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## Hospital prevention efforts reduce slips and falls by 20%

*Multipronged intervention saves thousands*

**Y**our hospital is filled with hazards that employees walk past every day. There may be puddles on the floor when it's raining, grease on the kitchen floor, a spill outside the cafeteria.

Slips, trips, and falls, the second most common cause of injury in hospitals, are not just accidents. They're preventable — and a sustained effort to reduce hazards can save you thousands of dollars.

In early results from a federally sponsored study, a comprehensive prevention program led to a 20% decline in fall-related injuries at BJC HealthCare in St. Louis. "We're talking about \$200,000 worth of savings on [about] \$1 million worth of [systemwide slip-and-fall-related] compensation claims," says **James Collins**, PhD, MSME, epidemiologist/engineer and project officer for the Slips and Falls Prevention in Health Care Workers project at the National Institute for Occupational Safety and Health in Morgantown, WV.

Collins and his colleagues are analyzing three years of pre-intervention data and three years of post-intervention data. The interventions began in 2003. "The preliminary results from this study are indicating that a comprehensive slips, trips, and fall prevention program can significantly reduce staff injuries due to falls on the same levels," he says.

Unlike patient handling injuries (the most frequent injury in hospitals), slips and falls often are viewed as isolated events. Not so, says **Laurie Wolf**, MS, CPE, ergonomist of WellAware program at BJC HealthCare, which has 13 hospitals, five nursing homes, and about 25,000 employees. "We've come a long way" in preventing the injuries, says Wolf, who notes that the program also prevents patient falls, as well. It's important to use many different approaches and to maintain your commitment, she adds.

Here are some of the interventions that made a difference:

- **Conduct a hazard assessment.**

"The first thing we did was look at our environment and try to make changes," says Wolf. While slips and falls rarely come in clusters, there

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are hazards that can be identified and corrected before an accident happens.

Several employees fell at an icy shuttle bus stop at BJC. A downspout was emptying water near the stop, which pooled and then froze on cold winter days. The health care system spent \$3,500 to reroute the drainage and place it under the sidewalk.

A hazard assessment also may identify cords that could be a trip hazard or clogged drains in the kitchen that lead to pooling of water or grease. BJC HealthCare improved lighting in parking garages and added handrails in some areas.

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## Editorial Questions

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## • Raise employee awareness.

With the slogan "Save yourself a trip," BJC launched a high-profile awareness campaign with table tents in the cafeteria, highlights in the newsletter, and e-mail alerts. BJC's "Ergo Rangers," or ergonomic specialists, conducted awareness fairs at the hospitals and helped coordinate the interventions.

Any employee who did something to help eliminate a slip-and-fall hazard was eligible to win a small gift certificate to a local store.

Employees used scoops in special bins placed outside entryways to distribute ice-melting chemicals on icy patches. They stooped over to wipe spilled coffee or rearranged electrical cords away from a pathway.

BJC also urged employees to "put a lid on it" — not to carry open cups out of the cafeteria where they could spill in a corridor or an elevator. Preventing slips and falls "is a responsibility of everybody," says Wolf.

## • Use specialized housekeeping materials.

BJC mounted rolls of bright yellow absorbent towels. If an employee sees a spill, he or she can place the towel on the spot and call a housekeeping hotline. All housekeeping managers have a beeper to respond to spills.

Wet floor signs — a type designed to cover the spill as well as provide an alert — are available on housekeeping carts and are mounted on a wall on each hospital floor. The facilities also provide plastic umbrella bags at the facility entrances for rainy days.

Meanwhile, Wolf and Collins also are reviewing floor wax or other products that would be less slippery.

## • Seek slip-resistant products.

With the help of the Finnish Institute for Occupational Health in Helsinki, Collins tested the slip resistance of several different brands of shoes in a laboratory. Nurses wore the shoes for a three-month test. They didn't find much appeal; at the end, most nurses went back to their previous shoes.

"In the priority order, it seems to be comfort and style, [and] slip resistance seems to be a distant consideration," Collins explains.

He continues to look for products that will reduce the risk of falls. For example, home health nurses can wear shoe covers in the winter that have ice cleats.

"You have to be innovative — look at new things and be persistent," Wolf notes. "You have to keep that awareness going." ■

# Lessons learned: Use PAPRs to avoid fit-tests

*Washington hospitals have years of experience*

**W**hile much of the country struggles to comply with the new requirement for annual fit-testing of N95 filtering facepiece respirators used to protect against tuberculosis, hospitals in Washington state have some advice:

Powered air-purifying respirators (PAPRs) are an important tool in decreasing the burden of fit-testing, employee health and safety professionals say. They have had many years to learn that lesson. Based on a rule of the Washington State Department of Labor and Industries in Olympia, they have conducted annual fit-tests since 1995.

When the U.S. Occupational Safety and Health Administration (OSHA) revoked its proposed tuberculosis standard Dec. 31, 2003, it placed hospitals and other health care employers under the General Industry Respiratory Protection Standard, which requires the fit-tests. Although OSHA was expected to further delay enforcement of the fit-testing rule, as of press time, hospitals and other health care facilities were still required to comply by July 1, 2004.

"When we first introduced this, we were able to get the [respirator] vendors to assist us with the fit-testing procedure," recalls **Patti Newsted**, HEM, safety manager at St. Joseph Hospital in Bellingham, WA.

It was a daunting task to fit-test 450 employees, she says. But even more troubling were some of the difficulties that arose with the fit-testing itself. Some men did not want to shave their beards, a requirement to allow the respirators to fit properly. "This went all the way up to our administrative levels," Newsted says. "They agreed we are not going to make an exception because someone is wearing a beard [for aesthetic reasons]. They have a job to do and the job requires them to work with TB patients."

The hospital decided to allow those employees to wear PAPRs — if they purchased the units themselves. At the time, they cost about \$300 each.

