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## Hospitals must stay on guard for emerging infectious diseases

*Joint Commission and the CDC push for better preparedness*

The flu season may be coming to a close, but the push for hospitals to improve their preparedness to prevent the spread of emerging infectious diseases is just gathering steam.

The Joint Commission on Accreditation of Healthcare Organizations has proposed a new infection control standard that would require hospitals to be ready to respond to epidemics. (See box, p. 43.)

The Centers for Disease Control and Prevention (CDC) has coordinated tabletop exercises and drills at hospitals around the country to enhance planning. As of late February, both avian flu and severe acute respiratory syndrome (SARS) still were confined to a handful of cases in Asia, but that doesn't reassure public health authorities; it just makes them more vigilant. Eventually, an emerging infectious disease will wreak havoc in the nation's hospitals, they predict.

"We haven't had a SARS case so far this year. That's about all we can say," says Deborah Levy, PhD, MPH, a senior epidemiologist with CDC and a commissioned officer with the U.S. Public Health Service. "We have no way of knowing what's going to happen in the future. I don't think you can ever consider yourself out of the woods."

Last year's SARS epidemic in Toronto showed the vulnerabilities of hospitals as they struggled with work-home quarantines of staff and screening of visitors and workers. The proposed Joint Commission standard, which was under field review in February, goes beyond the general emergency management standard.

"We're trying to push organizations to think through what potentially are we going to do if something happens," says Nancy Kupka, DNSc, MPH, RN, project director at the JCAHO Division of Standards and Survey Methods. "We're asking people to think about what's going to happen if your organization has to manage a large number of potentially infectious patients over a period of time. There are a lot of experts in this field who think [eventually] something is going to happen."

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Protecting health care workers is a cornerstone. Although the proposed Joint Commission standard doesn't specifically mention protection of staff, it is included in the broader concept, Kupka says.

"We don't in many of our standards specifically address staff. But staff are what makes up the organization. Staff are everything. You have to have enough staff. You have to have sufficient personal protective equipment [PPE]. [Staff] were kind of subsumed into the larger picture," she adds.

Emergency preparedness is not disease-specific, and it is not activated by evidence of an epidemic. It should be integrated with everyday practice, says **Will Shelton**, M(ASCP), CIC, manager of epidemiology and employee health at Swedish Medical Center in Seattle.

Swedish Medical Center has implemented respiratory hygiene, as recommended by the CDC. Patients with a fever, fever and a cough, or fever

and a rash receive a surgical mask and tissues. The hospital keeps alcohol-based gels in waiting areas for hand hygiene.

Swedish purchased masks that have built-in eye protection and disposable face shields that can be used with N95 filtering face-piece respirators.

"It's a challenge," Shelton says. "The majority of health care workers in the United States are not accustomed to wearing masks with eye protection. Masking is a new behavior we need to learn and implement."

Swedish recently participated in a National Military Defense System drill. In the scenario, 15 soldiers arrived in Seattle from Southeast Asia with respiratory symptoms. Health care workers immediately donned PPE as they began to evaluate the quarantined soldiers.

Shelton says he would like to see them grab the PPE in much less dramatic situations. For example, when an infant recently was hospitalized with suspected respiratory syncytial virus (RSV), health care workers wore PPE to prevent nosocomial spread. As soon as RSV was ruled out and the child was ready for discharge, the staff removed the PPE. It turned out the child had pertussis, and health care workers had been exposed when they removed their masks prematurely.

That's why any cough may be of concern, he says. "Seattle is in a 30-year high with TB. We're at a 20-year high for whooping cough [pertussis]. Everyone's aware of the major influenza activity this year. Our particular hospital has the largest neonatal ICU [intensive care unit] in our state [and has concerns about RSV]. We're encouraging a much greater use of masking of patients and personal protective equipment for our employees."

Shelton anticipates that preparedness for SARS and pandemic influenza will alter attitudes toward PPE. "All the work we're doing is for SARS, but it's not really for SARS," he says. "It's to protect [workers] against all the airborne infectious diseases we're dealing with all the time.

"[The danger] may not be SARS or avian influenza. It may be organism X," he says. "We don't know what's next. It is forcing us to do things we should do. Our concern for SARS may give us better personal protective equipment and habits for things we deal with every day."

