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## IN THIS ISSUE



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# Will harsher flu season raise rates of health care worker vaccination?

*Hospitals make a second push for influenza shots*

An early and widespread outbreak of influenza prompted hospitals to make an even greater push to immunize health care workers — with variable results.

It's too early to know whether hospitals immunized significantly more than 36% of health care workers, the rate of vaccination found in past national health surveys. Health care workers are in the high priority category for influenza vaccines, but hospitals typically have struggled to improve the dismal rates of immunization.

This year, **Julie L. Gerberding**, MD, MPH, director of the Centers for Disease Control and Prevention (CDC), made a specific plea for health care workers to receive their vaccine. Flu outbreaks in the fall may have bolstered her advice. By early December, the CDC reported widespread influenza activity in 24 states.

By mid-December, Children's Medical Center of Dallas had treated 225 patients, 32 of them in the intensive care unit. About 75% of the hospital's health care workers had received the vaccine, an increase from the usual rate of about 65%, says **Jane D. Siegel**, MD, infectious disease specialist at the medical center.

There only have been four cases of nosocomial transmission, and two of those can be linked to sick visitors, she says. "I think the media has really helped us this year. I think people are aware that there is a lot of disease around, and it can be bad disease even in healthy individuals. I think just having that word out helps people," says Siegel, who also is professor of pediatrics at the University of Texas Southwestern Medical Center in Dallas and a member of the Healthcare Infection Control Practices Advisory Committee (HICPAC).

Children's Medical Center uses "flu deputies" — specially trained floor nurses — to provide the vaccine in the units on mobile carts. The hospital puts up posters and educates employees about the importance of the flu vaccine. This year, Siegel analyzed the areas of lower flu vaccination and

sent flu deputies back with the cart. The extra push may have boosted the vaccination rates. "I think having an ongoing assessment with how you're doing [with immunization] is helpful," she says.

Two years ago, Children's Medical Center had 17 cases of nosocomial influenza. Siegel relates that in her education sessions with health care workers, explaining why it's important for them to be vaccinated.

Some unvaccinated health care workers did develop the flu this fall. The hospital emphasized infection control techniques, including "cough etiquette," and urged health care workers not to come to work sick.

At Vanderbilt Medical Center in Nashville, TN, the outbreak of influenza didn't exactly send health care workers streaming in for their flu shots. "It's nothing like the response of the general public [who have driven up demand for the vaccine]," says **William Schaffner**, MD, chair of the department of preventive medicine at Vanderbilt University School of Medicine.

"We have sent out an advisory to our health care workers refocusing the message that they don't want to be the vehicle of transmission of the influenza virus to their patients," he says. "Frankly, we need them to stay healthy to help care for those who are ill."

The hospital's infection control committee has been reviewing the immunization rates. Only about 35% of the hospital's health care workers received the vaccine. "There are some units that do better. I think those units are characterized by strong leadership that establishes a culture where immunization is expected," Schaffner says.

In December, the hospital made another push to increase immunization. The chief administrator sent out a message promoting the vaccine, and occupational health set up immunization sites. "We're doing essentially our initial campaign all over again," he adds.

Meanwhile, the hospital has promoted cough etiquette among patients in the emergency department and clinics. Coughing patients receive tissues, small bottles of alcohol-based gel, and surgical masks.

Although there are signs alerting patients to the cough-etiquette concept, "everybody understands what it's all about. In the context of influenza, you don't need to explain it very much," Schaffner states. ■

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# Taking a toll: Back pain sidelines nurses every day

*Debilitating injuries could be prevented*

*[Editor's note: Every day, 150 health care workers suffer musculoskeletal disorders (MSDs) that cause them to lose time from work. Countless more end their shifts with aching backs, shoulders, or necks. In hospitals, overexertion in lifting is the most common cause of lost workday injuries. Here are the stories of two nurses who suffered debilitating injuries — and the steps they say could be taken to prevent others from a similar fate.]*

**Anne Hudson** of Coos Bay, OR, was walking across her kitchen when she suddenly felt a surge of incapacitating pain. She barely could move. Ten years of lifting patients without

mechanical aids had led to cumulative trauma injury to two lumbar disks.

As she stood immobilized in her kitchen, Hudson didn't know about the condition of her back. She kept thinking the pain would go away and she would be able to return to work on her weekend shift that Saturday.

Her most immediate concern was finding temporary relief from pain. "I could just creep around," says Hudson, who is now 54. "I couldn't sit; I couldn't lie down; I couldn't get in a car to go to the doctor.

"I didn't recognize my pain as severe muscle spasms in response to spinal injury. All I knew was that I had pain like I had never experienced before. A deep severe ache and intense burning settled into my lower back, and I had pain and burning into my lower legs and sometimes into my feet."

The pain lessened at times, enabling Hudson to at least lie down and rest. But she was in no condition to return to the hospital that Saturday, where she worked as a floor nurse in the medical/surgical, telemetry, and intermediate care units.

### Hospital nursing career was over

Hudson began her conservative back therapy with the same mantra in her head: "This will pass, and I will be better." She couldn't imagine life without nursing, without caring for patients.

But her career as a floor nurse already was over.

While Hudson visited physical therapists, orthopedic doctors, and neurologists, and tried anti-inflammatories, heat and cold treatments, and pain medications, she faced a struggle over workers' compensation. At first, she was allowed to work in limited-duty jobs that used her nursing skills. That avenue shut down when workers' compensation denied her claim.

Hudson convinced one of her physicians to give her a work release, as long as she wore a back brace. That lasted three weeks — until she helped care for and reposition a 400-pound patient. She realized she could no longer handle the lifting and transfer tasks.

A workers' compensation judge and the workers' compensation board ruled that Hudson's injury was work-related. The hospital continued to appeal. Meanwhile, Hudson was allowed only two 90-day periods of light duty. There were no permanent accommodations for a floor nurse who could lift no more than 20 pounds.

