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IN THIS ISSUE

JULY 2004
VOL. 23, NO. 7 • (pages 81-92)

OSHA hears plea for annual respirator fit-testing delay

Hospitals hope for more time to comply with new rule

Fit-testing is still on, but the timing may be off. Hospitals may take as long as a year to implement their annual fit-testing of filtering face-piece respirators used for protection against tuberculosis.

As *Hospital Employee Health* went to press, the U.S. Occupational Safety and Health Administration (OSHA) was expected to grant an extra six-month moratorium on enforcement to give hospitals and other health care facilities more time to comply. Some state-plan states already provided extra time. Many hospitals had planned to stagger their compliance, taking as long as a year to complete their programs and fit-test their staff.

The fit-testing rule remains a source of controversy for the agency. When OSHA revoked its tuberculosis standard Dec. 31, 2003, it also placed hospitals and other health care employers under the general industry respiratory protection standard, which requires the fit-tests as well as medical evaluations, training, and record keeping. **(See *HEH*, March 2004, p. 29.)**

The Association for Professionals in Infection Control and Epidemiology (APIC) and the American Hospital Association protested the action with letters to OSHA and an appeal to supporters in Congress.

At hearings held before the House Appropriations Subcommittee on Labor, Health, and Human Services in April, APIC asked for the respiratory protection rule to be reopened and for the agency to provide an additional delay in enforcement.

In a meeting with APIC officials after the hearing, OSHA administrator John Henshaw said the agency would confer with experts at the Centers for Disease Control and Prevention (CDC) to discuss the broader issue of worker protection against biological hazards, says **Jeanne Pfeiffer**, RN, MPH, CIC, president of APIC. "That was a positive initiative from our perspective," she says.

OSHA also sent APIC a detailed response to its concerns about annual

fit-testing, and noted that the agency has always included biologic hazards in its respiratory protection rule. **(See a copy of the letter, p. 83.)**

Meanwhile, at hospitals around the country, many employee health professionals have already come to terms with the new reality.

"Whether or not this change had happened at OSHA, we would still have to deal with other diseases that did not fall under the TB respiratory protection standard," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic in Nashville, TN. "I think overall it's been beneficial because it's laid the groundwork for us to deal with other hazards."

Hospital Employee Health® (ISSN 0744-6470), including **JCAHO Update for Infection Control** and **Bioterrorism Watch**, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Employee Health**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

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Subscription rates: U.S.A., one year (12 issues), $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $359 per year; 10 to 20 additional copies, $269 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $75 each. (GST registration number R128870672.)

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 contact hours per year.

To reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, we disclose that Ball (editorial advisory board member) is a consultant and stockholder with the Steris Corp. and is on the speaker's bureau for the Association of periOperative Registered Nurses. Fine, Fisher, Fragala, Garb, Gruden, Jagger, Lantos, Shea, and Strode (board members) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

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Editorial Questions

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The fit characteristics of different N95 filtering face-piece respirators can vary significantly from one manufacturer to another. If a respirator has a high fail rate on fit-tests, it may be time to switch to another brand that has an overall better fit, says **William Buchta**, MD, MS, MPH, medical director of the Employee/Occupational Health Service at the Mayo Clinic in Rochester, MN.

When Mayo conducted recent fit-tests, "30% of the people who were refit actually needed a different respirator or a modification of what they had," he says. "That was a wake-up call."

Some employee health professionals have called **Denise Strode**, RN, COHN-S/CM, executive president of the Association of Occupational Health Professionals in Healthcare in Warrendale, PA, asking if they might get some relief from OSHA's rule. She advises them that any change in the approach toward biologic hazards would take time and study. "I think we just need to follow the guidelines and start the process," says Strode, clinical case manager at the OSF SFMC Center for Occupational Health at Saint Francis Medical Center in Peoria, IL.

It has taken hospitals several months to review their respiratory protection programs, determine who must receive the fit-tests, and train the personnel to conduct them. By late spring, many hospitals still were establishing their new systems. State-plan states are required to implement OSHA changes within six months of their adoption, so some states gave their employers extra time.

Many hospitals plan to stagger their annual fit-tests during the year. That is OK, says OSHA industrial hygienist **Craig Moulton**, as long as the employees who are currently interacting with TB patients or who are at the highest risk receive their fit-tests immediately.

"They should prioritize to fit-test those people who are going to be wearing [respirators] in order to be in compliance," he says.

Hospitals that do not treat TB patients and have virtually no TB in their communities do not need to conduct fit-testing, he says. However, they should have a respiratory protection program in place that can be activated if necessary for airborne diseases such as severe acute respiratory syndrome (SARS), he says.

