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# Hospital Employee Health

JCAHO Update for Infection Control —  
a free supplement — in this issue of HEH

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## U.S. hospitals act to prevent the spread of SARS to health workers

*Five HCWs have SARS, but transmission is limited*

Continued hospital transmission of severe acute respiratory syndrome (SARS) in Canada raised new questions about infection control precautions and whether those precautions were providing enough protection for health care workers. So far, swift identification of cases and adherence to infection control procedures have prevented widespread infection of U.S. health care workers, as has occurred in Asia and Canada. At least five U.S. health care workers may have contracted SARS from caring for patients, and one hospital worker was among the nation's 52 probable cases reported by April 28.

Yet breakthrough cases among health care workers in the critical care and SARS units at Sunnybrook and Women's College Health Sciences Centre and at Mount Sinai Hospital in Toronto caused concern worldwide. Four health care workers were admitted to the hospital with suspected SARS after they intubated a patient with SARS. Other health care workers also have come down with SARS despite the protective equipment.

James Young, MD, Ontario's Commissioner of Public Security, said there likely was a breach of infection control due to fatigue and "inadvertent actions." The Centers for Disease Control and Prevention (CDC) dispatched a team that included an environmental engineer, an industrial hygienist, and a medical epidemiologist to Toronto to assist in the investigation.

The team members will look for possible lapses in infection control procedures, including the fit of respirators and the functioning of negative pressure rooms, said CDC director Julie Gerberding, MD, MPH. "If there's any leakage around the mask, it really negates the whole value of having that filtration factor in front of your breathing zone."

Meanwhile, the World Health Organization (WHO) in Geneva advised those working with SARS patients should wear respirators equivalent to an N100 or N99 — providing 99.97% and 99% efficiency respectively. N95 respirators "could be worn where no acceptable higher protection alternatives are available," the WHO said. (For

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more detailed recommendations, go to: [www.who.int/csr/sars/infectioncontrol/en/](http://www.who.int/csr/sars/infectioncontrol/en/).)

Health officials also warned of the risk of surface contamination. In the investigation of transmission in Hong Kong, researchers found that the coronavirus identified in the SARS outbreak survived on surfaces for as long as 24 hours, the CDC reported.

Both the CDC and WHO have emphasized the importance of disinfection and hand hygiene.

"Soiled gloves, stethoscopes, and other equipment have the potential to spread infection," the WHO reported.

Toronto-area health care workers in high-risk units now wear N95 respirators, full-face shields, double gloves, and double gowns. "I just feel the incredible pressure they're under," says **Barb Wahl**, RN, president of the Ontario Nurses Association. "It's very difficult physically to work when you're gloved, gowned, masked, and wearing eye shields.

To know that there were people who became ill despite the precautions is very, very stressful."

U.S. hospitals have expanded their respiratory protection programs, but purchasing additional N95 respirators has become difficult because the respirators are diverted to Hong Kong, Singapore, Canada, and other countries struggling to contain transmission. (See related article, p. 67.) By late April, several countries had made progress in containing the SARS outbreak. The WHO removed Vietnam from its list of affected areas and canceled the travel advisory it had imposed that discouraged travel to Canada. Gro Harlem Brundtlands, MD, WHO director-general, noted that no new cases of community transmission had occurred for 20 days in Toronto. However, cases continued to mount in China, reaching a total of 3,303 probable cases and 148 deaths there.

Meanwhile, the Occupational Safety and Health Administration (OSHA) reminded employers of their duty to protect workers from recognized hazards. (Go to OSHA's web site: [www.osha.gov/dep/sars/index.html](http://www.osha.gov/dep/sars/index.html).) The agency stressed the need to train workers, to use standard precautions and personal protective equipment, and to comply with the bloodborne pathogens standard.

Yet the potential for an OSHA citation pales in comparison with the chaos that can occur from an undiagnosed case of SARS. In Ontario, the spread of SARS from a single undiagnosed patient led to the quarantine of hundreds of health care workers, the restriction of hospital visitors, and even the closing of hospitals. An undiagnosed case in a Hong Kong hospital before SARS had been identified led to transmission to 99 health care workers.

Active cases in Canada have declined, and Canadian health officials had lauded the stringent efforts of hospitals to contain the disease. The key, said Young, is identifying suspect cases based on symptoms and travel or contact with travelers to affected areas. Some patients have an atypical presentation and may not have a fever, he noted.

"They must approach every patient with a high index of suspicion that they have SARS, particularly if they have any type of respiratory illness, and treat everyone as if they had SARS until it is determined they do not," he said.

With posters in emergency departments (EDs) and alert personnel, U.S. hospitals have raised awareness of SARS and implemented screening. (See related article, p. 68.) As of April 28, there were 272 suspected or probable SARS cases in the United States. There had been 353 deaths worldwide, but none in the United States.

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Hospitals were anxious to obtain a diagnostic test that would help them identify, or rule out, SARS. Researchers in Canada and the CDC had moved with record speed to decode the genome of the new coronavirus, and Emory University in Atlanta became the first to develop a rapid PCR test to identify a genetic sequence in patients who presented to the hospital there. The CDC also was developing and testing a diagnostic tool.

But Gerberding cautioned, "Although we have

tests that can identify it when it's present, we don't know how sensitive they are. If they are not very sensitive, there may be patients who really have infection, but the test is negative because it just doesn't have the sensitivity to pick it up."

Gerberding also warned that United States remains vulnerable to broader transmission. "We have to remain vigilant because it is only one highly transmissible patient that can affect a large number of people," she said. "We must continue

## N95 shortage puts hospitals in a bind

*Surgical masks are a reluctant backup*

A shortage of N95 respirators has forced hospitals to scramble for supplies as they seek to expand their respiratory protection program in response to severe acute respiratory syndrome (SARS).

Faced with an unprecedented worldwide demand for the respirators, 3M Corp., a major manufacturer, stepped up production and focussed its supply on the most acutely affected areas. "Based on discussions with health authorities worldwide, 3M has decided our first priorities are health care workers and families directly in contact with SARS patients," the company reported.

Yet some U.S. hospitals were having difficulty filling new orders for the respirators, which are available from a number of manufacturers. Some hospitals are asking employees to reuse the N95s with TB patients if the masks are not damaged or obviously soiled — a procedure that is mentioned as acceptable in *TB Respiratory Protection Program in Health Care Facilities Administrator's Guide* from the National Institute for Occupational Safety and Health.

