institution know that this is what's now expected and that helps drive [participation] up."

Mandatory policies clearly play a role in the rapid rise in vaccination rates among hospital employees. In facilities with a requirement, 98% of health care workers are vaccinated, according to the Internet survey.

Mandates also may be a factor in differences among states. For example, Rhode Island requires all health care workers to receive the flu vaccine or wear a mask during influenza outbreaks. Hospitals reported a vaccination rate of 90% of employees and 88% of licensed independent practitioners.

New Jersey had the lowest vaccination rates: 71% of hospital employees and 39% of licensed professionals.

Many nursing homes don't offer free shots

Long-term care continues to lag in influenza immunization – despite the risk to vulnerable elderly residents.

Only 54% of nurses' aides in long-term care facilities reported that they received the flu vaccine in 2013-2014. About 43% of long-term care workers said their employers didn't promote or require the vaccine, and 73% said flu vaccination wasn't available on-site.

"It's distressing that administrators of those facilities don't provide the vaccine on site for free," says Schaffner. "Those are such elementary aspects of health care worker influenza immunization. I was stunned when I read that, frankly."

Public health authorities and infection control organizations will likely place a new focus on long-term care, he says. Public reporting may eventually be on tap, as well. "All the things that appear to be working in hospitals should apply to long term care facilities," he says. ■

REFERENCES

1. Lindley MC, Bridges CB, Strikas RA, et al. Influenza vaccination performance measurement among acute care hospital-based health care personnel — United States, 2013–14 influenza season. *MMWR* 2014;63:812–815.
2. Black CL, Yue X, Ball SW, et al. Influenza vaccination coverage among health care personnel — United States, 2013–14 influenza season. *MMWR* 2014;63:805–811.

NIOSH: Beware of new targeted cancer drugs

Repeated exposures can add up to a significant hazard

For the first time, conjugated monoclonal antibodies have been added to a list of drugs that pose an occupational hazard. The new cancer treatment targets tumors with deadly toxins – but also can produce some

residue that could put health care workers at risk, safety experts caution.

The drugs are among more than 150 on an updated list released by the National Institute for Occupational Safety and Health (NIOSH), which issues a roster of drugs that can cause cancer or reproductive effects. In 2014, 27 new drugs were added and 12 removed based on NIOSH criteria. The list will be updated again in 2016.

Health care employers need to constantly review new treatments to ensure that employees have the training and protection they need, says **Thomas Connor**, PhD, research biologist with the NIOSH's Division of Applied Research and Technology and an expert on hazardous drugs and occupational safety.

For example, the conjugated monoclonal antibodies produce fewer side effects for cancer patients than older chemotherapy agents. But manufacturers warn that trace amounts of the toxin could be in a free state and could pose a risk for workers handling the drugs, he says.

"These are extremely toxic compounds bound to the monoclonal antibody (which targets the tumor)," Connor says.

Overall, administering oral chemotherapy is safer for workers than intravenous versions. But if the pills are not coated, they may leave a powder residue in the counting tray, which poses a risk of inhalation or dermal contact, Connor says.

Crushing pills to place them in apple sauce or liquid and make them easier to ingest also may expose health care workers, he says. Repeated, small exposures add up to a significant hazard, he says.

A 10-member expert panel reviews drugs and places them on the list based on six criteria: carcinogenicity, teratogenicity (causing birth defects), reproductive toxicity, organ toxicity at low doses, genotoxicity (causing mutations or other genetic damage), or new drugs that have a structure and toxicity that mimics existing drugs that have been deemed hazardous.

States move to reduce HCW drug exposures

NIOSH's hazardous drug designation plays an important role as states develop new laws to protect health care workers from hazardous drugs.

In Washington state, employers must develop and implement a hazardous drug control program by January 1, 2015. They must complete employee training by July 1 and install "appropriate ventilated cabinets" to protect workers handling hazardous drugs by January 1, 2016.

Last year, the California legislature directed the Occupational Safety and Health Standards Board to develop a rule protecting health care workers from antineoplastic drugs. An advisory committee held its first meeting in June 2014.

And in July, North Carolina passed a law requiring new rules to protect health care workers from antineoplastic drugs, in line with NIOSH recommendations.