Hospitals are trying to integrate the annual fit-tests into existing programs. Pitt County Memorial Hospital in Greenville, NC, plans to conduct the fit-tests during annual health screens, which employees will receive during their birth month,

(Continued on page 84)

OSHA to APIC: Rule Always Applied to Hospitals

[OSHA wrote this letter to Jeanne Pfeiffer, RN, MPH, CIC, APIC president, responding to objections to the application of the General Industry Respiratory Protection Standard (1910.134) to health care.]

Dear Ms. Pfeiffer:

This is in response to your letter of Jan. 21, 2004, in which you comment on the recent actions by OSHA regarding the proposed rule for tuberculosis. More specifically, you express four major concerns regarding the application of the Respiratory Protection Standard (29 CFR 1910.134) to protect against TB.

First, you state that the general industry Respiratory Protection Standard is not applicable to occupational exposures to patients. It is important to note that the general industry Respiratory Protection Standard always has applied to hospitals and other health care institutions. The standard was developed to protect workers in all industries against airborne hazards, including biological hazards (63 *Fed Reg* 1,180). Since particulates containing TB bacilli (droplet nuclei) behave no differently from other types of particulates, their removal by respirator filter media would not be different.

Second, you state that TB was controlled prior to the use of certified respirators and/or performing initial or annual fit-testing. While progress has been made in reducing the rate of TB in the general population, employees still are required to care for individuals identified as having suspected or confirmed infectious TB. In such circumstances, these employees must be protected against occupational TB exposure. This includes appropriate respiratory protection. In its 1990 document, "Guidelines for preventing the transmission of tuberculosis in health care settings, with special focus on HIV-related issues," [Centers for Disease Control and Prevention (CDC). *MMWR* 1990; 39(RR-17)], the CDC questioned the ability of surgical masks to protect workers against inhalation of droplet nuclei. CDC stated that a better alternative was use of "disposable personal respirators." This recommendation was further refined in the CDC's 1994 guidelines, which stated that OSHA required the use of NIOSH-certified personal respiratory protection that met specific performance criteria set by CDC, including the ability to be fit-tested to assure 10% or less face-seal leakage.

Fit-testing is the only way to determine that a respirator fits properly and provides the expected protection. OSHA has previously established the necessity of annual fit-testing in the Respiratory Protection rulemaking, and the agency's conclusions have been upheld by the courts. OSHA's reasoning for requiring annual fit-testing is explained in detail in the revocation notice (68 *Fed Reg* 75,776-75,780). In addition, annual fit-testing already is required for other contaminants (e.g., ethylene oxide and formaldehyde) when their presence in health care facilities requires employees to use respirators. Therefore, the obligation to annually fit-test is not unique to tuberculosis and may be incorporated in to a health care facility's existing respiratory protection program.

Third, you indicate that current methods of fit-testing N95 respirators are not reproducible, reliable, or reflective of in-use situations. In support of this, you cite the article, "Comparison of five methods for fit-testing N95 filtering face-piece respirators," [Coffey, *et al. Applied Occupational and Environmental Hygiene* 2002; 17(10):723-730]. In the article you reference, the authors concluded that the ". . . error rates [observed in their study] should be considered when selecting a fit-testing method for fitting N95 filtering face pieces [p. 723]." Thus, it does appear to be the position of these researchers that fit-testing of N95 filtering face pieces is necessary in that current fit-test methods provide useful information about respirator performance. The authors also concluded that further research is needed (p. 729). These conclusions from the researchers' 2002 study should be considered in conjunction with the authors' conclusions from their 1999 article that ". . . fit-testing of N95 respirators is necessary to ensure that the user receives the expected level of protection." (Coffey, et al. Simulated workplace performance of N95 respirators. *Am Ind Hyg Assoc J* 1990; 60:618-624.) Also, in a 2002 presentation to the American Industrial Hygiene Conference and Exposition (Fitting characteristics of 18 filtering-face-piece respirators"), Coffey, et al. reported their findings from their studies of fit-tests and concluded that subject sample size, the fit-test panel, and the exercise regime, among other factors, limited the studies. In their summary, they concluded that N95 respirators vary in terms of performance, that fit-testing enhances performance, and that using well-designed respirators and performing fit-testing provide the most protection.