However, the Centers for Disease Control and Prevention (CDC) has advised hospitals not to reuse disposable respirators with SARS, and to thoroughly disinfect reusable respirators, such as powered air-purifying respirators (PAPRs). (See box, p. 69.)

Yet CDC acknowledged that hospitals may need to modify their practices if they run out of respirators.

Baystate Health System in Springfield, MA, which has treated two probable cases of SARS and another suspected case, was hoping to get additional supplies of N95s from the same manufacturer. Otherwise, the employees would all need to be fit-tested again — a daunting task, says **James R. Garb**, MD, director of occupational health and safety.

"We may have to use a standard surgical mask as a backup if we run out of the N95s," he says. "The surgical masks were never designed to protect the wearer. They were designed to protect the patient from the surgeon."

At Marshfield (WI) Clinic, **Bruce Cunha**, RN, MS, manager of employee health and safety, also found that the hospital's brand of N95 respirators was out of stock. Out of 6,700 employees, about 200 have been fit-tested for N95s — and all would need to be fit-tested again if the clinic changes manufacturers. "You can see the problems this is going to bring up," he says. "This is just going to be a nightmare."

If hospital transmission were to emerge in the United States, the protective efforts — and fit-testing — would intensify. In Ontario hospitals, all employees in the emergency department, intensive care, neonatal intensive care, and other high-risk areas wear masks. The Ontario Nurses Association (ONA) raised questions about nurses on medical floors who were not given masks.

"We did initially have concerns around supply of masks," says **Barb Wahl**, RN, president of the ONA. "Then we had concerns around distribution of masks. Today, my concern is around who's wearing them — employer policies around who should and who shouldn't be wearing N95 masks."

The province of Ontario ordered more than 4 million N95s, Wahl says. "The task of protecting an entire population of health care workers is mind-boggling," she says.

If N95s are in short supply, Wahl advises hospitals to be upfront about the problem and include frontline health care workers in the solution. "Don't leave the nurses out of the loop," she says. "Don't make decisions for them. They are the ones who will be on the front line. They have every right to be part of the decision making. If there is a limited number of masks, say so. Let them be involved in the decision about who gets the mask."

At the same time, you don't want to discourage appropriate use of the masks, says Garb. After all, the masks will protect health care workers, and ultimately the entire hospital population, from secondary transmission of SARS.

"We tell people in the emergency department to be liberal about when they decide to put on an N95 mask," he says. "If someone comes in with a cough and fever, until you know whether they have TB, you should put on a mask."

SARS simply underscores that basic advice. ■

to identify suspect cases and isolate individuals as quickly as we can . . . so we don't end up with an epidemic that is as rapidly progressive as what we are seeing in some parts of Asia."

**Julie Hall**, MD, medical officer with the Global Outbreak Alert and Response Operations of the WHO, stressed the risk of failing to use appropriate infection control practices.

"Attack rates at hospitals where infection control precautions had not been taken can be greater than 50%, highlighting the real need for infection control," she said. For example, in one Hong Kong hospital, 16 medical students examined a SARS patient without respiratory protection. All 16 subsequently developed SARS.

By stepping up preparedness for bioterrorism, many hospitals improved their ability to handle emerging infectious diseases, such as SARS. They installed new negative pressure rooms, improved internal communication, and conducted training.

But preventing transmission still relies on basic tasks. Here are some recommendations from **Linda Chiarello**, RN, MS, of CDC's division of health care quality promotion:

- Provide surgical masks to patients with respiratory symptoms who enter the ED until they can be evaluated for SARS.
- Patients with suspected SARS should be segregated as soon as possible, preferably in a private room under negative pressure.
- Use of a nebulizer should be avoided because of the greater potential for spread of the disease to health care workers.
- If health care workers are working in a SARS ward, they may wear the same gown to care for different patients. However, disposable respirators should be discarded, gloves should be changed, and hand hygiene should be performed between each patient contact. Health care workers also should wear fit-tested N95

## Triage nurse acts swiftly to detect SARS

*Screening prevents exposure in hospital*

When the elderly woman walked into the newly designed emergency department (ED) at Saint Joseph's Hospital in Atlanta, she went directly to the registration desk. A triage nurse greeted her, learned that she had a cough and difficulty breathing, and asked the telltale question: Have you traveled to Asia in the past 10 days?

The answer: Yes. [The Centers for Disease Control and Prevention (CDC) has since added Toronto to that question.]

Suspecting a case of severe acute respiratory syndrome (SARS), the nurse immediately placed a surgical mask on the 83-year-old patient and her daughter, who had accompanied her to the hospital — and on the trip to Hong Kong and China. The woman was taken swiftly to a negative pressure isolation room in the ED.

Because of her quick action, the triage nurse was the only person in the hospital who had unprotected exposure to the patient. And even that exposure was limited, only lasting about 10 minutes.

"I really am proud of how the whole hospital responded," says infection control specialist **Janet Keen**, RN, MS, CIC, who had posted information in the ED and conducted education.

"There wasn't anything magical about it," says **Robert Capparell**, MD, chair of the infection control committee and hospital epidemiologist. "It was something they had been trained to look for."

Once the patient was in isolation, health care workers entering the room wore gowns, gloves, masks, booties, head covers, and eye protection. The patient was taken to the intensive care unit. She recovered fully and was discharged after about a week.

The triage nurse took a 10-day leave of absence, the quarantine period for this disease. In this case, the CDC did not recommend quarantine, but the hospital decided to take an extra precaution, says Capparell. "Because it's new and we don't know all the ways it's spread, we felt it was best we take her out of the triage position and have her sit out the incubation period."

The nurse did not develop any symptoms and returned to work. The patient's daughter also did not develop symptoms.

In addition to the importance of training, this episode demonstrates the value of incorporating infection control into hospital design, notes Keen. For example, the ED uses nonrecirculated air, she says.

Keen also had prepared as soon as she learned of the emergence of SARS. She ordered extra respirators and checked on other supplies. "It had been my experience in the past that we could run out of isolation materials," she says. "I could see that it was spreading rapidly in some areas. I didn't know if it would spread rapidly in the United States or not, but I wanted to be prepared."

Meanwhile, education about SARS continues to be important to reduce concern among health care workers, says Capparell. "We certainly don't need the fear factor interfering with anything we do," he says. "Our job is to make sure people are educated and not fearful." ■

respirators and eye protection.

