



# HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

JANUARY 2015

Vol. 34, No. 1; p. 1-12

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**AHC Media**

## Ebola spurs hospitals to coordinate to protect health care workers

*Regional coalitions gather PPE, provide HCW training*

**W**hen the first Ebola case appeared in the United States last fall, demand for personal protective equipment surged and led to shortages. But as fears of Ebola transmission in the United States subsided, a silver lining emerged: Hospitals are working together to become more prepared not just for Ebola, but for other novel infectious diseases.

Hospitals have been buying powered air-purifying respirators (PAPRs) with disposable hoods, a device that is more protective—but also more expensive—than the N95 respirators typically used

with tuberculosis and novel influenza viruses. They are also connecting with regional and state health care coalitions that can manage resources and provide additional protective gear, as needed. The Centers for Disease Control and Prevention also announced a new \$2.7 million federal investment in a national stockpile of PPE.

“PPE is expensive, [so] it is much more efficient if

it is purchased at a coalition level or a community or state level than it is by every hospital in the country,” **Nicole Lurie**, Assistant Secretary for Preparedness and Response (ASPR)

**“IT'S ABOUT MAINTAINING THE ASSETS. MORE IMPORTANT THAN THE PHYSICAL ASSETS IS THE TRAINING COMPONENT,” SHE SAYS.**

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**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.

**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.

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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.

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

**EXECUTIVE EDITOR:** Gary Evans, (gary.evans@ahcmedia.com).

**CONTINUING EDUCATION AND EDITORIAL DIRECTOR:** Lee Landenberger

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#### EDITORIAL QUESTIONS:

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

at the U.S. Department of Health and Human Services, said on a conference call with coalition leaders.

Shortages were predictable as demand surged globally for protective equipment, says **Dan Shipp**, president of the International Safety Equipment Association in Arlington, VA. The need is obviously intense in West Africa, but U.S. hospitals should conduct a hazard assessment to determine what PPE they need to store and what they could obtain on an as-needed basis, he says.

“The coordination among regional organizations is something that is evolving and is going to be an important part of making sure there’s enough supply and it gets to the right places,” he says.

## Monitoring allows early identification of cases

The infection of two nurses with Ebola placed a harsh spotlight on hospital preparedness. It became a rallying cry as a national nurses’ union held protests around the country, saying that hospitals still did not have adequate protective equipment.

But in the aftermath of the first U.S. Ebola cases, the hazards and the needs became clearer. With CDC screening all travelers to the United States from Liberia, Sierra Leone and Guinea, public health authorities are actively monitoring those with a travel history from West Africa who are at risk for Ebola, says **Melissa C. Harvey**, RN, MPH, acting deputy director in the Division of National Health Care Preparedness Programs of the Office of the Assistant Secretary for Preparedness and Response in the

U.S. Department of Health and Human Services.

“It’s much less likely now that a patient that no one is aware of is going to walk into a random emergency department,” she says.

Still, every hospital needs to have enough PPE, including powered air purifying respirators (PAPRs), to assess and care for a suspected or confirmed Ebola patient until the patient can be transferred to a specialty care facility, she says.

In California, the only state with an Aerosol Transmissible Diseases standard, employees caring for a patient with suspected or confirmed Ebola infection “must use PPE that covers all surfaces of the body so that absolutely no skin is exposed,” according to updated Cal/OSHA guidance. (*See editor’s note on resources at the end of this article.*)

That includes PAPRs if there is a chance that an aerosol-generating procedure might occur or an N95 or higher if there is no risk of an aerosol-generating procedure, Cal/OSHA said.

Through regional planning, hospitals can coordinate so they are using the same models and brands of PPE and can assist each other with supplies, as necessary, says Harvey. (*For information on PPE cost, see box on page 3.*)

## Consider real-life conditions with PPE

Selecting the right PPE requires some careful consideration of the real-life dynamics – how long it would be worn, which employees would need to wear it, and under what circumstances.

Hospitals should conduct a hazard analysis of every job and determine the potential for exposure

and the nature of that exposure, says Shipp. Medical screening may determine that some employees cannot wear the required PPE for extended periods. For example, some hospitals have screened out pregnant women or employees with certain medical conditions, including asthma, diabetes and seizure disorders.

Meanwhile, employee health and infection control professionals should work with purchasing and safety officers to ensure that the PPE meets the appropriate standards, says Shipp.

“All of these things have to go into the hazard analysis to make the decision about not only what articles of PPE the person needs, but the capabilities of the PPE,” says Shipp.

“Human factors” should be part of that evaluation, says **Jim Davis**, MSN, RN, CCRN, CIC, HEM, infection prevention analyst at the ECRI Institute in Plymouth Meeting, PA. Working in PPE can be cumbersome and uncomfortable, and with Ebola, even just a simple urge to itch could be dangerous, he says.

Davis suggests conducting drills with a real-life scenario, with staff wearing the PPE in the same manner that they would in an actual event. Modifications can then be made either in the PPE selection (such as an N95 versus a PAPR) or in the design of the environment (such as cutting back the continuous wearing time).

“People are realizing the breaches aren’t the fault of the person doing the work,” he says.

And while small, rural hospitals may be unlikely to see an Ebola patient, they should develop an emergency plan that encompasses a high-level pathogen. “One of the things we learned from Katrina

is that help might not come if [a situation is] really bad,” he says.

“Even the small places need to have a comprehensive plan. They should have identified teams, do an equipment assessment, know exactly how much PPE they’re going to need, and have training in place,” he says.

## Training HCWs to prepare for Ebola

Even when Ebola fears subside, training needs to continue at least annually to keep employees current on the use of PPE and other emergency preparedness issues, says Harvey. Again, through regional coalitions, hospitals can collaborate.

“It’s about maintaining the assets. More important than the physical assets is the training component,” she says.

Some hospitals have designated teams of employees who volunteered

to care for an Ebola patient, if a case occurs. They receive more intensive training, but other employees with patient care duties who might encounter an Ebola patient also need training, safety experts say.

At Tampa (FL) General Hospital, all employees were required to watch videos with information about the Ebola virus and basics about the required personal protective equipment. The Ebola-designated care teams had training that included hands-on donning and doffing of the hazmat suits and PAPRs.

Providing information to all employees helps them safer, says **JoAnn Shea**, MSN, ARNP, director of employee health and wellness. “They feel that we’re giving them the resources they need to protect themselves. That’s important. That’s our job,” she says.