Finally, you express concern that the action to apply the Respiratory Protection Standard (29 CFR 1910.134) to TB was undertaken without the opportunity for public review and comment. Both the 1997 TB proposal and the Respiratory Protection proposal published a few years earlier contained provisions for initial and annual fit-testing. OSHA informed participants in the rulemakings for Respiratory Protection and Tuberculosis that it intended to consider all issues related to respirator use for TB in the TB rulemaking and incorporated all relevant submissions to the Respirator Protection Standard rulemaking into the TB record. In addition, in the TB proposal, OSHA asked for comment on whether a TB standard should contain separate respirator provisions or, alternatively, whether the general industry respirator standard should apply to TB-related use. The public comments on this issue are discussed extensively in the revocation notice (68 *Fed Reg* 75,776-75,778). The revocation of the interim TB respiratory protection standard in December 2003 was supported by the TB rulemaking record, including many suggestions that OSHA include TB-related respirator use within the scope of the general industry Respiratory Protection Standard and not have separate respirator provisions applicable only to potential TB exposures. With the application of the Respiratory Protection Standard to TB, workers occupationally exposed to tuberculosis are provided with the same protections as workers exposed to other air contaminants.

I hope that you find this information useful.

Sincerely,

John L. Henshaw

says **Pat Dalton**, RN, COHN-S, occupational health project specialist at Pitt County Memorial. North Carolina OSHA granted employers an extra six months to comply — time that the hospital will use to plan and launch the staggered tests.

At that health screen visit, they will have respirator medical evaluations, an update on immunizations, TB skin test and education, vision screen, and workers' compensation education. The hospital also plans to offer voluntary health risk appraisals and cholesterol and blood sugar tests.

Meanwhile, the hospital will try to limit the number of employees who need the fit-testing, says Dalton, who is chair of the safety subcommittee. "Optimally, that's something OSHA likes anyway," she says. "You put the fewest people you can at risk and then you use personal protective equipment."

Vanderbilt has linked the annual fit-testing to CPR recertification and staff competency testing. "The annual retesting will begin by July 1, but it will take a while to logistically retest everyone," Swift adds.

Vanderbilt will conduct the testing on the same days new employees receive their fit-tests, she says. Swift will use the same tracking software that she uses for TB skin testing. "I think we have a good plan in place," she says. "It's going to be fairly labor-intensive, but we can do it."

Still, the logistics are daunting. Even after reviewing the number of employees who may need to wear respirators, hospitals still have hundreds or even thousands of fit-tests to perform.

Vanderbilt previously provided initial fit-testing to everyone who had a TB skin test and would have patient contact. "Now we need to target the program to people who truly are at potential risk," Swift says. However, many units have a couple of isolation rooms. "You can't predict who's going to be assigned to that patient, who's going to be on that shift," she notes.

Swift eliminated certain employees, such as those who deliver food trays, from the fit-test list. They shouldn't be entering isolation rooms, she says. And the myelosuppression unit has positive-pressure rooms with patients who are severely immunocompromised. No TB patient would ever be placed there.

When they finished reviewing the employee lists, Swift and her colleagues reduced the fit-testing population from 5,500 to 4,500.

At Children's Hospital of the King's Daughters in Norfolk, VA, the list dropped from 2,000 to about 700. "For people who never ever have had to put on a respirator and probably will never have to, we just made the decision these people will not be fit-tested and they will not be going into a TB room," says **Patricia Higazi**, RN, COHN, occupational health manager.

Each unit will be responsible for evaluating and fit-testing employees, and Higazi has trained an additional 20 fit-testers. Occupational health will continue to fit-test about 250 employees and will provide quantitative fit-testing, when necessary, she says. "If there are any positive responses to the [medical evaluation] questionnaire, then they refer them to occupation health," she says.

Smaller hospitals are having a particularly difficult time because they don't have extra personnel or help from an in-house occupational health physician, Strode explains.

She advises employee health professionals to partner with infection control, to use the expertise of pulmonologists, and to discuss the new mandate with administration. They also may tap into other resources at the hospital.

"Look at the people you have on modified duty, whether it be occupational or nonoccupational. It wouldn't take very long to train somebody. It doesn't have to be a nurse," says Strode.

Many hospitals are trying to avoid the fit-testing altogether by using powered air-purifying respirators (PAPRs). They also can be used as backup protection for employees who have beards or haven't been fit-tested. Yet widespread use of PAPRs introduces other logistical issues, says Dalton. She sums them up with some questions: "How are you going to keep them clean, where are you going to store them, and who's going to keep up with them?" ■

Fire group allows alcohol rubs in hospital hallways

CMS still needs to adopt code change

Hand hygiene may get a boost from more widespread use of alcohol-based hand rubs, as the National Fire Protection Association (NFPA) voted to permit dispensers in corridors of hospitals.

Responding to concerns about the dangers of hospital infections, the NFPA amended its 2000 and 2003 Life Safety Code to allow the convenient use of dispensers and set criteria for their installation.