“Because there is evidence that coronavirus can survive on surfaces, protection of the environment of care is critical to interrupting transmission,” says Chiarello. “It should be assumed that the immediate environment around the patient is highly contaminated.”

That means hospitals should disinfect bedrails, bed tables, sinks, and other surfaces in the SARS patient’s room every day, she says. Linens and laundry should be placed in designated bags.

“Hand hygiene is the cornerstone of prevention — traditional hand washing followed by drying, or use of alcohol-based hand rubs. Alcohol-based hand rubs may be used as an alternative when hands are not visibly soiled.”

Health care workers who are exposed to a SARS patient before infection control measures are taken should be monitored for symptoms, but the CDC

has not recommended quarantine.

Beyond infection control, hospitals must cope with anxiety and the unknown. At Presbyterian Hospital in Albuquerque, NM, a patient with respiratory symptoms who had traveled to Hong Kong came into the ED on March 14 — the day the CDC activated its Emergency Operations Center to handle a new atypical pneumonia that had occurred in Asia.

Within six minutes, the triage nurse and other ED personnel suspected a connection between the apparent pneumonia and a newly emerging disease. They placed a mask on the patient and ushered him into a negative pressure room. They donned protective gear. The patient was discharged with a diagnosis of pneumonia, then contacted two days later and readmitted to the hospital. By mid-April, the patient had recovered, and the case still will be counted as a probable

## Respiratory protection: SARS advice from CDC

*[This is an excerpt from the Centers for Disease Control and Prevention (CDC) guidance document on the use of respirators to prevent transmission of severe acute respiratory syndrome (SARS). For more information, see [www.cdc.gov/ncidod/sars/respirators.htm](http://www.cdc.gov/ncidod/sars/respirators.htm).]*

The CDC recommends the following guidelines on the use of respirators to prevent transmission of SARS:

- ✓ SARS, unlike tuberculosis, appears to spread by direct contact with respiratory secretions, which makes touching contaminated objects a potential concern. Although re-aerosolization of infectious material is unlikely under normal use conditions, infectious material deposited on a respirator may cause it to become a vehicle for direct or indirect transmission.
- ✓ Respirators should be used in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) regulations. This includes training and fit testing to ensure a proper seal between the respirator’s sealing surface and the wearer’s face.
- ✓ Once worn in the presence of a SARS patient, the respirator should be considered potentially contaminated with infectious material, and touching the outside of the device should be avoided. Upon leaving the patient’s room, the disposable respirator should be removed and discarded, followed by hand hygiene.
- ✓ If a sufficient supply of respirators is not available, health care facilities may consider reuse as long as the device has not been obviously soiled or damaged (e.g., creased or torn). Data on reuse of respirators for SARS are not available. Reuse may increase the potential for contamination; however, this risk must be balanced against the need to fully provide respiratory protection for health care personnel.
- ✓ If N95 respirators are reused for contact with SARS patients (due to insufficient supply), implement a procedure for safer reuse to prevent contamination through contact with infectious droplets on the outside of the respirator. That may include wearing a loose-fitting barrier that does not interfere with fit or seal (such as a surgical mask or face shield) over the respirator.
- ✓ If respiratory protective devices with a filter efficiency of 95% or greater are not available, a surgical (procedure) mask should be worn. Surgical masks will provide barrier protection against large droplets that are considered to be the primary route of SARS transmission. However, surgical masks may not adequately protect against aerosol or airborne particles, primarily, because they allow for leakage around the mask and cannot be fit-tested. The mask should resist fluid penetration and fit tightly around the mouth and nose when properly applied to the face.
- ✓ Aerosol-inducing procedures should be performed on patients who may have SARS only when such procedures are deemed medically necessary. These procedures should be performed using airborne precautions as previously described for other infectious agents, such as *Mycobacterium tuberculosis*. ■

incidence of SARS. As a precaution, 15 ED workers, including the triage nurse, were asked to stay home until seven days after their brief, unprotected exposure. "We have no indications that any employee has shown any symptoms," says hospital spokesman **Todd Sandman**. "We feel that we have a case that was very well-contained, if this does, in fact, turn out to be SARS."

At El Camino Hospital in Mountainview, CA, located in Santa Clara County where several SARS cases have been identified, epidemiology coordinator **Peggy Takizawa**, MS, RN, went on rounds to reassure worried health care workers. She also uses a rapid influenza test to help rule out SARS among patients with respiratory symptoms. "Everybody has respiratory symptoms right now. The question is to ask about their travel or if anyone they have contact with has been in [affected countries]."

While hospitals respond to the threat of SARS, they should be honing their capacity to deal with any infectious disease, advises **Paul Penn**, MS, CHEM, CHSP, founder of Enmagine, a health care emergency management and health and safety consulting firm based in Diamond Springs, CA.

"The annual flu, anthrax, smallpox, SARS — no matter what the origin is — my recommendation is that they look at it as an overall infectious disease prevention and control approach," he says. "Rather than creating new approaches for every new disease, let us deal with an approach that addresses all diseases."

*(Editor's note: For updates on SARS, go to: [www.cdc.gov/ncidod/sars/index.htm](http://www.cdc.gov/ncidod/sars/index.htm).)* ■

## Cardiac screening further slows smallpox program

*Some hospitals await updates on cardiac risks*

Smallpox vaccinations slowed while some hospitals completed or halted their programs and others re-screened employees for cardiac contraindications. **(See the CDC's list of cardiac contraindications, below.)**

Yet concerns over cardiac problems did not stop some states from moving forward with Phase 2, which involves vaccinating first-responders such as firefighters and paramedics.

As of April 10, the Centers for Disease Control and Prevention (CDC) reported that 32,644 health care workers had received vaccines nationwide.

There were 49 moderate to severe vaccine-related adverse events, including 10 cases of myocarditis or pericarditis — inflammation of the heart or the lining of the heart. **(See list of events, p. 75.)** The CDC reported 37 other severe events, including five myocardial infarctions and six reports of angina, which occurred after vaccination but have not been conclusively linked to the vaccine.

Two of the five patients who had myocardial infarction died.