Meanwhile, some employees seemed unable to obtain a proper fit with the two brands of N95 respirators the hospital had purchased. Some health care workers complained that the N95s made them feel hot or uncomfortable.

"That's when we started looking at these

PAPRs more seriously," Newsted says. "We justified the cost by looking at the time involved for all the fit-testing and the advantages the PAPR had over the N95."

St. Joseph Hospital now relies on a stock of PAPRs — about two or three per inpatient floor. Employees use disposable hoods, which they keep for use on a single TB patient and then throw out when the patient is discharged. (The hospital treats about six TB patients a year, and has a number of other rule-outs.)

Newsted eventually learned about some drawbacks of the fit-testing process. She had used qualitative testing with saccharin, and employees later told her they had been impatient with the process.

"There were folks who really didn't want to deal with it, and there were folks who faked their way through it and said they didn't taste the saccharin when they really did," she says. "Then there were folks who said, 'I can taste it, I can taste it.' Did they really taste it or did they just not want to wear the respirator?"

The PAPRs were readily accepted by the staff, Newsted adds. "Initially, people were joking that they looked like beekeepers. Once they wore it, they realized, 'It's cool. I can see. My vision isn't obstructed. The patient can hear me. It's not that heavy to wear.' We worked out all of the barriers to this and it's actually worked quite well."

With the advent of severe acute respiratory syndrome (SARS) and the possibility of pandemic influenza, St. Joseph Hospital has purchased a stock of N95s. With those diseases, which have different transmission properties from TB, the cleaning requirements of the PAPRs would be too great, says **Lori Wilkinson**, RN, COHN-S/CM, occupational health nurse.

"When we first would see a SARS patient, we would go with the PAPR. You'd have to discard the hood," she says. "I think we would quickly move to N95s and would do N95 just-in-time fit-testing."

Group Health Cooperative in Seattle took a similar path in its respiratory protection program. The health system, with about 20 outpatient clinics, three specialty centers, and two hospitals, started with N95s then purchased PAPRs. Now the health system is conducting annual fit-testing for N95s.

"We currently are only fit-testing 215 staff [and physicians], which includes two hospital labs, micro lab, emergency room, urgent care, respiratory therapy, pulmonary, and selected staff in the operating room and environmental services,"

*(Continued on page 97)*

# GROUP HEALTH COOPERATIVE

## TB Respirator Fit-Test and Training Record

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)

Work Unit: \_\_\_\_\_

### Fitting

Type of qualitative/quantitative fit-test used: \_\_\_\_\_

1. \_\_\_\_ Number of Squeezes Taste Test
2. \_\_\_\_ Satisfactory Fit Check Test-Inhale/Exhale

<u>Respirator MFR/Model No.</u>	<u>Size</u>	<u>Pass/Fail</u>
3. _____	S M L	P F
4. _____	S M L	P F

Notes:

Name of test operator: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### Training Record

I certify that I have been trained in the use of the above respirator.

This training included the inspection procedures, fitting, maintenance, and limitations of the above respirator(s). I understand how the respirator operates and provides protection. I further certify that I have heard the explanation of the unit as described above, and I understand the instructions relevant to use, cleaning, disinfecting, and the limitations of the unit. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

Source: Group Health Cooperative, Seattle

says **Janie Garris**, RN, MN, director of infection control and employee health. "These numbers may be small compared to some facilities that do not use PAPRs in addition to N95s," she adds.

The fit-testing occurs in the emergency department and med-surg unit, where employee health relies on a "train-the-trainer" model. Employee health administers the medical screening questionnaires and maintains the respirator fit-test records. Staff on the units perform the fit-tests. (See sample record form, p. 96.)

Employee health simply would not have the staff to perform all the fit-tests, but instead manages the program and keeps track of which employees need the tests, Garris says.

"It's been challenging," admits Garris, who must contact managers to alert them about employees who haven't received their annual fit-tests. ■

## NIOSH lower profile spurs reorganization protest

*NIOSH to move down in CDC organization*

**W**orried that the future clout of the National Institute for Occupational Safety and Health (NIOSH) is in jeopardy, occupational health advocates are pressing the Centers for Disease Control and Prevention (CDC) to alter its reorganization plans.

NIOSH has a significant influence on occupational health practice through its research, recommendations, and hazard alerts. While its mission would remain the same, it could suffer from a lower profile, says **Susan Randolph**, RN, MSN, COHN-S, FAAOHN, president of the American Association of Occupational Health Nurses.

"NIOSH had its own identity. Under this new proposed [CDC] structure, it would lose some of that identity," says Randolph, who is a clinical instructor with the occupational health nursing program at the University of North Carolina at Chapel Hill. "It would be essentially [moved] down a level organizationally."

Randolph was one of several occupational health professionals who recently wrote CDC director Julie Gerberding about those concerns.

Franklin E. Mirer, PhD, director of the health and safety department for the United Auto Workers, also wrote Gerberding that the business-labor-academic partnerships could be weakened if NIOSH

has a lower organizational status.

"All of the work functions that the National Institute for Occupational Safety and Health perform are and will continue to be a high priority here at CDC," responded CDC spokesman **Tom Skinner**.

By integrating resources and coordinating with the CDC centers, "we'll be able to have an even greater impact on occupational safety and health than we do right now," he says.

NIOSH was created in 1970 by the Occupational Safety and Health Act to be a sister agency to the Occupational Safety and Health Administration (OSHA). With its research mission, it works closely with OSHA, employers, and unions.

At its inception, the Department of Health and Human Services placed NIOSH within CDC, but NIOSH has maintained a measure of independence. For example, each year, NIOSH officials lobby Congress for the agency's budget allocations.