Ultimately, the Ebola outbreak may be an impetus to provide more resources for infection control and employee health. As they learn more

## Is the price right? ECRI shares data on cost of PPE

Ever wonder if you were paying too much for your gloves, respirators and other personal protective equipment — especially as shortages develop in some areas? Now you can find out. The ECRI Institute has compiled monthly data from more than 2,000 hospitals for an Ebola PPE Price Index.

Some sample findings from mid-November: A pair of boot covers from Kimberly Clark (Hi Guard, regular full-coverage, universal size, No. 69571) ranged in price from 32 cents to \$2.28, with an average of 47 cents. A 3M model 1860 N95 respirator ranged from 41 cents to \$1.42 with an average cost of 58 cents.

The chart includes items that have been recommended by vendors for use in caring for Ebola patients. The data will be updated regularly and access is free from the ECRI website at [www.ecri.org](http://www.ecri.org).

“It’s very difficult to know how much you should be spending on products,” says **Laurie Menyo**, ECRI director of public relations and marketing communications. “We’re asking hospitals who aren’t even members of ours to contribute their pricing data so we can make it more robust.” ■

about protective equipment and how to properly don and doff gloves, respirators and gowns, employees may make changes in their daily practice that help prevent health care associated infections, says Harvey.

The national attention also brought new prominence to worker safety in hospitals and the risks that health care workers face. “The Ebola issue did shed some light on the epidemic of injuries and illnesses among health care workers overall,” says **Bill Borwegen**, MPH, an occupational health consultant and former health and safety director of

the Service Employees International Union.

Employee health and infection control should remain a key part of broader hospital preparedness efforts, including with regional coalitions, Harvey says. Hospitals that never see an Ebola patient still need to be ready for the next infectious disease outbreak — or any other emergency, she says.

“It takes an entire hospital, it takes an entire region, it takes an entire health care system to really do this well,” she says. “There’s never an end state for preparedness.”

*Editor’s note: The Occupational Safety and Health Administration recently created a matrix for PPE selection for Ebola: (<http://1.usa.gov/1zLQhNO>). Other resources include a CDC checklist for hospital preparedness (<http://1.usa.gov/1uE4yNP>) and PPE guidance (<http://1.usa.gov/10hXJoz>). The California Aerosol Transmissible Diseases standard is available at: <http://bit.ly/1yeHaXA> The International Safety Equipment Association provides information on PPE standards at <http://bit.ly/1FL296z> ■*

## Work restrictions on HCWs exposed to Ebola

The Centers for Disease Control and Prevention has created a risk assessment tool and clarified the level of restrictions required of health care workers traveling to countries with widespread transmission or caring for Ebola patients in the United States. The CDC guidance is summarized below. For more detailed information go to: <http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html>

### **Health care workers caring for Ebola patients in West Africa:**

Those who cared for patients in Guinea, Liberia, Sierra Leone or Mali are considered to be at “some” risk. If the health care worker has no symptoms, public health authorities will determine what restrictions are appropriate during a 21-day period of daily direct active monitoring for symptoms (that is, symptom checks observed by a public health representative). Daily monitoring includes measuring

temperature twice a day. The restrictions could include exclusion from planes, trains, subways and other public transportation, from shopping malls, movie theaters and other gathering place, and from workplaces.

**Health care workers assisting in West Africa without patient contact:** Epidemiologists, contact tracers, airport screeners and others who never enter patient care areas are considered to have “low but not zero” risk. This includes people who were briefly in a room with a symptomatic Ebola patient but were wearing personal protective equipment. They should have daily monitoring for symptoms but do not have restrictions on travel or work as long as they are not symptomatic.

**Health care workers caring for Ebola patients in the United States:** A health care worker who has been wearing PPE, has no known breach of infection control and has no symptoms is considered

to be at “low but not zero risk”. They should have daily direct active monitoring but have no restrictions on travel, movement or work.

**Health care workers caring for a U.S. Ebola patient when another HCW develops Ebola:** If a health care worker has been diagnosed with a confirmed case of Ebola and no known breach of infection control occurred, co-workers also caring for the patient are considered to be at “high risk.” After an assessment of infection control practices and re-training, the health care workers can continue to care for Ebola patients, but not other patients, during the 21-day direct active monitoring period, as long they have no symptoms. They should be restricted from travel, public transportation and public places. If they do not develop symptoms within 21 days of the re-training in infection control, but they are still caring for an Ebola patient, they return to the “low-but-not-zero” risk category. ■

# Progress lags on needlestick prevention

*Massachusetts hospitals rate same for 3 years, 44% of sharps injuries in the OR*

**N**eedlestick injuries remain stubbornly common, despite a long-standing federal law and worker safety regulations requiring an annual review of safety devices. Forging a path to improvement requires collaboration with hospital purchasing and quality improvement, says the coordinator of the nation's most comprehensive needlestick surveillance system.

"It's clear that devices that lack sharps injury prevention features are still available for purchase and hospitals are buying them," says **Angela Laramie**, MPH, epidemiologist with the Massachusetts Department of Public Health Occupational Health Surveillance Program.

Massachusetts hospitals reported 3,019 sharps injuries in 2012, for a rate of 19.1 per 100 beds in acute care hospitals.<sup>1</sup> That reflects a decline of about 18% from 2002, when surveillance began. But the rate of sharps injuries remained essentially the same for the past three years.

Why has progress on sharps injury prevention stalled? An increase in reporting could make it seem that prevention efforts aren't providing new improvements, Laramie cautions. Conversely, as other occupational injuries such as patient handling get more attention, sharps injury awareness may have lagged, she says.

Massachusetts plans to conduct some analysis into the types of devices used and the units where injuries continue to occur, she says.

Some concerning trends are apparent from the surveillance reports. Little progress has been

made in the operating room, where 44% of sharps injuries occurred in 2012. Almost one in four injuries (23%) was from a suture needle.

About 200 sharps injuries occurred with hypodermic needles that lacked safety features — although the Bloodborne Pathogen Standard of the Occupational Safety and Health Administration requires employers to use safety-engineered devices, when feasible. About 21% of sharps injuries involved devices from pre-packaged kits used in the OR.

That illustrates why it is important for employee health and infection preventionists to work together with hospital purchasing to ensure that the proper devices are included in kits, says Laramie.

Meanwhile, 54% of sharps injuries occurred with safety devices (excluding suture needles).

"[That] tells us we need to take a look at the devices that do have sharps injury prevention features and we need to do more research on the efficacy of the various mechanisms for these devices," she says.