All hospitals will be subject to new standards when the U.S. Pharmacopeial Convention finalizes its proposed chapter on "Hazardous Drugs — Handling in Healthcare Settings" (USP 800). The USP standard provides specific guidance on personal protective equipment, handling and transport, cleaning and waste disposal, and medical surveillance of workers.

For example, compounding or other manipulation of drugs must occur using engineering controls in a negative pressure environment, with external venting, the USP chapter states. USP standards are enforced by state boards of pharmacy, Connor says.

With the proposed chapter, the USP would require facilities to use the NIOSH hazardous drug list and suggests that they may add other substances not on the NIOSH list. "The entity's list shall be reviewed at least annually and whenever a new agent or dosage form is used," the proposed chapter says. "If the information provided is deemed insufficient to make an informed decision, the drug should be considered hazardous until more information is available."[1]

Make your own hazardous drug list

Ultimately, employers are responsible for determining which of their drugs pose occupational hazards, NIOSH says in its guidance.

"Not every institution is going to use every drug on this list. Go through the formulary. See which drugs match up with the hazardous drug list, then make a list for [your] employees," advises Connor.

Hospitals also should review new drugs and look at the properties of specialty and investigational drugs, he says.

NIOSH also reminds health care employers that:

- They must comply with the Hazard Communications Standard of the Occupational Safety and Health Administration (OSHA), which requires labeling of hazardous chemicals and annual training of employees. Training also must be provided when hospitals introduce new drugs or new ways of administering drugs.
- The tablet or capsule form of hazardous drugs should not be placed

in automated counting machines.

• If toxicological data isn't available on an investigational drug, but "the mechanism of action suggests there may be a concern," it should be treated as hazardous until there is enough information to show that the drug does not pose a risk. ■

[Editor's note: The updated NIOSH list is available at www.cdc.gov/niosh/docs/2014-138/pdfs/2014-138.pdf.]

REFERENCE

1. U.S. Pharmacopeial Convention. General Chapter <800> Hazardous drugs—handling in healthcare settings. Available at www.usp.org/usp-nf/notices/compounding-notice.

CA takes another aim at workplace violence

New standard could become a model for health care

Early in the morning on Easter Sunday, a man strode past the weapons screening area of Olive View-UCLA Medical Center in Los Angeles and, without warning, began stabbing a nurse in the torso. She survived, but was in critical condition. Seven hours later, at Harbor-UCLA Medical Center elsewhere in Los Angeles, another man evaded screening and approached a group of nurses. He stabbed one in the ear with a pencil.

Those incidents may have been fresh in the minds of safety regulators when the California Occupational Health and Safety Standards Board voted unanimously to accept the petitions of two unions and begin work on a workplace violence standard.

A Cal-OSHA advisory committee began the rulemaking process in September, after the Standards Board concluded that "[v]iolence against health care workers is a serious and ongoing problem." Current regulations aren't adequate, the board said, agreeing with the unions' contention.

"This has become an emergency," says **Richard Negri**, health and safety director of SEIU Local 121RN in Pasadena. "It's not an isolated issue in one part of California, or with one class of worker. It's happening so regularly, and the agencies that are charged with enforcing it have their hands tied because they don't have the [necessary] regulation."

California currently enforces a workplace violence rule through the state's Department of Public Health, which doesn't have inspectors geared toward worker safety violations, Negri says. The state's Injury and Illness Prevention Program rule also isn't adequate to address this hazard, he says.

Although they had denied two previous petitions, the Standards Board agreed, stating that "the necessity for improved workplace violence prevention standards has been established."

Violence grows nationally, states pass safety laws

Twelve states have laws or regulations that address workplace violence in hospitals. Violent incidents in hospitals capture the nation's headlines and continue to attract concern.

The rate of injury from workplace violence in hospitals actually rose from 2011 to 2012, according to the U.S. Bureau of Labor Statistics. The General Accounting Office is reviewing the effectiveness of the voluntary guidelines of the U.S. Occupational Safety and Health Administration.

In that context, California can provide a framework for addressing the issue, says **Jane Lipscomb**, PhD, RN, FAAN, professor in the University of Maryland School of Nursing and Medicine in Baltimore and an expert on workplace violence.

"California has a long history of leading the way around a lot of progressive policies. I really think [the new standard] is going to have implications far beyond California," she says. "If it's successful, there will be a better model out there for the rest of us to emulate."