Despite the cardiac concerns, CDC had some

*(Continued on page 75)*

### Cardiac contraindications for smallpox vaccination

The Centers for Disease Control and Prevention (CDC) issued the following statement on cardiac risk factors and smallpox vaccination:

As a precautionary step, if you have been diagnosed by a doctor as having a heart condition with or without symptoms you should NOT get the smallpox vaccine at this time while experts continue their investigations. These include conditions such as:

- known coronary disease including:
  - previous myocardial infarction (heart attack);
  - angina (chest pain caused by lack of blood flow to the heart);
- congestive heart failure;
- cardiomyopathy (heart muscle becomes inflamed and doesn't work as well as it should);
- stroke or transient ischemic attack (a "mini-stroke"

that produces stroke-like symptoms but no lasting damage);

- chest pain or shortness of breath with activity (such as walking up stairs);
  - other heart conditions under the care of a doctor.
- In addition, you should NOT get the smallpox vaccine if you have 3 or more of the following risk factors:
- You have been told by a doctor that you have high blood pressure.
  - You have been told by a doctor that you have high blood cholesterol.
  - You have been told by a doctor that you have diabetes or high blood sugar.
  - You have a first-degree relative (for example mother, father, brother, or sister) who had a heart condition before age 50.
  - You smoke cigarettes now.

*(Editor's note: For more information, go to: [www.bt.cdc.gov/agent/smallpox/vaccination/heartproblems.asp](http://www.bt.cdc.gov/agent/smallpox/vaccination/heartproblems.asp).)* ■



# JCAHO Update for Infection Control

*News you can use to stay in compliance*

## Will the Joint Commission's unannounced surveys catch infection control professionals off-guard?

*Concerns about housekeeping, environment of care*

Given recent events from emerging infections to the threat of bioterrorism, infection control professionals likely will be prepared for unannounced visits from the Joint Commission on Accreditation of Healthcare Organizations. They can't afford not to be.

"The job is too important," says **Patti Grant**, RN, MSN, infection control manager at RHD Memorial Medical Center in Dallas. "We can't let policies and procedures lapse and say, 'They're not coming until next year.'"

However, the Joint Commission's move to unannounced surveys may undermine the educational aspects of the triennial visit, she laments. "I have always learned things during a Joint Commission visit," she says. "They share ideas. You're going to be a better institution because they were there. It's a teaching experience on both sides, and I wonder if that will be lost through the surprise visit."

By the same token, the Joint Commission has drawn fire from both the press and politicians about its collegial inspections and lack of stringent oversight in infection control and other areas. Now JCAHO is making the bold move to begin conducting all regular accreditation surveys on an unannounced basis beginning in January 2006. Unannounced surveys will be pilot tested in volunteer organizations during 2004 and 2005.

The Joint Commission plans to introduce a substantially new accreditation process in 2004, Shared Vision/New Pathways. The discussions of the new approach have frequently included infection control, and as a result, the Joint Commission is considering making the reduction of nosocomial infections a national patient safety goal in 2004.

(See related story, p. 74.)

The transition to unannounced surveys — approved by the Joint Commission board of commissioners at its March 28-29, 2003, meeting — also was a direct outgrowth of the Shared Vision discussions.

"Being ready for a thorough survey at any time is a logical extension of the accredited organization's commitment to continuous improvement," says **Bernard Hengesbaugh**, chairman of the Joint Commission board of commissioners.

The Joint Commission will begin pilot testing its new unannounced triennial survey process next year in up to 100 hospitals that have volunteered to be among the first participants.

Four multihospital systems and alliances — Ascension Health, Tenet Healthcare, Veterans Health Administration, and North Shore-Long Island Jewish Health System — have committed to having a number of their hospitals participate in unannounced triennial surveys in 2004 or 2005.

Also in 2005, JCAHO will continue to conduct voluntary unannounced surveys on a limited basis — opening up the option to all types of accredited organizations, and then transition to a completely unannounced survey program in 2006. During this period, JCAHO will work closely with its various advisory groups, accredited organizations, and other stakeholder groups to gain their input to refine the new accreditation process and smooth the transition to unannounced surveys.

The Joint Commission plans to continue to conduct one-day random, unannounced surveys in an annual 5% sample of the health care organizations it accredits through the end of 2005. After

that time, the random unannounced surveys will be discontinued.

The era of surprise triennial surveys will have begun. Essentially, instead of having a scheduled visit in the third year of the triennial process, the organization will only know that the surveyors will show up sometime that year.

### **Prepare now**

Given the Joint Commission's recent emphasis on infection control, it takes no great leap in logic to expect some emphasis on infection prevention programs when surveyors come knocking. Bring it on, says Grant, who notes that many ICPs have long since gone to a concept of continuous readiness.

"From an infection control standpoint, particularly for any of us who had training and had gone to annual conferences, you learn that your program is an ongoing process," she says. "It is not just paperwork. Unannounced inspections should not impact infection control [negatively]."

Still, there are concerns that housekeeping, which falls under the bailiwick of infection control and environment of care, may not fare well in a surprise inspection, she says. A major part of the problem is that housekeeping departments are chronically understaffed, then geared up prior to a Joint Commission survey. Without the luxury of a scheduled visit, there is some question about how well hospitals will fare in this area, Grant says.

"Things like that will reflect on infection control," she says. "Basic cleanliness is an infection control issue. But this can be both a good and bad thing. You get dinged [with a citation] but hospitals might have to fill the FTEs [positions] they need for housekeeping."

Joint Commission environment of care standards address a broad array of health care standards that may make it vulnerable to surprise inspections. Indeed, a recent report in the JCAHO's *Environment of Care News* strongly emphasized maintenance of the hospital environment and equipment as a cardinal aspect of infection control.<sup>1</sup> (See checklist p. 73.)

"For the first time in JCAHO's history, organizations will truly need to be in compliance and prepared for survey at all times," says **Bob Bartels**, BS, president of Safety Management Services (SMS), a Joint Commission consulting firm in Arlington Heights, IL. "Relative to the environment of care, the effects will be profound.

[Our] experience with hospital environment of care programs is that they are rarely in a condition to be surveyed until a month or so prior to the scheduled date. Our analysis of the situation is that hospital safety and facility leaders will have to adjust this routine dramatically to accommodate this new process."