Today, Hudson works for the county health department, a job she enjoys but one that pays significantly less. Workers' compensation payments, which brought her income up to two-thirds of her wage at injury, stopped at claim closure. Still, Hudson is very grateful to be working as a public health nurse. "Many back-injured nurses never work as nurses again. Either they are too severely injured to work or they are unable to find an employer willing to accept an injured nurse."

A chiropractor helped ease her pain, and a neurosurgeon fused two of the disks, giving her relief from some of the most intense pain. But not a day goes by without a deep aching in her back.

Hudson can no longer work in the garden. Doing laundry or grocery shopping brings pangs of pain. She rarely enjoys a night of sound sleep.

But for Hudson, there is another pain that is not physical. She has become an unwitting expert on the ergonomic hazards of manual patient handling and MSDs among nurses, and she now knows that a zero-lift policy and proper lifting equipment could have saved her career and her back. She also stresses it is unethical for hospitals to deny permanent light duty to injured nurses after not providing safe patient lift equipment and policies to protect them from lifting injuries.

Hudson formed WING USA (Work-Injured Nurses' Group USA), an advocacy organization patterned after similar organizations in the United Kingdom and Australia. Hudson also has co-edited a book with health and safety expert William Charney, which includes the personal stories of injured nurses as well as technical information on ergonomics and safe patient handling. **(For more information, see editor's note, p. 16.)**

"Injured nurses retain all their clinical knowledge and skills. Many times, the only thing they can't do is heavy lifting. But they're still not welcomed back to work by many hospitals," she says. "Through activities with WING USA, I hope to bring injured nurses together and let them know they're not alone."

Hudson also is working on state initiatives for Zero Manual Lift for Healthcare legislation and promotes industry-specific ergonomic solutions that could spare other nurses from a similar fate. "Their careers, their finances, their lives are being impacted by a preventable injury," she says. "It's devastating."

**Maggie Flanagan**, a 46-year-old registered nurse, cared for tiny neonates in Anchorage, AL.

So how could she have work-related MSDs?

There was no problem with patient lifting. Flanagan's injury stemmed from constant reaching and twisting in the cramped neonatal unit, where she was silencing the incessant alarms that sounded on monitors positioned above shoulder level.

After months and years of that daily action, Flanagan didn't realize how vulnerable she was to the effects of cumulative trauma. "I would have some soreness on my days off, but it would go away," she says. "Eventually, it didn't go away. That to me is one of the most serious problems with the injuries. You think it's going to go away, but all of the sudden it doesn't. It can have subtle onset."

Actually, Flanagan can pinpoint the action that turned her aches into debilitating pain. One day, her charge nurse needed to move a monitor. She had called for help, but no one was available. The alternative to moving the monitor involved moving a neonate who was barely clinging to life, and Flanagan agreed that was too risky. She offered to help move the monitor.

"I had seen men move it by themselves," she says. "Surely, the two of us could do it safely. Never in a million years did I think I would be injured from that."

The monitor weighed about 75 pounds. It was positioned on a recessed shelf above shoulder level. The movement mimicked the same one she had done for hours on end.

"I realized I moved the monitor in the exact same movement as the reaches," Flanagan says. "It was the same exact height. It was the same distance. I did it this time forcefully with incredible weight. That was my weakest point."

Half an hour later, she began to feel muscle spasms. She continued to work, monitoring a critically ill neonate who had just come out of emergency surgery. She needed to constantly twist to watch the infant and monitor skin temperature.

By the time Flanagan got home, she couldn't reach for a milk carton in the refrigerator or hold her 3-year-old.

She returned to work the next weekend, but it became too painful. "Every shift becomes the down payment for the injury. I made the final down payment on my injury."

Flanagan says she was lucky. After eight months of medical rehabilitation, without surgery, she has returned to work. (She moved from Alaska and now lives near Tacoma, WA.) While she has no medical restrictions, she works eight-hour shifts by choice and vows to be careful.

She also has noticed that the design of neonatal units hasn't improved. When possible, she uses remote control devices or pulls small monitors or keypads to a better position. But the unit still is rife with twists and reaches.

"I've worked in five different hospitals. Most of the NICU [neonatal intensive care unit] monitors are above our shoulders. I think that's a pretty common situation," Flanagan explains.

"We have not increased our patient space, but we have increased the machines that need to be in the space," she adds. "It's a cluster around the beds. The nurse can't see them all; the nurse can't reach them all. Our technology has exceeded the space we give our patients."

Flanagan is a member of her hospital's safety committee. She also is working with the American Nurses Association to promote ergonomics legislation that would protect health care workers.

"We see where the problem is; we know how to fix it; and we're going to be after that fix," adds Flanagan.

*[Editor's note:* Back Injury Among Healthcare Workers: Causes, Solutions, and Impacts, *edited by William Charney and Anne Hudson, is available from CRC Press (Catalog No. L1631, $79.95). Phone: (800) 272-7737. Web: www.crcpress.com.]* ■

# Hospitals escape sting of tough enforcement

*None have citations for ergonomic hazards*

The tougher enforcement touted by the U.S. Occupational Safety and Health Administration (OSHA) so far has failed to significantly affect the hospital sector. No hospitals have received citations related to ergonomic hazards, despite the fact that overexertion in lifting is the leading cause of injury in the industry.

Overall enforcement at hospitals has remained stable while enforcement efforts increased in other high-hazard workplaces, such as nursing homes. OSHA reported that overall inspections increased by 5.9%, and targeted inspections of high-hazard workplaces rose by 9.2% in fiscal year 2003.

In fiscal year 2003, OSHA conducted 537 inspections of hospitals, compared to 513 in fiscal year

2002 and 581 in fiscal year 2001. The most commonly cited standard was bloodborne pathogens. **(For a list of the top 10, see box at right.)**

Department of Labor Secretary **Elaine Chao** touted statistics that showed an increase in inspections and violations cited by OSHA and a decrease in injuries. "They are an indication of how seriously this administration takes its commitment to protect the safety and security of America's workers," she said in a statement.

While there are several regional or local emphasis programs that include hospitals, they have not had the impact of the National Emphasis Program that targeted nursing homes. Since July 2002, OSHA has conducted about 1,000 nursing home inspections and issued citations against about 500 of them.