Staffing, security and training are all important components of workplace violence prevention, says Lipscomb. But enforcement is necessary to ensure compliance, she says.

The Standards Board is convening stakeholder meetings to draft the regulation, listening to both the employer and worker perspectives.

The SEIU has compiled more than a hundred stories of health care workers injured in violent incidents. "Health care workers are among the highest victims of [workplace] violence. All of the statistics and studies are proving that this is an issue that needs to be regulated," says Negri.

He is hopeful that a new regulation will spur hospitals to take a more proactive approach to preventing violence. "Health care workers are on the frontlines of this violence that we can regulate by looking at the predictability of the incidents and bringing on mechanisms of prevention," he says. ■

Fantastic 4: Diligence, culture, leaders, ergonomics

Practices and policies reduce injury rates

Hospitals with solid organizational practices and policies, including better ergonomic practices, have lower injury rates among nurses, a new study finds.

Lower injury rates also were reported by nurses in units where they described better safety leadership, greater safety diligence, stronger people-oriented culture, and higher social support from coworkers.[1]

"We were interested in finding out the extent to which policies and procedures that were implemented at the unit level affected reported injury rates," says **Les Boden**, PhD, a co-author of the study and a professor of public health at the Boston (MA) University School of Public Health.

"We looked at the number of injuries on different units where nurses and aides worked and we asked nurses and aides on those units to describe different aspects of the unit, including the support they received from their supervisors and coworkers, the safety leadership on the unit, ergonomic practices on the unit, and the unit's culture," Boden explained. "Was the culture oriented toward thinking about the lives of people working on the unit?"

Researchers looked at injuries where employees missed work, as well as injuries where they did not take a day off from work. Ergonomic injuries caused the most days-away-from-work injuries, Boden notes.

"These were predominantly back and shoulder injuries," he says. "Most of the non-day-away-from-work injuries were sharps injuries."

Four positive factors

Nurses were positively impacted by four policies: safety diligence, people-oriented culture, safety leadership, and ergonomics. In hospital units where these four factors received positive reports from nurses, injury rates among

OSHA: Report all work-related hospitalizations

New recordkeeping rule effective Jan. 1, 2015 requires OSHA report within 24 hours

If an employee is hospitalized for a work-related injury, employers must now report the incident to the Occupational Safety and Health Administration within 24 hours.

OSHA updated its recordkeeping standard in September to expand the type of serious injuries that must be reported promptly. The agency previously required the reporting when three or more employees were admitted to the hospital for work injuries from the same incident.

Employers also must report any amputations or the loss of an eye within 24 hours and any fatalities within eight hours. The new requirements become effective on January 1, 2015.

With the recordkeeping changes, OSHA also is moving toward electronic submission and public reporting. The agency will make the information about these serious injuries available on its website.

The reporting of these serious injuries will spur greater efforts for prevention and trigger dialogue between employers and OSHA, OSHA administrator **David Michaels**, PhD, MPH, said in a press conference.

"We believe that as a result of this interaction the employer will be more likely to take the steps necessary to protect the lives and limbs of their employees," he said.

In November 2013, OSHA proposed a rule that would require employers with 250 or more employees to submit their injury and illness logs electronically each quarter. OSHA said the electronic reporting would provide more complete and timely data about occupational injuries and illnesses. Critics say that such public reporting is shaming and may backfire as employers would become more reluctant to report. (See related article in *HEH*, December 2013, p. 133.) ■

[Editor's note: More information on the new OSHA recordkeeping requirements is available at www.osha.gov/recordkeeping2014/index.html.]

nurses were lower, Boden says.

From a hospital employee health perspective, the findings suggest that overall hospital injury rates can be lowered with strong policies and education related to ergonomics. Also, hospitals can reduce injuries among nurses with further policies and practices, including promoting safety leadership and a people-oriented culture, Boden suggests.

The study evaluated the four factors in these ways:

Safety diligence: Researchers asked nurses and aides about housekeeping on the unit and whether there were unsafe working conditions.

"We asked whether supervisors confronted and corrected unsafe behaviors and hazards and whether action was taken when safety rules were broken," Boden says.

Safety leadership: "We looked at whether supervisors were trained in recognizing job behaviors and safe practices," Boden says.

People-oriented culture: "We asked whether employees on the unit are involved in decisions affecting their daily work and whether working relationships on the unit are cooperative," Boden says.