### **Pitfalls in the area of environment of care**

According to Bartels, unannounced surveys may expose potential vulnerabilities in the following environment of care areas:

- 1. Management Plans:** Health care organizations are dynamic places, and change occurs quickly. As major changes occur related to services, geography, and technology, management plans should be updated to reflect these changes. SMS recommends these plans be serviced at least annually to insure they are current.
- 2. Annual Evaluations:** In the past, minor (and sometimes major) lapses in annual evaluations were either overlooked or not detected. Now it will be more critical to have these evaluations done for each of the three years between surveys and done in a timely fashion. SMS strongly suggests that annual evaluations be done within 60 days of year-end.
- 3. Performance Measures:** Many organizations list performance measures in their management plans but are only able to show evaluation of these measures within the last few months prior to survey. Now that organizations will not know when their surveys are coming, it will be more important to maintain a relatively strict schedule of evaluating and reporting on performance measures. SMS recommends not less than semiannual analysis and reporting.
- 4. Statement of Conditions:** The history of many organizations is to not keep these documents current and to frequently miss deadlines. These documents should be reviewed and updated no less than semiannually and preferably quarterly.
- 5. Interim Life Safety Measures:** Keeping records current on ongoing construction activities will help avoid an unnecessary and unwanted deficiency during announced surveys. The second tier of items requiring regular attention includes documentation of fire drills, disaster drills, pre-construction risk assessments, preventive maintenance, hazard surveillance, fire protection equipment testing, and training records.

“While ongoing compliance with all JCAHO environment of care standards is important, the ones identified above will be some of the more critical ones during an unannounced survey,” Bartels says.

## Reference

1. Joint Commission Resources. The facility manager’s role in infection control: Doing your part to reduce organization-required infections. *Environment of Care News: The official Joint Commission Environment of Care News Source*. May 2003; Vol 6, Issue 5. ■

# Infection control and the environment of care

## Key points to Joint Commission readiness

In a special report on infection control and the environment of care, a Joint Commission publication cited the following suggestions as key points and checklists regarding infection control and the environment of care.<sup>1</sup>

- General housekeeping is adequate for dust and odor control.
- Only facility-approved disinfectants are present on each unit, and they are labeled and used appropriately.
- Refrigerators are cleaned, temperatures are monitored, and a detection system for power failure is in place.
- Face shields, goggles, and personal protective equipment are provided to employees and used during procedures and in cleaning when appropriate.
- Sharps containers are emptied when three-fourths full, and filled sharps containers are secured at all times until properly disposed of by an organization. Linen bags are free of holes/tears and are emptied when two-thirds full.
- Dirty surgical and other patient care instruments transported through the facility are in a closed cart or bio bag.
- When required, all high-level disinfection/sterilization logs are appropriately maintained.

## Infection control and equipment, supplies

- Make sure that instructions for preparing equipment and supplies for contact with care

recipients are appropriate and staff members are adhering to these instructions.

- Provide comprehensive and intensive training for all staff members assigned to reprocessing equipment and supplies.
- Separate broken pieces of equipment or instruments in the warehouse or storage area.
- Perform appropriate cleaning, disinfecting, and sterilizing procedures for equipment and supplies.
- Conduct performance testing with biological indicators (or equivalent) to show effectiveness of sterilization processes.
- Establish a central sterilizing system to maintain consistency.
- Quarantine instruments used in neurosurgery, including brain biopsies with unknown diagnoses or uncertain diagnoses, until a confirmation can be determined or use disposable instruments, if possible.
- Destroy reusable instruments that come into contact with highly infectious tissues that are not proven to respond to regular sterilization techniques.

## Infection control and utility systems

- In addition to combating the bacteria and viruses that flourish on general surfaces and equipment, your facility could be at risk of infection transmitted by water (such as Legionella) or air (such as tuberculosis, aspergillus fungal spores, chickenpox, and measles). One goal of your utility systems management program (EC.1.7) is to reduce the potential for organization-acquired illness.
- Open communication between plant managers and infection control professionals can decrease risk of pathogens in water and air-handling systems.
- Utility managers must make sure that equipment that recirculates water continuously is properly designed, accurately installed, and adequately maintained. If this is done, pathogenic biological agents will be controlled and not allowed to harm those with impaired autoimmune systems.
- Correctly designing, installing, and maintaining air-handling and ventilation systems are also critical to control the spread of infection, specifically pressure relationships, air exchange rates, and filtration efficiencies.
- The concerns are paramount in areas where staff care for individuals who may have suppressed

autoimmune systems, including operating special procedure, delivery, protective isolation, and sterile supply rooms and laboratories.

### **Infection control and construction**

- The creation and spread of contaminants and other environmental problems resulting from construction and renovation projects are a major concern in health care facilities.
- When planning projects that involve demolition, you must assess the risks that the project will compromise care in occupied areas of your organization (EC.3.2.1). The risk criteria should address the potential impact on air quality and infection control, among other things.
- The scope and depth of the particular project drive the degree of the preconstruction risk assessment.
- For example, replacing a sink in an occupied room might require you to remove individuals from the room and take care that airborne particles are not pulled into the ventilation system. On the other hand, constructing a new wing requires assessing risks and implementing safeguards for fire safety, air quality, infection control, and other criteria in a much more comprehensive and systematic manner.
- Regardless of the scope and nature of the assessment, your organization must develop and implement controls to reduce risk and minimize the impact.

### **Reference**

1. Joint Commission Resources. The facility manager's role in infection control: Doing your part to reduce organization-required infections. *Environment of Care News: The official Joint Commission Environment of Care News Source*. May 2003; Vol 6, Issue 5. ■

## **Nosocomial infections may be 2004 focus**

*JCAHO identifying patient safety goals*

Reducing the risk of serious nosocomial infections is being considered as a 2004 national patient safety goal by the Joint Commission.

The Joint Commission's Sentinel Event Alert Advisory Group met in March to begin identifying the 2004 National Patient Safety Goals. Identified

as potential new topics for 2004 goals were preventing surgical fires, eliminating kernicterus, and reducing the risk of serious nosocomial infections.

The advisory group will evaluate and consider both the potential new topics and existing goals in developing its recommendation for 2004 goals to the board of commissioners.

The 2004 goals and recommendations are expected to be announced in July following approval by the board.

According to Joint Commission spokeswoman **Charlene Hill**, if preventing serious infections becomes a patient safety goal, then surveyors will ask accredited facilities about their specific programs and policies to accomplish that goal.

Nosocomial infections would appear to be a strong candidate for a patient safety goal because the Joint Commission recently advised organizations that infections that lead to patient deaths or permanent loss of function should be regarded as sentinel events and subjected to a root-cause analysis with the idea of preventing such infections in the future.<sup>1</sup>

In addition, some of the Joint Commission's 2003 patient safety goals may continue into 2004. As of Jan. 1, 2003, JCAHO began surveying health care organizations' compliance with the 2003 National Patient Safety Goals.