In the reorganization, which becomes effective on Oct. 1, NIOSH will be part of the Coordinating Center for Environmental Health, Injury Prevention and Occupational Health. That center also will include the National Center for Environmental Health/Agency for Toxic Substances and Disease Registry and the National Center for Injury Prevention and Control. It will be headed by Henry Falk, MD.

The change came as a surprise for some in the occupational health field who had commented on the reorganization, but not the NIOSH move.

"In reading the materials that were sent, it appeared as if it was more of a realigning within CDC itself and not so much [of] a separate organization, such as NIOSH," says Randolph. "I really did not think that would affect the placement of NIOSH."

In fact, NIOSH actually should have a more independent status, contends **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union. "I think the intent of Congress is that it be a separate institute of health like all the other institutes of health," he explains.

The CDC reorganization is part of the "Futures Initiative," which is intended to streamline the agency and focus its resources. CDC's two overarching goals are preparedness and "health promotion and prevention of disease, injury, and disability." Targeted goals will focus on improving health in "every stage of life," CDC says.

However, working is not linked with a particular life stage, notes **Sharon Morris**, who was a

former legislative officer at NIOSH and worked at the agency from 1972 to 1982.

CDC says in its explanation of the Futures Initiative that the agency will "meet statutory requirements regarding CDC's Centers, Institute, and Agency (for example the director of NIOSH will continue to serve at the pleasure of the secretary of Health and Human Services)."

Little else is mentioned of NIOSH's distinctive position. "The institute has a separate law that governs it and a separate mission from the rest of CDC," says Morris, who is now assistant chair of the department of environmental and occupational health sciences at the University of Washington in Seattle. "Its mission is worker safety and health, not general public safety and health."

"It's an important mission. It needs to be visible and able to fulfill that mission and not become homogenized with a lot of other related or unrelated missions."

This is not the first conflict between CDC and NIOSH, or supporters of NIOSH. NIOSH's headquarters have moved from Washington, DC, to Atlanta and back to Washington, notes Morris. "There have been a number of issues over the years where there have been differences of opinion, which relate sometimes to their different constituencies," she says. ■

## Hospital gets close to zero — in WC claims

*With lifts, workers comp drops by 98%*

Ceiling lifts save backs. That is what Salina (KS) Regional Medical Center concluded, and the investment paid off.

After installing tracks throughout the hospital, in patient rooms, and some hallways, with 138 lifts, the hospital saw its workers' compensation costs related to patient handling drop from \$213,000 to \$5,279 — a reduction of 98%.

Average lost workdays dropped from 17 in 2001 to zero in 2003. Average restricted workdays declined from 22.3 in 2001 to 7.8 in 2003.

"It certainly has improved the life of our employees," explains **Barb Herrman, RN**, employee health coordinator.

The Salina experience showed "how you can save money by doing the right thing," says **Esther Carlson, MSN, ARNP, BC, FNP**, a cardiovascular

## Criteria for Ceiling Lifts

These are the criteria used by Salina (KS) Regional Medical Center when the hospital evaluated ceiling lift systems:

- ✓ Automatic stop if lift is too high or too low
- ✓ Emergency stop
- ✓ Sling base safety latches
- ✓ Quick release capability
- ✓ Meets International Organization for Standardizations standards
- ✓ 400- and 800-pound lift units
- ✓ Slings in small to extra large sizes
- ✓ Walking slings
- ✓ Hours of on-site training
- ✓ H design with exposed mounting leg support (offers most flexibility)

advanced practice nurse who was involved in researching and developing the program.

Patient handling incidents were causing one or two life-altering injuries each year, with nurses who could no longer work. For example, one nurse injured a disc, required back surgery, and was permanently disabled.

An ergonomics equipment vendor provided an analysis of ceiling lifts at no charge to the hospital. It reported that nurses performed an average of 14.4 lifts per day at an average weight of 173 pounds.

Research supported the use of ceiling lifts to reduce injuries, Carlson explains. So did the hospital's own experience, where floor lifts often languished unused in storage areas. It was too difficult and time-consuming for nurses to retrieve those lifts, she says. "We weren't going to throw money away on something that wasn't going to work."

Carlson couldn't find an example of a hospital that used ceiling lifts throughout the facility. Salina Regional was convinced that was the only way to make a difference.

"The answer is to put a lift in every room, and then look at changing practice," says **Jane Wahlgren, RN, MA**, vice president of patient care services. "It won't be any good to put them in half the rooms because half the patients won't be in those rooms."

The hospital's board of trustees was willing to make a major investment in lifts to stop the costly and debilitating back injuries. Salina spent \$450,000 on the ceiling-lift system. Getting the right lift was crucial. So was employee buy-in.

*(Continued on page 103)*



# JCAHO Update for Infection Control

*News you can use to stay in compliance*

## ICPs have the answers for JCAHO questions

*Surveyors particularly curious in making rounds*

**B**e proactive and get ready for an onslaught of questions — from critical inquiries to the out-of-the-blue variety — if you're preparing for a visit from the Joint Commission on Accreditation of Healthcare Organizations, advise two infection control professionals who recently went through the process.

"I think the hardest thing to me about the Joint Commission survey is the chaos and the craziness that happens ahead of time," said **Karen Anderson**, MT(ASCP), an ICP at Marin General Hospital in Greenbrae, CA. "The survey itself is almost a relief when it [arrives]."

When it does, be prepared for all manner of questions, added **Rouett Abouzelof**, an ICP at LDS Hospital in Salt Lake City. (**See sample questions, p. 101.**)

One of the questions that was asked — and I'm not kidding — is what are you doing to prepare for your replacement? . . . [Meaning] how are you mentoring others?" she said. "You never know what kind of question you might be asked."

### **'Tips from the Troops'**

The two ICPs detailed their recent survey experiences in a special "Tips from the Troops" session in Phoenix at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC).

"Basically, you're going to have your opening conference, where you introduce yourself, you look at the survey schedule, and make some plans," Abouzelof explained.