The questions also focused on trust between employee and employer and whether a unit's communication is open and whether employees feel free to voice concerns and make suggestions, he adds.

Ergonomics: "We asked whether the work is designed to reduce patient lifting and to reduce lifting heavy equipment, pushing and pulling, and bending, reaching, and stooping," Boden says.

There's an inherent variation in the risks of injury between units.

For instance, a neonatal unit will have less risk of injury from lifting patients. Also, an emergency department will have greater risk of injuries from sharps or exposure to infectious diseases. And a psychiatry department has greater risk of violence, Boden explains.

"But we found in addition to these differences there were policies that generally tended to be associated with higher or lower risk," he adds.

"We found in general that units that have a focus on identifying and correcting hazards on units and paying attention at the unit level to potential injury risk appear to make a difference," Boden says. "In addition, a hospital that has supervisors who work to improve -- not just the health and safety of staff -- but also to improve the culture of the unit and cooperation and trust, have an additional effect on safety." ■

REFERENCE:

1. Tveito TH, Sembajwe G, Boden LI, et al. Impact of organizational policies and practices on workplace injuries in a hospital setting. *JOEM* 2014;56(8):802-808.

Employee health can lead efforts to make hospitals an age-friendly workplace

Address falls, hearing and vision issues

With 5.7 million workers employed in hospitals, population workforce aging trends are hitting the industry hard.

The nursing and nursing aides' shortages are combining with the demographic trend of older female employees — an average of 47 years for RNs — suggest that nurses and other health care workers will need to continue working into advanced age in the next decade.[1]

These statistics also point to the need for hospitals to be proactive in addressing the physical needs of older workers, who may need accommodations in their workspace to help prevent falls and other injuries. Other changes might include addressing older workers' lower stamina when it comes to 12-hour shift work and improving lighting and noise issues that disproportionately impact older staff, says **Kenneth A. Scott**, MPH, former outreach director of the Mountain and Plains Education and Research Center in Aurora, CO. Scott has researched the issue of aging hospital workforces.

Hospitals that overlook this demographic trend and fail to make accommodations for older workers might experience rising retirement rates among nurses and other staff. Research shows that older nurses are more likely to retire if they experience poor health and perceive their work ability to be declining.[1]

Federal labor data show that hospital workers are among those with high injury and illness rates, and the number of lost work days resulting from injuries and illnesses increases steadily with age. Employees who are 65 and older have nearly three times the median days away from work as those in their early 20s.[2]

"Severity of injury tends to increase with age, regardless of the type of injury," Scott says.

The U.S. Department of Labor's data on median days away from work provide a glimpse at severity of injury

or illness. The longer they're away from the job, the longer it is taking them to recover.

Hospital workforces are aging as more health care workers delay retirement, and this trend requires employers to adjust their programs and policies to accommodate older workers, Smith says.

While older hospital workers miss more work due to their injuries, they do not have a monopoly on worksite injuries.

"Injuries tend to be more and less frequent with age," Scott says. "Slip and fall injuries tend to be more common with age, and overexertion injuries people suffer while lifting patients tend to be less frequent with increasing age."

One possible explanation is that hospital workers tend to become less involved with the manual labor aspects of work as they get older, Scott adds.

"If people in their early 20s are doing most of the manual patient transfers, then it stands to reason they'd be more likely to be injured," he explains. "Fall injuries have to do with physiological changes that occur with age – balance issues."

Hospitals should address slip and fall prevention injuries among older employees because it's a cost-effective strategy, Scott says.

"If we know an injury will be more severe or more costly among older workers then it might change the cost-benefit analysis of implementing a certain technology," he explains. "A nurse who is 67 years old and who throws out her back while handling a patient might have a much higher workers comp claim and medical costs than would a worker who is 25 years old."

From an occupational health nurse's perspective, this suggests a need for patient handling programs and return to work programs, Scott says.

"If there is a return to work program that helps people without pushing them too hard then that might be worth considering by hospitals' occupational health nurses," Scott says.

Consider workplace modifications

Another way to prevent injuries among older staff is to modify physical working space. Scott offers these suggestions:

Focus on age-friendly design: Hospitals are better designed for older and disabled people than are many worksites, but there still is much they could do to improve their workplaces, Scott says.