As of Feb. 21, 313 surveys were completed and most health care organizations were found to be in compliance with the patient safety goals. However, some of the recommendations are proving more challenging than others.

Seven percent of those surveyed are not complying with the goal requiring standardizing abbreviations or symbols that are used in providing care. (For example, when "u" is handwritten to indicate units, it can often look like a zero and lead to incorrect medication dosages.)

A noncompliance rate of 2.6 was found for the goal requiring at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.

In addition, 2.2% of those surveyed were not marking the site where surgery is to be performed, e.g., the left foot, and involving the patient in the process.

### **Reference**

1. Joint Commission on Accreditation of Healthcare Organizations. Infection control-related sentinel events. *Sentinel Event Alert* Jan. 22, 2003; Issue 28. ■

(Continued from page 70)

good news to report: No health care workers developed eczema vaccinatum or progressive vaccinia, serious conditions previously associated with the vaccine.

“That suggests that our screening has been very successful. We did not vaccinate individuals who had underlying skin conditions or immune deficiencies,” says **Jane Siegel**, MD, a professor of pediatrics at the University of Texas (UT) Southwestern Medical Center in Dallas and co-chair of the Healthcare Infection Control Practices Advisory Committee.

And none of about 20,000 military health care workers and 30,000 civilian health care workers transmitted vaccinia to patients. “The one thing I think we’ve learned is that it’s safe for recently vaccinated health care workers to continue to have patient contact as long as they use the semipermeable dressing, have site checks before work, and change the dressing as necessary,” she says.

Siegel, who is on the vaccine safety group and a liaison member of the Advisory Committee on Immunization Practices, says the advisory panel will analyze the experience of health care worker vaccination before making recommendations about Phase 2 vaccination. Identifying new cardiac risk factors, CDC advised those with heart

conditions or three or more known cardiac risk factors, such as hypertension, high cholesterol, and smoking, not to receive the vaccine. (See *Hospital Employee Health*, May 2003, p. 53.)

Some states all but shut down their smallpox clinics, but others moved forward to expand the program. Florida health officials announced that they would use remaining stocks of vaccine to start Phase 2 on May 1. Florida vaccinated about 3,600 health care workers with six potentially vaccine-related adverse events, including one nurse who died from a heart attack. That case is still being investigated and may not be linked to the vaccine.

“For us, it’s never been a numbers game. It’s about capacity — throughout the state making sure we have enough people to respond should we [suffer a bioterrorism attack],” said **John O. Agwunobi**, MD, MBA, secretary of the Florida Department of Health in Tallahassee.

Some hospitals had already completed their vaccinations when the new cardiac recommendations came out. Others quickly added new screening questions and found a sudden drop in the number of volunteers.

At UT Southwestern Medical Center, the number of volunteers declined from 60 to 30, as some employees chose not to have the vaccine.

But there were no serious adverse events, and only two employees missed work for just one day

## Vaccine-Related Adverse Events

- Eczema vaccinatum.** Serious (potentially life-threatening) skin rash caused by widespread infection of the skin in people with skin conditions such as eczema or atopic dermatitis — 0
- Erythema multiforme major/Stevens-Johnson syndrome.** A toxic or allergic rash in response to the vaccine that can take various forms and range from moderate to severe — 0
- Fetal vaccinia.** Vaccinia virus infection of a fetus resulting from exposure to smallpox vaccine during pregnancy — 0
- Generalized vaccinia.** Widespread vaccinia rash (ranging in severity from moderate to serious) involving sores on parts of the body away from the vaccination site resulting from vaccinia virus traveling through the bloodstream — 9
- Inadvertent inoculation, nonocular.** Spread of the vaccinia virus to another part of the body, except the eyes, caused by touching the vaccination site and then touching another part of the body, usually mild in severity — 31
- Myocarditis/pericarditis.** Inflammation of the heart/membrane around the heart ranging from mild to life-threatening in severity — 10
- Ocular vaccinia.** Eye infection that can be mild to severe (leading to loss of vision) usually resulting from touching the eye when vaccinia virus on your hand — 2
- Postvaccinial encephalitis.** Severe, potentially life-threatening brain swelling, which can lead to permanent brain damage — 0
- Progressive vaccinia.** Severe, potentially life-threatening skin and tissue destruction starting at the vaccination site and spreading to the rest of the body; occurs in people with severely compromised immune systems — 0
- Pyogenic infection of vaccination site.** Infection of the vaccination site (usually bacterial), which is typically mild to moderate in severity — 0

*Note: These are vaccine-related events as of April 18. For updated information, go to: [www.cdc.gov](http://www.cdc.gov).*

*Source: Centers for Disease Control and Prevention, Atlanta.*

each, Siegel says. "I'm pleased with how things went in my hospital. We do have a team of people who are protected."

For some hospitals, the cardiac cases led to an alteration of plans. "We're on hold," said **James Garb**, MD, director of occupational health and safety at the Baystate Health System in Springfield, MA.

The cardiac concerns arose just a day before public health officials had scheduled to begin vaccination. Garb postponed the vaccines, and plans to re-screen employees. But he is taking a cautious approach.

"Until there's a little more clarity and assurance, we're going to sit tight," he says. ■



## Be alert but not afraid of new privacy rules

*HIPAA won't be a radical change for EHPs*

By **Sandra Adams**, PhD, RN, COHN-S/CM  
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*(Adams and Lucas are consultants who offer training on the new privacy regulations to occupational health nurses. The information they present in this article is for educational purposes only. It does not constitute legal or professional advice. For specific concerns about regulatory compliance, they recommend that you consult an attorney or other professional.)*

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created anxiety among employee health professionals (EHPs). It shouldn't. Privacy and confidentiality are issues that have long been respected in occupational health.

While EHPs must learn the technical aspects of the privacy rule, they already are carrying out the spirit of the law.

HIPAA's Privacy Rule went into effect April 14, 2003, requiring most health care providers and organizations to implement new policies and procedures to ensure the protection of an individual's protected health information (PHI).

The complexity of HIPAA is especially challenging for employee health professionals, who must figure out when they are covered by the act and when they are not.