The "leadership" interview involves a review of the organization's structure and goals. "Then

[surveyors] start filtering out and doing system tracers and patient tracers," she said.

### ***Grilling the guards***

Patient tracers may involve tracking a patient through an entire clinical care path, from admission to discharge.

For example, Anderson noted that her surveyor took a particular interest in the hospital's eight-bed correctional treatment center, a locked unit for prisoners from San Quentin. A patient/prisoner had been admitted to the unit with rule-out tuberculosis, and the surveyor questioned the guards assigned to the unit.

"She wanted to know, what kind of hospital-specific infection control training and safety training they had," Anderson said.

"What would they do in the event of a fire, of an evacuation? What were the codes, things like that. They got questioned a lot, but they are very well-trained," she added.

In contrast, a system tracer may involve review of an entire area such as infection control, environment of care, medication management, and information management.

"They wanted us to go on this facility inspection," Abouzelof noted. "So we went with the surveyors, and we were climbing ladders, looking for dust, seeing if there were barriers [to safety]. You never know what you will be called to do. That's something that might happen or it might not. It only happened at one of our hospitals, but we were up there on those ladders with them."

With patient tracers, surveyors will wind their way through a variety of clinical departments, she added.

"They are going to be in your clinical areas, your emergency department, acute care floors, intensive care units, or neonatal intensive care units," Abouzelof pointed out.

"They might go down to your X-ray or interventional radiology department and watch them do something. It just depends on what patients they choose, but they will be in the clinical areas," she noted.

The health care facility typically will find out a couple weeks in advance at least part of what surveyors will be reviewing.

"They might base it on something that happened in the past in your hospital, on your previous surveys or ORYX [quality indicator] data you put in, or public data that are submitted. Any of those things could trigger how they want to look at your facility and patients."

## **2004 patient safety goals**

Of course, the Joint Commission has specific safety goals for infection control this year involving hand hygiene and infection-related sentinel events.

"Those are things they are going to really be focusing on, and that is something that I was concerned about," Abouzelof says.

"They asked us questions about sentinel events. Have you had a sentinel event? How did you identify it? If you haven't had a sentinel event, how are you looking for them. What do you do when you think you might have found one?"

"One thing we do is if there is something that looks like a sentinel event, like a death, then we review it with our infectious disease physicians, and we also have a sentinel event team that reviews these things," she explained.

One of the surveyors wanted to focus heavily on data, reviewing rates and charts, Abouzelof added. "He didn't ask us a question about hand hygiene," she told APIC attendees. "He wanted to see the data. It was like, 'Show me the money.'"

In reviewing the data and charts, the surveyor found a large spike in infections and questioned the ICPs accordingly.

"We were able to tell him exactly what type of problem was going on — it was catheter-related — and we could show him directly from the broad picture looking at PICC lines all the way down to this one specific unit where the problem was. He loved it. Within about five minutes, he slapped his hand down on the table and said,

"You get an A-plus!"

Anderson had a similar moment of triumph, in part, through her own initiative as a big meeting with several departments was winding down and the surveyor's focus turned to her department.

With her infectious disease physicians and employee health nurse in attendance, Anderson knew she had the support she needed.

Rather than merely answering the surveyor's questions, she took the opportunity to highlight the strengths of her program.

"I thought, 'I've worked really hard on this; we've done a good job. I'm going to speak up,'" Anderson said. "So I got my nerve up and did that. I talked about the areas that I was proud of."

## **Front-end documentation important**

One of the keys for both ICPs was documentation on the front end, even though the Joint Commission wants to focus more on process than paperwork.

"I put together a JCAHO compliance manual," Anderson said. "I list the standards and behind each standard, I put my documentation and data that show how I met compliance with that standard. This is not something that surveyors asked to see. They did not want to see a lot of manuals. But for me, it centered my thoughts. I was able to review that and make sure I met all of the standards."

She also gave them surveillance data, infection control committee minutes, and something she called infection control improvements "in a nutshell." Those included a special focus on ventilator-associated pneumonia and an assessment of appropriate antibiotic timing.

"They asked me about my biggest challenges. I told them hand washing was one of them," said Anderson.

"The physician surveyor was in agreement and felt it was going to be very tough for people to do. The infection control survey for me was really a very pleasant experience.

"The surveyors were supportive, educational, [and] they really want to look at the good things that you are doing and support you in that. It was really a good process for me. But a word of warning: You may have a lovefest with the Joint Commission, but it may not be that way with other [regulatory and health department] surveys. You still have to look for the dust bunnies, and you still have to look at refrigerator temperature charts," she explained. ■

# Real-world examples of JCAHO questions

## How do you review line-related infections?

The following questions were among those asked during two recent surveys by the Joint Commission.

The questions do not represent any kind of official survey, but were simply noted anecdotally by two infection control professionals as the questions were asked to them and other staff members. (See related story, p. 99.)

Surveyors asked these questions during individual patient tracer inspections and system tracer inspections of the infection control department:

- Do you do 100% surveillance, or do you focus on specific populations?
- What are some of the challenges you have had to deal with in the past year?
- If a sign "construction" pops up, how do you address this?
- How does employee health fit into this picture?
- Have you had any outbreaks among the employees?
- What have you done regarding smallpox vaccination in response to bioterrorism threat?
- How does pharmacy interact with infection control?
- Do you do random monitoring to make sure the pharmacy processes are working the way they should?
- What have you done about fingernails?
- As a group have you identified how an infectious problem might have led to a patient's death?
- Has behavioral health had any outbreaks?
- Do you keep data on infections in behavioral health?
- Has the lab converted to needleless devices?
- How is the OR doing on converting to needleless systems?
- Has respiratory therapy made any changes to prevent nosocomial infections?
- How does engineering fit into the infection control process?
- Does engineering participate in the infection control committee?
- How does bioengineering participate in the infection control process?
- Where do dialysis water testing results go?