"I'd recommend they make changes based on the principals of universal design," he says.

For example, one strategy is to take a cut out of the curb on the outside of the hospital, Scott suggests.

"This is something not many hospitals are adopting yet," he notes.

Another strategy is to use slip-resistant floors in more than the geriatric wings.

"These floors are better for older adults, who are more likely to fall, but they can help younger adults, as well," Scott says.

Focus on age-related hearing loss and eyesight issues: Older nurses and other staff would benefit from plastic magnifying glasses and magnifying sheets that help them read medication labels and instructions, Scott suggests.

"Another issue worth mentioning is background noise," Scott says. "As people age, their hearing tends to decline, and it makes it difficult for them to concentrate and hear a conversation."

Also, background noise can interfere with communication for those experiencing hearing loss, he says.

"Some emergency rooms are being redesigned to be better for the older population by eliminating background noise," Scott says. "It's better for older patients who may have a difficult time hearing what the health care provider is telling them, and it may be better for aging health care providers who have age-related hearing loss – or for younger health care providers who have hearing loss because their iPods are cranked up too high."

These types of design strategies are better for everyone, which is what universal design is about, Scott says.

"The goal is to design workplaces that are accessible for everyone," he adds.

Design work schedules to accommodate age-related sleep problems: "Shift work is an issue because people's sleep patterns change as they age," Scott says. "So sometimes health care workers have a tougher time working nights than they did when they were younger."

This is a difficult subject for employee health staff to approach because hospital shift work is necessary and often based on particular employee issues. But it is worth discussing with managers the possibility of scheduling shifts according to what will work with aging staff.

"Aging is a very personal thing," Scott notes. "When you look at the life of an individual there are things related to age that you can't capture with statistics." ■

REFERENCE

1. McPhaul KM, Lipscomb J. Healthy aging for a sustainable workforce. Report by the Association of Occupational and Environmental Clinics. 2009. Available online: http://www.elcosh.org/document/1684/957/d000987/2b-.html.
2. Bureau of Labor Statistics, U.S.

Department of Labor. 2012 Nonfatal occupational injuries and illnesses: cases with days away from work. November 2013. Available online: http://www.bls.gov/iif/oshwc/osh/case/osch0050.pdf.

Hypertension a major risk for many hospital workers

Stress triggers include job insecurity, hostile workplace in health care support positions

Hypertension is a major risk factor for cardiovascular disease and other leading causes of death, and now a new study has found that some hospital workers have significantly higher risk of developing the disease.

Hospital workers have an 18% greater chance of dying from hypertensive disease as someone in the general population, according to the Centers for Disease Control and Prevention's (CDC's) workplace safety data.[1]

However, when researchers, using the 2010 National Health Interview Survey, recently compared hypertension by profession they saw a slightly different picture: nurses, physicians, and pharmacists reported hypertension at a rate quite similar to the general population. But significantly higher rates of the disease were reported by staff in health care support positions, including nursing assistants, phlebotomists, pharmacy assistants, and medical transcriptionists, says **Haripriya Kaur**, MPH, PhD-candidate, an instructor at the University of Nebraska Medical Center in Omaha, NE. Kaur worked with CDC investigators on the recently-published study.

"We looked at hypertension and four factors: worried about being unemployed, being threatened or harassed on the job, working long hours, and having difficulty balancing work and family responsibilities," Kaur explains. "Our study found that hypertension was higher among workers worried about becoming unemployed and among those working in hostile environments."

Investigators concluded that the stress associated with job insecurity or a hostile work environment should be addressed by employers to improve workers' health.[2]

Employee health programs should address both individual and workplace factors that contribute to hypertension, Kaur suggests.

"More in-depth studies are needed," she adds. "We think there is a need to consider workplace interventions aimed at reducing hypertension, as well as addressing individual behaviors involving diet and exercise."

For instance, a hospital could provide counseling for employees who say they are experiencing a hostile work environment or stressful shift work, Kaur says.

"There definitely is a lot of stress in the hospital with people working odd shifts and night shifts," she says. "A changing sleep pattern can be responsible for those things. It has been shown that night shift workers have a higher risk of hypertension, and they might smoke more or have a higher intake of caffeine."

All of these factors can contribute to poor sleep patterns, poor physical health, and stress, she adds.

Employee health directors can educate staff to report workplace problems that cause them stress.