The nurse in a hospital employee health unit potentially can function under two separate "covered entities" while also functioning in a "noncovered entity" capacity. Here are some examples:

1. The hospital is a *covered entity* under HIPAA as a health care provider. So when the employee health nurse performs functions for the hospital that involve a patient's PHI, such as assisting with quality assurance functions or monitoring nosocomial infections, the nurse is acting as a member of the hospital *covered entity*. If you are dealing with medical information from a hospital patient, you must follow HIPAA rules for protecting PHI.
2. If the hospital has a medical health plan for its employees that is covered under HIPAA and the nurse is involved in reviewing medical claims or assisting with complaint resolution involving PHI, the nurse would be acting as a member of the health plan's *covered entity*.
3. Workers' compensation and disability plans are not covered under HIPAA. However the nurse will be involved in creating, receiving, and using individual medical information in the course of managing these cases. In this instance, the nurse is functioning in a *noncovered entity* capacity. For example, information gathered in a pre-employment physical or in the evaluation of a needlestick injury would not be covered by HIPAA. But the EHP would need a signed HIPAA-compliant authorization form from the employee to receive pertinent information from a primary care physician related to that occupational health issue.
4. If an employee health nurse provides care that is not related to employment, such as blood pressure screening or health services related to a respiratory ailment, the employee might be considered a patient. State privacy laws would apply for the protection of this confidential medical information.

So how do we make sense of when HIPAA applies and when it doesn't?

Fortunately, for most nurses in this field, we

already are protecting confidential health information in a manner that meets most of the HIPAA regulations. We protect PHI and share it only with those who are entitled to use or disclose the PHI. We protect employee health records in the same manner.

Here are a few tips on areas that might need clarification or where you might wish to update or create policies and procedures to address:

- **Make sure your authorization forms (formerly known as the medical release of information form) comply with HIPAA.**

The act provides specific guidance on what must be in an authorization form that allows health care professionals to disclose an individual's PHI.

By using a HIPAA-compliant form, you obtain certain protections for your organization regarding the re-disclosure of the PHI you released and, when requesting PHI on your employees, you avoid a denial of the request or a delay in obtaining the PHI due to a noncompliant form.

- **Organize your employee health records to separate employment-related records and personal health records.**

For example, post-offer applicant physical exams and drug tests are not subject to HIPAA because they are employment-related records. You could use a simple divider in the chart to keep these records separate from other records created for an employee's personal health problem, such as nursing treatment of an upper respiratory infection.

- **Establish guidelines for verifying a requester's identity and right to receive information prior to releasing it.**

This is a good practice regardless of HIPAA. Consider comparing the signature on an authorization form with the individual's signature that you already have on file.

If they don't match, call the individual and confirm that you have a valid authorization form that you can act upon or allow the individual to revoke the form.

For phone requests, ask the callers very specific questions that an average person would not know about the individual to verify that the callers are who they say they are. For example, if a wife calls requesting information about her husband, ask for his employee number and their anniversary date.

By documenting the answers to these questions, you verify that you made a valid effort to ensure appropriate release of the PHI.

- **Under HIPAA, the individual has a right to request that amendments be made to his or her records if there is inaccurate or incomplete information.**

When functioning under a covered entity, you must have procedures to handle these requests. You may want to use the same procedures, even though not required, for noncovered functions as well. In most cases, when information is incorrect, we already are making the changes.

Remember that even though workers' compensation, disability, Family and Medical Leave Act, and Americans with Disabilities Act cases are not covered under HIPAA's Privacy Rule, there are very specific privacy protections outlined for each of these, in some cases, more stringent than HIPAA; and these must be followed. Whenever your state's privacy regulations are more stringent than HIPAA, then those must be followed.

Lastly, have patience. There will be a period of confusion and misunderstanding, especially in releasing information to employee health and occupational health nurses. Become familiar with the HIPAA regulations and how they impact your work situation. Develop appropriate procedures as needed. Enjoy the opportunity to further educate those you interact with when they experience confusion or misinterpretation of what they can or cannot share with you.

*[Editor's note: Adams and Lucas provide information on how HIPAA applies to employee health through seminars organized by the American Association of Occupational Health Nurses. For more information, call (770) 455-7757 or visit the web site [www.aaohn.org](http://www.aaohn.org). More information on HIPAA also is available at [www.hhs.gov/ocr](http://www.hhs.gov/ocr) and at [www.cdc.gov/mmwr/early\\_release.html](http://www.cdc.gov/mmwr/early_release.html).] ■*

## **Safety success: Sharps injuries are cut in half**

*New devices lead to fewer needlesticks*

**S** safer sharps led to a dramatic decline in the number of needlesticks, with nurses sustaining about half as many injuries in 2001 as they did in 1993.<sup>1</sup>

The study, one of the first to document the impact of the Needlestick Safety and Prevention Act of 2000, involved an analysis of data from

the EPINet Multihospital Sharps Injury database of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

"It's great news for health care workers," says **Jane Perry**, MA, director of communications for the center. Sharps injuries likely will continue to decline as hospitals fully implement safety devices, she says.

Perry and center director **Janine Jagger**, PhD, MPH, compared the percutaneous injuries for nurses at teaching hospitals per 100 occupied beds. As a group, teaching hospitals have a higher rate of needlesticks than community hospitals, and nurses sustain more of the injuries than other occupational groups.

Overall, injuries from conventional devices dropped from 18.75 per 100 occupied beds to 7.3. Yet there was tremendous disparity in the implementation of effective safety devices.

Needleless IV systems eliminated sticks from needles on IV lines; there were no such injuries among 11 teaching hospitals in 2001. Yet there was virtually no change in the injury rate from suture needles — a decline of only 5%.

In most conventional device categories, percutaneous injuries declined by more than 50%. Injuries from phlebotomy needles declined by 70%, and those from intravenous catheters declined by 55%.

The data also illustrate the difficulty in completely eliminating conventional devices. By 2001, OSHA regulations required hospitals to convert all sharps to safety devices, except in rare cases where such a device was not available or medically acceptable. Yet the hospitals continued to use conventional devices.

"The reality is that it takes time to evaluate and implement safety devices," Perry says. "It's definitely a step-by-step process."

The operating room has been one area in particular that has lagged behind, she says. In the EPINet data as a whole, covering 58 hospitals in 2001, 29% of all percutaneous injuries occurred in the OR.

"It's been very difficult to get surgical personnel and particularly surgeons to convert to the safety devices," she says. (See related article, at right.)

As injury rates from conventional devices have declined, needlesticks from safety devices have increased. Safety devices were involved in 2.3 nurse injuries per 100 occupied beds in 2001.

About 30% of all needlesticks occur during use, according to EPINet data. "Whether it's

[safety engineered] or not, that's the fraction of injuries that will be difficult to eliminate," Perry says.