Seven nursing homes received "general-duty clause" citations related to ergonomics hazards, and OSHA issued another 104 ergonomic alerts. (OSHA administrator John Henshaw recently announced that he had ended the nursing home National Emphasis Program.)

Most programmed inspections of work sites are triggered by the emphasis programs and targeted inspections of workplaces with high injury rates. In hospitals, inspections most often are the result of complaints or referrals, says **Dionne Williams**, MPH, an OSHA industrial hygienist.

"The inspections are really based on the complaints we get," she says. "That's the reason the numbers for that sector aren't [higher]."

In fact, unions have not been aggressive in filing complaints related to ergonomic hazards. Without a standard, there isn't much point, explains **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU) in Washington, DC. "We don't file [ergonomics] complaints because we know it's a waste of time. We know OSHA doesn't cite for ergonomics. It would really undermine our relationship with our members to give them the impression that OSHA was actually out there protecting them from ergonomic hazards if we file a complaint."

Williams acknowledges that the lack of a standard makes ergonomics a more difficult area for inspectors. "The hurdle for ergonomics citations is far greater than for things for which we have a standard," she says. "Certainly, we're issuing letters to get employers to correct wherever we find there are deficiencies in that area."

That impediment puts OSHA out of sync with the major health and safety issue facing nurses and other health care workers, Borwegen adds.

"They're not getting to the crux of what is showing up on the OSHA 300 log," he says. "That's why the agency is becoming increasingly irrelevant to growing sectors of the economy, especially health care. It's really absurd to walk around the elephant in the room and basically ignore it."

OSHA is most likely to cite hospitals for failing to use safety devices to protect against bloodborne pathogens, failing to update the exposure

## Top 10 Standards OSHA Cited at Hospitals in 2003

Here are the standards that the Occupational Safety and Health Administration cited most often at hospitals in fiscal year 2003:

1. 1910.1030 (d)(2)(i) **Engineering and work practice controls**: Engineering and work practice controls shall be used to eliminate or minimize employee exposure [to bloodborne pathogens]. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used.
2. 1910.1030 (c)(1)(iv)(B) **Updating exposure control plan**: Document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.
3. 1904.29 **Record keeping**: Using OSHA 300, 300-A, and 301 forms, or equivalent forms, for recordable injuries and illnesses.
4. 1910.22 (a)(1) **Housekeeping:** All places of employment, passageways, storerooms, and service rooms shall be kept clean and orderly and in a sanitary condition.
5. 1910.22 (a)(2) **Wet floors:** The floor of every workroom shall be maintained in a clean and, so far as possible, a dry condition. Where wet processes are used, drainage shall be maintained, and false floors, platforms, mats, or other dry standing places should be provided where practicable.
6. 1910.36 (b)(4) **Unobstructed means of egress.**
7. 1910.36 (b)(5) **Clearly visible signs and routes to exits.**
8. 1910.36 (c)(2) **Maintaining exits in buildings under construction/repair.**
9. 910.36 (d)(1) **Unobstructed way of travel from exit.**
10. 1910.37 (f)(1) **Readily accessible exits.**

control plan annually to consider new technology, and failing to include nonmanagerial employees in the selection of devices.

The next most common citations involve housekeeping hazards that could lead to slips and falls, such as water on the floor. According to data from the Bureau of Labor Statistics, slips and falls are the second greatest source of injury in hospitals, after lifting. "When we see hazardous conditions that would contribute to those types of injuries, we address it," Williams says.

The other top areas of enforcement in hospitals relate to obstructions to building exits.

In another development that may affect OSHA's enforcement of the most egregious cases, the Occupational Safety and Health Review Commission ruled that an employer who failed to provide protective equipment or training to 11 workers exposed to asbestos committed only a single violation of OSHA personal protective equipment and training requirements.

In such cases, OSHA generally issues citations for 11 violations of the standard.

"OSHA has appealed a decision that could harm its ability to protect worker safety and health," Henshaw announced. "When an employer commits especially flagrant violations of its requirements, OSHA has a longstanding policy of citing each instance of the violative conduct." ■

# Handle with Care campaign targets ergo

*ANA seeks zero-lift laws, education*

The American Nurses Association (ANA) in Washington, DC, is making a major push for zero lift.

In its campaign, Handle with Care, the ANA is promoting education on ergonomics and asking hospitals to adopt a zero-lift policy. The nurses' organization also will target some states to lobby for ergonomics legislation that would be specific to health care. The ANA campaign mirrors the one for needle safety, which led to legislation in numerous states before Congress passed the Needlestick Safety and Prevention Act, says **Anna Gilmore-Hall**, RN, CAE, ANA's director of nurse advocacy programs.

"Most of the [ergonomic] injuries that occur in health care aren't the result of an isolated incident," she says. "It's a cumulative effect over time of repositioning patients, lifting patients, getting patients up from a chair or bed.

"I think until recently people felt it was just part of the job and there weren't any alternatives," she says. "That's not true. There are alternatives, and cost-effective things you can do. Now we have some research that indicates that not only is this good for the nurse and good for the patient, it's good for the facility as well. It's cost-effective."

The ANA is teaming up with the Patient Safety Center of the James A. Haley Veterans' Hospital in Tampa, FL, a leader in research and implementation of safer ergonomics devices. The ANA is a co-sponsor of the center's Safe Patient Handling and Movement Conference to be held March 2-5 in Orlando. **(See editor's note, p. 23, for more information.)**

"It gives a national backing to move the work we're doing outside the VA," says **Pat Quigley**, PhD, ARNP, CRRN, deputy director for patient safety at the James A. Haley VA Medical Center.

In fact, the conference moved from the Tampa area to Orlando this year to accommodate a larger attendance. Quigley expects 400 to 500 attendees, compared to about 300 in the past.

The Patient Safety Center also supports state and national policy changes that would promote ergonomics in hospitals, says Quigley, who is immediate past president of the Florida Nurses Association. The state nurses' association recently announced its support for state legislation establishing a zero-lift policy for patient handling.