"This question needs to be asked more," Kaur says.

There was no hypertension association with those reporting long work hours and having difficulty balancing family life and work.

Job insecurity also was associated with higher risk for hypertension, and this could also be a problem more for lower-level hospital workers than for nurses, pharmacists, and physicians.

"We cannot say why there was a higher risk among lower level health care workers," Kaur says. "Possible reasons could be their lower level socioeconomic status and their working more odd shifts."

Researchers did not take into account shift work, although other studies have found an association between shift work and hypertension, she adds.

"So that could be a reason," Kaur says. "Shift and night work interfere with cortisol levels and could be a reason why these workers have increased stress." ■

REFERENCE

1. Workplace Safety & Health Topics: Proportionate mortality for cardiovascular, neurodegenerative, & renal diseases by industry for health care & social assistance sector. Centers for Disease Control and Prevention. Available online: http://www.cdc.gov/niosh/topics/noms/noms2charts/healthcare/noncancer-index.html.
2. Kaur H, Luckhaupt SE, Li J, et al. Workplace psychosocial factors associated with hypertension in the U.S. workforce: A cross-sectional study based on the 2010 National Health Interview Study. *Am J Ind Med* 2014;57(9):1011-1021.

Next crisis? Prepare with a systems approach

Expecting the unexpected : 'The best managers are people who don't lose that human touch.'

Whether it's a rare flu epidemic like H1N1, a natural disaster or a major hospital technology overhaul, hospital employee health departments can just about predict the arrival of something unpredictable every year or two.

The key is to apply a systems approach to any project or crisis that takes attention away from daily challenges and priorities.

Hospital occupational health nurses (OHNs) are very good at juggling many priorities, but it is all too easy to get bogged down in the details, says **Linda Meuleveld**, RN, COHN-S, CCM, occupational health consultant and trainer at Med Manage Consulting, LLC, in Salem, OR.

"The best managers are people who don't lose that human touch and who are able to look at their work from a systems approach," Meuleveld says.

When a hospital OHN is asked to take on new work, it's important to think about the end game, Meuleveld says.

"What is it you are trying to achieve today? What is the end game here?" she says. "Kind of work backwards to see how you are going to achieve that."

When a crisis occurs or when the hospital starts a project that promises to be time-consuming, an OHN will need to carve out time even when every minute of the work day has been covered already. One way to do this is to identify the essential functions of what has to be done and break these down into steps that can be followed, Meuleveld says.

"Network with people and find out everything you can about the project or crisis and who it's going to influence," she advises.

"You don't work in a silo; you may be employee health, but there are layers of management you are working with and upstream and downstream contacts," she adds. "The more people you know through networking, the easier your job will be."

Meuleveld suggests each new crisis or project be approached systematically, following these steps:

Step 1: Identify your objectives and synch those with your manager: Research is part of identifying objectives, Meuleveld says.

"You have to give it thought to decide your plan of action," she explains. "In the first blush of a new project, not everyone really knows where it's going to go."

So the hospital OHN should clarify the employee health office's goals and align these with management's goals.

"That's a step that nurses do not always do," Meuleveld notes. "When they're given the task of getting something done, they will have lots of ideas and experience and then just go for it."

If the plan isn't successful then it's probably because it wasn't in synch with management's goals, she adds.

"If you want to have a successful project you always have to have a good discussion with your boss," she explains. "Set a meeting, saying, 'Hi, I have some ideas and would like to see what you think.'"

It likely would take only 15 minutes to make sure a plan agrees with management's objectives, Meuleveld adds.

Step 2: Identify the key players: Determine key players and whether it's necessary to ask other nurses for help, Meuleveld advises.

"Do you need to ask industrial hygiene or safety to become involved?" she says. "This project may not be a concern for all hospital employee health nurses, but it is for many.

Email communication is fine for setting up short meetings, Meuleveld says.

"You can make it a stand-up meeting, saying, 'Hey, we're going to get together and talk about this after our next team meeting, so if you could stick around for 15 minutes that would be great,'" she suggests. "Then get their buy-in."

The goal is to give key players a heads up, letting them know that you'll need their help down the road, Meuleveld says.

Step 3: Work on the details: Projects and crises might require new schedules, new products, reserved rooms, and marketing.