Yet hospitals also need to think about and plan for a worst-case scenario: an influx of patients with a highly infectious disease that could be transmitted throughout the hospital. How would you move sick patients from the emergency department to the ICU to avoid infecting other patients

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or staff? How would you expand your isolation capacity? How would you monitor the health of health care workers? How would you make sure your staff felt safe enough to come to work? What do you do about staff who work at more than one hospital? If staff are quarantined, how will you provide for their basic family needs?

Hospitals can use the CDC's SARS preparedness checklist to pose these sorts of questions and come up with answers in a tabletop exercise that involves a hypothetical scenario but not an enactment, Levy says. "You have to work through your plan periodically. Just having a plan is really not good enough."

At Evergreen Healthcare in Kirkland, WA, the emergency preparedness team includes members from communications and social services as they consider how to support the frontline health care workers. "What would we tell the staff? How could we support them from a human resources standpoint to help with their fears?" says **Sarah Smith**, RN, CIC, infection control manager.

Evergreen purchased additional powered air

purifying respirator units for higher-level respiratory protection. They evaluated the traffic flow of patients and the negative airflow rooms. But not all preparations are easy to accomplish. Hospital engineers designed a system that would create negative airflow in an entire unit. But that carried a price tag of \$50,000. The hospital is considering other options as well.

Evergreen's multidisciplinary preparedness team has fielded other issues and found ways to problem-solve, even conducting role-playing to decide the best way to don and remove PPE. "We've even thought about how we would provide child care for our staff," says Smith.

The CDC hopes that hospitals around the country will continue to pose questions — and find answers that make them more prepared. "Having all the [relevant] people at the table and talking together is the best way to manage this," says Smith. "You can never do it alone."

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

## JCAHO considers new epidemic preparedness standard

The Joint Commission on Accreditation of Healthcare Organizations has proposed a new infection control standard. As part of emergency management activities, organizations should prepare to respond to epidemics or infections likely to require expanded care capabilities over an extended period of time.

### Rationale

The health care organization is an important resource for the continued functioning of a community. An organization's ability to deliver services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded care capabilities over an extended period of time.

Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced. This plan may include a broad range of options including the temporary halting of services, limiting visitors within an organization, and fully activating the organization's emergency management plan. The actual plan depends upon issues such as the extent to which the community is affected by the spread of the infection, the types of services offered, and the capabilities of the organization.

The concepts included in these standards can be found elsewhere in the manual. However, they are emphasized in this section because of risk to an organization, associated personnel, patients, and the entire community if an epidemic or an infection likely to require expanded care capabilities over an extended period of time is recognized slowly, not well-contained, and/or an inadequate response is mounted.

### Elements of Performance for IC.6.10

1. The organization determines its role, if any, in the potential provision of care, treatment, or services to patients in the event of an epidemic or infections likely to require expanded care capabilities over an extended period of time.
2. If the organization plans to continue to accept patients, it has a plan for managing an ongoing influx of potentially infectious patients over an extended period of time.
3. As part of planning:
  - A. The organization determines how it will keep abreast of current information about the emergence of epidemics or new infections that may result in the organization activating its plan.
  - B. The organization sets parameters for when it will activate its plan.
  - C. Resources in the community through local, state, and/or federal public health systems for obtaining information are identified.
  - D. Mechanisms for interacting with these organizations are established. ■

# CDC launches study of HCV transmission

*How many are linked to health care?*

Like most cardiac surgeons, **William Fiser**, MD, of Little Rock, AR, occasionally cut or nicked his hand during delicate procedures. He did not use blunt suture needles or double gloves. He did not routinely order blood tests on himself or his patients after blood exposures.

But his life changed in 1999 when he discovered, almost by accident, that he had hepatitis C. So did one of his recent patients, who was his receptionist.

Fiser's experience made him an advocate for safer practices in the operating room and for addressing the issue of hepatitis C transmission during exposure-prone procedures. Although his case was never conclusively linked to his patient's — the RNA mapping showed one difference in the HCV viruses — it, once again, has raised the issue of provider-to-patient transmission of hepatitis C.

More information about such transmissions soon may be forthcoming. The Centers for Disease Control and Prevention (CDC) has enhanced its surveillance of health care-related transmission of hepatitis C. The search for new cases stems from recent reports that involved surgeon-to-patient transmission in New York and reuse of contaminated needles during medical procedures in other states.