There is a caveat: Local or state fire marshals may still restrict the hand rubs, and hospitals must follow the strictest regulatory authority. And though the Centers for Medicare & Medicaid Services (CMS) views the NFPA votes as a positive move, the agency may need to go through rulemaking before it is CMS-sanctioned.

"Right now, the policy is if you don't have them in the corridor, don't put them in yet," says a CMS official. "If you already have them in an exit access corridor, ask for a temporary waiver from CMS and say the action is pending resolution."

The Joint Commission on Accreditation of Healthcare Organizations has no problem with the hand-rub dispensers. In fact, it strongly supports their use to reduce hospital infections, a national patient safety goal of the organization.

"We will allow the installation of the dispensers and the storage of any replenishment supplies, per the Temporary Interim Agreement that has been approved by the NFPA Standards Council," says **Dean Samet**, CHSP, CJCS, associate director of accreditation operations and the Joint Commission's senior engineer.

"As long as the requirements they have listed out in there are followed, I don't see any problem with it," he adds.

Alcohol-based hand rubs have been touted as a way to reduce the 2 million hospital infections per year. When the Centers for Disease Control and Prevention (CDC) issued its updated hand hygiene guidelines in 2002, the main question was how to change health care worker habits.

But fire officials questioned the placement of flammable material in a hallway. In the case of a fire, the alcohol-based gels could be an accelerant. The hand rubs have been allowed in patient rooms or suites.

Infections outweighed fire risk

But convenience is an important issue for health care workers. Studies show increasing the availability of alcohol-based hand rubs can make health care workers more compliant with hand hygiene, says **Loretta Litz Fauerbach**, MS, CIC, director of infection control at Shands Hospital at the University of Florida in Gainesville.

She recommends providing dispensers in the patient rooms as well as outside in the hallway. Pocket-sized containers provide a backup if dispensers are not nearby.

"As one physician described to me, it is very easy to hit the dispenser as you walk in the door and decontaminate your hands by rubbing them together with the alcohol rub as you approach the patient," Fauerbach points out. "Your hands are clean, and the patient also sees that you have done that."

Visibility and convenience were important issues as the American Society for Healthcare Engineering (ASHE) of the American Hospital Association pushed for the NFPA change.

"Now we can put them where people will see them and, therefore, be more likely to use them," notes **Susan McLaughlin**, MBA, CHSP, MT(ASCP)SC, president of SBM Consulting in Barrington, IL, and a codes and standards consultant to ASHE.

ASHE conducted a study that showed no significant additional fire risk from having dispensers at or near the entrance to patient rooms. That was a significant factor in the NFPA approval, explains McLaughlin.

ASHE now is seeking a similar change in the International Fire Code from the International Code Council. The NFPA Temporary Interim Amendment will need to be incorporated in the 2006 Life Safety Code.

The NFPA now allows the dispensers in corridors with these conditions:

- The corridor width must be 6 feet or greater and dispensers must be separated at least 4 feet apart.
- The maximum individual dispenser fluid capacity is 1.2 liters for dispensers in rooms, corridors, and areas open to corridors, and 2 liters for dispensers in suites of rooms.
- The dispensers may not be installed over or directly adjacent to electrical outlets and switches.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces are permitted only in sprinklered smoke compartments. Each smoke compartment may contain a maximum aggregate of 10 gallons of alcohol-based hand-rub solution in dispensers and a maximum of 5 gallons in storage.

Despite some initial reservations, CMS supported the change. However, when the NFPA retroactively amended its 2000 Life Safety Code, it created a technical difficulty for CMS. The change can't automatically become part of CMS regulation, says a CMS official.

"The NFPA code is written by a private organization," he says. "In order to adopt it as a federal agency, we have to go through rulemaking." ■

CDC guide to PPE: Remove gloves first

Work practices, sequence are important

There is a right way to put on and remove personal protective equipment (PPE). Now there's a step-by-step guide to teach health care workers how to do it.

The Centers for Disease Control and Prevention (CDC) has considered all the elements needed to safely treat patients in isolation and released a fact sheet on the correct use of PPE. **(See editor's note at the end of this article.)**

Improper use of PPE could cause health care workers to become infected. In Toronto last year, about 15 health care workers became infected with severe acute respiratory syndrome (SARS) despite wearing respirators and other protective gear. That could have resulted from loosely fitted masks, inadequate respirators, breaches in infection control, or other factors.

"We don't really know exactly what happened in all of those circumstances," explains **Linda Chiarello**, RN, MS, of CDC's Division of Healthcare Quality Promotion. "It's clear that very rigorous infection control measures need to be taken during those [high-risk, aerosolizing] procedures."

