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New Joint Commission mandate: Be ever ready for surveyors

Surveyors may ask employees about safety

This year, surveyors from the Joint Commission on Accreditation of Healthcare Organizations may not ask you much about employee health. But they may question employees — or observe their safety practices — to find out how well your hospital protects them from hazards.

In 2004, surveys become more patient-centered, focusing more on the patient's experience and less on paperwork and policy. The revised standards eliminate EC1.1.1, which was specifically directed at employee health, and substitute a more general standard, EC1.10, which states, "The organization manages safety risks."

That change actually may strengthen the position of employee health, says **Geoff Kelafant**, MD, MSPH, FACOEM, medical director for occupational health and employee health at McLeod Regional Medical Center in Florence, SC.

"What it really is saying is that the organization has to have an integrated safety plan," says Kelafant, who was involved in the development of the prior employee health standard as a consultant to the Joint Commission. "Staff safety and patient safety and environmental safety are all equally important."

The Joint Commission promised streamlined standards as part of its new Shared Visions — New Pathways program. The elimination of the employee health standard was a part of that, says **Britt Berek**, CCE, MBA, associate director for standards interpretation.

The new wording in no way lessens the emphasis on employee health and safety, he says. "Whether there's greater emphasis . . . depends on what surveyors see" as they track a patient's experience, he says. For example, they may ask an employee administering chemotherapy about personal protective equipment (PPE) or a nurse where a lift is kept and how it is used. "They should know their job rather than just memorizing our standard," Berek says.

This new process is less scripted and less focused on review of policies

and procedures, he says.

The rhythm of the survey process also has changed. Instead of spending several months preparing for a scheduled visit, hospitals will conduct a self-assessment, which the Joint Commission surveyors will use to streamline their visit. However, hospitals will have the option to undergo a short midcycle survey by JCAHO rather than conducting a self-assessment.

Beginning in 2006, the survey will be unannounced, which means hospitals must be ready to face scrutiny at any time. Some hospitals will pilot test the unannounced survey process in 2004 and 2005. Additionally, 5% of all accredited organizations will be randomly selected for unannounced surveys each year beginning in 2004.

The Joint Commission will no longer publish scores, and it has changed its accreditation categories. **(For an outline of the changes in the survey process, see box, p. 151.)**

"They're going to be looking at all the key areas," says **Mary Ann Codeglia**, RN, CIC, administrative director of clinical process improvement at San Ramon (CA) Regional Medical Center. "Obviously, safety and quality are a key focus for them."

Employee safety has been tied to patient safety, and patient safety is the centerpiece of the Joint Commission's seven National Patient Safety Goals. "The fact that they are going to unannounced surveys puts hospitals on notice to make sure they comply with all the standards all the time," she says.

Preparing for this new style of survey will be far different than for the previous surveys, which placed more emphasis on interviews and document review. *Hospital Employee Health* asked employee health experts to share their advice on how to get ready, and stay ready, for the Joint Commission:

- **Review your safety-related training.**

Now you have a new reason to make sure your employees are getting the message from your health and safety training. For example, they need to know not just where to find the lift equipment and how to use it but *when* to use it. If a surveyor randomly asks a nurse or nursing aide about the ergonomic equipment, will they get an explanation — or blank stares?

"This is going to be a challenge to make sure everybody is trained and understands what they're doing," Kelafant says. "It's probably going to be an awareness-building exercise for a lot of organizations to find out how poorly their employees retain information. That's going to be the weak link. All it takes is for the employee to fail to put on PPE or not activate a safety device, and then [surveyors] are going to start asking questions," he adds.

You may want to add some additional health and safety items to your annual competency exams. Some hospitals may need to revamp their training to make it more effective, Kelafant points out.

Pitt County Memorial Hospital in Greenville, NC, has an employee health nurse who responds to all blood exposures. She is able to track and follow up on problems with safety devices or work practices, says **Pat Dalton**, RN, COHN-S, occupational health administrator. The blood exposure nurse contacts managers after needlesticks, counsels employees, and can provide additional training.

- **Make your written policies user-friendly.**

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Suppose a surveyor asks an employee about a certain policy and procedure — and he or she doesn't know the answer. "The staff member is allowed to say, 'I don't remember, but I know where to look it up,'" Kelafant adds.

Your job will be to ensure that the policies and procedures are accessible and easy to understand. You may need to put some additional policies in writing. Also keep in mind the range of both clinical and nonclinical employees.

"The surveyors could potentially go to a lot of different places, some of which they may not have gone to in the past," Berek says. For example, a nurse surveyor may visit the lab or pharmacy as a part of tracking the patient experience and then may ask safety-related questions, he explains.

- **Conduct walk-throughs to observe compliance with safe practices.**

Employee health may take a more prominent role in regular environment-of-care rounds or walk-throughs. By visiting different departments in weekly or biweekly rounds, employee health professionals can check on safety knowledge and compliance. In a see-through sharps container, they may be able to estimate how often employees are activating safety devices. They may ask office workers about their comfort and adjust their workstations for better ergonomics.

Anticipating the new style JCAHO survey, San Ramon Regional Medical Center is adding new questions for rank-and-file employees as part of the checklist for environment-of-care rounds. **(For a sample checklist, go to: *www.HEHonline.com.)***

"[We want to] ensure that they actually know what they should be doing in certain circumstances," says **Cindy Fine**, RN, MSM, CIC, director of infection control and employee health. "Where do you find the PPE? What would you do if you got a needlestick? Do you know where the lift equipment is and how to use it?"

On his environment-of-care rounds, Kelafant takes along a camera. In his written reports, he highlights safety issues that need to be addressed, before an injury occurs.

- **Keep paperwork updated continually.**

You can't cram for an unannounced survey. Would your paperwork be up to date if the Joint Commission showed up tomorrow?

"Every hospital does the best they can to stay survey ready," Codeglia says. "We do the best we can, but we all know people are crunching a couple months before their scheduled survey to make sure everything's in line."

JCAHO: Spend more time with staff, less with documents

Much of the survey work will occur before the surveyors arrive from the Joint Commission on Accreditation of Healthcare Organizations, and you'll be doing it. Hospitals will conduct self-assessments midway (18 months) through the accreditation cycle. They will then draft a plan of action to correct any areas identified as needing improvement. The Joint Commission will use several data sources as well as the plan of action to guide the actual survey, which it calls a priority focus process.

Instead of giving scores, the Joint Commission will publish a Quality Report that uses symbols such as checks, pluses and minuses to compare the hospital with other JCAHO-accredited hospitals within the state and nationally. For example, the Quality Report will rate compliance with the Joint Commission's National Patient Safety Goals. The new accreditation categories will be:

1. Accredited
2. Provisional Accreditation
3. Conditional Accreditation
4. Preliminary Denial of Accreditation
5. Denial of Accreditation
6. Preliminary Accreditation (under the Early Survey Option)

The new survey agenda includes:

- Opening conference
- Leadership interview
- Validation of organization's implementation and monitoring of plan of action emanating from the periodic performance review (self-assessment)
- Visits to care and service areas guided by the priority focus process using the tracer methodology

Surveyors will select charts at random, then will visit units, sites, or departments "in the exact sequence experienced by the patient chosen. Staff in the various units will be interviewed with regard to specifics pertaining to the care of the patient under consideration, and relevant standards will be surveyed as applicable to the particular case."