"We have implemented a broader look at all of the cases reported nationwide in older individuals — persons unlikely to have traditional risk factors — for hepatitis B and acute hepatitis C," says **Miriam Alter**, PhD, associate director for epidemiologic science in the CDC's division of viral hepatitis. In these elderly patients, public health authorities will look for past medical procedures "to determine if there's a reason to believe there might be transmission occurring in the health care setting," she says.

The CDC also is conducting extensive interviews in its surveillance in sentinel counties that help track HCV and other diseases. "Every patient who did not have a known risk factor for infection is asked in detail about all of their potential health care-related exposures," Alter explains.

So far, the evidence indicates that the health care-related transmission of hepatitis C is sporadic, she says. For example, in 2001, North Shore University

Hospital in Manhasset, NY, tested patients who had surgery with a well-known cardiac surgeon over a 10-year period. Three were positively connected; four were considered a probable link.

"Usually one would expect [cases] to occur in clusters," Alter notes. "If they're not appearing in clusters, we may be missing the single cases."

She acknowledges that even the enhanced surveillance may miss cases. Most people are asymptomatic when they acquire hepatitis C and may not know they have the disease for many years. "This is a way to evaluate it to some extent. If there are asymptomatic cases, there are likely to be symptomatic ones as well."

**Jane Perry**, MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville, applauds CDC's enhanced surveillance. The center advocates more research into the risk of provider-to-patient transmission. "It can be a Catch-22. If you don't look for the cases, you might assume they're not there," she says. "And patients don't always make the connection with their health care provider if they are infected with HCV."

Fiser rarely thought about the occupational risks of surgery until he discovered he was HCV-positive during a life insurance exam. He had been feeling fatigued and achy. He had even mentioned the symptoms to his internist. But he didn't imagine that he could have a serious liver disease.

Like other surgeons, he didn't think about the hazards of bloodborne pathogen exposure that he lived with every day.

"Surgeons by nature are risk takers. You're calculating the odds on everything," says Fiser, who is medical director of the Arkansas regional organ recovery agency and heads a cardiac research program at Arkansas Children's Hospital.

"What are your odds of dying from the surgery? What are the odds of a bad result? They just don't perceive this as enough of a risk to change their behavior," he says. "We need to raise the level of awareness to try to cause people to change their behaviors and adopt safer techniques."

In fact, the rate of HCV transmission appears to be very low. Hepatitis C has a transmission rate of about 0.5% from occupational exposures — slightly greater than that of HIV and less than that of hepatitis B, according to a review of literature by needle safety expert **Janine Jagger**, PhD, MPH.<sup>1</sup> The CDC estimates the HCV transmission rate at 1.8%.

Yet hepatitis C is problematic, because about 80% of those infected are asymptomatic and may

not know they harbor the virus. CDC estimates that about 2.7 million Americans have chronic HCV infection.

There have been sporadic reports of provider-to-patient or patient-to-patient transmission of HCV, most of them involving reuse of needles. An outbreak in 2001 occurred in a private endoscopy practice when an anesthesiologist reinserted used needles into multidose vials of fentanyl to provide additional anesthetic during surgery. In that case, 12 patients contracted HCV from one chronically infected patient within a three-day period.<sup>2</sup>

Reuse of needles was linked to HCV transmission to 69 patients in an Oklahoma pain clinic and 99 patients at a Nebraska chemotherapy clinic.<sup>2</sup> In a German case, an anesthesiology assistant transmitted HCV to five patients from a wound on the finger when he performed procedures without wearing gloves.<sup>3</sup>

For HIV and hepatitis B, CDC guidelines call for expert review panels to identify exposure-prone procedures and consider applying restrictions in individual cases. As years have gone by with only one subsequent documented case of provider-to-patient transmission of HIV, occupational health experts have concluded that no procedures are exposure-prone for HIV.<sup>4</sup>

The CDC has never updated its guidelines to include HCV, and it states simply: "Currently, no recommendations exist to restrict professional activities of health care workers with HCV infection. As recommended for all health care workers, those who are HCV-positive should follow strict aseptic technique and standard precautions, including appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments."<sup>5</sup>

That's not enough guidance, according to Fiser. He worked with the Arkansas medical board to develop a policy on surgeons with HIV, hepatitis B, and hepatitis C.