"We've said consistently that devices with engineered sharps injury protection are not fail-safe and they are not the only answer. They are one component of a comprehensive sharps injury program," she says.

## Look beyond numbers

OSHA requires employers to provide annual training on bloodborne pathogens and sharps injury prevention, and employers must review their safety devices at least annually.

While you should look at your data, go beyond the numbers and ask frontline employees which devices they like or don't like, Laramie says. If your injuries indicate that the safety feature was not activated, probe deeper, she says.

"Why aren't people using the mechanism? It might be that they're unfamiliar with the device. It could be a training issue," she says. "It could be that it's a poorly designed device. It should be intuitive. It should be easy and simple. If it's not, people might not be using it."

Laramie suggests partnering with quality improvement at the hospital to look more deeply at the causes of sharps injuries. A root cause analysis can reveal factors, such as a device that requires two hands to activate or a nurse feeling uncomfortable with the device.

The best strategy is to eliminate the sharp, such as using surgical glue rather than sutures. Passive devices, such as needles that retract without any additional action, are preferable to devices that require the users to activate the safety feature, Laramie says.

"I think there will always be a human component, but more and more we need to look at the design of devices [to reduce needlesticks]," she says. ■

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# Small hospitals to OSHA: Proposed infectious disease standard is too costly, 'redundant'

*OSHA panel draws flak about agency's initial proposal*

A proposed rule designed to protect health care workers from infectious diseases places a costly burden on small hospitals, clinics, doctors' offices and long-term care centers, representatives from those facilities recently told the Occupational Safety and Health Administration.

In three days of hearings to gather information from small businesses, OSHA heard concerns about recordkeeping, unnecessary regulation and the provision for job protection of employees removed from work because of exposures.

"Just this year alone, 20 small hospitals closed. [That shows] what the costs can do to small hospitals," said **Leslie Marsh**, MSN, RN, chief executive officer of Lexington Regional Medical Center in Nebraska.

OSHA presented a framework for an infectious diseases rule in October that is patterned after the Bloodborne Pathogen Standard and California's Aerosol Transmissible Diseases Standard. It would require health care facilities to maintain a worker infection control plan, with input from frontline health care workers and annual updates.

The plan would include hazard

assessments, standard operating procedures that outline protective measures and exposure response, and a list of vaccinations offered to employees with possible declination statements. (See *HEH*, December 2014, page 137.)

In one provision, the draft rule would require employers to maintain pay, benefits, seniority and job status for employees who were removed or restricted from work due to a workplace exposure to an infectious disease for a period of up to 18 months — except for the common cold or influenza. Several of the small employers said they were concerned about the potential cost of that payment beyond workers' compensation.

They also noted that they follow guidelines from the Centers for Disease Control and Prevention and requirements from OSHA, the Center for Medicare and Medicaid Services, state and local health departments, and accrediting agencies. OSHA's draft rule would require employers to "consider applicable regulations and current guidelines" but would not specifically make CDC guidelines mandatory.

"We are all very, very highly

regulated already," said **Judy Dahl**, RN, assistant director of nursing at Johnson Memorial Health Services in Dawson, MN. "So much of what you have in here is really redundant to what we're already doing."

Dahl also expressed concern about what would trigger the provisions of the proposed rule. "The thing that bothers me the most is how you decide what is an exposure at work versus what is a community exposure," she said.

The draft rule also requires medical records, including exposure incident records, to be maintained for 30 years beyond the duration of an employee's tenure, which is similar to a provision in the OSHA Bloodborne Pathogen Standard.

**Robert Burt**, deputy director of OSHA's Directorate of Standards and Guidance, assured the participants that the comments would help shape any future rulemaking. The small business panel is the first step before OSHA formally proposes a new rule, he said.

"The fact that we are holding a panel does not necessarily mean there will be a proposal and it definitely doesn't mean there will be a final rule," he said. ■

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## Time to take a stand: 'Sitting Disease' can lead to a host of maladies for sedentary workers

*Even nurses spend a third of time doing documentation*

When employee health leaders envision daily challenges for health care workers, desk work typically is not at the top of the list. Yet, some workers, including nurses,

spend plenty of time sitting at a desk, increasing repetitive stress injuries and risk for chronic illness.

Plus, every hospital has a large contingency of office support staff

whose work primarily involves sitting, keyboarding, answering phones, or handling patients. These employees are at risk of so-called "sitting disease," shorthand for an overly sedentary

lifestyle that negatively impacts health. It is viewed by medical researchers as a risk factor for obesity, high blood pressure, diabetes, cancer, depression, and other health problems.<sup>1</sup>

Ergonomics has evolved in health care settings in the past decade, but facility changes have not always kept up.

“It’s been a challenge, particularly for facilities that have made rather rapid transitions to electronic medical records and put computers in a lot of places that never were intended for computers to be,” says **Rick Barker**, MA, CPE, senior consultant at Humantech in Cincinnati, OH.

“Or even when the change wasn’t so rapid, the hospitals have these old work stations built 10 or 20 years ago before they considered electronic medical records, and these areas are not really suited to the specifics of using the computer,” Barker says. “This creates extra challenges that facilities that were planned around the computer do not have.”

Nurses are less at risk for sitting disease than other health care workers, such as unit clerks and secretaries and admissions and triage staff, Barker notes.

“They’re sitting at the desk the entire day,” he says. “They don’t get up and down like a nurse does, so they’re much more vulnerable to sitting disease issues than a nurse would be.”

While front desk staff and assistants are most at risk of injuries related to long hours sitting at a desk and using computers, nurses also can develop health problems resulting from too many hours sitting.

“We’ve found that a nurse typically spends 35% of the day doing clinical documentation,” says **Steve Reinecke**, MT[CLS], CPHIMS, assistant vice president at Ergotron Healthcare in Minneapolis/St. Paul, MN.

The Centers for Disease Control

and Prevention has a “Take-a-Stand Project,” initiated to suggest strategies for reducing health problems associated with sitting disease. One of the project’s suggested solutions is for organizations to install work stations that encourage standing. Implementation of these changes in a pilot study showed 66 minutes per day reduction in sitting time, and workers had a 54% reduction in upper back and neck pain.<sup>1</sup>

## Is there a light at the end of the carpal tunnel?

In addition to sitting disease, there are common ergonomic injuries that can occur to any employees – including nurses – who use computers.

Carpal tunnel syndrome is one of the most common injuries that occur as a result of desk work, but it’s not the only one, says **Margaret Senn**, MS, RN, informatics nurse specialist at the Mayo Clinic in Rochester, MN.