- Environment of care review
- Human resources review
- Credentials review
- System tracers

Specific time slots will be devoted to in-depth discussion and education regarding patient safety, the use of data in performance improvement (as in core measure performance and the analysis of staffing), medication management, infection control, and/or other current topics of interest to the organization.

- Closing conference

(For more information on the new survey process, go to: www.jcaho.org.) ■

For example, you'll need to make sure you keep your TB skin testing documentation continually up to date. As surveyors track the experience of a particular patient, they may pull the employee health records of individuals who provided clinical care — rather than asking employee health to provide some sample files, Dalton notes. They may then look for hepatitis B vaccination or other issues.

"They're going to want the hospitals to prove that we have provided a safe working environment, that we have employees who follow the [U.S. Occupational Safety and Health Administration} guidelines for vaccinations," Codeglia explains.

"You'll have to keep on your toes all the time," Dalton says. ■

CDC: Six key elements of SARS preparedness

According to the Centers for Disease Control and Prevention, hospitals should take these steps to prepare for severe acute respiratory syndrome (SARS):

1. Organize a planning committee to develop an institutional preparedness and response plan.
2. Develop surveillance, screening, and evaluation strategies for various levels of SARS activity.
3. Develop plans to implement effective infection control measures.
4. Determine the current availability of infrastructure and resources to care for SARS patients and strategies for meeting increasing demands.
5. Determine how the staffing needs for the care of SARS patients will be met.
6. Determine strategies to communicate with staff, patients, and the health department and to educate staff and patients. ■

CDC: Use surgical masks around respiratory patients

Precautions, planning will prevent SARS spread

Severe acute respiratory syndrome (SARS) forever may alter the way hospitals handle patients with respiratory illnesses. Patients with fever and cough should be segregated in waiting areas and asked to use "respiratory etiquette," and health care workers should wear surgical masks as an infection control precaution, the Centers for Disease Control and Prevention (CDC) has recommended in draft SARS preparedness guidance.

"We think it's important not only for SARS preparedness, but also [to prevent] transmission of other viral respiratory illnesses," says **John Jernigan**, MD, MPH, chief of the intervention and evaluation section in CDC's division of healthcare quality promotion.

For example, the droplet precautions would help stem the spread of pandemic influenza, which public health experts cite as a looming threat. The last influenza pandemic occurred in 1968.

Patients with respiratory illness also may be asked to wear surgical masks, or at least cough into a tissue and use hand hygiene. **(For an explanation of respiratory etiquette, see box, p. 154.)**

During the cold and flu season, the use of surgical masks could become commonplace in hospitals. Some hospitals may view the surgical masks as an awkward barrier between the patient and provider. But Jernigan notes that the precautions are used routinely for some other conditions. "I've cared for lots of patients in droplet precautions. I think it's a workable solution," he says.

The CDC is recommending the use of surgical masks, as a part of droplet precautions, if no known cases of SARS have been identified. Respirators such as N95s still are recommended when caring for SARS patients or in an outbreak situation. Although SARS is transmitted primarily through close contact, CDC has not ruled out airborne spread of the disease.

The plan uses a tiered approach, offering different recommendations based on the presence or absence of SARS worldwide, in the community or in the facility. For example, if nosocomial cases of SARS occur in the hospital, the hospital would need a method to monitor health care workers daily for symptoms.

Planning for SARS can be incorporated into other preparedness plans for handling infectious diseases, including bioterrorism. But in its document, *Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS)*, CDC urges hospitals to take steps now that would allow them to act swiftly if SARS re-emerges.

"SARS-CoV transmission in a health care setting presents occupational and psychological

challenges that, in the 2003 outbreaks, required heroic efforts to overcome," according to the report. "Experience also indicates, however, that early detection and isolation of cases, strict adherence to infection control precautions, and aggressive contact tracing and monitoring can minimize the impact of a SARS outbreak."

Planning should occur across the country, and all hospitals should consider themselves at risk for encountering SARS, Jernigan adds. "We can't predict who with SARS is going to walk into which facility. Every facility needs to be able to recognize a case of SARS and be able to manage a case of SARS." **(See box, at right.)**

The first step is to create a multidisciplinary planning team with a designated SARS coordinator. **(See box, p. 152.)** This team would be linked into communitywide planning with public health agencies, health care facilities, law enforcement agencies, and other organizations.

Employee health would be a part of the planning team along with other related areas, including infection control, environmental services, respiratory therapy, and the hospital disaster/emergency coordinator.

Here are some key areas covered by the guidance document:

1. Strengthen infection control training.

The SARS outbreak eventually was controlled by relying on basic infection control precautions. Yet in the absence of a crisis situation, studies have shown that adherence to basic practices, such as hand hygiene, is poor.

"I'm not sure we've successfully communicated the importance of infection control to health care workers," Jernigan says. "Something like SARS underscores the education. Perhaps education pointing to SARS as an example is something that might actually motivate change."

Hospitals should reinforce their ongoing infection control training with an emphasis on how the precautions can prevent transmission of SARS, pandemic influenza, and other illnesses.

The plan also recommends conducting a readiness drill, which would include a method for monitoring compliance with infection control practices and other preparedness issues.

2. Review the provisions of personal protective equipment (PPE).

Make sure that your staff are fit-tested for N95 respirators and have received adequate instruction on their use, the CDC says. Hospitals should review their available supplies of PPE and determine how they could get additional items in an emergency situation. For example, hospitals might want to conduct fit-testing using more than one brand of respirator, which would allow for flexibility if supplies were limited during an outbreak.

The CDC is planning to issue additional guidance on the use of PPE.

3. Create SARS response teams.

"Ideally, you want to have everybody prepared." But a focused team would be familiar with the hospital's contingency plans for setting up a SARS unit and would be a resource to other employees, Jernigan adds.

Response teams could include medical, nursing, housekeeping, and ancillary staff who would provide initial care for suspected SARS patients. Hospitals might develop an emergency response team to provide resuscitation, intubation, and emergency care. Similarly, a respiratory procedures team would be trained to use the highest levels of PPE with highest levels of protection in the high-risk procedures.

Could it be SARS? Check for these clinical clues

Severe acute respiratory syndrome (SARS) isn't distinctive enough to diagnose only from clinical symptoms, according to the Centers for Disease Control and Prevention.

But there are features that are common to SARS cases:

- ✔ Symptoms emerge within two to 10 days of exposure, with a median incubation of four to six days.
- ✔ Fever, headache, and myalgia will often develop first, with respiratory symptoms coming two to seven days later.
- ✔ Patients may have a nonproductive cough or shortness of breath but usually do not have a sore throat, runny nose, or other upper respiratory symptoms.
- ✔ All laboratory-confirmed SARS patients had radiographic evidence of pneumonia. Most (70% to 90%) had lymphopenia.
- ✔ The overall fatality rate was 10%, but could be more than 50% in people older than 60.
- ✔ Spread of the virus does not seem to occur before symptoms emerge. Most transmission occurs late in the illness when patients are likely to be hospitalized. ■

Universal Respiratory Etiquette Strategy

- Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.
- For patients who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.
- Provide hand hygiene materials in waiting room areas, and encourage patients with respiratory symptoms to perform hand hygiene.
- Designate an area in waiting rooms where patients with respiratory symptoms can be segregated (ideally by at least 3 feet) from other patients who do not have respiratory symptoms.
- Place patients with respiratory symptoms in a private room or cubicle as soon as possible for further evaluation.
- Implement use of surgical or procedure masks by health care personnel during the evaluation of patients with respiratory symptoms.
- Consider the installation of plexiglass barriers at the point of triage or registration to protect health care personnel from contact with respiratory droplets.
- If no barriers are present, instruct registration and triage staff to remain at least 3 feet from unmasked patients and to consider wearing surgical masks during respiratory infection season.
- Continue to use droplet precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond standard precautions.