The medical board will now consider cases on an individual basis, taking into account the nature of the procedures and the safety measures that can be used to prevent exposure.

### **'Was I the source?'**

By coincidence, Fiser and his former patient found out about their hepatitis C at around the same time. He suspected a connection and asked the Arkansas Department of Health to investigate. But when the state epidemiologist contacted the CDC, the agency declined because there was

no cluster of cases, Fiser continues.

He eventually submitted samples to a private lab and paid for the testing himself. His receptionist's blood was drawn before she began treatment; his sample was drawn a year later, after treatment. "I just wanted to know the truth," Fiser says. "Did this happen? Was I the source?"

"It took over a year for me to ever get a report. Basically, they said there was one difference," he says. The lab concluded the virus didn't match, but Fiser doesn't consider that finding conclusive.

Before his patient's surgery, her liver enzymes were normal. Her problems began after surgery. "The circumstantial evidence was extremely strong," he says. None of Fiser's other patients have been tested for hepatitis C.

His patient responded favorably to treatment, but Fiser was not as fortunate. He suffered from severe side effects to eight months of treatment with ribavirin and interferon. His viral load remains high — more than 2 million viral particles per cc of blood. He has liver fibrosis.

"It's a life-changing experience. After I was diagnosed, I had a liver biopsy, which showed advanced liver disease, which was news to me. Your whole plan of life changes drastically. You have to deal with your mortality sooner than you want to," Fiser notes.

Despite his fatigue, he has been able to maintain his nonclinical work. "As long as I get adequate rest, I do pretty well," he says.

Fiser never intended to become an advocate for sharps safety, HCV testing of health care providers, or anything else. But he firmly believes there needs to be more information about HCV transmission in the health care setting — and stronger recommendations to govern exposure-prone procedures.

He says he hopes surgeons will become more aware of the risks and adopt sharps safety practices in the OR. **(For a related article, see *Hospital Employee Health*, September 2001, p. 104.)**

"I really believe that if we had some objective data on this, it would make a huge difference in terms of surgeons being willing to change the way they practice," he says.

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## Lesson No. 1: Needle safety never stops

*Hospitals share advice on progress*

Two years after needle safety became a mandate nationwide, hospitals face what may be their greatest challenge: keeping the momentum.

It's tempting to feel that the job is just about done. Needle safety committee members may start missing meetings. Meetings may be delayed. Newer devices might be overlooked. But the U.S. Occupational Health and Safety Administration (OSHA) requires an ongoing commitment to needle safety. And so should you.

In fact, success in reducing needlesticks in some areas should be an impetus for doing even better, says **Paula Bowers**, MSN, RN, CNN, CAN, director of the intermediate care unit and progressive care unit at Memorial Hermann Southeast Hospital in Houston.

"The first year when we put the task force together, we were looking at overfilled sharps containers," she says. "We saw a 63% reduction in needlesticks from overfilled sharps containers. When we fixed [that problem], then other things came to light that we had to work on."

Memorial Hermann Southeast Hospital is one of eight hospitals that have shared their "lessons learned" on the web site of the National Institute for Occupational Safety and Health (NIOSH) ([www.cdc.gov/niosh/topics/bbp/safer/](http://www.cdc.gov/niosh/topics/bbp/safer/)). Much of the advice relates to the structure of the committee: how often it meets, how it sets an agenda for action, and who serves on it.

"It's important for the composition of the committee to reflect administration, management, purchasing, infection control, and the frontline health care worker," says **Janice Huy**, MS, senior adviser for HIV and health care research at NIOSH in

Cincinnati. Top leaders are not always members — but their commitment to the committee's work will determine your success, Huy advises. That includes the director of nursing, the chief medical officer, and the CEO.

"We found that in a couple cases in which upper management wasn't included in the very beginning, when they tried to buy the devices, upper management said, 'Why do we need these?'" she says.

At Memorial Hermann Southeast, the chief operating officer is a liaison member of the committee. He doesn't attend regular meetings but is available as needed. Other members serve two-year terms. "If you have given all you think you can give to a topic, a fresh set of eyes can rejuvenate the committee," Bowers adds.