The guide uses a common-sense approach to working with PPE, and it emphasizes the need for good work practices while wearing PPE. It applies to TB, SARS, and any other infectious disease that requires patients to be in a negative-pressure room.

Here are some key points:

- **Make sure the PPE fits properly.**

Health care workers wearing a respirator should conduct a fit check and make sure it fits snugly to their face and below their chin. Gloves should fit snugly at the wrist and extend over the wrist of the gown. For example, vinyl gloves that don't have that snug fit would not be recommended, Chiarello says. Double-gloving and sterile gloves are not recommended for working with patients in isolation, she notes.

- **Use good work practices.**

Safe work practices are essential to maintaining the integrity of the PPE, Chiarello adds. "There's been so much emphasis on the ritual of donning and removing PPE, I worry that when people get into a room, they aren't thinking about how they might contaminate themselves or spread greater contamination in the environment," she says.

If health care workers have a sudden urge to scratch their noses or adjust their glasses, they would need to remove their gloves, make the adjustment, wash their hands, then put on clean gloves.

Health care workers also need to touch as few surfaces as possible in the patient's room to avoid spreading the infectious disease. (TB is not spread through surface contamination, as is SARS and other diseases.)

- **Remove PPE in proper sequence.**

The CDC recommends removing all PPE except the respirator at the doorway or anteroom of the patient's room. The respirator should be removed after leaving the patient room and closing the door.

The gloves should be removed first and discarded. "Sequence is important," says Chiarello. "The gloves are generally the most contaminated part of the isolation garb. When you're removing the isolation garb, you need to bring your hands up around the face and the neck. We recommend removing the gloves first."

The goggles should then be removed, handling them by touching the earpieces or headband. Untie the gown, then handle it from the inside. The respirator should be handled by touching the top ties or elastics.

"Perform hand hygiene immediately after removing all PPE," CDC advises.

If the employee is wearing a powered air-purifying respirator or elastomeric respirator that covers the entire head, that must be removed before the gown — in the ante room, Chiarello explains.

(Editor's note: A copy of the poster is available on-line at www.cdc.gov/ncidod/sars/pdf/ppeposter1322.pdf.) ■

APIC: Boost health care workers' flu vaccine rates

Hospitals must promote the shots

Immunize your health care workers against influenza every year, infection control officials are urging.

The Association for Professionals in Infection Control and Epidemiology (APIC), based in Washington, DC, has added its voice and power to that message.

APIC recently released a position paper on influenza immunization and is urging hospitals to improve their rates.

Only 36% of health care workers receive the vaccines annually, according to the National Health Interview Survey.

"With other preventable diseases, we've placed much more emphasis on making sure we have immunity," says **Jeanne Pfeiffer**, RN, MPH, CIC, APIC president, who is infection control program coordinator at Hennepin County Medical Center in Minneapolis.

APIC joins other organizations, including the National Foundation for Infectious Diseases and the Centers for Disease Control and Prevention, in making a greater push for influenza immunization.

It won't be easy, acknowledges Pfeiffer. "Even in our facility, where we've had an active program in place for about 10 years, we are at a little over 50%," she says.

Here are the recommendations issued by APIC:

1. All health care facilities should prepare a written policy stressing the importance of influenza vaccination among health care workers. This policy should strongly recommend that health care workers receive annual influenza vaccination to prevent spread of the virus to vulnerable patients. Every organization, regardless of size or type, should demonstrate its commitment by creating and distributing the policy to all employees.
2. Influenza immunization programs should be designed and implemented annually to increase vaccination rates. These programs should be designed to:
   - Educate health care workers about the importance of influenza immunization in health care settings and the low risk of adverse events associated with immunization.
   - Increase vaccine demand among health care workers.
   - Reduce barriers to health care worker immunization, by developing programs that increase access to immunization and reduce cost of the vaccine.
   - Facilitate the influenza vaccination process, such as through the use of standing orders issued by the Occupational Health Program for health care worker influenza vaccination.
3. Monitor annual immunization rates of employees and provide feedback through the infection control and patient safety programs.
4. Monitor and track health care-associated influenza in comparison to the health care worker immunization rates. Providing this information may stimulate health care workers to seek vaccination.
5. Track community incidence of influenza with public health officials using data from emergency departments, physician offices, and clinics. As the incidence increases, infection control and hospital administration should work together to identify pending admissions of potential influenza cases and to establish parameters for visitor restrictions.