Source: Centers for Disease Control and Prevention, Atlanta.

In the past SARS outbreak, health care workers became more comfortable with the SARS-specific practices over time. Response teams would leverage experience and training. "It might be potentially advantageous to have a team who knows it might be called upon to deal with this if an outbreak occurs," Jernigan explains.

4. Consider special staffing needs.

A SARS outbreak could require hospitals to furlough health care workers who have had high-risk exposures. Some employees might be asked to be on work-home quarantine, in which they travel only between their home and work during a designated period. Employees using PPE will need "PPE breaks," when they are able to remove the equipment.

All of those scenarios would put a strain on staffing and could create staffing shortages.

The CDC is asking hospitals to consider the staffing issues as a part of their planning, including determining the minimum number of staff needed to care for a patient or group of patients on a given day. Hospitals might want to use non-health care workers or retired health care workers to help out with supplementary duties.

"It might require some level of community coordination," says Jernigan. "The most important thing we're trying to say is anticipate that contingency now."

And while you're considering the needs of patients and the hospital, keep in mind the potential needs of your employees. If they are on work-home restrictions, they may need support with basic issues such as child care and buying groceries. "Health care workers should have access to mental health professionals to help them cope with the emotional strain of managing a SARS outbreak," the CDC advises.

[Editor's note: For a copy of Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), *go to: www.cdc.gov/ncidod/sars/sarsprepplan.htm.]* ■

OSHA restates edict: Don't reuse tube holders

Information bulletin may spark enforcement

Consider this the final and official notice: The Occupational Safety and Health Administration (OSHA) has stated again that blood tube holders cannot be removed from devices for reuse.

OSHA's information bulletin on blood tube holders is likely to lead to increased enforcement action. That will mirror the enforcement that has occurred in California, where Cal-OSHA has issued citations for reuse of blood tube holders since 1999.

"It's not optional," stresses **Deborah Gold**, MPH, CIH, Cal-OSHA senior industrial hygienist. "[Hospitals] are going to need to make this

change. They need to sit down and think about how they're going to do this."

In case anyone didn't understand OSHA's previous compliance directive on the topic or a 2002 letter of interpretation, the bulletin stated: "Prevention of needlestick injuries during disposal of sharps, following phlebotomy procedures, depends on immediate disposal of the blood tube holder unit, with SESIP [sharp with engineered sharps injury protection] attached, and as a single unit after each patient's blood is drawn."

If a blood tube holder must be reused for a procedure, OSHA requires "documentation by the employer that alternatives are infeasible or that this action is required by a medical procedure."

For clarification, the agency added, ". . . This includes a prohibition against the removal of contaminated needles from blood tube holders following a blood drawing procedure."

"Single-use blood tube holders, when used with engineering and work practice controls, simply provide the best level of protection against needlestick injures," OSHA administrator **John Henshaw** said in a release. "That is why the standard generally prohibits removing needles and reusing blood tube holders."

OSHA noted that some hospitals and other health care facilities may need to purchase new disposal containers to hold the single-use devices. "Many sharps containers are designed with openings that do not allow for disposal of a SESIP that is attached to the blood tube holder," the bulletin stated. "These containers would not be in compliance with the bloodborne pathogens standard. Employers must ensure that where blood is being drawn, the sharps container is appropriate for immediate disposal of sharps."

OSHA also addressed a specific scenario involving the removal of the needle from a tube holder:

"A situation may exist that necessitates using a syringe to draw blood and transfer the collected blood into a test tube before disposing of the contaminated syringe. In such a situation, a syringe with engineered sharps injury protection must be used. Removal of the safety-engineered needle must be accomplished after activation of the safety feature and using safe work practices [including use of mechanical means of removal whenever possible]. Transfer of the blood from the syringe to the test tube must be done using a needleless blood transfer device."

The switch to single-use blood tube holders has been a major adjustment for hospitals, as they dealt with greater quantities of medical waste. California hospitals began wrestling with this issue in 1999, when Cal-OSHA began enforcement action.

At some hospitals, phlebotomists use a small disposal container on their carts as they go from room to room. "Those small containers will obviously fill up faster," Gold says. Some hospitals have designated a "dirty room," where they temporarily keep red bag [medical] waste. "They dealt with it by just having a supply of the small containers on the floor."

Hospitals have fitted the trays or carts with larger containers or have added containers at the patients' bedside, she says.

San Ramon (CA) Medical Center reevaluated its sharps containers and installed larger containers. Overfilled disposal containers create a hazard and have led to needlesticks, notes **Cindy Fine**, RN, MSN, CIC, director of infection control and employee health.

The hospital also was able to work with manufacturer Becton Dickinson to obtain a lower price for the Vacutainer devices, since they would be purchasing a much greater quantity, she says.

"Hospitals have been able to make this change, and it hasn't had a huge financial impact," Fine says.

The cost of converting is outweighed by the astronomical cost of a single seroconversion to HIV or hepatitis C from a stick with the back end of a needle, notes Gold. Add to that the emotional cost — the anxiety felt by employees after a needlestick as they wait testing of the source patient or undergo post-exposure prophylaxis, she says.

"Dealing with that needlestick is not cheap, even with a needlestick that has the best outcome," Gold stresses.

Lab companies object to single use

Yet not everyone is on board with OSHA's edict to switch to single-use devices. Clinical laboratories have argued that there virtually is no risk of needlestick from the back end of a needle if mechanical devices are used to release the needle into the disposal container.

EPINet data from the International Health Care Worker Safety Center at the University of Virginia in Charlottesville indicated that 11% of injuries from vacuum blood collection needles/tube holder sets occurred while the health care worker was

disassembling the device. Of 114 descriptions of injuries from phlebotomy devices in the last two years, 12 health care workers reported being stuck by the back end of the needle.

The American Clinical Laboratory Association (ACLA) in Washington, DC, asked OSHA to retract its position on multiple-use holders. The single-use holders are "flimsy" and could actually increase the risk of needlesticks, the association asserted in a position paper. "[T]he perverse effect of OSHA's arbitrary action is that phlebotomists will be exposed to more risk of needlesticks, not less," the ACLA said.

Use of single-use holders would create as much as 10 times the amount of waste, result in a fivefold increase in cost, and create risks from overfilled sharps containers, according to the association.

Using single-use holders is consistent with the bloodborne pathogen standard because "no alternative is feasible," the ACLA said. In fact, with large laboratories performing 50 million or more specimen draws a year, it is "presently not possible" to obtain enough single-use holders for clinical laboratories, it added.