The U.S. Occupational Safety and Health Administration requires employers to include frontline workers on the needle safety committees. But when San Francisco General Hospital started the first needle safety advisory committee in 1986, there were no rules or regulations to follow.

The union had conducted a survey and found a large number of housekeepers had been stuck by discarded needles but had not reported their injuries. The joint labor-management committee began talking about work practices and about safer devices.

"I remember saying they don't exist," recalls **June M. Fisher**, MD, director of the TDICT Project at San Francisco General Hospital, which focuses on evaluation and training related to sharps safety. "And the response was, 'Then they should exist.' That for me was a real turning point. What we used to say to people was, 'Take your time; be careful.' People would be angry about that, saying, 'You're blaming us.' We wouldn't say to a carpenter, 'We don't have safe saws; just be careful.'"

Today, needle safety committees ask for new devices when they can't find what they want. "We've had the manufacturers in and talked to them about our needs," Bowers says. "This is an opportunity for us to have an impact on the kinds of devices that come out."

In fact, tracking the constant advance in technology is the core business of the committee. "Until the market stabilizes in this area, they're going to have to continue to evaluate new devices," says Huy. "I'm hoping, over time, they will all become safer and safer and safer."

The other major role involves careful monitoring of injury reports. For example, at Holy Cross Hospital in Chicago, the needle safety committee

learned that employees were using the wrong adapter for the needleless IV system.

"We identified every product we had. We assembled a chart and reference chart for our employees, so they knew what the device was and what the intended use was," says **Carol Cagle**, MT, SM, infection control manager.

She brought the board to each unit, quizzing the employees on the devices and providing pictorial education. Meanwhile, a phlebotomy technical specialist follows up on needlesticks associated with blood draws to see if further training is needed.

Those efforts, along with the adoption of safer devices, resulted in a 75% decrease in needlesticks since 2001, Cagle adds. "I think it's important for the committee to celebrate its successes," she says. "That is one of the things that keeps it going. It's only by vigilant monitoring that you'll be able to maintain success."

Those on the front lines of needle safety offer these do's and don'ts for needle safety committees:

- **Don't get discouraged.**

"Performance improvement is rarely quick," says Bowers. "Sometimes you have to find that silver lining to keep you motivated. You have to stay at it."

- **Do consider the views of physicians.**

In some cases, physicians may want to be on the committee. But even if they're too busy to attend meetings, you may find other ways to keep them abreast or include them in decision making, Huy says. "Some of our facilities have found that they excluded physicians from the committee because they assumed they would be too busy and wouldn't want to participate. But then when they tried to introduce the device on the floor, the physicians said, 'We aren't going to use this.'"

- **Listen to your frontline workers.**

"[The needle safety committee] should be joint labor-management," Fisher points out. "There should be frontline health care workers there, and it should have authority. If you incorporate health care workers and then you don't even listen to them, don't bother."

- **"Don't be afraid to challenge your system processes or your hospital administration," Bowers notes.**

"If there's a product out there that can better serve your needs and you can prove it, don't be afraid to issue those challenges," she adds.

Memorial Hermann Southeast found a sharps container with a lid it felt would be more protective. The vendor wasn't on the hospital's

contract. Bowers conducted a successful pilot test and did a cost analysis. She found that the cost would actually be comparable to the current containers. "Don't let the fact that they're not one of your normal vendors stop you from pursuing [a device] if they have a product you really need," she says. "I didn't let it stop me."

*(Editor's note: Safer Medical Device Implementation: Sharing Lessons Learned is available at [www.cdc.gov/niosh/topics/bbp/safer/](http://www.cdc.gov/niosh/topics/bbp/safer/).)* ■

## Beyond devices: A new level of sharps safety

*CDC workbook encourages 'culture of safety'*

**Y**ou've brought in safer needle devices and reduced your needlesticks. Do you declare success? What more should you do?

A new, on-line workbook from the Centers for Disease Control and Prevention (CDC) provides advice and tools to bring hospitals beyond the basics of device safety. It includes 13 forms that help hospitals assess their current needle safety programs and culture of safety and analyze their injuries.