“Anytime you have repetitive use there’s a potential for injury, and some people are more prone to develop an injury than others,” she says.

Handwritten notes and charts have nearly disappeared. Their electronic record replacements are more efficient, but also increase the risk of repetitive stress injuries, Reinecke says.

“From everything I’ve observed, nurses now spend more time charting than they did before electronic health records,” Barker notes. “It’s not just that it’s so much worse, but it’s also that they spend so much more time doing it, and if you’re spending twice as much time doing something then that’s twice as much wear and tear.”

Some hospitals require record updates at point of care, which can lead to back injuries as nurses and other workers lean over work carts to update tablets and electronic charts.

“How do you address issues related to the nurse who is 4 foot, 8 inches and the nurse who is 5 foot, 11 inches?” Reinecke asks. “The tall nurse might be leaning over, looking down, and getting neck pain.”

Work stations typically are fixed stations used by many different people throughout the day. Without adjustability, it can create ergonomic issues for staff, Barker says.

“There are a couple of things that can be done to help a great deal without substantially adding to the expense,” Barker adds. “One is to make sure chairs are easily and sufficiently adjustable, and you can even provide visuals on how to adjust them.” (*See story on simple ergonomic changes, p. 8.*)

When first using mobile work stations, the Mayo Clinic found they were not very adjustable and caused problems, Senn says.

“We had more problems with nurses who were tall,” she explains. “The monitors would be lower than they would have liked.”

After soliciting nurses’ feedback on feasibility, the hospital system made some changes that solved various complaints, including height and lighting at work stations, she adds. Work carts now are height adjustable so nurses can lower or raise these to a comfortable level, Senn says.

“Our night shift was concerned about having to use computer screens in a dark room, so we came up with a solution where we had small lights that wouldn’t disturb patients, but would allow them to see their keyboards,” she says.

## Nurses cite staffing needs

Ergotron Healthcare conducted a survey of full-time nurses, asking about how on-the-job technology

impacted their physical health and comfort. Most — 81% of the 250 nurses surveyed — used standard desktop computers. Laptops, smart phones and tablet devices also were used.

The findings showed that nurses felt their health would improve with increased nursing staff to alleviate workloads and with a redesigned physical space within patient rooms and on floors.

The nurses surveyed reported back pain, exhaustion, and sore necks as their most common discomforts in the past year. More than one-quarter of nurses suggested they would like a dedicated ergonomics team to ensure equipment is ergonomically supportive to staff.<sup>2</sup>

While replacing all work stations might not be an economically feasible solution for most hospitals, there are other ways employee health can help staff prevent injuries.

For instance, the Mayo Clinic makes sure desk workers have

adjustable chairs with proper lumbar support, Senn says.

“They need to be adjustable because with different shift changes you have different sized people using them,” she explains. “We have chairs that support elbows, and all chair arms are adjustable, as is the height of the chair.”

Employee health also can suggest behavioral changes, including teaching staff how to prevent flexing their wrists at the keyboard, which can reduce carpal tunnel risk, she adds.

Staff diagnosed with carpal tunnel can wear wrist bands while they work. If a worker reports an injury related to desk work, or if a supervisor observes a worker in pain, then this worker is given an ergonomics evaluation. A specialist will watch the person work to see if the desk and chair are set up optimally, Senn says.

Following the formal assessment, any identified risks and/or concerns

are shared with the worker.

Recommendations to mitigate the risk and concerns are provided to the worker. Then the worker is provided any needed special equipment, such as standing desks and cushion mats.

“Ergonomics is very important for our staff,” Senn says. “We have stretching diagrams in some of our offices, encouraging workers to stand, rotate their necks, bend, stretch, and walk around during their shifts.” ■

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# Quick tips on simple ergonomic changes to reduce health care worker aches and pains

*‘Doing 21st century work with 20th century furniture’*

**H**ealth systems typically have limited resources when it comes to making ergonomic changes in their facilities. However, there are some simple ways to improve work stations for hospital staff that will not break an organization’s budget.

Here are some suggestions:

- **Use adjustable chairs:**

Often, hospital work stations are at fixed heights. If it’s not feasible to replace these with adjustable stations, then the health system

could use adjustable chairs, suggests **Rick Barker**, MA, CPE, senior consultant at Humantech in Cincinnati, OH.

This change should include placing the chair adjustment instructions on the wall, not underneath the chair, Barker says.

“If you put those underneath the chair people won’t bend over to look at them, and we all know how little time employees have for inservices — particularly if it’s about their chairs,” he says.

Some stations are taller because that’s where patients’ families will approach hospital staff.

“That’s one element of 21st century work on 20th century furniture,” Barker says. “Employees are trying to do simultaneous customer service work and computer entry work, and this creates a challenge.”

While computer entry work might require a lower desk and work area from an ergonomic perspective, customer service work

requires someone to be several feet higher in order to talk to people, he adds.

One solution to providing a work station that works both from computer entry and customer service perspectives is to have chairs that adjust to one of three different stops, according to height, at these stations, Barker says.

“They can rotate the chair to one of those different stops that would best suit their height,” he explains. “That’s an intuitive way to let different height people use the chair easily.”

- **Provide adjustable footrests:**

Another simple change is to have an adjustable footrest for staff of different heights, Barker adds.

“Having an easy-to-adjust footrest that you can move up and down with your foot is really helpful for different height people, especially if they’re going to be sitting there for a while,” Barker says.

- **Consider adjustable keyboards:** Adjustable keyboard trays will allow a worker to move the keyboard up and down, according to what’s comfortable for them. This change can help prevent ergonomic shoulder and wrist injuries even when the cabinetry is fixed, Barker says.

- **Create standing computer stations:** It’s possible to have standing work stations where computer work can be done. “Instead of sitting on a chair, you can have these lean-against stools where you’re leaning back a little bit, and it keeps you at the same heights as people standing at the station,” Barker says.

- **Give employees a variety of work spaces:** Health care organizations can reduce sitting disease and ergonomic problems by giving employees a variety of places to work, Barker says.

For example, an employee could sometimes work at a standing work

station and other times in the day work at a seated work station, he suggests.

“Or if they need to be at the same spot all the time, give them a variety of tasks so they’re not seated continuously,” Barker says.

“It’s harder for clerks and secretaries to get up because you want them in the stations,” he says.

But since these workers often are asked to be front-line customer service representatives, it might work best to have their desks near a customer service work station, so they can stand up and greet customers throughout their day, he says.