Last spring, OSHA withdrew citations against corporate laboratory giants Laboratory Corp. of America and Quest related to the reuse of blood tube holders and met with industry representatives to discuss their concerns. However, with the information bulletin, OSHA makes it clear that the interpretation of the bloodborne pathogen standard has not changed.

(Editor's note: For a copy of the information bulletin, go to: www.osha.gov/dts/shib/shib101503.html.) ■

Cardiac problems still plague smallpox program

Four cases of dilated hearts under review

Public health experts continue to puzzle over the possible link between the smallpox vaccine and heart problems, as they investigate four recent cases of serious heart ailments. Meanwhile, a study of a 1947 mass smallpox vaccination in New York City lends credence to the theory that the three cardiac-related deaths that occurred after vaccination were not associated with the vaccine.

Two health care workers and two military vaccinees have developed dilated hearts, a severe cardiomyopathy that began gradually and was diagnosed three to five months after smallpox vaccination, says **John Neff**, MD, chair of the Smallpox Vaccine Safety Working Group of the Advisory Committee on Immunization Practices.

All four cases of dilated cardiomyopathy occurred among people who had previously been vaccinated, and all were older than their vaccination cohort. The two military men were 37 and 43 years old, while the median age for military vaccinees is 27. The two female health care workers were 53 and 55, while the median age for civilian vaccinees is 48. The women had a history of obesity and hypertension but no history of ischemic heart disease, according to a report in the Centers for Disease Control and Prevention's *Mortality and Morbidity Weekly Report (MMWR)*. With treatment, the women have been able to continue to work, the report said.[1]

"We continue to feel this is a very, very important avenue to follow [for investigation]," says Neff, who is professor of pediatrics at the University of Washington School of Medicine and director of the Center for Children with Special Needs at Children's Hospital and Regional Medical Center in Seattle.

"These people have significant heart disease," says **Raymond Strikas**, MD, director of CDC's Smallpox Preparation and Response Activity. "We don't know if it's related to the vaccine. We're concerned that's a possibility."

Among about 577,000 military vaccinees, two cases of dilated cardiomyopathy would not be above the normal, expected rate for that population, says Col. **John Grabenstein**, RPh, PhD, deputy director of clinical operations for the Military Vaccine Agency. The rate for unvaccinated individuals would be 1.6 per 100,000, he adds.

"At this point, our number of cases is not above what we normally see," he says, noting that the Department of Defense continues to follow up on its vaccinees.

CDC has asked clinicians to report cases of dilated cardiomyopathy among vaccinees, even if they occur months after vaccination. "Smallpox vaccination has not been associated previously with [the condition]," the *MMWR* report said. "Because smallpox vaccination appears to be associated causally with myocarditis, which can cause dilated cardiomyopathy, further evaluation is warranted."

Screening vaccinees for cardiac risk factors was designed to avoid ischemic events that may be

related to the vaccine. But according to a study by the CDC and the New York City Department of Health, history shows that the vaccine doesn't lead to higher rates of cardiac-related deaths.

About 6 million New Yorkers — 80% of the city's population — received the smallpox vaccine in a four-week period in 1947 after a smallpox outbreak. Public health officers recently sorted through 81,000 death certificates in the municipal achieves, looking for variations in cardiac deaths or overall deaths during a two-week post-vaccination risk period. The 1947 strain of vaccinia was identical to the one used in the 2003 vaccine.[2]

"We were able to pull all of the death records for that year as well as one year before and one year after," says **Melissa A. Marx**, PhD, MPH, an epidemic intelligence service officer with the New York City Department of Health and the CDC. "We didn't see any increase in cardiac-related deaths after vaccination."

Marx notes that in 1947, no one was screened for contraindications. Anyone who wanted the vaccine could get it. The population at the time also had a higher overall rate of cardiac death and more risk factors, such as smoking.

"[The study] is part of the growing body of evidence that smallpox vaccination isn't causally related to cardiac-related deaths," she says.

Autopsies of the three vaccinees who suffered fatal heart attacks did not show any evidence of myopericarditis, which has been associated with the vaccine. However, Marx stresses that screening for cardiac risk factors should continue in the absence of any known cases of smallpox.

Will myocarditis cases recover fully?

Meanwhile, public health officials continue to track the cases of myocarditis or pericarditis, inflammation of the heart or heart lining, which they say may be linked to smallpox vaccination. Of about 500,000 military personnel vaccinated, 58 developed the condition (56 probable, two confirmed). At an eight-week follow-up of 35 cases, 28 reported complete clinical recovery, Grabenstein says. Seven had intermittent chest pain, and two of those had persistent, nonspecific ECG changes.

In the civilian program, which now has vaccinated 38,489 health care workers, public health workers, and first responders, there are 22 cases of myopericarditis (16 suspected, six probable).

Myocarditis can sometimes lead to recurrent heart problems or eventual heart failure. "We don't know if the people with myocarditis will stay completely recovered," says Strikas. "We're working with a group of cardiologists to see how long we need to follow up."

There is no known way to screen future vaccinees to lesson the risk of myocarditis.

"We don't know what the predisposing factors are for people to develop myocarditis or pericarditis," he says. "It's not clear what the risk factors are."

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Ergonomics program gives a lift to morale

Hospital survey shows satisfaction

Ergonomics is more than a way to lift patients. As Butler (PA) Memorial Hospital found, it can lift morale and employee satisfaction, as well.

The challenge is to overcome negative perceptions and convince staff that hospital administration is serious about reducing injuries, says **Karen Bosley**, RN, manager of the employee health service of the western Pennsylvania hospital.

In a five-question survey, Bosley found that employees did not feel they had adequate training or equipment. The survey indicated that employees believed that injuries were not a high priority to hospital administration.

As a consequence, the employees paid little attention to the ergonomic devices the hospital provided. "We found we had employee reluctance to take the time to either use the equipment or get additional staff [to help with a lift]," she explains.

During the following year, the hospital spent $80,000 on equipment, developed a training program, and initiated an incentive program to reward employees who complied.

Visible support for ergonomics was evident from administration.

Injuries declined by 33%, and related medical

costs were reduced by $123,000.

Just as important, however, was the change in attitude, as demonstrated in a post-implementation survey. "It's absolutely amazing," she says. "Now people think administration cares. They know they've gotten education. They know we've got equipment."

Ergonomics now has become one aspect of the hospital's efforts to be an "Employer of Choice" — a hospital that has an edge in recruitment and retention.

Nurses suffered permanent disability

Butler Memorial actually began to investigate ergonomics because of concern over several serious injuries. It was not just the cost that concerned Bosley; although at $400,000 in workers' compensation, the cost was significant.

"We identified employees who had been injured previously, whose quality of life had been [permanently] changed." Employees had undergone back surgery, including fusions and discectomy, due to work-related injuries, she says.

"They're still working here, but they are not able to do the job they were doing before," Bosley points out.

"They are RNs who will probably never be able to go back to the nursing job they did before. Most of them are in nonpatient care-related jobs, such as data collection or staff education.

"We didn't want any other person to have to go through that," she says. "We wanted to see what we could do to prevent future injuries."

In July 2001, the hospital's safety committee decided to create a subgroup to investigate the injuries and develop a plan of action. The committee included Bosley, the safety officer/risk manager, an ergonomist, an employee educator, a floor nurse, the physical therapy director, and the systems improvement manager.