The goal: a "comprehensive approach to eliminating sharps injuries," says **Linda Chiarello**, RN, MS, epidemiologist with the CDC's division of health care quality and promotion. Zero tolerance of needlesticks would be a new perspective for most hospitals, she acknowledges, but it would lead to a safety culture that does not simply assume that the injuries will happen.

The workbook provides a step-by-step method to take your sharps safety program to a higher level. "It will help you focus on specific problems within a facility, identify interventions, and measure the impact of interventions," she says. "It's a very good method for documenting the processes that are being used to improve the sharps injury prevention program."

In fact, needlestick data show devices alone have not addressed the challenges of needlestick prevention. While needlesticks from conventional devices have been reduced by more than half, injuries from safety-engineered devices have increased, according to an analysis of data from the EPINet Multihospital Sharps Injury database

*(Continued on page 49)*

# Sharps Injury Form

Source: Centers for Disease Control and Prevention, Atlanta. Web site: [www.cdc.gov/sharpssafety/pdf/AppendixA-8.pdf](http://www.cdc.gov/sharpssafety/pdf/AppendixA-8.pdf).

of the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville. (See *Hospital Employee Health*, June 2003, p. 77.)

Similarly, data from CDC's National Surveillance System for Healthcare Workers (NaSH) showed dramatic reductions in injuries due to the implementation of needleless IV systems. But injuries from safety devices have increased.

"We've seen a shift in the proportion of injuries due to safety devices," Chiarello states. "Some of this is attributed to the fact that even though it's a safety device, the sharp is still exposed when it's used. [The device] cannot necessarily prevent those injuries during use. There are workers who still don't activate the safety devices, so as a result, injuries still occur — not due to a flaw in the safety feature but due to the circumstances involved."

Winchester (MA) Hospital used the injury profile worksheet to focus prevention efforts. "We were able to pinpoint more specifically where the injuries occur, and we've been able to target those areas with education," says **Pat Fleming**, RN, COHN-S, manager of employee health services.

For example, she presented data at the department of surgery meeting to heighten awareness about needlesticks from suture needles. The hospital also discovered that employees were not activating the self-blunting needle in phlebotomy because they feared the extra pressure would hurt patients. The hospital ended up switching to a different safety device.

At Quincy (MA) Medical Center, the workbook tools helped identify injuries among nurse technicians who were using butterfly phlebotomy devices. The hospital evaluated and purchased a new device, then focused its education and training efforts on helping the nurse technicians adapt to the change, says **Deborah Hylander**, RN, CIC, director of infection control, employee health, and workers' compensation.

Due to that and other interventions, the hospitals' bloodborne pathogen exposures declined by 50%. The result: Needlesticks among the nurse techs declined by 50%. "[The CDC tools] are like road maps to help you organize what the problems are, help you plan interventions, and do an evaluation," she says.

Hospitals can pick and choose tools from the workbook that would be most helpful, Fleming notes. "It's a fresh way of looking at things."

The workbook includes:

- An assessment tool to help facilities determine the current status of their program. Questions

can spur dialogue at the facility and even provide a way to focus the attention of administrators and others to the needs of the program.

- A staff survey to measure the facility's safety culture. The culture of safety influences work practices, reporting, and other behaviors.
- Forms to conduct a root cause analysis of injuries and to report a near miss. For example, if a housekeeper sees a needle lying on the floor or on a bed and disposes of it without injury, she can report a hazard observation. Actions can then be taken to prevent future injuries. (See **sample form**, p. 48.)
- Worksheets to identify the top needle safety priorities and to calculate injury rates that take into account unreported events.
- A survey and worksheet to gather information on the current use of devices and the qualities that are most important in a device.

(Editor's note: The workbook is available at [www.cdc.gov/sharppsafety/](http://www.cdc.gov/sharppsafety/). A CD-ROM version of the workbook is under development.) ■

## Complaints flood OSHA over TB fit-testing

*AHA, AOHP urge comment period, new rule*

A fight is brewing over requirements for annual fit-testing of filtering face-piece respirators to protect against TB. Opponents to annual fit-testing at hospitals have flooded the U.S. Occupational Safety and Health Administration (OSHA) with letters asking for reconsideration of its decision to apply the general respiratory protection standard (1910.134) to tuberculosis. Worker advocates have responded with letters asking OSHA to stand firm.