"We're not going to get rid of needlestick injuries with safety devices," she says. "Our data on safety devices show that they do still occur."

The next step for injury prevention will involve getting rid of sharps altogether through alternatives, such as needle-free injectors or adhesives instead of sutures, she says.

## Reference

1. Jagger J, Perry J. Marked decline in needlestick injury rates. *Advances in Exposure Prevention* 2003; 6:25. ■

# How to make the OR a sharps safety zone

*EHPs gain support for safer OR practices*

Major advances in reducing sharps injuries have not yet pervaded the operating room, where one out of four sharps injuries takes place. Employee health must be involved in helping change attitudes in the OR to promote safety, sharps safety experts say.

"I think it's a rare exception to find a surgeon who doesn't care about the safety of his co-workers," says **Mark Davis**, MD, FACOG, an Atlanta surgeon who has become a major proponent for sharps safety in the OR. "The problem is just getting their attention."

The overall data are convincing. While percutaneous injuries from needles, syringes, and lancets dropped by at least 55% from 1993 to 2001, injuries from suture needles declined by only 5%, according to data from the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville. (See related article, p. 77.)

But employee health professionals must share the injury data from their own OR with the staff, says **Joan Blanchard**, RN, MSS, CNOR, CIC, perioperative nursing specialist in the Center for Nursing Practice at the Association of Perioperative Registered Nurses in Denver. Quality improvement projects focused on specific practices can bring improvement, she says.

"I have been out in the field and found that when you do that, there is more apt to be compli-

ance," Blanchard says.

Gaining support from administration and physician leaders also is crucial, says Davis. "The infection control or occupational health nurse can't do it alone," he says. "Physicians typically want to speak with physicians if they're being asked to do something. If the top levels of administration don't support the change, then it's really a tough job."

### **QI project gains advocates**

Ultimately, change must come from within the OR itself. So the first step in any injury reduction program should involve building a team of OR safety champions, says Davis, who works as a consultant and wrote the book, *Advanced Precautions for Today's OR* (Sweinbinder Publications, \$14.95).

Hospitals often begin by implementing safer practices, such as no-hands passing. At Rose Medical Center in Denver, operating room educator **Pat Koehmstedt**, RN, CNOR, met with staff and helped them design a neutral zone and select a sharps holder. Instead of passing the instruments directly to OR staff, the surgeon would place them in the neutral zone.

To back up the new process, Koehmstedt put posters above the scrub sinks and educated surgical technicians and nurses at their monthly staff meetings. The chief of surgery discussed the new practice with surgeons.

"For a week when we started it, I went from room to room, talked to the surgeon, talked to staff," says Koehmstedt. "It was quite difficult to start off with it, but the approach was for their benefit."

Sharps injuries related to passing declined from about four a month to two or fewer. Some months, there are none. Over time, the surgeons stopped using the special plastic device. But the neutral zone, with no-hands passing, has remained, Koehmstedt says.

"The whole theory was to decrease [sharps injuries], which we have accomplished," she says. "Even though they're not using an instrument, the technique is improved."

Convincing surgeons to use other safety

## **CE questions**

This concludes the CE semester. An evaluation form has been enclosed. Please fill out and return in the envelope provided.

21. When transmission of SARS to health care workers occurred despite infection control precautions, what additional step did Toronto hospitals take?
  - A. use of powered air-purifying respirators
  - B. use of self-contained breathing apparatus
  - C. use of face shields over N95 respirators
  - D. assignment of SARS-infected workers to care for SARS patients
22. If N95s or comparable respirators are not available, what does the CDC recommend?
  - A. Use snug-fitting surgical masks.
  - B. Use face shields.
  - C. Divert patients to another hospital.
  - D. Rely on HEPA filters and negative pressure.
23. According to Jane Siegel, MD, what is one positive lesson of the smallpox vaccination program?
  - A. Smallpox vaccination does not cause serious adverse events.
  - B. Most health care workers are willing to be vaccinated.
  - C. Smallpox vaccination prevents bioterrorism events.
  - D. Proper use of semipermeable dressings and site monitoring prevent vaccinia transmission.
24. According to consultants Sandra Adams and Barbara Lucas, if an employee health nurse provides quality assurance functions or monitors nosocomial infections that involve a patient's protected health information, the nurse is:
  - A. acting as a member of the hospital "covered entity" and is covered by HIPAA
  - B. acting as a member of the hospital "covered entity" but is not covered by HIPAA
  - C. acting as a member of a hospital unit that is specifically not covered by HIPAA
  - D. performing quality-based functions that are not covered by HIPAA

**Answer Key:** 21. C; 22. A; 23. D; 24. A

## **COMING IN FUTURE MONTHS**

■ How to justify the cost of ergonomics

■ Strategies for improving safety behaviors

■ Update on managing exposure to HCV

■ What is the future of smallpox vaccination?

■ Expert advice on reducing workers' compensation costs

But as new products are developed, they may become more acceptable, says Blanchard.

"You really have to look at what's being offered and work with the companies to help them improve the product," she says.

For example, adhesives may be an alternative that could remove the risk in some circumstances.

### **Use data to build your case**

Surgeons are data-driven, so show them the numbers, says Davis. "The occupational health nurse knows how many people got stuck last year. The surgeon doesn't. The scrub tech doesn't," he says. "If they weren't the ones stuck, they don't know anyone got stuck. You've got to get the data so people will be motivated to accept change."

OR blood exposure rates should be posted in the lounge at least on a quarterly basis, Davis says.

Awareness of the risks — both medical and regulatory — also can have an impact. An estimated 2.7 million Americans have chronic hepatitis C, many of them without knowing it; and that creates a risk of infection from bloodborne exposures.

Both hospitals and surgeons may come under scrutiny from the U.S. Occupational Health and Safety Administration through their stronger enforcement of the bloodborne pathogen standard. That is the most frequently cited standard in hospitals. Surgeons also can receive citations and fines for noncompliance, Blanchard says.

"[Inspectors] want to see that you are using safety devices wherever they're available," she says.

The bottom line: Surgeons may not initially embrace some of the changes that are necessary for sharps safety, but they will adapt, Davis says.

"To say that surgeons are resistant to change and stubborn is throwing in the towel," he points out.

*(Editor's note: For more information on OR sharps safety or to order Davis' book Advanced Precautions for Today's OR, go to: [www.orprecautions.com](http://www.orprecautions.com).)* ■

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### **CE objectives**

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

- identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- describe how those issues affect health care workers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■