Identifying the causes

The causes identified by the team are common ones: Employees used poor transfer and lifting techniques. The hospital had no policy defining safe lifting techniques. It lacked adequate equipment.

Employees needed patient assessment tools to define when equipment should be used. And employees were reluctant to take the time to use equipment or get additional staff.

CE *questions*

21. How will the new patient-centered surveyors of the Joint Commission on Accreditation of Healthcare Organizations affect employee health?
    A. Surveyors will ask patients if employees used safety devices.
    B. Surveyors will no longer be concerned about employee health.
    C. Surveyors will observe employees and ask them about safety practices.
    D. There will be no effect on employee health.

22. In the CDC's draft guidance document on preparing for SARS, which of the following is a key part of respiratory etiquette?
    A. saying "excuse me" when you cough
    B. asking patients not to cough near other patients
    C. asking patients with respiratory symptoms not to smoke
    D. wearing surgical masks when evaluating patients with respiratory symptoms

23. A study of cardiac-related deaths in New York City after a mass smallpox vaccination in 1947 found that:
    A. There was no elevated level of cardiac-related deaths.
    B. The number of cardiac-related deaths peaked after vaccination.
    C. Most deaths were related to smoking.
    D. The data couldn't be compared to current concerns.

24. At Butler (PA) Memorial Hospital, a method of motivating employees to use ergonomic equipment involved:
    A. brightly colored posters in patient rooms
    B. rewards for units with the lowest injury rates
    C. incentives for employees observed using the equipment
    D. charts comparing ergonomic-related medical costs by unit

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

Bosley and her colleagues wrote a policy and developed patient assessment algorithms. But they knew that was just the first step.

The safety team sought strong administrative support as well as employee buy-in. She and her colleagues were able to get a commitment for $80,000 to purchase equipment — and the team

agreed to be accountable for results. They assured administrators they would achieve a reduction in lifting injuries by at least 25% and a savings of $100,000 in related costs.

"We really were adamant that we could do it," Bosley stresses. "We asked for this money and asked for a chance to prove that we could make a difference."

The survey of 1,500 employees provided a way to measure another outcome: employee satisfaction. The safety team was very hopeful it would improve after the intervention.

Incentives add to motivation

Staff and managers were an integral part from the start of the program. Employees helped evaluate and select the lifting equipment. They acted in a video that became the training tool for the lift devices. Supervisors added ergonomics to their annual staff competency testing. Additionally, the hospital's ergonomist went to office workstations to make adjustments and improve comfort.

They also faced a common challenge: How do you keep employees motivated to use the equipment? She uses an incentive program to reward staff who were observed using lifts, Hover mats, gait belts, or other ergonomic items. Employees receive $5 gift certificates for pizza, ice cream, movie theaters, and other local stores, along with a congratulatory note.

"It wasn't a great deal of money, but it's made a tremendous impact," explains Bosley, who estimates she spent about $1,000 on the incentives. "People really do appreciate that they've been noticed."

She adds that she was pleased recently when she learned of two employees who followed the appropriate lifting policy when a patient lost her balance and began to fall. The nurses eased her gently to the floor. Then, instead of manually lifting her, one stayed with her while the other got a lift.

"They didn't put their own backs at risk," says Bosley. "The patient wasn't injured, and neither were the employees. It's a win-win." ■

Fire safety precautions needed with hand rubs

Fire safety measures should be used when installing dispensers or storing alcohol-based hand rubs, the Centers for Disease Control and Prevention (CDC) advises.

Concerns about fire hazards arose after CDC altered its hand hygiene guidelines to recommend the use of hand rubs, which are effective and less irritating to the skin than repeated hand washing.

When hospitals began installing hallway dispensers with the new products, some encountered restrictions from their local fire marshals, who told them they must be moved.

Survey found no fire incidents

A survey of 798 hospitals using the alcohol-based hand rubs nationwide found no instances of fires related to the products. Eighty-one percent of those facilities had placed dispensers in patient rooms, 89% in treatment rooms, and 61% had placed them in hallways.[1]

While the risk of fire related to the hand rub dispensers appears to be low, the CDC recommends these precautions:

- Health care personnel rub their hands until the alcohol has evaporated (i.e., hands are dry).
- Alcohol-based hand rubs should be stored away from high temperatures or flames, in accordance with CDC and National Fire Protection Agency recommendations.
- Supplies of alcohol-based hand rubs should be stored in cabinets or areas approved for flammable materials.

The CDC notes that national fire codes "permit hand rub dispensers in patient rooms, but prohibit their installation in egress or exit corridors." Local or state fire codes may have additional requirements.

"Health care organizations are encouraged to install dispensers in patient rooms, treatment

COMING IN FUTURE MONTHS

■ Here's the proof: More EHPs mean fewer injuries

■ Needle safety still isn't fully implemented

■ Experts meet to find ways to increase flu vaccination

■ Alternative staffing helps injured employees return to work

■ Simulations help in safe needle device selection

rooms, suites, and other appropriate locations [not in egress corridors]," the CDC states.

"Health care facilities should work with local fire marshals to ensure that these installations are consistent with local fire codes," the CDC adds.

Reference

1. Boyce JM, Pearson ML. Low frequency of fires from alcohol-based hand rub dispensers in health care facilities. *Infect Control Hosp Epidemiol* 2003; 24:618-619. ■

NEWS BRIEF

OSHA: Protect HCWs from West Nile blood exposure

The U.S. Occupational Safety and Health Administration (OSHA) cautioned health care workers that bloodborne exposures could spread West Nile virus.

In an information bulletin, OSHA noted that two laboratory workers handling West Nile-infected fluids or tissues have become infected. Exposures could occur from needlesticks, accidental cuts, or contact with an existing open wound, OSHA said.

OSHA underscored the importance of using safety devices, personal protective equipment including gloves, and in some cases, goggles, gowns, and face shields.

No health care workers have become infected with West Nile Virus after treating patients.

"Nevertheless, health care workers and emergency response personnel must continue to use universal precautions to protect against exposure to human blood and other potentially infectious materials as required by OSHA's Bloodborne Pathogens Standard, 29 CFR 1910.1030," OSHA stated in the bulletin. ■

