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Special Report:
Defining Provider Roles

Hartford uses report cards to teach nurses to teach

Having patients see nurses as caring proves tough

(Editor's Note: This is the last of a three-part series examining how effective definition of provider roles can enhance patient and staff satisfaction. In the first article, we reported on some recent research on job role complexity. Last month, experts shared their thoughts on why proper role definition is important and signs that you don't have the mix right. This month, Patient-Focused Care and Satisfaction *looks at how one hospital found problems in this area and solved them.)*

In its most recent survey of its hospital clients, consulting firm EC Murphy of Amherst, NY, found that the less satisfied staff members were in their jobs, the more likely they were to be sick.

"That's quite a twist," says the firm's president and CEO **Emmet Murphy**, PhD. The preliminary results of the study, which is due out later this winter, reinforces the importance of making sure your staff are doing the right jobs. "If their positions aren't well-defined, you'll have a problem with job satisfaction," explains Murphy. "And we have found that if you have dissatisfied nurses, your patient satisfaction scores will suffer, too. You have to redesign the jobs so that it works. If 40% of what a nurse does is inappropriate to his or her training, then you are spending big dollars to make your staff unhappy. Health care professionals have to get truly serious about redesign."

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Special Report: Defining Provider Roles

That's precisely what Hartford (CT) Hospital did when it implemented a quality report card program in 1997. **(See *Patient-Focused Care and Satisfaction,* December 1999, p. 133.)** The goal was to find out what nurses were doing right, where processes and procedures needed changing, and then develop programs that addressed the problems the report cards identified.

The report cards look at clinical, financial, functional, and satisfaction indicators, explains **Laura Caramanica**, RN, PhD, co-director of the women's health and cancer programs at the hospital. "This was the first time we developed a data set of important indicators and shared that information with staff so that they could do something about it."

Among the problems identified were lapses in patient teaching, patient satisfaction with pain control, and patient ratings of nurses as "caring." The first two areas have responded well to the programs Hartford Hospital has put in place to address them. **(For more on how Hartford Hospital fixed its patient education problems, see p. 3.)** Subsequent quality report cards have shown tangible improvements in those areas.

Pain control satisfaction is something Caramanica might not have considered looking at if not for the report card program. "We didn't collect data on that before," she says. The hospital put together an interdisciplinary team of pharmacists, nurses, and physicians to develop improvements. In the six months between March and September 1998, the satisfaction with pain control measures improved from 75.3% to 78.9%.

How patients view nurses has been a tougher nut to crack, though. "We are adamant that we don't just produce reports, but use them," says Caramanica. Not having at least 95% of patients seeing nurses as caring was hard to take, so the hospital decided to take action. "We did two different treatments with two different teams," Caramanica says. The first was a research round table in which faculty and nurses reviewed the literature on what were caring behaviors.

The behaviors that were decided upon are currently being tried out on a surgical unit. Two tools are used — one for the nurses to complete, and one for the patients. But Caramanica says it is too soon to see if the program is working. "We

are doing a study to see if it makes a difference. The results should be out in March."

In obstetrics, a different approach was taken. All staff — from physicians and nurses to housekeepers — went through a two-day training program. The program included team-building exercises that increased everyone's awareness of their communication behaviors and learning to understand and respond to the needs of the customer so as to meet or exceed in meeting their needs, Caramanica explains.

Training to be caring

It took nearly two years to get 80% of the staff through the training. Patient satisfaction scores from the pre-training days of 1996 and 1997 were compared to 1998 and 1999 scores. That was over 2,000 surveys, says Caramanica. "What came out was that nurses are caring and are viewed as more caring after the training. And also that there was a decrease in the response time for the call bell." **(For more on the results of the training, see chart, p. 4.)** The latter is probably due to the fact that staff members now have beepers due to the size of Hartford Hospital's new facility — four times the size of the pre-training building. Caramanica says she expects those scores to increase in the next surveys.

Caramanica thinks there are a couple of reasons patient satisfaction scores aren't as high as she would like them to be. First, Hartford Hospital uses a scale that only includes the word "always" for its most positive response. There is no "most of the time" or "often" option. That means that scores might be lower than they would be if the facility were using another scale.

"If you do 'often' and 'always,' you might get 95+ scores. But our goal is to delight the customer, not just satisfy."

Another reason could be related to what EC Murphy found: workers are less satisfied than they might be, and that probably comes across to patients. "I would guess that when we look at our 1999 report card and include employee, physician, and nurse satisfaction ratings, they will be lower than they used to be," Caramanica says.