"[O]ne of the reasons OSHA withdrew the TB rule is that there appears to be greater compliance with the CDC [Centers for Disease Control and Prevention] guidelines than there was when we proposed the standard," says OSHA spokesman **Frank Meilinger**. "Nevertheless, OSHA does have the responsibility to ensure that workers exposed to tuberculosis are adequately protected, and the existence of the CDC guidelines does not supplant that responsibility."

When OSHA withdrew the proposed tuberculosis standard on Dec. 31, 2003, it also rescinded the temporary TB respiratory rule, which did not

require annual fit-testing. The issue of fit-testing had been a contentious part of the proposed tuberculosis rule. However, the general industry respiratory protection standard has required annual fit-testing, medical screening, training, and record keeping for everything except TB since 1998. That would include severe acute respiratory syndrome or other airborne infectious diseases. (See *Hospital Employee Health*, March 2004, cover story.)

The American Hospital Association decried OSHA's recent action as a new mandate without a public comment period or rule-making. "[T]he General Industry Respiratory Protection Standard is not applicable to occupational exposure to biologic agents or to patients with communicable infectious diseases," AHA executive vice president **Rick Pollack** wrote to OSHA. "To now apply the General Industry Respiratory Protection Standard intended for chemical aerosols to biologic agents, such as TB, constitutes a significantly different action [than what was debated during the TB rule-making], and as such, OSHA must provide an opportunity for public comment to examine the scientific basis required for such an action."

Other organizations have taken a similar position, arguing that OSHA needs to consider the distinct characteristics of airborne biologic hazards. Both the Association of Occupational Health Professionals in Health Care (AOHP) and the American Association of Occupational Health Nurses have written OSHA, asking for a separate standard to address airborne biologic hazards.

"We want a safe working environment for our employees, and we want that based on science and on practices that are going to protect our workers," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, past president of AOHP and manager of employee health services at Western Pennsylvania Hospital in Pittsburgh.

Yet worker advocates are arguing that health care workers should receive the same protections as other workers. Twelve unions joined forces as "the Coalition to Fight TB in the Workplace" and offered "strong and unequivocal support" for OSHA's decision to apply the general industry respiratory protection standard to TB. The American Public Health Association also wrote OSHA in support of its action.

In fact, the AHA letter represents an admission that hospitals have not been adequately protecting health care workers against other infectious diseases, says **Bill Borwegen**, MPH, director of occupational health and safety for the Service Employees International Union and author of the

coalition's letter. "They're telling OSHA and the public at large that [they] haven't been following this for a long time. It's quite a startling disclosure," he says. ■

## Ergo controversy: Experts shun OSHA symposium

*Rehash of research a waste of time, they say*

Even something as benign as a research symposium can cause a ruckus when the topic is ergonomics.

Eleven leading researchers declined an invitation to present their findings to a recent symposium of the National Advisory Committee on Ergonomics (NACE), a panel set up by the U.S. Occupational Safety and Health Administration (OSHA) to guide the research element of the agency's comprehensive approach to ergonomics.

They said the panel's mission to study the work link of musculoskeletal disorders (MSDs) was just another way to stall action on ergonomics. Meanwhile, the National Committee on Ergonomics complained to OSHA that the panel was biased toward creating more ergonomics regulation.

In fact, the controversy highlights the contentious atmosphere surrounding ergonomics, one that dogs any efforts by OSHA to reduce work-related MSDs.

**John Henshaw**, OSHA administrator, contended that the symposium "demonstrates how much NACE members value getting a full picture of the research being conducted and looking at ways the science is being reduced to practice in the workplace.

"Our challenge is to continue to move the dialogue forward and work toward a common end — reducing injuries and illnesses in the workplace," he said in a statement.

Any reduction in injuries is occurring despite OSHA, not because of it, contends **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union. "We've seen literally a handful of ergonomics citations issued [in general industry] since this program was announced," he adds.

The research portion of the ergonomics program has also been ineffective, Borwegen notes. "People are arguing over things we've known for years, if not decades," he says.

Last fall, NACE sent invitations to leading ergonomics researchers to submit papers for the symposium connected with the panel's January meeting. The topic: Musculoskeletal and Neurovascular Disorders — The State of Research Regarding Workplace Etiology and Prevention.