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. ■

Hospital Employee Health®

Management is the road to higher employee health salaries

Most EH managers earn more than $60,000

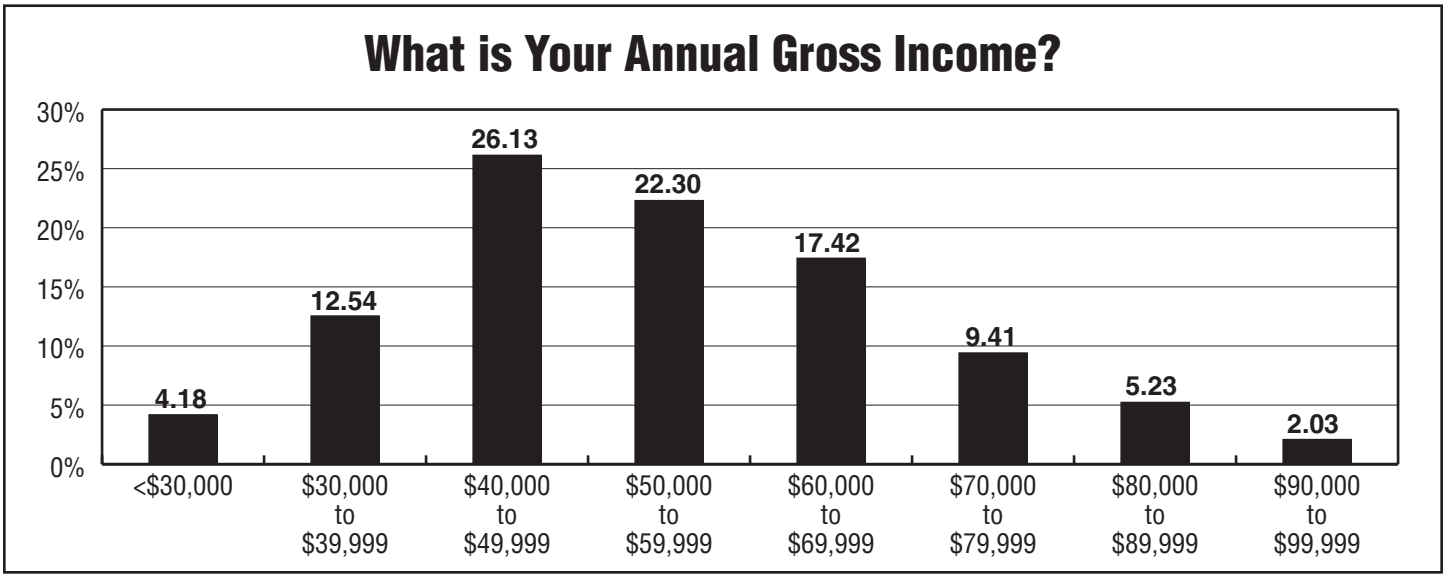
Don't expect much of a raise this year. If you're looking for a substantial increase in salary, you'll have to get a promotion or move to an urban or suburban hospital.

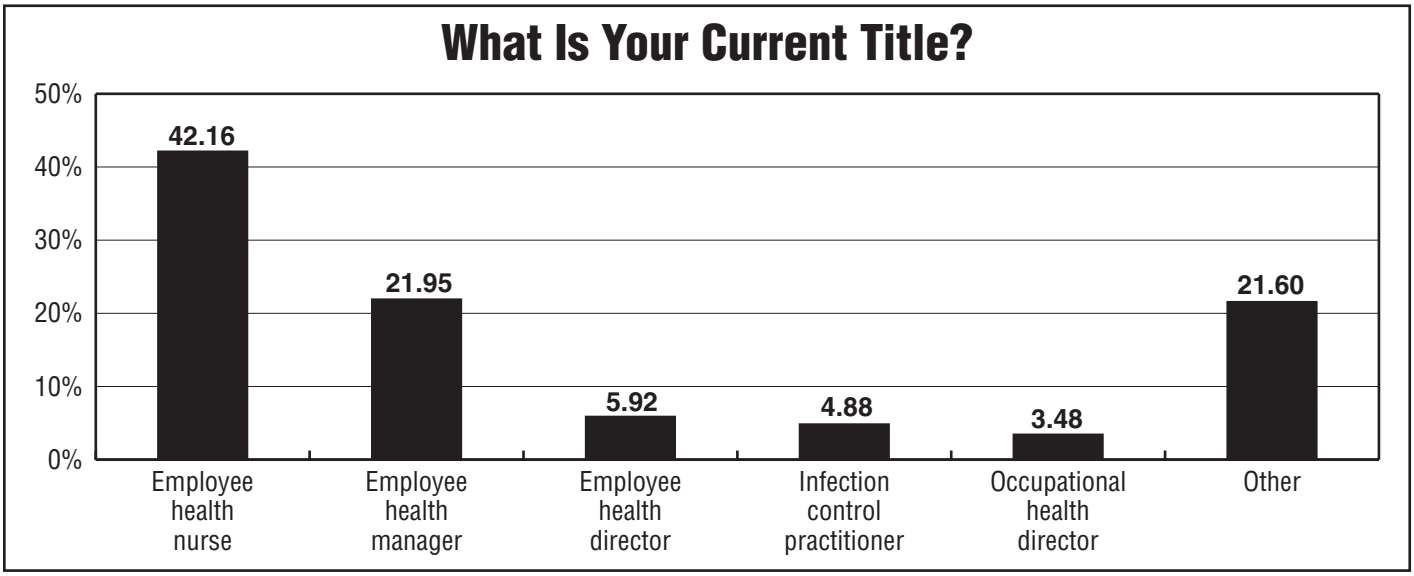
The annual *Hospital Employee Health* salary survey found that most employee health professionals are getting no more than a 1% to 3% raise (with one in 10 getting no raise at all). Those in urban or suburban settings tend to earn more. Only about 10% of big city-based employee health professionals said they earn less than $40,000, compared with about 20% of their counterparts in medium-sized or rural communities.

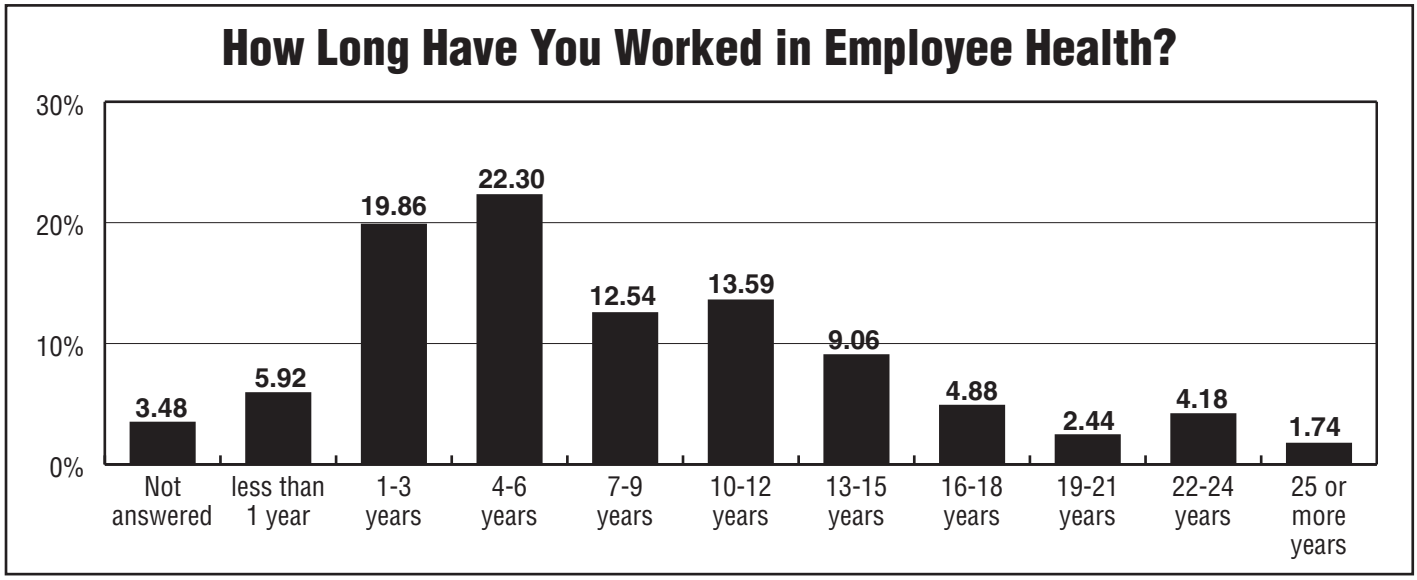
Your best chance for bettering your pay is to gain more administrative responsibility. Most employee health managers and directors (63% and 53%, respectively) earn $60,000 or more, while just 15% of employee health nurses earn that much, the survey found. *HEH* analyzed the responses of 285 employee health professionals from around the country. Most of them work at nonprofit hospitals.