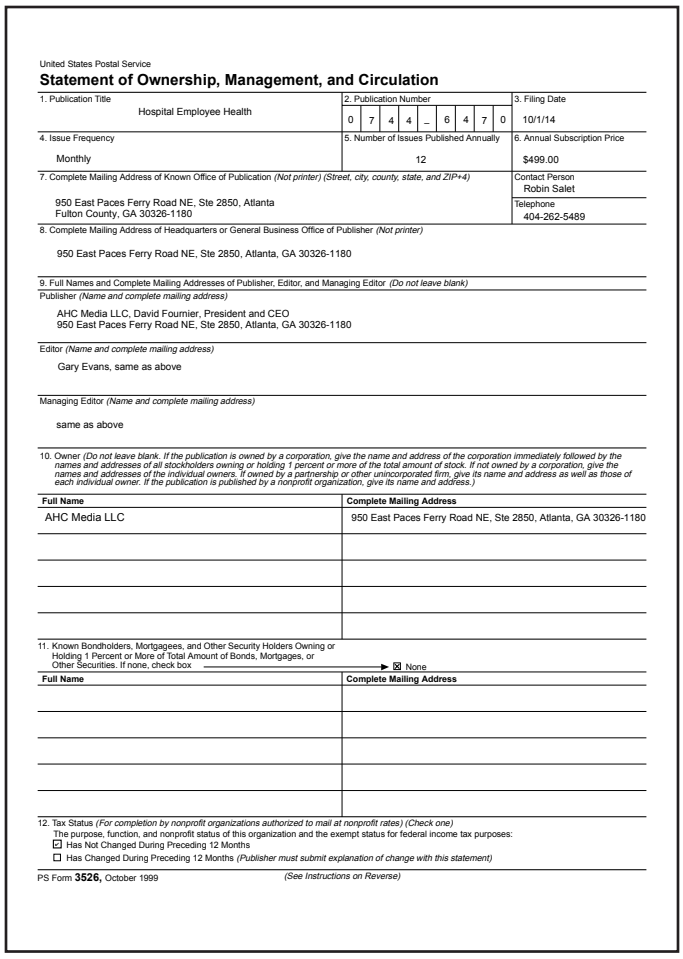
"If you're doing flu shots for something like H1N1 then you will need a flu shot schedule, a room, personnel, and supplies," Meuleveld explains.

After writing a detailed plan, show it to a manager or colleague so someone else might catch anything left out, she adds.

Step 4: Implement: If implementation runs into trouble it could be the result of incomplete steps one through three.

"Some of the things I've seen go wrong are people getting so involved in details that they forget to publicize the project," Meuleveld says. "The marketing is very important."

Or someone might have



United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Hospital Employee Health	0744-6780	10/1/14
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$499.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta
Fulton County, GA 30326-1180
Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
AHC Media LLC, David Fournier, President and CEO
950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

Editor *(Name and complete mailing address)*
Gary Evans, same as above

Managing Editor *(Name and complete mailing address)*
same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

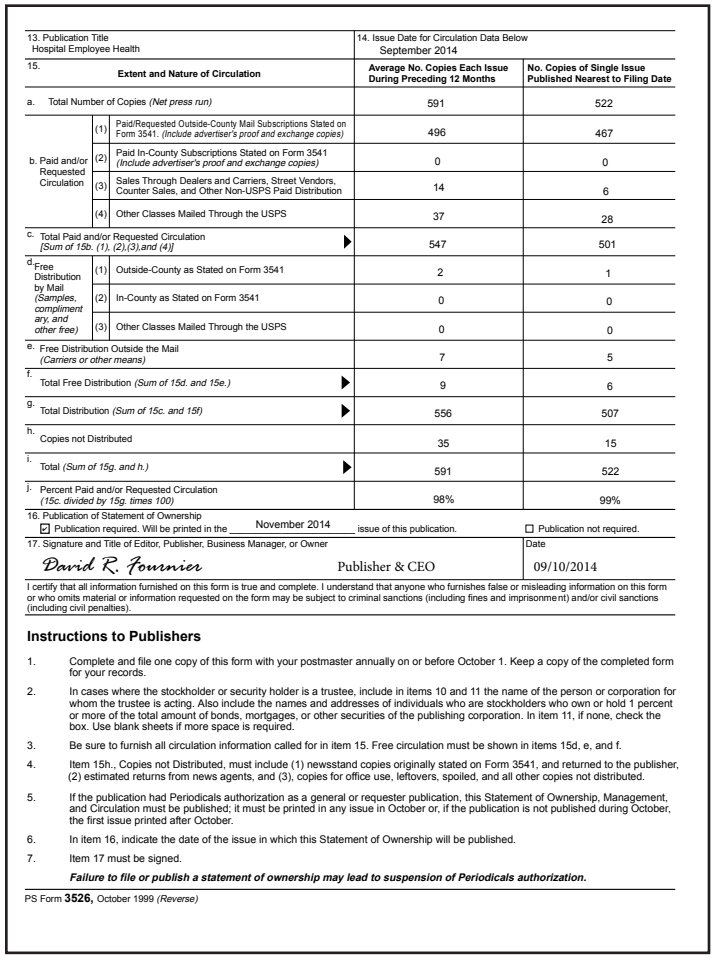
Full Name	Complete Mailing Address
AHC Media LLC	950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** October 1999 *(See Instructions on Reverse)*