“They can change back and forth between the two,” he says.

“We want people moving and changing positions,” Barker adds. “It’s just a sedentary world right now, and sitting disease has become a very prevalent thing that everybody wants to talk about.” ■

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## Health care workers’ exposure to oncology drugs creates risk, need to reinforce safe handling

*‘We allow people to be exposed to known carcinogens [but] safety practice is voluntary’*

Evidence continues to accumulate that oncology drugs used to treat cancer patients pose a risk to health care workers.

“We have recommended safe practices and guidance for 30 years, but now we have better documentation,” says **Melissa A. McDiarmid**, MD, MPH, DABT, director of occupational and environmental medicine at the University of Maryland in Baltimore.

For instance, pharmacists and nurses who prepare antineoplastic agents in their work practice have

the highest potential exposure to the drugs.

“We now can prove what was assumed to be true before,” McDiarmid says. “That’s good news for health care workers because it means there can be more buy-in from both leadership in terms of investing and from occupational and employee health and health care workers to comply with handling practices.”

For example, one study showed detectable oxidative DNA damage in pharmacy technicians exposed to antineoplastic drugs.<sup>1</sup>

“One of the ways we knew these drugs were toxic was from the secondary, unplanned effects in patients treated with the drugs,” McDiarmid notes. “Over the years we’ve used observations from treated patients to predict or hypothesize in lesser exposed drugs what potential effects might befall workers who handle these drugs.”

### Drugs can cause cancer while treating it

Antineoplastic drugs can cause

cancer even as they're used to treat cancer: "Treated patients develop second malignancies in the course of treatment," she says. "For them, the risk-benefit ratio is reasonable because the alternative is a more serious illness or death."

Researchers and health care professionals wondered whether the small theoretical, aerosolized exposures to the drugs created enough exposure to be a risk to health care workers, McDiarmid says.

HCWs have much less exposure to the drugs than do their cancer patients, but that doesn't mean their risk is minimal.

"We know from studies the schedule — frequency and time period over which someone is exposed may be important for cancer development," McDiarmid says. "Large numbers of oncology nurses and pharmacists might be getting a small amount of exposure on their skin, and we do not know they're exposed."

Exposure that occurs daily over a long period of time can be a significant risk, she adds.

Research also demonstrates that some HCWs who work with anti-cancer drugs test positive for the drugs in their urine. "This suggests there is ongoing exposure," she says.

McDiarmid was involved in a study showing that occupational exposure to antineoplastic drugs appears to increase risk of congenital malformations and miscarriage, as well as increase risk of infertility.<sup>2</sup>

A separate study showed an increased risk of miscarriage in nurses handling chemotherapy agents.<sup>3</sup>

Hospital employee health professionals should heed the

evidence regarding infertility and miscarriages and find alternative work practices for workers who are concerned about reproductive risk or who are planning to have a baby, she suggests.

"There should be employee health policies for handling this situation," McDiarmid advises. "Talk with workers about alternative duty and how to think about this situation before someone

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becomes pregnant."

Policy decisions could include having these workers continue working in oncology, but without handling the drugs. "There has to be official notifications, and employee health would handle all of this," McDiarmid says.

## **Chromosome damage**

Another recent study found that oncology personnel handling anti-cancer agents had a dose-related increase in the incident rate ratio

for aberrations in chromosomes 5, 7 and 11.<sup>4</sup>

"I worked on a cancer outcome concern area, looking at one of the early markers of genotoxic exposure, which is alteration of chromosomes," McDiarmid explains.

Researchers were concerned that general chromosome abnormalities might be caused from smoking or hazardous hobbies.

"There was this nagging worry," McDiarmid says. "The unique thing our study did was use the exact same markers in chromosomes that cancer patients get as a result of their treatment with these drugs — abnormalities in chromosomes 5 and 7 — and we found an excess of these in oncology workers who handle these drugs."

The excessive amount related to their frequency of handling the drugs: the more a worker handled, the more abnormalities were found, she adds.<sup>4</sup>

"We had workers keep a diary for six weeks to capture in real time their exposure to the drugs," she says. "That was one of the big strengths of the study — that they didn't have to remember how many times they handled the drug."

While the absolute numbers were not particularly alarming, the evidence from a population perspective was troubling, she notes.

"All of these oncology workers were employed at safe handling organizations," McDiarmid says. "We used psychiatric nurses as controls because they don't handle these drugs."

Research like this informs the growing consensus that abnormalities found in workers who handle anti-cancer drugs

indicates a problem related to the drugs and not to other environmental factors. “On an individual basis it’s not predictive, but on the population basis, researchers have found it is predictive of future risk,” McDiarmid says.

## Reducing the risk

The next question from a hospital employee health perspective is: What can hospitals do to reduce exposure and risk?

First, they should continuously educate and reinforce safe handling guidelines. This requires more than an annual computer training update, McDiarmid says.

“For other types of standards, it’s okay to do it with the computer,” she says. “But we’re talking about really complex safety behaviors like manipulating drugs that come as a solid and then introducing a liquid into the vial under pressure and reconstituting it into a solid.”

A good training strategy is to teach workers safe handling through dry runs and practices. Use a fluorescent dye — in a vial that oncology personnel use — to follow the same procedures used in handling the anti-cancer drugs. After they complete the practice activity, turn on a black light to see if there are any droplets — suggesting exposure, McDiarmid suggests.

“This is a way for people to get a sense of their technique,” she explains.

For ongoing training, hospitals can have observers watch oncology personnel handling the drugs during a typical work day. Observers can make certain corners aren’t cut when workers are in a

hurry.

“We don’t know if the current safety recommendations are good enough, but before we can say what we’re doing isn’t protective, we have to meet the current standards and then see if we still have a problem,” McDiarmid says.

“It’s not that people aren’t trying to do it correctly, but there always will be folks in a hurry,” she adds. “And people you think are doing it correctly might have some contamination of the work surface or an unrecognized spill.”

In that regard, a recent study showed that nurses and other health care workers who administer antineoplastic drugs in health care settings are not following safe handling practices. For instance, 80% of those surveyed reported not always wearing two pairs of chemotherapy gloves and 15% did not always wear even one pair. Also, 42% said they failed to always wear non-absorbent gowns with closed front and tight-fitting cuffs.<sup>5</sup>

It would also help if the Occupational Health and Safety Administration enforced safe handling practices as some states do, McDiarmid says.