The key is to position yourself as a valuable member of the hospital organization, says **Mary Amann**, RN, MS, COHN-S/CM, FAAOHN, executive director of the American Board for Occupational Health Nurses (ABOHN) in Hinsdale, IL.

Be visible and be vocal, she says. "Volunteer to participate to work on teams with some of these complex issues that are multidimensional," she says. "Occupational health nurses have a great deal of knowledge to share and to add to some very complex solutions. I think it takes a little bit of







assertiveness sometimes, and a little confidence."

You should demonstrate how your job contributes to the major goals and mission of the organization, stresses **Charlene M. Gliniecki**, RN, MS, COHN-S, vice president for human resources at El Camino Hospital in Mountainview, CA.

"As one of our indicators, we look at the cost of salaries, wages, and benefits as compared to operating revenue," she says. "If, as an occupational health nurse, I can be effective in helping people get back to work, decreasing the cost of workers' compensation, disability, or medical care and demonstrate that I have made a contribution to that indicator, that is showing my value in the language that the corporate culture understands."

The bottom line: "If you're not making your boss look good, you probably aren't going to be seen as a key player," says Gliniecki.

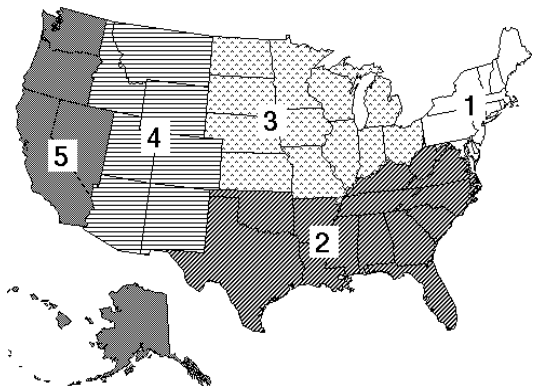
The opportunities for moving up may grow significantly in upcoming years as long-term employee health professionals retire. Some 54% of survey respondents said they have worked in health care for 25 or more years; 44% are 50 or older.

Broadening your background and credentials may better position you for future opportunities. For example, a survey conducted by ABOHN found that 22% of nurses got a pay raise or bonus and 14% got a promotion or new position after receiving their OHN certification. (The survey included occupational health nurses in any industry; 23.5% of all credential holders are hospital-based, Amann says.)

Those who stayed in their same position were more frequently recognized as experts in their field, consulted in business and practice decisions, and included in multidisciplinary activities, she says."Being certified does make a difference. Beyond the tangible differences, people voiced that they experienced some intangible gains [in

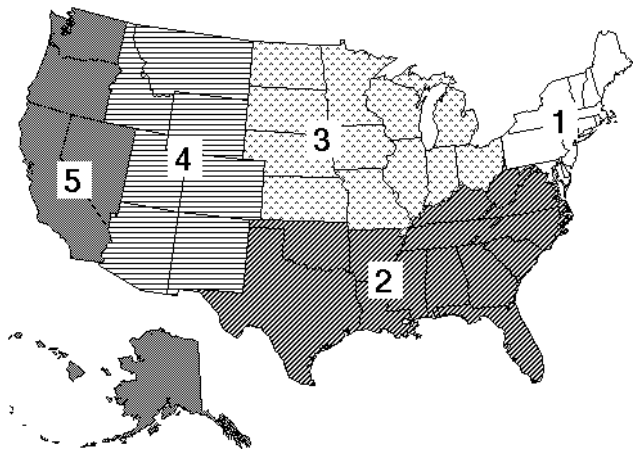
Where Is Your Employer Located?

Region 1 (Northeast)	**17.07%**
Region 2 (Southeast/Southwest)	**36.24%**
Region 3 (Midwest)	**27.87%**
Region 4 (West)	**4.88%**
Region 5 (West Coast)	**13.59%**
Other	**0.35%**



Salary by Region

Income	Total	Region 1	Region 2	Region 3	Region 4	Region 5
Less than $30,000	4.21%	0%	6.73%	3.75%	14.29%	0%
$30,000 to $39,999	12.63%	10.42%	16.35%	11.25%	7.14%	10.53%
$40,000 to $49,999	26.32%	27.08%	28.85%	28.75%	21.43%	15.79%
$50,000 to $59,999	22.46%	20.83%	22.12%	32.50%	14.29%	7.89%
$60,000 to $69,999	17.54%	16.67%	15.38%	13.75%	28.57%	28.95%
$70,000 to $79,999	9.47%	12.50%	6.73%	7.50%	7.14%	15.79%
$80,000 to $89,999	5.26%	10.42%	2.88%	2.50%	7.14%	10.53%
$90,000 to $99,999	2.11%	2.08%	0.96%	0%	0%	10.53%
$100,000 to $129,999	0%	0%	0%	0%	0%	0%
$130,000 or more	0%	0%	0%	0%	0%	0%



their] level of satisfaction and confidence. They were more comfortable in their roles. I think the certification in general helped to validate their knowledge and abilities, as well."

Expertise in additional areas also can enhance your value to the organization. For example, gaining skills or knowledge in infection control, ergonomics, or workers' compensation case management may broaden your scope, Gliniecki says. Her own background in industrial hygiene helped her take on the role of hospital safety officer when she was director of employee health and safety at the hospital.

Allying with other professionals, such as the safety officer or infection control, may strengthen your capabilities, says Gliniecki. "If you leverage your effort with their effort, you can get at least 10% more done," she says. "When I came here, the infection control person and the person before me were at war. Do you know how much energy that takes?" she asks. "This is relationship building, and it means fence building at times. It takes only one bad thing sometimes to ruin a relationship; and sometimes, it takes years to build it up again."

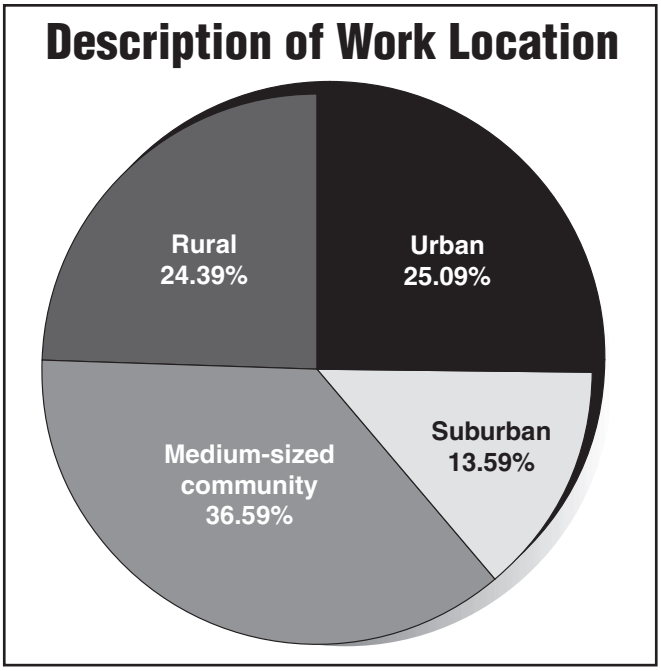
The benefits you gain won't always come in the form of salary. By raising your profile in the organization, you may be able to get more resources for employee health.