The numbers bear out her feelings. While most nurses feel they are doing something worthwhile, a large minority feel their positions don't give them enough opportunities for professional development and growth. A significant number also feel they have adequate input into their work activities.

"This is a tough time for nurses," says Caramanica. "And we have been putting a lot of pressure on them to improve quality of care; we have put them in a unit four times the size of the old one with the same staffing ratios. We have instituted mandatory call- and cross-orientation. Those things have impacted staff satisfaction."

Despite that, Caramanica has reason to be proud: patient satisfaction is rising. And in the future, she thinks that worker satisfaction will also go up. "We are putting in a shared governance structure, we are sharing meaningful data with them. And we will look at the correlation between units where the supervisors and administrators were rated highly and those where staff and patient satisfaction were high to see if there is a relationship."

Managing the kinds of data that Hartford's quality report card generates is tough, but worth it, she says. "You can really use this information to improve patient care, as long as you get the support to make interventions work. Getting our staff to the classes, having faculty work with staff to identify caring behaviors, you need that additional support because staff can't do it by themselves." ■

Nurse team creates patient education model

IDEA system is road map to problem solving

When surveys from local home care agencies showed that teaching — or communication about discharge teaching of patients — was lacking at Hartford (CT) Hospital, a team of nurses was put together to find a way to solve the problem. Using the hospital's IDEA (Identify Opportunities for improvement, Determine root causes, Establish an action plan, and Act on it) program, they created a patient education model that solved the problem.

Without adequate teaching, continuity of care

Patient Satisfaction Scores Before and After Training

Satisfaction Question	Before Training Percent Answering "Always"	After Training Percent Answering "Always"
Treated me with respect and courtesy	86.2	88.1
Staff introduced themselves and explained role	73.2	75.2
Staff responded to my questions in a professional manner	86.3	86.6
Call button answered promptly	83.9	82.7
Help received in reasonable time	71.9	73.5
If I had a concern or complaint, someone listened and responded	82.5	81.4
The doctors were caring	90.2	90.9
The nurses were caring	83.4	87.4

Source: Hartford (CT) Hospital.

is compromised, the team found. And if the patients are taught, but that teaching isn't documented, then repeating what has already been taught to patients wastes time.

The desired outcome, according to the team's charter plan of action, was to create progressive and individualized teaching and a "synergistic approach to caring across the continuum."

The team then looked for root causes. Among them, they found that current documentation didn't have a place to document what teaching specifics and tools were used. There was also limited time to teach patients, or to document how far the patient has progressed in his or her learning. In some areas, the team found a lack of consistency in the tools used, and a lack of consistent teaching methods among caregivers.

And in some cases, if the patient's condition has a critical pathway, the document which would note any patient teaching didn't accompany the patient into home care, but rather stayed with the patient chart.

The action plan the team established included creating preprinted forms that were easily accessible to staff. Communication with home care staff should be increased, and perhaps facilitated with more use of faxes. There were suggestions to print forms in triplicate so that a copy could go to home care agencies or clinics, to the patient, and the remaining copy could stay at the hospital.

Lastly, the team decided to ensure all new staff and home care agency personnel are oriented to the teaching process and new and existing discharge "hand-off" tools when they become available. They also decided to invite the home care agencies that returned surveys to participate in meetings designed to improve the patient education process.

As a result of all of those efforts, interim scores from surveys show an improvement in patient education. ■

SOURCES

- **Laura Caramanica**, RN, PhD, Co-Director, Women's Health & Cancer Programs, Hartford Hospital, Hartford, CT. Telephone: (860) 545-2635.
- **Emmet Murphy**, PhD, President and CEO, EC Murphy, LLC, Amherst, NY. Telephone: (716) 836-5552.

New cardiac tool asks about women's usual tasks

Questions target neglected patient population

At a recent meeting of the American Heart Association in Atlanta, one session seemed to draw more interest from the nonmedical population than others. Session monitors, who normally sit outside the room, crowded into doorways with other event staff. They were all listening to a speech given by **Laura Kimble**, RN, PhD, associate professor in the adult and elder health department at Atlanta's Emory University on a better way to find out how female cardiac patients were progressing.

Kimble says the interest comes from a lot of things. First, there has been a lot of news in recent years about how prevalent heart disease is in women, and how often it goes unrecognized. Secondly, there has been an interest in how to provide better care to female patients who have been subjected to treatment regimens based on studies that included only men.