13. Publication Title: Hospital Employee Health			14. Issue Date for Circulation Data Below: September 2014	
15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*			591	522
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	496	467
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	14	6
	(4)	Other Classes Mailed Through the USPS	37	28
c. Total Paid and/or Requested Circulation *[Sum of 15b. (1), (2),(3),and (4)]* ▶			547	501
d. Free Distribution by Mail *(Samples, complimentary, and other free)*	(1)	Outside-County as Stated on Form 3541	2	1
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e. Free Distribution Outside the Mail *(Carriers or other means)*			7	5
f. Total Free Distribution *(Sum of 15d. and 15e.)* ▶			9	6
g. Total Distribution *(Sum of 15c. and 15f)* ▶			556	507
h. Copies not Distributed			35	15
i. Total *(Sum of 15g. and h.)* ▶			591	522
j. Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*			98%	99%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2014 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: David R. Fournier, Publisher & CEO — Date: 09/10/2014

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form **3526,** October 1999 *(Reverse)*

shortchanged the research part in step one.

A flu project will require research into the Centers for Disease Control and Prevention's latest advisories and health care professional guidance. Each hospital also has its own data and this information should be researched and found.

Step 5: Assess and report: OHNs should assess the work done to handle the crisis or project and create a final report, Meuleveld says.

"Hospital employee health nurses might not always do a final report, but they will have to do a tally, and within that little report they can make recommendations for next year or the next time this occurs," she explains. "Learn from your experiences and pass on the things you've learned to other nurses." ■

CNE OBJECTIVES

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

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. 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;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.

COMING IN FUTURE MONTHS

- A link between workplace violence and MSDs?
- Renewed push for a national safe patient handling standard
- Do workers have 'sitting disease'?
- CMS regs coming on antibiotic stewardship programs. Is there an EH role?
- Novel strategies for motivating employee health behavior

HOSPITAL EMPLOYEE HEALTH

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right 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 e-mailed to you instantly.

CNE QUESTIONS

1. **In hospital reports to the National Healthcare Safety Network, what portion of licensed independent practitioners had an "unknown" influenza vaccination status in 2013-2014?**

   A. 12%
   B. 25%
   C. 35%
   D. 42%

2. **According to the National Institute for Occupational Safety and Health, what is the risk of handling oral forms of chemotherapy?**

   A. Touching the outside of a pill is hazardous.
   B. Counting or crushing pills can produce a toxic residue.
   C. Opening a pill bottle produces a toxic aerosol.
   D. There is no risk because they are in pill form

3. **A way to measure severity of an injury or illness is to track the number of days away from work as employees recover. Federal data show that employees who are 65 and older have a median number of days away from work that can be characterized as which of the following?**

   A. Workers who are 65 or older have twice the median days away from work as those under age 65.
   B. Older workers have a median number of days away from work due to illness and injury of 25, versus 9 for workers under age 50.
   C. Employees who are 65 and older have nearly three times the median days away from work as those in their early 20s.
   D. Older workers have a median number of days away from work of 8.9 versus 2.1 for workers in their 20s.

4. **A recent study found that hospitals with solid organizational practices and policies in which of the following areas had lower injury rates among nurses?**

   A. Better safety leadership
   B. Stronger people-oriented culture
   C. ergonomics
   D. All of the above