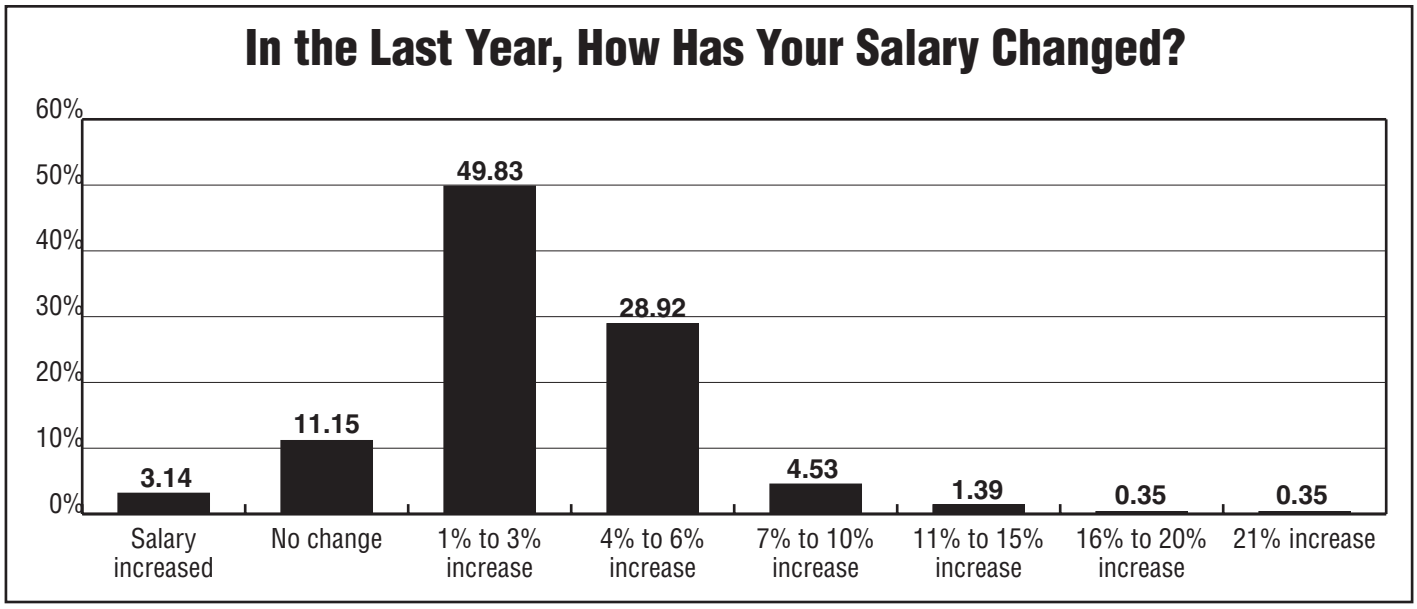
"It might be a trade-off that if you get this additional responsibility, you get some clerical support or other support in your office to carry out the responsibilities," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, employee health coordinator at Western Pennsylvania Hospital in Pittsburgh. "If it's something you want to do and it's important for you to do, then you need to bargain with administration."

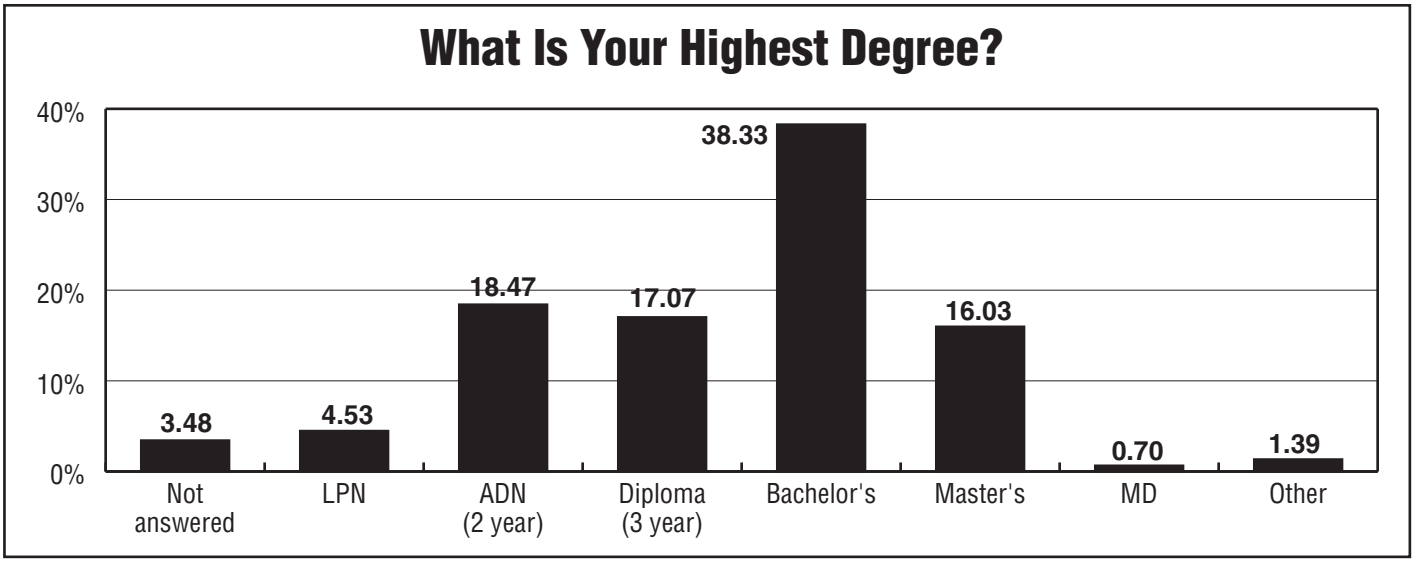
Gruden, who is executive president of the Association of Occupational Health Professionals (AOHP) in Healthcare in Warrendale, PA, makes sure the higher-ups know about her involvement with the professional organization. She recently sent a letter to the manager and director of human resources, the employee health medical director, the CEO, and the COO to thank them for their support of her work with AOHP and included the brochure from the annual conference and an article written by

a first-time attendee, describing how valuable the conference was to her. "When I came to West Penn, it was important to me for employee health to be a valued part of the organization and that my efforts as [AOHP] president would be supported. I used it as an opportunity to make them aware and to thank them at the same time."

While much of your job may involve complying with regulations, administration needs to realize that you have a much broader focus, Gliniecki advises. If you're a solo practitioner without the manager title, you should still think of yourself as a manager. "You're really marketing yourself to your internal customers. Whether you call yourself a manager or an occupational health nurse or specialist, [you should] become so aligned with the operation and getting things done that you become someone they think about including when there's a new unit opening that may affect ergonomics." ■







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