- What kinds of data do you routinely collect?
- How do you collect your data?
- How do you use your data?
- How do you review line-related infections?
- What is an example of a success that you have had in the past 12 months?
- Do you attend environment-of-care meetings?
- What data are you collecting relative to the national patient safety goals?
- Have you already collected evidence on this topic?
- How are the doctors involved in the infection control process?
- How many nosocomial infections do you see in a year?
- What is the average cost of a nosocomial infection in this hospital?
- Do you track prophylactic antibiotic use for each surgeon?
- Do you track endoscopic infections, cleaning of scopes, outbreaks, etc.?
- How do you know that techs who clean the scopes are doing it correctly?
- Do you keep records of the infection rate for gastric by-pass surgeries?
- How do you do outpatient surveillance on infections?
- How are total joint infections identified and tracked?
- How does the director of central processing communicate with infection control?
- If there is a failure of the sterilizer (biological indicator), how is this communicated and what do you do?
- Have there been any infection control concerns with the rehab swimming pool?
- Since you have three emergency departments (in three affiliated hospitals), what is the same and what is different in preparing for bioterrorism?
- How do you work with the community and health department?
- Do all of your hospitals use the same protocols for infection control, and what about the outpatient clinics?
- Several specific questions were asked about hand hygiene evaluations, interventions, and explanations of rates
- How often do you educate employees about infection control issues?
- In response to a specific cluster of infections, how did you respond, who was involved in the decision-making process, what guidelines did you use, how was nursing involved, and

what is the current status and follow-up for these infections?

- What are you doing to prevent ventilator-associated pneumonias, and what specific evidence-based practices are you using?
- What is your community pneumonia protocol?
- Do you have a SARS plan? If there was a patient with signs and symptoms of a respiratory infectious disease, who initiates the plan and who calls the infection control staff or infectious disease physician?
- Give me an example of how you select products for clinical use that might have infection control implications.
- Show me your construction risk assessment and how you monitor the site. How do the construction or engineers know what to do to prevent possible construction-related infections?
- Tell me about infections in total joint replacements. What are your rates and how does this compare with other hospitals (locally or nationally)?
- Do you use antimicrobial-coated IV catheters? Why or why not? ■

of a community. An organization's ability to deliver care, treatment, or services is threatened when it is ill-prepared to respond to an epidemic or infections likely to require expanded or extended care capabilities over a prolonged period. Therefore, it is important for an organization to plan how to prevent the introduction of the infection into the organization, how to quickly recognize that this type of infection has been introduced, and/or how to contain the spread of the infection if it is introduced. This planned response may include a broad range of options including the temporary halting of services and/or admissions, delaying transfer or discharge, limiting visitors within an organization, or fully activating the organization's emergency management plan. The actual response 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 organization's capabilities. The concepts included in these standards are supported by standards found elsewhere in the manual including standard EC.4.10.

#### **Elements of Performance for IC.6.10**

**B 1.** The organization plans its response to an influx or risk of an influx of infectious patients.

**B 2.** The organization has a plan for managing an ongoing influx of potentially infectious patients over an extended period.

**B 3.** The organization does the following:

- Determines how it will keep abreast of current information about the emergence of epidemics or new infections, which may result in the organization activating its response.
- Determines how it will disseminate critical information to staff and other key practitioners.
- Identifies resources in the community (through local, state, and/or federal public health systems) for obtaining additional information. ■

## **JCAHO adds standard on infectious patients**

*Becomes effective Jan 1, 2005*

The Joint Commission is adding a new infection control standard for health care facilities that requires them to prepare for an influx of infectious patients. As part of emergency management activities, institutions must prepare for such an influx or the risk of an influx effective Jan. 1, 2005.

In response to an e-mail inquiry regarding compliance with the standard, a Joint Commission official clarified that "the organization may choose to conduct a drill, but they are not required to do so." The final standard reads as follows:

**Standard IC.6.10:** As part of emergency management activities, the organization prepares to respond to an influx, or the risk of an influx, of infectious patients.

**Rationale:** The health care organization is an important resource for the continued functioning

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*(Continued from page 98)*

Salina developed a multidisciplinary task force, including floor nurses, and the team created a list of criteria for the equipment. (**See Lift Protocol, inserted in this issue.**) The lifts should have an automatic stop to keep the slings from going too high or too low and an emergency stop, the hospital decided. They should have slings that could hold at least 400 pounds and some that would hold at least 800 pounds. The H design for the tracks would allow the lifts to move in multiple directions in the rooms. (Some patient rooms have C-shaped tracks.)

Salina narrowed the choices from six vendors to three, then conducted pilot tests. The vendors installed tracks for the evaluation. The hospital's board of trustees chose Wy'East.

Based on published research on ceiling-mounted lifts in nursing homes, the hospital expected to recoup its investment within 2½ to four years.

The hospital then began a training program with the ultimate goal of creating a no-lift workplace. Wy'East provided 11 days of training, available for all shifts. Salina's challenge was to incorporate the lifts into daily practice.

One nurse had a serious shoulder injury shortly after the lifts were installed. The workers' compensation committee asked her to explain why she hadn't used the lift. "This is to save your life and not just your nursing practice," Wahlgren told the nurses. "That is probably what began to resonate."

Salina wanted the nurses to sign a no-lift commitment, but the nurses wanted more guidance on when to use the lifts. After some additional research, Carlson and her colleagues created a needs assessment and flowchart. It asks simple questions about whether a patient can bear partial or full weight, or how cooperative the patient is.

"You have to change the way people practice," Wahlgren points out. "You have to incorporate it into orientation. You have to have an assessment tool, so nurses assess the need for a lift. If a patient meets the criteria, the nurse has to use the lift. It's not really optional. The goal is to reduce injuries."