“On a rare occasion, OSHA has cited problems with hazard drugs,” she notes.

But OSHA’s own language on the subject is considered guidance and voluntary, so any enforcement is done under other rules, she adds.

“There is a new movement in half of the states to pass laws to

enforce [safe handling] guidance,” McDiarmid says. “I think we’re moving in that direction because there is recognition that this is serious — I can’t think of another industry where we allow people to be exposed to known carcinogens and safety practice is voluntary.” ■

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## COMING IN FUTURE MONTHS

- CMS finalizes hospital survey — compliance issues for employee health
- The link between sharps purchasing and needlesticks
- Predicting problems with return to work after injury
- Healthy Worksite Toolkit for hospitals



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## CNE QUESTIONS

- 1. According to Dan Shipp, president of the International Safety Equipment Association in Arlington, VA, what should hospitals do before selecting personal protective equipment for Ebola preparedness?**
  - A. Check availability from manufacturers
  - B. Determine the likelihood of caring for an Ebola patient
  - C. Conduct a hazard analysis of all jobs
  - D. Check pricing
- 2. According to needlestick surveillance at Massachusetts hospitals, what is the trend for the past three years?**
  - A. Sharps injuries have declined significantly.
  - B. The rate of sharps injuries has not changed.
  - C. Sharps injuries have increased significantly.
  - D. Sharps injuries have declined in the operating room.
- 3. Which of the following is a simple strategy for improving ergonomics among health care workers who spend long periods working on computers or sitting at desks?**
  - A. Provide adjustable footrests
  - B. Provide adjustable keyboards
  - C. Create standing computer stations
  - D. All of the above
- 4. New studies of antineoplastic agents and their impact on oncology health care workers who handle them confirm which of the following?**
  - A. Health risks to oncology workers are no different from risks to psychiatric nurses who do not have access to anti-cancer drugs
  - B. Pharmacists and nurses who prepare antineoplastic agents in their work practice have the highest potential exposure to the drugs, and studies suggest these can cause DNA damage and negatively impact their fertility
  - C. Health care workers who are exposed to small amounts of antineoplastic agents in their work places have a greater risk of cancer only if they also smoke cigarettes
  - D. None of the above

## 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.



# HOSPITAL EMPLOYEE HEALTH



## Employee health professionals raise program profiles, build partnerships to stretch resources

*Leverage experience, relationships to boost EH*

When **JoAnn Shea**, MSN, ARNP, began supervising employee health at Tampa (FL) General Hospital 28 years ago, she worked with two other employee health nurses and no clerical staff to cover about 4,000 employees. They only had time for the basics: Vaccinations, workplace injuries and exposures, workers' compensation claims.

Today, Shea is director of employee health and wellness, leading a department that provides an acute care clinic for employees, leave management and chronic disease management, encompassing 18 employees. She also oversees the hospital's lift team, which involves 26 employees, an ergonomist and a physical therapist, and a wellness staff that includes three employees and a 5,000-square-foot fitness center with its own staff.

It took time, money, hard work, and support from senior leadership to make the evolution from a minimal program to a full-fledged commitment to protect and improve the health

of employees. But the Tampa experience illustrates how much employee health professionals can contribute if they demonstrate their value to the organization.

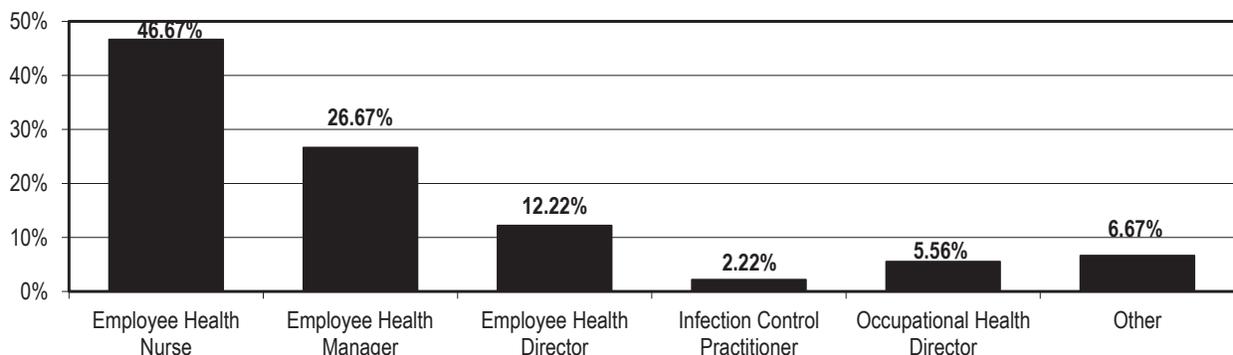
"Our motto is 'caring for our caregivers.' That is what we're here for," says Shea. "You have to have that passion for what you're doing. I'm always looking for ways to be more visible."

Most employee health professionals come to their positions with many years of health care experience, which gives them a breadth of knowledge. The 2014 *HEH* salary survey found that about two-thirds of respondents (69%) have worked in health care for 25 or more years.

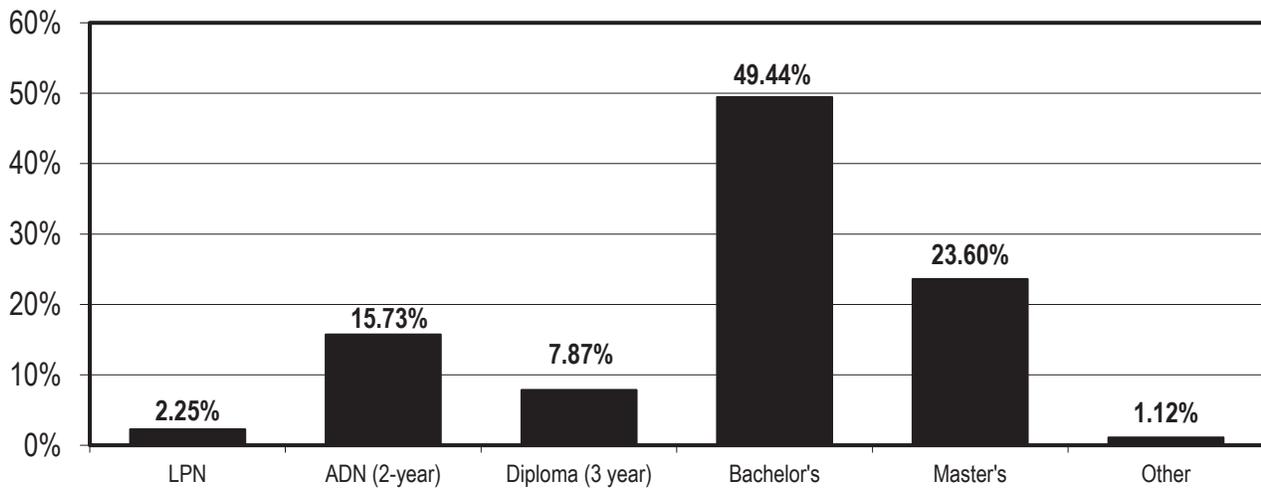
Many also have had long careers in employee health; three in 10 have worked in employee health for 19 or more years. But an equivalent number (29%) are relatively new to the field, with six or fewer years.