"It would be wonderful to have some legislation that would be put into place for hospitals to integrate current practice to reduce lifting and keep nurses at the bedside," she says.

As with needle safety, the involvement of frontline nurses in ergonomics' efforts will be essential, says Gilmore-Hall. Nurses need input into the selection of equipment and the amount of equipment to be purchased, she says. "They're involved in establishing the whole program for a hospital because, frankly, that's the only way it's going to work," she says.

At the conference, ergonomics' experts will lay out the data supporting a no-lift policy, and speakers and vendors will present information on new technology. A pre-conference session will address special patient populations, such as bariatric patients and agitated or cognitively impaired patients.

*(Continued on page 23)*

JCAHO Update for Infection Control

*News you can use to stay in compliance*

*Joint Commission Infection Control Conference*

# ICPs have skills to expand job; do they have resources?

*Meeting bioterrorism, new infection challenges*

Infection control professionals have the expertise to handle a rapidly expanding job definition, but must have the resources and staff to accomplish the new demands on the profession, a leading ICP recently said in Chicago at a conference held by the Joint Commission on Accreditation of Healthcare Organizations.

The Joint Commission held the Nov. 17-18, 2003, meeting to discuss the future of infection control and release its new 2005 standards for the field.

Effective Jan.1, 2005, the new infection control standards describe a facilitywide program that enjoys both administrative support and staff collaboration. **(See standards highlights, p. 20.)**

Whether such a vision truly becomes a reality may well depend on how serious the Joint Commission is about the infection control revolution it appears to be trying to start.

Right now, as evidenced by the meeting in Chicago, the bulk of the preaching still is being done to the choir. "People who have the power to allocate resources are not necessarily [ICPs], and we need something that's validated to take to those people who allocate resources," **Barbara M. Soule**, RN, MPA, CIC, the 2003 president of the Association for Professionals in Infection Control and Epidemiology, told conference attendees.

"We need to develop a deep culture of infection control and prevention in our organizations. That is the challenge that we have ahead of us. How can we accomplish that so we are prepared for whatever comes?" she asked.

And whatever comes appears to be on its way. Bioterrorism, emerging infections, and patient safety issues are exploding on all fronts, and ICPs find their job responsibilities broadening out across the continuum of care. But their epidemiologic skills put ICPs in an excellent position to meet the challenge, Soule emphasized.

"New knowledge and core skills will continue to evolve," she said. "These new skills do not fundamentally define who we are, but they add to our role, scope and complexity. [But], we need some assistance in terms of resources so we can accomplish all of our goals."

While some attendees questioned whether the Joint Commission put enough emphasis on those needed resources in the 2005 standards, Soule noted the importance of the longstanding partnership between ICPs and the nation's leading accreditation organization.

"The Joint Commission can be a powerful ally because our missions are right in line," she said. "They really care about the quality and safety for patients and so do we. We need their help to be fairly persuasive with the administrators and other folks. Not just in the hospitals, but out among the federal agencies. So I am hoping that they will take that challenge on."

## Knowledge must expand

The current skill base of ICPs, the knowledge of infectious disease detection and prevention has to expand with every new pathogen such as severe acute respiratory syndrome (SARS). ICPs must not only know how to prevent transmission, they must master teaching abilities, use available research, and ensure they know the employee health ramifications, she said.

"As each new pathogen or disease presents

itself, we need to understand the epidemiology of the organism," Soule said. "Is it the same challenges in new clothes, or do we need a whole new wardrobe? Obviously, we can't focus on bioterrorism and emerging pathogens to the exclusion of preventing health care-related infection."

### Battle in the balance

The ongoing battle against old enemies still is in the balance. While it is well and good to look to future challenges, Soule pointed to a recently published study that tallied the extraordinary costs of infections resulting in postoperative sepsis.[1]

"You can see we still have a lot of work do," she said. "If you look at post-op sepsis, excess days are almost 11, excess charges close to $60,000, and attributable mortality close to 22%."

With such issues still ongoing, the field must hold its current focus while expanding to meet the new challenges, she said. "I don't believe we need a bioterrorism and emerging infections section [in Joint Commission standards]. New knowledge and skills essential for bioterrorism and emerging pathogens expand the scope and complexity of infection control practice."

But again, that begs the question of resources and staffing. Concerning the latter, Soule noted

## JCAHO cites collaboration, adequate resources for 2005

*New standards effective Jan. 1, 2005*

New infection control standards by the Joint Commission describe a widely supported and collaborative program that represents one of a hospital's top priorities. Highlights of the 2005 standards, which are effective next Jan. 1, include this statement in the overview: "Health care-associated infections (HAIs) represent one of the major safety initiatives an organization can undertake, making the effective evaluation and possible redesign of existing infection prevention and control programs (IC program) a priority. Key program support standards include:

**STANDARD IC.8.10**
Representatives from relevant components/functions within the hospital collaborate to implement the infection control program.
**Rationale**
The successful creation of an organizationwide IC program requires collaboration with all relevant components/functions. This collaboration is vital to the successful gathering and interpretation of data, design of interventions, and effective implementation of interventions. Managers within the hospital who have the power to implement plans and make decisions about interventions related to infection prevention and control participate in the IC program. While a formal committee consisting of leadership and other components is not required as evidence of this collaboration, the hospital may want to consider this option.
**Elements of Performance for IC.8.10**
1. Hospital leaders including medical staff, licensed independent practitioners, and other direct and indirect patient care staff (including, when applicable, pharmacy, laboratory, administration, central supply/sterilization services, housekeeping, building maintenance/engineering, and food services) collaborate on an ongoing basis with the qualified individual(s) managing the infection control program.
2. Those representatives participate in these activities:
   - Development of strategies for each component's/function's role in the IC program.
   - Assessment of the adequacy of the human, information, physical, and financial resources allocated to support infection prevention and control activities.
   - Assessment of the overall failure or success of key processes for preventing and controlling infection.
   - The review and revision of the IC program as warranted to improve outcomes.