To many of the researchers, that was like asking for evidence that smoking causes cancer.

"It became clear to me that the symposium was not going to be looking at how to build upon the results of past research," says **Bradley Evanoff**, MD, associate professor of medicine at the Washington University School of Medicine and medical director of the BJC ergonomics program at BJC Health Care Inc. in St. Louis. "It looked like it was going to rehash a lot of what was done before. We should quit arguing about whether physical exposures are related to musculoskeletal disorders and start talking about how to decrease musculoskeletal disorders."

In the letter to OSHA, the 11 researchers cited three previous, in-depth reviews of evidence that linked workplace factors to MSDs and cited ergonomic interventions as preventive tools. Most recently, in 2001, a National Academy of Sciences (NAS)/Institute of Medicine (IOM) panel issued a report that documented a relationship between occupational risk factors and MSDs.

"The weight of the evidence justifies the introduction of appropriate and selected interventions to reduce the risk of musculoskeletal disorders of the low back and upper extremities," the panel concluded. (See *Hospital Employee Health*, March 2001, p. 30.)

Evanoff and other researchers told OSHA they would participate in the symposium "if the NACE decided to take the next logical step and directed the symposium instead toward evaluating the progress made in addressing the recommendations of the NAS/IOM panel, especially the evaluation of effectiveness of company-based ergonomic programs."

Ergonomics advocates also have criticized the makeup of NACE, noting that it includes a labor lawyer who has represented the U.S. Chamber of Commerce on ergonomics issues and a hand surgeon who has testified for employers in workers' compensation cases, arguing that

**CE questions**

13. A proposed JCAHO infection control standard would require hospitals to be able to respond to epidemics. Which of the following requirements is included in the proposed standard or elements of performance?
  - A. minimum staffing levels
  - B. provisions for protecting staff
  - C. plans to manage an ongoing influx of potentially infectious patients
  - D. policies on restricting visitors and limiting services
14. CDC's enhanced surveillance of hepatitis C patients will look at:
  - A. links to health care related exposures in elderly patients
  - B. review of case in cardiac surgery patients
  - C. areas that have above-average rates of HCV
  - D. physician-reported cases that may be linked to health care procedures
15. When 11 leading ergonomics researchers declined an invitation to attend symposium of the National Advisory Committee on Ergonomics, what was their main concern?
  - A. OSHA would not allow them enough time to present their findings.
  - B. The symposium topic rehashed well-established issues.
  - C. The symposium presented a negative view of ergonomic interventions.
  - D. The topic was too narrowly focused.
16. According to Janice Huy, senior adviser for HIV and health care research at NIOSH, what determines the success of a needle safety committee?
  - A. the breadth of its membership
  - B. the skill level of its members
  - C. the frequency with which it meets
  - D. the support of top hospital leadership

**Answer Key:** 13. C; 14. A; 15. B; 16. D

injuries were not work-related.

One well-respected member of NACE is **Audrey Nelson**, PhD, RN, FAAN, director of the Patient Safety Research Center at the James A. Haley Veterans Hospital in Tampa, FL. Nelson has conducted research that has influenced patient-handling interventions nationwide.

### COMING IN FUTURE MONTHS

■ An agenda for the future: Keeping older nurses on the job

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■ Making a success out of latex safety

She notes that the symposium was arranged to share ergonomics information from specific fields of work.

“One of the goals of that presentation was to make sure that all of the NACE members had a solid foundation. We all bring unique experience and expertise to the table. Everyone is not broad-based.” NACE members already had been briefed on the IOM report, Nelson explains. Meanwhile, workgroups have discussed which areas should be the focus of OSHA guidelines and how to create incentives for employers to follow the guidelines, she says. “I think maybe we’re not moving as fast as some people would like, but we’re moving in the right direction.”

Nelson also defends the panel against criticism that it is biased, noting concerns have come from both sides of the ergonomics debate. But she also expresses some empathy for the researchers who failed to attend the symposium.

“I think that they mirror some of the frustration that many people have in the field, that the ergonomics [standard] did not go through and several other major initiatives did not go forward,” she adds.

“My philosophy is that you can’t give up. You have to keep pushing, and you have to have a voice. And any opportunity to share that information is important so things don’t stop and slow down,” Nelson stresses. ■



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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. ■