Interventions for consideration

Specific interventions that facilities should consider include:

- Holding vaccine clinics in easily accessible locations and at varied times, so clinics are convenient for workers on all shifts.
- Bringing vaccine to employees, wherever they might be, via a rolling cart. Areas to consider include cafeterias, employee entrances, medical records department, medical wards, grand rounds, etc.
- Educating employees, by a variety of channels (e.g., employee newsletters, e-mails, posters), about the need to be vaccinated, and dispelling myths (e.g., inactivated influenza vaccine can cause the flu). Employees should be educated about prevention of transmission, as well as benefits of vaccination.
- Removing all costs associated with vaccination. As a patient safety measure, institutions should provide employees with influenza vaccination just as it does other infection control interventions, such as personal protective equipment and hand hygiene products (e.g., soap or alcohol hand rubs, etc.).
- Conducting a public health campaign with media coverage.
- Adding influenza immunizations to the standard curricula in teaching institutions. Immunizations should be available to students at the academic institutions and paid for through student fees.
- Implementing additional mechanisms as necessary to facilitate the administration of vaccinations to health care workers in all settings.

[Editor's note: A copy of the APIC position paper on influenza vaccination of health care workers is available at www.apic.org/position%20statement1.pdf.] ■

Flu vaccine expands this fall to prevent shortages

CDC: Start campaigns in October

The supply of influenza vaccine will be increased this year in an effort to prevent the shortages that occurred during the past flu season, the Centers for Disease Control and Prevention (CDC) announced.

Manufacturers will make 90 million to 100 million doses for the 2004-2005 season, compared with 87 million doses available last year, the agency said.

Media attention about influenza led to an "unprecedented demand," the CDC said.[1]

If vaccine shortages occur, the CDC said it may stagger the availability, giving priority to high-risk groups, such as health care workers and people at risk for complications from the flu.

The CDC also made these points:

- Vaccination campaigns should begin in mid-October because supply cannot be ensured for early fall.
- The new vaccine will contain three strains, including A/Fujian/411/2002 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens.
- "If a health care worker receives LAIV, the health care worker should refrain from contact with severely immunosuppressed patients for seven days after vaccine receipt. No preference exists for inactivated vaccine use by health care workers or other persons who have close contact with persons with lesser degrees of immunosuppression."

Reference

1. Centers for Disease Control and Prevention. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2004; 53:1-40. ■

Nurses still stuck with unsafe needles

Conventional devices still widely used

Many nurses still do not have access to sharps safety devices, and conventional devices are available in most health care facilities, according to a survey conducted by *Nursing2004*.[1]

Nurses also report inadequate training, which may contribute to continued injuries from safety devices.

Despite the progress made in almost four years since Congress mandated for safety-engineered sharps in all aspects of health care, much work remains to be done, says **Jane Perry**, MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

Perry and center director **Janine Jagger**, PhD, MPH, provided analysis of the survey for the nursing journal.

"There is still a significant portion of hospitals that either are only partially converted or use very few safety devices at all, if any," Perry points out. "I would suspect that it would be unusual to find hospitals that are 100% converted to safety."

That echoes what other needle safety experts find in training sessions and site visits around the country. **June Fisher**, MD, director of the Training for Development of Innovative Control Technology (TDICT) Project of the Trauma Foundation at San Francisco General Hospital, asserts that health care workers need better training and access to better devices.

"This is consistent with what we hear in our training," she says. "It tells you that the job is not done and we need more resources."

Last fall, *Nursing2003* asked readers to respond to questions about needlesticks and safety devices. Most of the 498 respondents were employed at hospitals (60%), but they also worked in long-term care (13%), home health care (8%), physician offices (6%), and outpatient/clinics (5%).

They are not a random sample and may not be representative of all nurses, the journal noted, but their responses do shed light on practices at health care facilities around the country.

Among the findings:

- Almost one-third (64%) of nurses said conventional devices still are readily available in their facilities.
- 13% of nurses said they used safety devices for few or no procedures, and another 27% said they used them for some but not all procedures.
- 18% of injuries in the safety-device group

occurred after use of the device, which indicates that the safety feature was not activated or failed.
- One in four nurses said they received inadequate training or no training at all.
- One-quarter of nurses said they had at least one needlestick in the past year, but 42% said they did not report their needlesticks.

"There are injuries that continue to occur with safety devices," Perry notes. "A significant proportion of those are from nonactivation of the safety mechanism. If the safety mechanism isn't activated, it basically negates the purpose of the device."

Health care workers need to feel comfortable with the devices through proper training, she says. Only about half (53%) of nurses said they received training on newly introduced sharps devices.

"I think the message that needs to stay in the forefront is that the aim is for 100% conversion to safety, not 75% or 80%," Perry explains. "Hospitals need to continue to direct resources and attention not only to purchasing the devices and evaluating and implementing them, but to the training as well."

In comments, nurses also expressed concern about the safety features. One reported that a sheath on a syringe slipped. Another complained that it takes too much force to activate the retractable feature on a syringe.