**STANDARD IC.9.10**
Hospital leaders allocate adequate resources for the infection control program.
**Rationale**
Adequate resources are needed to effectively plan and successfully implement a program of this scope.
**Elements of Performance for IC.9.10**
1. Leaders review on an ongoing basis (but no less frequently than annually) the effectiveness of the hospital's infection prevention and control activities and report their findings to the integrated patient safety program.
2. Adequate systems to access information are provided to support infection prevention and control activities.
3. When applicable, adequate laboratory support is provided to support infection prevention and control activities.
4. Adequate equipment and supplies are provided to support infection prevention and control activities. ■

that a recent study confirmed that the old ratio of one ICP per 250 beds is insufficient for today's demands.[2]

"[That] study that showed that 0.8 to one ICP per 100 occupied beds — based on current practice today — was more in line with resources needed for effective programs," she told attendees. That same study found that 100% of participants agreed that identifying the occurrence of infectious diseases and assessing patients were critical functions, but 10% said they did not have time to do such tasks.

"The primary factors influencing nonperformance were competing priorities and responsibilities for traditional and nontraditional infection functions," Soule said. Competing issues cited included bioterrorism, workers' compensation, and latex allergies. In addition, staffing and lab support often was lacking.

The price for undersupporting infection control programs already has been exacted on Toronto, Soule reminded, citing the comments of Canadian clinicians that directly linked some of their considerable problems with SARS to reduced infection control resources.

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*Joint Commission Infection Control Conference*

# Between the unknown and the uninformed

*ICPs must craft 'message,' provide answers*

Amid increasing sensational press exposés and consumer advocates demanding release of hospital infection rates, comes this cold truth from a leading public health official: Health care-associated infections are fraught with so many variables that epidemiologists don't really know how many occur and how many can be prevented.

For example, it has been estimated 2 million nosocomial infections occur annually, but projections are as high as 4 million, said **Steve Solomon**, MD, acting director of the division of health care quality promotion at the Centers for Disease Control and Prevention (CDC).

Solomon spoke at an infection control conference held recently in Chicago by the Joint Commission, which has taken an increasing interest in collecting data about serious nosocomial infections. While much is unknown, Solomon stated flatly that one thing is clear — there is an inherent risk in entering the health care system.

"Who is at risk? Everybody is at risk," he said. "Every time you come into contact with the health care system there is some potential risk."

He also reminded conference attendees that the traditional wisdom that some one-third of infections are preventable is essentially a baseline estimate. The CDC data from the study on the efficacy of nosocomial infection control (SENIC) was collected decades ago by researchers who were not trying to answer the question of preventability of any given infection.[1]

"How preventable are nosocomial infections? That is the $64,000 question," Solomon said. "It is uncertain. For many years at CDC, we used the figure 28% to 32%. We got that from the SENIC study. It certainly is a good baseline number. What they [really] said was in 1975 if all hospitals had infection control programs — according to certain criteria of infection surveillance and control — the number of infections would be 28% to 32% lower than hospitals that don't have such programs."

Yet with scathing press coverage and public demands for medical data increasing, there is a growing perception that health care infections are medical errors that can be prevented. Given that, consumers want to know where and how many infections are occurring before they seek medical care.

"Health care is a commodity," he said. "It is bought and sold, and that's why consumers want information. They want information about health care to be transparent, and they want it to be accountable."

### Time for a public education campaign?

Epidemiologists have long stressed that data that are not risk adjusted for patient severity of illness — or otherwise taken out of epidemiologic context — actually could make good hospitals look worse than poor ones. For example, hospitals with lax surveillance programs detect fewer

infections — and thus may have lower infection rates — than those that strive to identify and prevent every one. In light of such complex issues, Solomon was asked if the CDC would consider a public education campaign to explain the inherent risks of infection in the health care environment and the ongoing efforts of ICPs to prevent such outcomes.

"What is the [campaign] message?" Solomon said, pondering the question. "The message can't be that there is a risk that you can't control. The message can't be that there are things out there that are preventable that we are not preventing. We've got to figure out what the message is [for] our industry. Is it risk-free care? Is it the best care available? I'm not sure that we know. I agree with you [that there] is a breakdown in communication. I think we need to have a frank and honest dialogue within the industry about what is it we really want to communicate."

## Barbarians at the gates?

That dialogue might need to come sooner than later, because consumer groups and attorneys are starting to demand data that hospitals traditionally have fiercely protected. For example, the Consumers Union — publishers of *Consumer Reports* — have set up a web site: www.stophospitalinfections.org.

"We're going to have little [ratings] circles eventually, black and red, like they do for the cars," Solomon told conference attendees.

"It sounds silly but it may not be that far away. There is tremendous press and public scrutiny, a lot of discussion in Congress. This is a very real issue. In Illinois and Pennsylvania at the state level, [there are demands] for reporting infections. . . . We have to address the public perception. We have got to do something about those screaming headlines [in] paper after paper," he continued.

Yet while there are, so to speak, barbarians at the gates, there is little comfort on what is going on inside the castle. Solomon described a health care system overwhelmed by information, hampered by antiquated systems, and thoroughly undercut by chaos.

For example, there currently is an unprecedented exchange of medical information, with more than 20,000 articles published on infectious diseases in 2003, he said. Roughly 1,000 of those articles deal with severe acute respiratory syndrome (SARS).

"We have added close to a thousand new articles on a disease that didn't exist last New Year's Eve," he said. "We have today in health care reached and exceeded the ability of the system to adapt to the input that is coming in to it."

## Chaos within, pressure without

As a result of all the chaos within and pressure without, the CDC is striving to become more "responsive and accountable," he said. New fast-track approaches under study for infection control in clinical settings include more practical surveillance methods such as random chart review, charts screened based on certain thresholds like antibiotic use, and syndromic surveillance to detect clusters. While many private companies feature elaborate tracking systems that can tell where your order is at any time, the health care system is in need of a massive overhauling of computer and information systems to meet current demands for information, he said.