Salina continues to look for other interventions to reduce patient-handling injuries. For example, the hospital is purchasing air-based lateral transfer devices, such as the Hover Matt.

The lift system has greater potential, as well. Walking slings allow patients to be hooked to

tracks in the hallway in the orthopedic and rehabilitation units, so they can be ambulatory but protected from falling. The hospital also is testing the use of slings to reposition patients in bed — a significant cause of patient-handling injuries nationally. Based on feedback from nurses, the hospital adapted its policy to allow minimal lifts for those patients who can assist.

"We continue to investigate each [injury] as it occurs, to see what we can do to prevent it from happening again," Herrman says. ■

## Ergonomics committee struggles to define MSDs

*Dispute delays research agenda*

The most basic questions have stumped the National Advisory Committee on Ergonomics (NACE) as it tries to set a national research agenda: Just what is ergonomics? And what is a musculoskeletal disorder (MSD)?

"It's been troubling to me and puzzling to me why [committee members] don't want to define the terms, yet they want to use them," says **Morton Kasdan, MD, FACS**, clinical professor of plastic surgery at the University of Louisville (KY).

He also takes umbrage at the use of "ergonomic" as an adjective, as in "ergonomic interventions" and "ergonomic tools." Ergonomics is the study of the interaction of the individual and his or her work environment, Kasdan says.

Panel members argued about how narrow or broad the definition of MSD should be, or even if they should use that term. The choice has implications both for science and politics. A narrow definition could exclude some body parts that are involved in workplace injuries, while a broad one could be construed as imprecise. Even using the word "disorder" implies a chronic condition rather than an acute injury.

Ultimately, the definition affects employers, who must pay for work-related injuries through workers' compensation but balk at paying for injuries that may be caused by nonwork-related activities.

"Many of these disorders don't have clear diagnostic criteria, so there's a vagueness about the diagnosis as well as the etiology. That's what gives people concern," says **Audrey Nelson, PhD, RN, FAAN**, director of the Patient Safety

Research Center at the James A. Haley Veterans Hospital in Tampa.

The report of the research workgroup referred to "diseases and injuries including but not limited to those of the upper extremity and lower back."

The members added a reference to the definition used by the American College of Occupational and Environmental Medicine: "disorders characterized by an abnormal condition of muscle, tendon, tendon sheath, nerve, bursa, blood vessel, bone, joint, or ligament resulting in altered structure or impaired motor or sensory function."

Further discussion ensued when the issue reached the full committee.

"There is no universally accepted definition for musculoskeletal disorders," says **Lisa Brooks**, CIE, manager of health and safety regulatory affairs for the International Paper Co. in Memphis, TN. "These are not single disorders. They're a group of injuries and illnesses. What you include in that group may change depending on who defines them."

Brooks suggests that NACE reach a consensus, perhaps not a unanimous one, for a definition of MSDs to be used in the research agenda. The workgroup on guidelines called efforts to define MSDs "an exercise in futility." Nonetheless, it will use data based on the definition of the Bureau of Labor Statistics for work-related MSDs. (**See box, at right.**)

"It would be fantastic if we could come up with a recommendation and everyone used it, but I don't think that's realistic," says Brooks.

Ergonomics as a field is still evolving, and reaching agreement on terminology is part of that process, says Nelson. "To me, I think precision in terms is very important, but I don't think that should outweigh the research priorities that were identified," she says.

In fact, NACE had little difficulty agreeing on research gaps. They are:

- More research is needed to examine the validity of diagnostic techniques, including but not limited to those used in evaluating upper extremity and lower back diseases and injuries.
- More research is needed to examine the role of psychosocial factors that contribute to or impact diseases and injuries, including but not limited to those of the upper extremity and lower back.
- Studies are needed to develop additional animal models in which the effects of physical loading on living tissues can be studied in a controlled manner.

## What's in a name? Define MSDs

What exactly is a musculoskeletal disorder(MSD)? Here are some definitions in use by federal agencies:

### **U.S. Occupational Safety and Health Administration (OSHA):**

OSHA's definition of MSDs died along with the ergonomics standard, which was revoked in 2001. (It referred to disorders of the muscles, nerves, tendons, ligaments, joints, cartilage, blood vessels, or spinal discs caused by workplace exposure to one or more of the following risk factors: repetition, force, awkward postures, contact stress, and vibration. It did not include injuries caused by slips, trips, falls, vehicle accidents, or similar accidents.) OSHA now says, "There are a wide variety of opinions on how the Agency should define an ergonomic injury and that the definition adopted by OSHA depends on the context . . . there is no single diagnosis for MSDs."

### **Bureau of Labor Statistics:**

"Work-related MSDs include cases where the nature of the injury or illness is sprains, strains, tears; back pain, hurt back; carpal tunnel syndrome; hernia or musculoskeletal system and connective tissue diseases and disorders and when the event or exposure leading to the injury or illness is bodily reaction/bending, climbing, crawling, reaching, twisting; overexertion; or repetition. Cases of Raynaud phenomenon, tarsal tunnel syndrome, and herniated spinal disc are not included. Although these cases may be considered MSDs, the survey classifies these cases in categories that also include non-MSD cases."

### **National Institute for Occupational Safety and Health:**

"Although definitions vary, the general term 'musculoskeletal disorders' describes the following:

- disorders of the muscles, nerves, tendons, ligaments, joints, cartilage, or spinal discs;
- disorders that are not typically the result of any instantaneous or acute event (such as a slip, trip, or fall) but reflect a more gradual or chronic development (nevertheless, acute events such as slips and trips are very common causes of musculoskeletal problems such as low back pain);
- disorders diagnosed by a medical history, physical examination, or other medical tests that can range in severity from mild and intermittent to debilitating and chronic;
- disorders with several distinct features (such as carpal tunnel syndrome) as well as disorders defined primarily by the location of the pain (i.e., low back pain)."