Other inconsistencies were found

There are other inconsistencies, as well. Prefilled syringes may come with different types of safety mechanisms, creating confusion for nurses. One manufacturer of the flu vaccine packaged it with conventional devices, Perry notes.

There are times that conventional devices are necessary because no safety-engineered version is available, Fisher adds. But those conventional devices should not be stocked side-by-side with safety devices, making it easy for health care workers to select one without protection, she says.

Manufacturers also should get more input from nurses, the end-users, to help them design more acceptable products, Fisher says.

Reference

1. Perry J, Robinson ES, Jagger J. *Nursing2004* needlestick and sharps-safety survey: Getting to the point about preventable injuries. *Nursing2004* 2004; 34:43-47. ■

Union claims GPO swayed needle choice

SEIU files complaint against Yale-New Haven

A union complaint against Yale-New Haven (CT) Hospital alleges the hospital switched from a retractable needle to a safety device with a gliding cover because of a restrictive purchasing contract and without employee input.

The hospital has denied the allegation, asserting that employee input was solicited and the switch occurred because of supply problems. The U.S. Occupational Safety and Health Administration (OSHA) is investigating.

The complaint once again raises the issue of group purchasing organizations (GPO) and contracts that provide significant financial disincentives for buying products from outside vendors.

The Service Employees International Union (SEIU) in Washington, DC, recently launched a web site (www.gpo watch.com) to track information about GPO contract issues.

In 2002, *The New York Times* ran a series of articles on GPO financial dealings and anticompetitive activities. The Senate Judiciary Antitrust Subcommittee held hearings, as did the Federal Trade Commission and Department of Justice. Some changes occurred in GPO contracts since that time.

"My understanding is that most group purchasing organizations have made accommodations for individual facilities purchasing off-contract if the device they want to use is deemed more appropriate or preferable," says **Jane Perry**, MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

The union became involved in the Yale case when workers said that they hadn't had a say in the switch from the Vanish Point retractable device to the Becton Dickinson Safety Glide.

"When we analyzed the exposure control plan that Yale had, what we were struck by was that the hospital had made the switch without consulting workers," says **Nicholas Rudikoff**, senior field researcher at SEIU.

"That led us to believe that they acted more out of concern with their relationship with Novation [GPO] and less out of concern for their workers. We think workers should be consulted about needle purchases," he notes.

In fact, the bloodborne pathogen standard requires the input of frontline health care workers, and that formed the basis for an OSHA complaint.

In its complaint, the union also asserted:

- The hospital failed to document the solicitation of employees in the exposure-control plan.
- Employees were stuck due to recapping, improper needle disposal, and overfilled sharps containers.
- "Some needles that are in use at [the hospital] do not have safety features that effectively reduce the risk of an exposure incident," the complaint said.

In fact, the hospital's purchasing officers had tried to find a stable supply of the retractable syringes and had even looked into contracting directly with the manufacturer, but they were unable to obtain a commitment for the quantity the hospital would need, says **Mark Russi**, MD, MPH, director of occupational health. The hospital conducted a pilot test of the Safety Glide with general medicine wards, respiratory therapy, and adult and pediatric primary care, he says.

"We have an active process that involves input from employees. I think it's been a very successful process," Russi adds. Needlesticks have actually declined since the switch; the hospital will continue to evaluate available safety devices, he says.

"We have taken this issue [of sharps safety] very seriously for a long time," Russi explains. "We're continuing to identify new products on the market." ■

CE *questions*

1. According to OSHA industrial hygienist Craig Moulton, hospitals can stagger the annual fit-tests for employees as long as:
   A. They are completed within a year.
   B. They are completed within three months.
   C. They are at low risk for tuberculosis.
   D. The employees who are likely to encounter patients with tuberculosis receive their fit-tests immediately.

2. According to CMS, how should hospitals respond to the National Fire Protection Association amendment of the Life Safety Code allowing alcohol-based rub dispensers in hallways?
   A. They should wait for formal CMS adoption of the new requirements.
   B. They should place dispensers in all hallways.
   C. They should contact their local fire marshal and report the use of dispensers.
   D. CMS said it would never allow the dispensers in hallways.

3. What piece of personal protective equipment does the Centers for Disease Control and Prevention say should be removed first?
   A. respirator
   B. goggles
   C. gloves
   D. gown

4. In a survey in *Nursing2004*, what percentage of nurses said conventional devices still were readily available in their facilities?
   A. 75%
   B. 64%
   C. 42%
   D. 23%

Answer Key: 1. D; 2. A; 3. C; 4. B

Cal/OSHA fines hospital in death of physician

Psych hospital failed to protect HCWs

John George Psychiatric Pavilion in San Leandro, CA, has been fined $54,000 for failing to take adequate precautions to prevent violent assaults against its staff.