"We need to free your time to do hands-on prevention," he told the ICPs in the audience.

Better statistical models are needed to delineate patients with "suspect" infections, who may or may not be epidemiologically significant but remain outside the grasp of surveillance definition. "There is a group of patients who have suspect infections who live in a nether world between confirmed infections and no infection," Solomon said.

Given such gray areas, the demands by some for hospital infection data — like a reading off a meter — seem all the more counterproductive. But the demands will not stop, so the challenge is to make the data more meaningful and understandable, he said.

"I think the thing for us to do as infection control professionals and epidemiologists is to figure out how we are going to make the data more meaningful, and convince the people that want that data that a lot of [that information] isn't going to help them," Solomon said. "We have got to figure out which data are going to help them and show them why they can help them. We have got to turn that sow's ear into a silk purse, and it's not going to be easy."

## Reference

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(Continued from page 18)

Momentum is growing for ergonomics, says Gilmore-Hall. But she acknowledges that there will be barriers — including resistance from nurses who are accustomed to manual lifting and believe their patients won't like mechanical lifts.

What's the ANA's answer? Education. Nursing schools need to revamp their curricula to incorporate ergonomics, and working nurses need to understand the science behind it. The ANA will even target a part of its message to consumers.

"I'd like to get to the point where a patient would even say to a nurse, 'Aren't you going to use the lifting device to get me up?'" says Gilmore-Hall. "It's going to be a whole culture change."

*[Editor's note: The Safe Patient Handling and Movement Conference will be held in Orlando, March 2-5. It is sponsored by the VISN 8 Patient Safety Center of Inquiry of the James A. Haley Veterans' Hospital, the University of South Florida, and the ANA. A conference brochure and registration are available on-line at www.cme.hsc.usf.edu/safepatient/#6. For more information, contact Valerie Kelleher at the Patient Safety Center at (813) 558-3948.]* ■

# An influx of nurses won't solve shortage

*Biggest group is older than 50, report says*

Older nurses returning to work have helped ease the nursing shortage, but they also create a greater imperative for ergonomic modifications, says **Peter Buerhaus**, PhD, senior associate dean for research at the Vanderbilt University School of Nursing in Nashville, TN.

Buerhaus, an expert on the nursing work force, reports enormous demographic changes that will have a long-term impact on hospital staffing. "In the last couple of years, I think there has been a much deeper awareness that this shortage probably is different than previous ones because it has a lot to do with the aging of the work force," he continues.

In 2002, more than 104,000 nurses entered the work force, a huge resurgence, Buerhaus reported in *Health Affairs*.

Two-thirds of that growth came from nurses older than 50. About 15,000 foreign-born nurses came to U.S. hospitals from other countries,[1] the report said, which was co-authored by Douglas Staiger, PhD, professor of economics at Dartmouth College, and David Auerbach, PhD, an associate analyst in the health and human resources division of the Congressional Budget Office.

The older nurses were attracted by higher wages (an increase of nearly 5%), when their spouses were facing job insecurity or unemployment in an economic downturn, Buerhaus says.

As the economy rebounds, many of those nurses may once again leave the work force, he points out. "If hospitals change the ergonomic workplace, these nurses may decide to stay."

In fact, Buerhaus grimly notes, "There's nobody out there but these older nurses. So you better do what you can do and do it quickly."

Few young women are choosing nursing as a career. From 2001 to 2002, the number of RNs younger than 35 actually declined by 8.3%. Twenty years ago, about a third of the nursing work force was younger than 30. Today, younger nurses only account for about 10% of the work force.

That means that just as the baby boom generation is retiring and requiring more health care services, nurses also will be retiring in large numbers, deepening the shortage. Even the kind of surge in employment seen in 2002 wouldn't be enough to stem a shortage, Buerhaus says.

The nursing supply needs to increase by 40% per year, he says.

### Nursing school enrollment rises

The statistics are bleak, but there are some bright spots. The American Association of Colleges of Nursing (AACN) in Washington, DC, reported that enrollment in entry-level baccalaureate programs in nursing rose by 15.9% in fall 2003 compared to the prior year. That is the third year of growth after six years of declining enrollment.

Renewed interest in nursing actually could have produced even more new workers if the schools had the capacity. Tight state budgets and shortages of nursing faculty forced nursing schools to turn away qualified applicants, the AACN reported.

Congress should intervene by providing the funding to rapidly increase the capacity of nursing schools. "I can't emphasize enough how important it is to have nurses in school," Buerhaus says.

Meanwhile, the influx of foreign-born nurses is

four times greater than during previous shortages, he says. That creates a host of other issues, including the impact on shortages of skilled nursing care in other countries and on quality of care. "We're moving down that path without any debate or discussion about the merits of that approach," he explains.

Enticing older nurses to stay will require changes in the work environment, Buerhaus says. Medicare should provide supplemental payments for hospitals that make improvements to ease the burden on nurses, he adds.

"I think Medicare is very shortsighted in not looking at a payment system that ties payments to hospitals with efforts to improve ergonomic environment," Buerhaus says.

He even suggests that medical device and supply companies provide grants to stimulate the use of ergonomic equipment. After all, in a severe nursing shortage, hospitals would have to close units or floors, which would cut deeply into their revenues and their purchases.

On a more personal level, Buerhaus envisions the impact of a severe nursing shortage on patient care. "I want enough nurses, there. I don't want them overworked," he says. They'll [be more likely to] make a simple mistake, and it will cost me my life."

### Reference

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# Fatal assault on physician highlights violence risk

*Violence prevention can reduce incidences*

The fatal assault of a physician at a California psychiatric facility once again has highlighted the need for strong workplace violence prevention programs at hospitals.

In fact, California is the only state that requires a violence prevention program at hospitals — a law that has been largely successful in promoting violence prevention, training, and better reporting, according to a researcher studying the issue.

John George Psychiatric Pavilion in San Leandro, a locked, inpatient facility, cares for patients in acute crisis — those deemed a possible danger to themselves or others.