As the country emerged from the recession in 2014, employee health nurses received small raises. Two-thirds of

### What is your current title?



## What is your highest degree?



survey respondents said they had a raise of 1% to 3% in the past year. The overall salary of employee health professional is comparable to the average pay for nurses. Respondents were most likely to earn between \$60,000 and \$69,999, and about half earned between \$60,000 and \$89,000. The average salary for nurses in the United States was \$70,590 in 2013, according to the U.S. Bureau of Labor Statistics.

Many employee health departments are short-staffed, and it may seem impossible to add new services when it is hard just to comply with required duties. Building partnerships with other departments is one way to extend your reach, Shea says.

For example, Shea collaborated with the Pulmonary Department to start a sleep apnea screening program for employees. Employees are screened by the employee health nurse practitioners and then qualifying employees are referred for a portable sleep study. “It’s been a huge success and a great example of how to collaborate within the healthcare

setting,” she says.

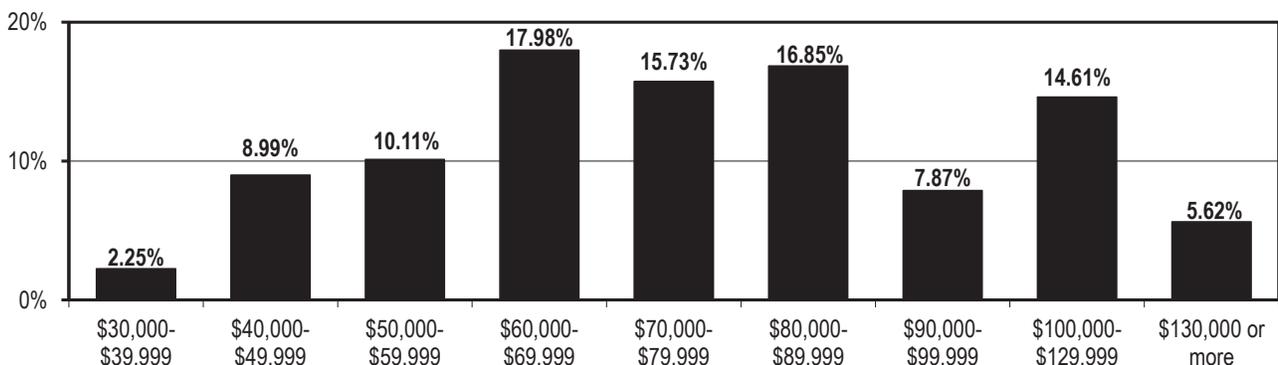
Shea started the fitness center with a \$10,000 grant from the hospital’s foundation, and she reconfigured a break room with the help of the hospital’s facilities management. In May of 2014, Tampa General Hospital opened a new 5,000 square foot fitness center for employees under Shea’s direction.

She also has written many proposals to senior leadership, using workers’ compensation and medical claims data to demonstrate the needs and potential cost-savings. When a proposal was denied, she revised and resubmitted it.

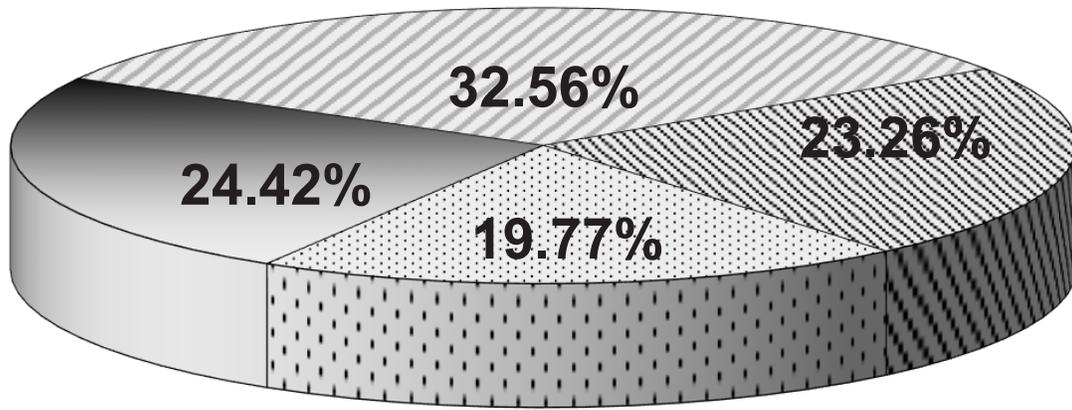
Now she has a winning track record. The lift team reduced the cost of patient handling injuries by 82%. By analyzing medical claims data, she was able to show the impact of diabetes on health costs – and potential savings by helping employees control their blood sugar.

Employee health even helps boost morale, bringing 20-minute bursts of Zumba fitness or line-dancing to

## What is your annual gross income from your primary health care position?



## Where is your facility located?



- Urban area
- Suburban area
- Medium-sized city
- Rural area

different departments in their Well-2-U program.

“If the hospital sees that you’re getting involved in ways to improve the quality of life for your clinical staff, you’re perceived as a benefit,” she says.

At Lancaster (PA) General Hospital, **Bobbi Jo Hurst**, MBA, RN, BSN, COHN-S, manager of employee and student health and safety, is a member of the Innovation Team. She looks for new ways to deliver care and services to employees and to raise awareness of employee health.

For example, when the hospital developed a telemedicine capability, she proposed using it to streamline the response to employee exposures and injuries. The occupational medicine physician, who is at another location, can evaluate sharps exposures, look at X-rays after an employee fall, and talk to employees. The telemedicine exam saves them the hassle of an emergency room wait or a trip across town.

Employee health also led the effort to become a Voluntary Protection Program (VPP) hospital, a designation of the

U.S. Occupational Safety and Health Administration that recognizes employers with top-notch safety programs. There are only eight hospitals currently designated as VPP sites.