The California Division of Occupational Safety and Health (Cal/OSHA) issued four citations against the locked, inpatient facility after a physician was beaten and strangled to death in an isolated exam room.

The patient of internist Erlinda Ursua, MD, has been charged with her murder.

The hospital, which cares for patients in acute crisis and is a part of Alameda County Medical Center, already faced $30,000 in fines for failing to report previous assaults on two nurses and failing to implement an injury/illness prevention program to protect workers from assaults.

After Ursua's death, John George Psychiatric took immediate steps to prevent such violent assaults and already has corrected the situations that led to the citations, says Alameda County Medical Center spokesman **Jeff Raleigh**. For

example, Alameda County sheriff's deputies are now on-site 24/7, he says.

"There's a new administration there," he says. "I think that will be a fairly significant change."

The incident occurred Nov. 2, 2003, when Ursua took a patient into a private exam room and began conducting a medical history and physical.

Later, staff became concerned when they saw the patient wandering around with a partially completed medical form. Soon after, Ursua was found dead; she had been beaten in the head and strangled.

The hospital had not taken precautions to protect health care workers, says Cal/OSHA spokesman **Dean Fryer**. "One [citation] was issued for using an isolated exam room and not inspecting for hazards when using that room," he says.

John George Psychiatric also failed to follow its own policy not to allow staff to be alone with a potentially violent patient, he says.

Cal/OSHA also cited the hospital for failing to enforce its dress code that prohibited scarves and jewelry, and for having an ineffective alarm system. "They did have an alarm system [in the exam room], but it was in a position that was not reachable," Fryer points out.

After Ursua's death, the hospital closed all isolated exam rooms and created and enforced a written policy that two staff members must be in the room during patient evaluations, Raleigh says. The dress code has been posted and is enforced, he says.

"Now all employees carry a personal alarm with them while they're in the facility," he says. "I'd like to emphasize that all of the actions were taken by John George before the citations were issued."

The hospital has not decided whether to appeal the citations, Raleigh says. An appeal of the previous citations still is pending.

Fryer notes that Cal/OSHA representatives met with hospital officials before the November death and made recommendations on how to correct the violations, "a step we very rarely take with employers.

"Our suggestions were not implemented, nor were there apparently any other measures implemented that would have prevented this attack in November," he says. "It's highly likely that we will do a follow-up inspection to ensure these measures are taken to protect employees from attack." ■

OSHA seeks employers' input on SST inspections

Employers have a chance to give the Occupational Safety and Health Administration (OSHA) an earful about its Site-Specific Targeting (SST) Inspection Program.

The agency has asked for comment on its method of selecting high-injury work sites for comprehensive inspections. Currently, OSHA uses an annual data initiative survey to collect overall injury and illness information from employers.

In 2004, if an employer's lost workday injury and illness (LWDII) rate was above 16 per 100 full-time employees, the workplace would be on OSHA's primary list for comprehensive health and safety inspections. A lost workday rate between 10 and 16 would land an employer on the secondary list for possible inspection.

This year, OSHA also added an additional factor: the days away from work injury and illness (DAFWII) case rate of nine or greater per 100 full-time employees. That focuses on injuries that lead to at least one day away from work — not just restricted work activity.

Twenty hospitals out of 4,000 high-hazard workplaces landed on the targeted inspection list this year.

In a *Federal Register* notice [69:25,445-25,446 (May 6, 2004)], OSHA said it seeks to make the targeted enforcement more effective. OSHA wants answers to these questions:

- Are the LWDII/DART (days away, restricted, or transferred) rate and the DAFWII case rate appropriate measurement tools for the SST?
- Should OSHA consider other measures for

injury and illnesses at individual establishments? If yes, what measures should be considered?
- Should OSHA be looking at injury and illness data over multiple years rather than in a single year?
- Should an establishment's priority for inspection take into account whether the establishment is in an industry with a high rate or a low rate of citations?
- Should the SST include additional focuses such as on specific industries, or past citation history?
- Are there particular areas/hazards OSHA should be focusing its enforcement efforts on?

The agency is accepting written comments through July 6. Electronic comments can be sent to ecomments.osha.gov. Two copies of other written comments should be sent to the Docket Office, Docket No. C-08, Room N-2625, Occupational Safety and Health Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210. Telephone: (202) 693-2350.

Comments of 10 pages or fewer may be faxed to the Docket Office to (202) 693-1648. The original and one copy must then be mailed immediately to the Docket Office. ■

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. ■