For months, nurses at John George complained to Cal-OSHA (the California Occupational Safety and Health Administration) about inadequate security at the county-run facility, which has suffered from budget deficits and staffing problems.

In April, Cal-OSHA cited the facility for failing to report two serious assaults on nurses and for failing to sufficiently implement an injury and illness prevention program. The hospital is contesting the citations.

On Nov. 20, John George staff became concerned when they saw a new patient wandering around with a partially completed medical form. Soon after, internist Erlinda Ursua, MD, was found dead in a private exam room; she had been conducting a medical history and physical on the patient. Ursua had been beaten in the head and strangled, according to reports from the patient's arraignment.

"It's a longstanding issue. We've been trying to get them to improve the employee and staff patient safety there for a while," says **Bradley Cleveland**, communications and research director of Service Employees International Union (SEIU) Local 616. John George is a part of Alameda County Medical Center.

"I don't think our facilities are unique in terms of the kinds of incidents that may occur," he says. "I think at these kinds of facilities, you have a potential danger of assaults on staff. They have to have systems in place to address these potential threats."

Hospitals in California are required to have a violence prevention program to receive their state license. When **Corinne Peek-Asa**, MPH, PhD, associate professor of occupational health at the University of Iowa's Injury Prevention Research Center in Iowa City, surveyed 16 hospitals as a part of a research project on the violence prevention law, she found they had all complied.

The content of those programs differs widely. But since the law was implemented in 1995, the number of violent events at hospitals has decreased — even with an improvement in reporting, she says. Hospitals could make even more progress if they analyzed their violent incidents to look for opportunities for improvement, she says.

"Even though every facility that we visited had a reporting system, and some of them had multiple reporting systems, the reporting system was never used to form prevention strategies. That was the missing link," says Peek-Asa,

whose research is sponsored by the National Institute for Occupational Safety and Health and conducted in conjunction with the California Department of Health Services.

The John George case illustrates the challenges for facilities working with troubled patients and the importance of security and violence prevention policies.

John George had a performance improvement task force that was working on the issue of security when the incident occurred. Last summer, the facility underwent a survey and received accreditation from the Joint Commission on Accreditation of Healthcare Organizations. John George had stated that it would work on lowering patient assaults on staff and reducing lifting injuries as part of its performance improvement plan, says Cleveland.

Meanwhile, in April, Cal-OSHA had received six written complaints and numerous phone calls from John George employees about the risk of patient-on-staff violence, says Cal-OSHA spokesman **Dean Fryer**. Cal-OSHA sent John George a letter asking the hospital to explain how it planned to reduce the hazard, but didn't get a response until the agency launched a formal investigation in late May.

"During our interview process, we found that there were assaults against nurses on two occasions," he says.

"On Dec. 25, 2002, a nurse was stabbed by a patient. It was a nonfatal injury. On April 9, there was another assault on a nurse who suffered a fractured nose. We had not received notice of either one of those attacks, which was required," Fryer explains.

Cal-OSHA issued citations and fines totaling $30,000. The agency also recommended that John George install security cameras, hire armed peace officers, and implement a policy that staff should never be alone with a patient. The hospital appealed the citations, which meant it wasn't required to make changes, he points out.

"To our knowledge, none of those suggestions were implemented," Fryer says. "We're now looking at what steps they may have taken since our last citation."

Since Ursua's death, computer flags have been added to all records of patients with a history of assaultive behavior, according to a medical center spokeswoman.

An attendant will be present with medical staff during histories and physicals. The facility also hired sheriff's deputies in addition to private security staff, so there will be a staff of five security personnel on each shift, the spokeswoman said.

Despite those changes, a patient committed suicide at the facility in early December.

Staffing shortages and financial constraints can contribute to a stressful environment, says Peek-Asa. "That makes [violence] prevention programs even more crucial," she says.

Peek-Asa and her colleagues are planning to study violence prevention in other states, to provide a comparison with the California experience.

One of the key aspects of violence prevention is training, a requirement of the California law, she notes. "Every hospital we went to had training programs. The content and the delivery of those programs varied dramatically. We definitely need to take a better look at what the best delivery system is."

Training needs to continue to be relevant and effective to keep the issue in the minds of employees, she says. "The potential for threat is always there. I think you sort of get inured to it when it's something you see every day," Peek-Asa says. "It's important just to keep the word out there that there are strategies that can help reduce that threat."

Staffing also can affect worker safety, says Cleveland. He notes that California's minimum staffing ratios went into effect in January. "That alone could have a positive effect on the employee safety issue," he says. ■

# Medicare bill closes needle safety gap

*All public hospitals must now comply*

A small section in the massive new Medicare law brings all hospitals into compliance with the bloodborne pathogens standard. State and local hospitals now will be subject to the same provisions — including the involvement of front-line health care workers — as other hospitals that fall under the purview of the U.S. Occupational Safety and Health Administration (OSHA).

OSHA does not have jurisdiction over public employers outside the federal government. State plan states must cover all employees, but public sector employees in some federal OSHA states remained without the protection of the bloodborne pathogens standard. (Some states, such as Texas and Georgia, adopted legislation

to cover public employees.)

"This closes the gap of needle safety coverage and provides protection for those not covered by the Needlestick Safety and Prevention Act," says **Jane Perry,** MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville. "We can now say that all U.S. health care workers are covered by the same standard."

Workers now will be able to have access to the exposure control plan at public hospitals, and those hospitals must update their plan annually to consider new technology. The provision will be implemented as of July 1, 2004.

"We think it's significant that there will not be this second category of these people not covered by the OSHA bloodborne pathogens standard," says **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union in Washington, DC.

He notes that many of the county- and state-run hospitals are located in inner cities. "The challenges these people face are probably greater than what the private-sector facilities are facing," he says.

It isn't clear how the new provision will be enforced in those states, which include Alabama, Alaska, Arkansas, Colorado, Florida, Idaho, Illinois, Louisiana, Mississippi, Montana, North Dakota, Nebraska, South Dakota, and Wisconsin.