- Additional studies are needed to examine the validity and reliability of existing exposure assessment methods and develop additional methods.
- High-quality studies are needed to determine the economic impact to organizations of what are commonly described as ergonomic interventions.
- More studies are needed focusing on interactions of the acknowledged occupational and nonoccupational multifactorial causes of diseases and injuries including but not limited to those of the upper extremity and lower back.
- Additional studies are needed on the natural history of diseases and injuries, including but not limited to those of the upper extremity and lower back.
- Studies are needed of the impact of workers' compensation and other statutory payment mechanisms on the duration of disability and other outcomes on upper extremity and lower back disorders.
- Review the consistency of definitions used by OSHA and compare to the definitions used by the medical and scientific community. ■

## Hospital considers rule for mandatory flu vaccination

*Voluntary program isn't working, expert says*

If you could reduce absenteeism, protect vulnerable patients, and keep employees healthier with one yearly shot, what would you do?

To **Gregory Poland**, MD, director of the Vaccine Research Group at the Mayo Clinic in Rochester, MN, the answer is obvious. You would make it mandatory for employees with patient care duties.

The shot is the influenza vaccine. And though many Americans think of the flu as just a little worse than the common cold, influenza causes thousands of complications and deaths every year. Children, older people, and those with chronic illnesses are most at risk.

"In an average year, 36,000 Americans die of a disease that's preventable. That is exactly that same number as if we had a World Trade disaster every month, month after month," says Poland.

The Mayo Clinic is considering whether to become the first acute care facility to require the vaccine for those who work with vulnerable

## Strategies to Increase HCW Flu Vaccination Rates

- ✓ Select a leader to administer the influenza immunization program.
- ✓ Get a commitment from top management.
- ✓ Create a policy statement affirming institutional commitment to increasing health care worker influenza vaccination rates.
- ✓ Use every possible means to deliver messages.
- ✓ Provide education and reeducation.
- ✓ Make influenza vaccine easily accessible.
- ✓ Remove cost barriers to immunization.
- ✓ Audit immunization programs and provide feedback to key personnel.
- ✓ Repeat the influenza immunization program annually.

*Source: National Foundation for Infectious Diseases. *Improving influenza vaccination rates among health care workers*. Bethesda, MD; 2004.*

patients, such as in the intensive care unit.

Maryland, New York, and North Carolina already require the flu vaccine for employees of long-term care facilities.

This year, several organizations have launched campaigns to improve immunization of health care workers, including the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology, and the National Foundation for Infectious Diseases (NFID).

Only about 36% of health care workers receive the annual vaccine, according to data from the National Health Interview Survey.

"It's immensely frustrating that we say we'll 'highly recommend it.' That's fine," says Poland. "More than four decades of data disprove the notion or the hypothesis that a voluntary program for health care workers is going to work."

Poland has become a national advocate for mandatory influenza vaccination. Health care workers who do not receive the vaccine should be required to sign a declination, as they do with the hepatitis B vaccine, Poland says.

"All of us physicians made a promise, we took an oath to protect our patients," he says. "I intend that we live up to that promise."

The failure of health care workers to get the flu vaccine has grabbed national attention. Earlier this year, after a flu season marked by strong public demand for the vaccine, the news media

picked up on this paradoxical story that a minority of health care workers received it.

"There were many surprised comments by lay persons that this was not routine," says **William Schaffner**, MD, chair of the department of preventive medicine at Vanderbilt University School of Medicine and a board member the National Foundation for Infectious Diseases.

Schaffner says he is intrigued by the idea of a mandatory program. "We will be looking at [Mayo's] program to see how well it indeed works. Hospitals and other health care facilities will learn from it. If it's successful, [they will] adopt it in whole or in part in order to increase their own vaccination rates." But he also thinks there's room for progress even without a mandate. For example, if surveyors from the Joint Commission on Accreditation of Healthcare Organizations began asking about influenza vaccination programs, hospitals would respond, Schaffner says.

The NFID recently released a "Call to Action" and a list of strategies for improving immunization of health care workers. That includes debunking a number of myths, he adds, including:

- **I'll get the flu from the vaccine.** "The myth that you can get flu from flu vaccine is alive and well in the nursing population," says Schaffner. "We need to address that in a reassuring, positive way. That has two bad impacts. Many nurses won't get vaccinated because of that myth. If they believe it, they are not going to be strong advocates for flu vaccination among their patients."

- **I never get the flu.** They aren't just getting the vaccine to protect themselves from sickness. They are doing it to protect their patients, he says. About 30% to 50% of people with influenza may be asymptomatic, but they still can transmit the illness, the NFID says.

- **I don't have enough time.** The goal of influenza vaccination programs should be to make them as convenient as possible, Schaffner says. For example, Mayo has a peer vaccination program, in which nurses on a unit vaccinate each other.

- **I don't like shots.** A surprising number of nurses are themselves afraid of needles. The CDC recently issued guidelines that allow health care workers to use the new nasal-administered vaccine, unless they work with "severely immunosuppressed" patients.

(Editor's note: More information on the NFID Call to Action and strategies for increasing immunization of health care workers is available at [www.nfid.org](http://www.nfid.org).) ■

## Long hours may lead to injuries, poor health

NIOSH reviews studies on work schedule

Long hours and overtime are linked to higher injury rates, more frequent illnesses, and even increased mortality, according to a review of 52 published research reports by the National Institute for Occupational Safety and Health (NIOSH).

The health effects were magnified when shifts of 12 hours or longer were combined with a work week of more than 40 hours. For example, two studies of physicians who worked very long shifts reported a decline in cognitive performance.<sup>1</sup> Although the review was not limited to health care, 19 of the studies were conducted in the health care arena.