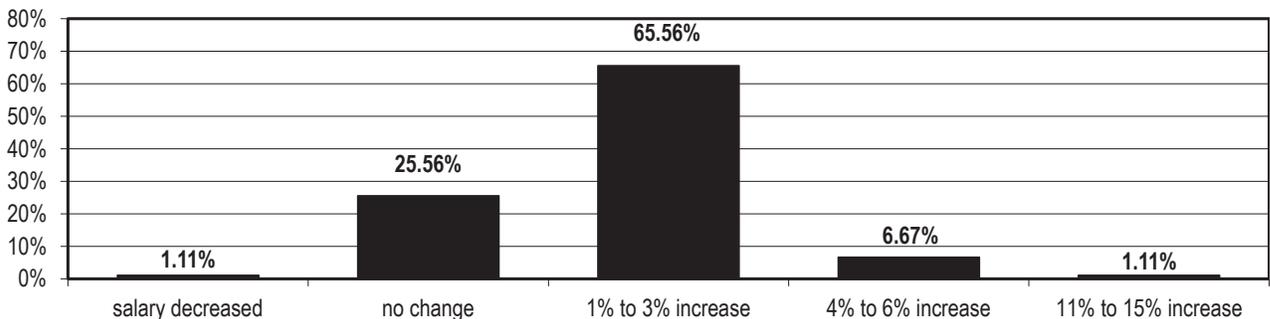
When OSHA officials came to deliver the VPP flag, a local television station covered the ceremony. The flag now flies at the hospital.

“You have to be willing to step out and do extra work,” Hurst says of the VPP application process. But the recognition helps build support for employee health and safety throughout the organization, she says.

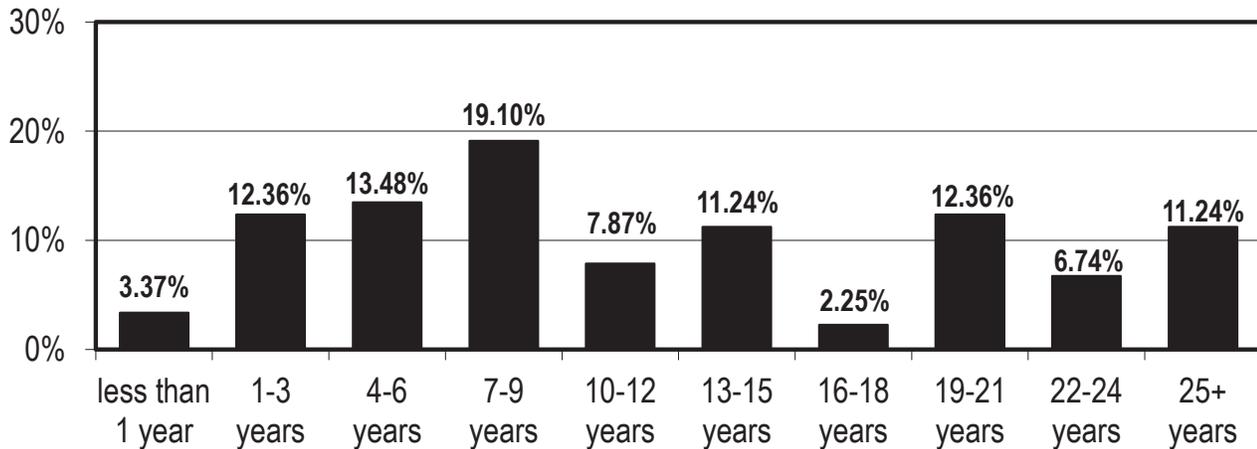
Hurst also works hard to build awareness among staff. One tool: The mascot, Baxter the Safety Bug. New employees receive a Baxter pin for their badges, and Baxter smiles from posters and emails that relate to safety. There’s even a Baxter costume so a mascot can appear at special events to highlight the safety program.

Employee health also stays visible in other ways — with an ergonomist who conducts work-station evaluations and by

## In the last year, how has your salary changed?



## How long have you worked in employee health?



chairing committees that focus on safety improvements.

“It’s not a boring place. There’s always something happening,” says Hurst. “You can make your job in employee health as much as you want to make it.”

Employee health calls for a unique set of skills, including teamwork, communication, collaboration, and the ultimate in multi-tasking. For that reason, nurses who once worked in the emergency department or an outpatient clinic often feel comfortable with the myriad demands of employee health, says **Kim Stanchfield**, RN, COHN/S, occupational health team coordinator at Sentara RMH, Harrisonburg, VA and executive editor of the AOHP Journal.

Trust and respect is built one-on-one, through personal relationships, she says. “These are your clients. They’re also your colleagues, your coworkers, your managers, your

administrators,” she says.

Employee health professionals also must make the important link between employee safety and patient safety, working with infection control and quality improvement. “If something is unsafe for an employee, it’s likely unsafe for a patient, too,” she says. “Employees who are doing unsafe acts likely are doing unsafe acts that affect patients. You really can’t separate the two.”

The Association of Occupational Health Professionals in Healthcare (AOHP) offers resources for new as well as experienced professionals, including a Getting Started manual, annual conference, ongoing email listserv and practice-based journal.

“There’s also a sense of belonging and comradery. We learn from each other,” Stanchfield says. ■

## Profile just got a little higher: CMS survey includes employee health responsibilities

In a move that could give employee health programs more clout and job security, the Centers for Medicare & Medicaid Services (CMS) recently finalized an infection control survey for hospitals that includes vaccination requirements and several other areas that will involve occupational health. While annual flu shots are required to be “offered,” the hospital can be cited if other vaccinations are not administered. According to the CMS survey the hospital must:

- Provide Hepatitis B vaccination series to all employees who have potential occupational exposure and offer post-vaccination testing for immunity after the third vaccine dose is administered.
- Show that health care workers have evidence of

immunity for measles, mumps, and mumps, and rubella.

- Provide Tdap (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis) vaccination for all personnel who have not previously received Tdap. Note: Tdap is not licensed for multiple administrations; therefore, after receipt of Tdap, health care workers should receive Td (Tetanus diphtheria) for future booster vaccination against tetanus and diphtheria.

- Ensure and document that all personnel have evidence of immunity to varicella.

CMS has told its inspectors the requirements are “effective immediately” and can be used to issue citations in visits that are typically unannounced. Look to more upcoming coverage in *HEH* on the CMS survey requirements. ■

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