State and local employees still aren't covered by the Occupational Safety and Health Act (OSH Act) which means OSHA cannot conduct inspections or issue citations. Instead, the provision would be enforced by the Centers for Medicare & Medicaid Services (CMS), which has never handled occupational health issues.

The new section of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that "in the case of hospitals that are not otherwise subject to the OSH Act, [they are] to comply with the Bloodborne Pathogens Standard under section 1910.1030." Employers are subject to fines equivalent to those in the bloodborne pathogens standard.

"We're studying the act and finding out what we need to do to implement it," a CMS spokesperson said.

For some, it was a bright spot in an otherwise controversial bill. In Colorado, state Rep. **Andrew Romanoff** (D-Denver) had tried unsuccessfully a couple of years ago to convince the state legislature to require public-sector employers to comply with the needle safety provisions.

## CE *questions*

5. According to OSHA industrial hygienist Dionne Williams, OSHA hasn't cited hospitals for ergonomic hazards because:
   A. The industry has voluntarily complied and uses lifts.
   B. OSHA has no jurisdiction in that area.
   C. There aren't enough inspectors to cover that issue.
   D. Without a standard, it's more difficult to make an ergonomics case.
6. The most frequently cited standard in hospitals in fiscal year 2003 was:
   A. engineering and work practice controls for bloodborne pathogens
   B. wet floors
   C. obstructed exits and egress
   D. tuberculosis
7. According to Peter Buerhaus, senior associate dean for research at the Vanderbilt University School of Nursing, the recent rise in the supply of nurses won't solve the shortage because:
   A. They are only part-time nurses.
   B. The nursing supply needs to increase by 40% per year.
   C. They aren't as skilled as other nurses.
   D. They are likely to leave in a few years.
8. According to Corinne Peek-Asa, MPH, PhD, associate professor of occupational health at the University of Iowa's Injury Prevention Research Center, a California law requiring hospitals to have a violence prevention program has had what effect?
   A. Other states have adopted similar laws.
   B. The number of violent events at hospitals has decreased.
   C. The number of reported assaults have increased.
   D. It has had no uniform effect; not all hospitals have complied.

**Answer Key:** 5. D; 6. A; 7. B; 8. B

"The populations that public facilities serve are generally at higher risk for bloodborne pathogens than at private facilities," says Romanoff, who is the minority leader in the Colorado House of Representatives. "It didn't make any sense in the world that you would protect employees at private facilities and not at public facilities."

Romanoff's staff used a questionnaire to gather information about practices at public hospitals.

"Our research said half of Colorado's public

hospitals and the state prison system were not using safer devices," he says.

Romanoff acknowledges that even without the measure, times were changing and needle safety was becoming more commonplace. "It's been almost three years since my survey," he says. "Maybe these hospitals have decided voluntarily to come into compliance."

However, without pressure from unions or regulators, some hospitals have been slow to comply, says **Barbara Coufal**, legislative affairs specialist with the American Federation of State, County, and Municipal employees in Washington, DC. She notes that the provision had strong bipartisan support.

"We thought for something that's a life-and-death matter, that there ought to be a strong standard applied to all facilities," Coufal says. "By covering these public facilities under the OSHA protections, we accomplish that." ■

# Injured employees can file for smallpox benefits

*HHS releases criteria, forms for injured vaccinees*

Employees who have suffered from medical injuries related to the smallpox vaccine now can file for federal benefits.

The Department of Health and Human Services (HHS) published an interim rule in the *Federal Register* Dec. 16, setting criteria for compensation.

HHS had previously published a Smallpox Vaccine Injury Compensation Table listing "medical injuries and adverse effects presumed to have been caused by a smallpox vaccine or contact."

Injured vaccinees can apply immediately, even though the rule may change somewhat after a period of public comment. Vaccinia contacts and survivors of recipients who died from vaccine-related complications also are eligible for compensation. Congress provided $42 million to provide for medical costs, lost wages, and death benefits.

The table covers the adverse events generally associated with the smallpox vaccine, such as inadvertent inoculation or generalized vaccinia. It also includes myo- and pericarditis, inflammation of the heart that has been linked to the vaccine.

Fifty-eight of about 500,000 vaccinated military personnel developed myo- or pericarditis; 22 of 38,489 civilian health care workers and first responders who were vaccinated developed the condition. Public health officials also reported that two health care workers and two military vaccinees developed dilated hearts, a severe cardiomyopathy that began gradually and was diagnosed three to five months after smallpox vaccination. Investigations continue on the possible link between those cases and the vaccine.

Cardiomyopathy is not listed on the HHS table, but that would not necessarily prevent it from being covered by the program.

"Because it is possible to incur a medical injury not listed on the table that may have been caused by a smallpox vaccination or contact, a person who can present sufficient evidence to prove likely causation may still be eligible for program benefits," the HHS stated.

*[Editor's note: More information about the compensation program is available at www.hrsa.gov/smallpox injury or at (888) 496-0338.]* ■

# Report: States unprepared for bioterrorism response

*They lack facilities, plans for pandemic flu*

Despite an infusion of federal money, states are not substantially better prepared to respond to bioterrorism, according to a report by the Trust for America's Health in Washington, DC.

Although all states have at least initial bioterrorism plans, only six have sufficient laboratory equipment and facilities; and only two — Florida and Illinois — have adequate staff to distribute emergency vaccines and medications in a bioterrorism event, the trust reported.

The federal government spent $940 million to

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beef up the public health infrastructure in fiscal year 2002, but that was partially offset by cuts in about two-thirds of the states, the trust found.

The trust urged the Centers for Disease Control and Prevention to allow states to use preparedness funds for an "all-hazards" approach that "simultaneously addresses the potential for biological, chemical, radiological, and natural disease outbreaks."

Only one-quarter of states have a plan to respond to and outbreak of pandemic influenza, and few states have mechanisms to communicate about severe acute respiratory syndrome or other emerging health threats, the trust found.

*(Editor's note: For a copy of the report,* Ready or Not? Protecting the Public's Health in the Age of Bioterrorism, *go to: http://healthyamericans.org.)* ■





## 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. ■