This NIOSH review adds to the findings of a 2003 Institute of Medicine report, which recommended restricting nurses from working more than 12 hours at time or more than 60 hours in a week to prevent "error-producing fatigue." While the IOM focused on patient safety, the NIOSH study relates overtime and long hours to worker health.

The relationship between work schedule and worker health is a complex one, says **Claire Caruso**, PhD, RN, a NIOSH research health scientist based in Cincinnati and an author of the report. "When you have a combination of several demanding work characteristics together, it seemed to produce more consistently negative outcomes," she says.

For example, working night shift or rotating shifts adds to the burden if someone also had long shifts with mandatory overtime, adds Caruso. "There's an issue about the pattern of workdays to rest days. Are you working seven 12-hour shifts in a row and then you've got four days off . . . or are there interspersed short runs of workdays?"

Having time to rest improves function and health outcomes, she says. Yet researchers still have much to learn about how longer shifts affect worker health, she says.

One study linked shifts of 12 or more hours to increased risk of back disorders for nurses, compared with those who worked an 8-hour shift. The combination of 12-hour shifts and 40 or more hours of work per week also was associated with greater risk for neck, shoulder, and back disorders

compared with nurses who worked five 8-hour days.<sup>2</sup>

"Are 8-hour shifts better, or are 12-hour shifts better? We don't have a clear-cut answer to that," says Caruso. "One of the problems is that the studies often don't give us enough details about the work schedules."

Overtime is a research area that is just gaining more attention, she notes. In a handful of studies, overtime was linked to "unhealthy weight gain," increased smoking and alcohol use, and poorer neuropsychological test performance.

Yet there are far fewer studies on the effects of overtime than on other work schedules, such as night shifts and rotating shifts, says Caruso. She is midway through a comprehensive study that will use overtime diaries and sleep/activity diaries to track the work life of nurses. The study will include information on demographics, home environment, child care, second jobs, elder care, educational courses, health history, medications, the family's health history, and sleep characteristics, she says.

"Coping styles probably influence how people respond to these work schedules," she says.

Nursing shortages have led to increased pressure on nurses to work overtime. The American Nurses Association (ANA) has lobbied for state and federal legislation to restrict mandatory overtime for nurses.

A number of states have responded. For example, a new West Virginia law prohibits hospitals from mandating nurses to accept an assignment of overtime. In Connecticut, hospitals may not require a nurse to work more than a predetermined scheduled work shift except in certain circumstances, such as a public health emergency.

In Oregon, nurses may not be required to work more than two hours beyond a regularly scheduled shift or 16 hours in a 24-hour time period.

"We've always been concerned about overtime and its implications for patients. Our concern has broadened also to consider the implications for nurses and other health professionals in terms of health and safety," says **Katherine Kany, RN**, of the ANA's Department of Nursing Practice and Policy.

Studies will shed light on how much a person

## CE questions

5. According to Laurie Wolf, MS, CPE, ergonomist and manager of the WellAware program, what is the first thing the health system did to reduce slips and falls?
  - A. Raise employee awareness.
  - B. Conduct a hazard assessment.
  - C. Change housekeeping products.
  - D. Install handrails.
6. Washington state hospitals have complied with annual fit-testing of N95 filtering facepiece respirators for almost 10 years. What is one lesson learned?
  - A. You need to conduct quantitative fit-testing.
  - B. Few employees actually need to be fit-tested.
  - C. PAPRs can be a useful tool in reducing fit-testing.
  - D. Fit-testing does not present a burden to employee health.
7. Occupational health experts argue that NIOSH should have a higher status in the structure of the CDC because:
  - A. It is more important than other CDC centers.
  - B. It is the only center without a disease focus.
  - C. It needs more money than the other centers.
  - D. It was created by a congressional act to be a sister agency to the Occupational Safety and Health Administration.
8. Salina (KS) Regional Medical Center saw its workers' compensation costs decline by how much after installing ceiling lifts?
  - A. 30%
  - B. 50%
  - C. 76%
  - D. 98%

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

can safely work, she says. "We have people working 12 hours [in a shift], anyway. You keep them overtime for even half a shift, and that's 18 hours. I've actually talked to nurses who worked 20 hours in critical care areas.

"The reality is that people are working way too long," Kany adds. "There are implications for patients and implications for health care workers."

## COMING IN FUTURE MONTHS

■ Creating a 'return-to-work' program that works

■ A model for a flu vaccination program

■ TB nightmare: A nurse dies of tuberculosis

■ Depression takes its toll at work

■ Do you have an indoor air problem?

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## Is your facility ready for next influenza season?

**B**race yourself: Flu season is right around the corner. Are you prepared? If an influenza pandemic hits, the entire U.S. population could be at risk. The annual impact of influenza on the United States is staggering: 10% to 20% of the population will get the flu. Some 36,000 people will die, and 114,000 will be hospitalized. Most of those who die will be older than 65, but children 2 and younger will be as likely to be hospitalized as the elderly.

Thomson American Health Consultants is offering an audio conference with the information necessary to help you diagnose and treat patients with flu symptoms and prepare for an influenza pandemic.

**Get Ready For Influenza Season: What You Need to Know About the Threat, Diagnosis, and Treatment**, which will be held on Tuesday, Sept. 28, 2004, from 2:30 to 3:30 pm, EST, will be presented by **Benjamin Schwartz, MD**, and **Frederick Hayden, MD**.

Schwartz, who is with the National Vaccine Program Office and is spearheading the development of the National Pandemic Influenza Preparedness and Response Plan, will discuss the potential impact of an influenza pandemic.

Hayden, a professor of internal medicine and pathology at the University of Virginia School of Medicine in Charlottesville, will discuss current methods of diagnosis and the latest information on treatment with antivirals.

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## CE objectives

**A**fter reading each issue of *Hospital Employee Health*, the nurse will be able to:

- 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. ■

# **Lift Protocol**