And her own interest in the subject was further spurred by an article Kimble read in the *Journal of the American College of Cardiology* that focused on the energy requirements of various household activities. (Wilke NE, Sheldahl L, Dougherty S, et al. Energy expenditure during household tasks in women with coronary artery disease. 1995; 75:670-674.)

"Making a bed required the most energy," says Kimble. "I found it intriguing to think of that. And my own work and other things I have read made me aware that doing housework is a worry to women with heart disease. While others don't consider it work, if they can't do it, these women felt guilty."

Most of the instruments used to measure functional ability of patients with heart disease are geared toward men. They ask questions about swimming and jogging that aren't relevant to most of the older female patients, says Kimble. "There are several instruments that can be used to evaluate a cardiac patient's functional status, but mine — to my knowledge — is the only one that focuses solely on housework. The problem with other tools is that they often include activities that aren't salient for women, especially older women."

With that in mind, Kimble set to work to create a tool that could evaluate functional status over time using physical activities that women routinely do. The result is the Kimble Household Activities Scale **(see list of chores included on the scale, above)**. It asks patients to state how easily they can do 14 tasks, whether they have had to modify how they do those tasks, or if they can do them at all any more.

Chores Included on Kimble Household Activities Scale

- ❒ Cooking
- ❒ Washing dishes by hand
- ❒ Loading the dishwasher
- ❒ Scrubbing pots and pans
- ❒ Carrying laundry
- ❒ Loading / unloading clothes washer and dryer
- ❒ Carrying a 10-pound bag of groceries into the house
- ❒ Unpacking and putting away groceries
- ❒ Vacuuming
- ❒ Sweeping the floor
- ❒ Mopping the floor
- ❒ Scrubbing the floor on hands and knees
- ❒ Changing the bed linens
- ❒ Moving furniture

Source: Laura Kimble, Atlanta.

Quick and appropriate

The tool can be administered quickly — it is only one page and requires the patient to check one of five boxes for each of the 14 chores. It can be used in both inpatient and outpatient settings, and Kimble thinks it holds up well against other standardized tools. "The idea is to find something sensitive to change that is relevant to [female patients]. We know these are relevant things for women. That paradigm hasn't shifted, particularly in the retirement years. Men may have been physical in work, but when they retire, you have to measure different activities. With women, the work doesn't change as much."

Using this tool should help physicians determine if there has been disease progression or if a patient is doing better, says Kimble. "Women may give up doing some tasks because of symptoms. That means there is some de-conditioning, which means they do less, and you have a vicious cycle. This helps you avoid that."

SOURCE

- **Laura Kimble**, RN, PhD, Associate Professor, Adult & Elder Health Department, Emory University, Atlanta. Telephone: (404) 727-9678.

While the tool generated a lot of interest and subsequent inquiries at the November conference, Kimble says it has yet to be integrated into a large-scale organization for regular use. "We piloted it with 30 women, which is a small sample. But the physician who oversaw the cardiology database was very supportive of it. The next study is to do this over time to see whether my hypothesis that this is sensitive to change holds true." ■

Privacy standard will increase regulatory chores

It means extra training, notice to patients

As the Clinton administration works toward a final rule protecting patient privacy, it's not yet certain what the details of the new regulation will be. What is clear, leaders in the field say, that access managers will feel the impact in myriad ways.

Peter Kraus, CHAM, systems liaison manager for patient accounts services at Atlanta's Emory University Hospital, suggests these likely results of new dictates on medical confidentiality:

- Staff data security training and continuing education requirements will increase.
- There may be more "rights" information to convey to patients, either verbally, through forms, or both.
- The way data are handled and displayed may be subject to scrutiny. Access to monitors and paper flow within an office or department may be subject to scrutiny.
- It may become more difficult to obtain and share information needed for patient care and billing.
- Authorization of release of information may require more specific documentation and explanation.
- System access granted a particular staff member may require more elaborate justification. Multiple log-in identification codes and other system access aids, useful to allow multitasking users to log in to one system without first logging out of another, may become a thing of the past.
- Software updates may be required to meet more stringent security expectations.
- Everything will have to be well-documented to protect against allegations of wrongdoing, as well as potential audits.

"In short," adds Kraus, "there will be more work to do, and the process will likely be more burdensome for patients and staff."

Kraus gives this possible example, which he says he hopes is exaggerated: "Suppose the law requires that every unattended personal computer that provides access to patient information be signed off. Whenever staff leave their workstations, even to pick up a form or escort a patient, they have to sign off, then sign back on again when they return.

"At Emory, a log-off takes over a minute, a log-on probably three or four," Kraus adds. "Staff leave their workstations many times each day, sometimes while in the middle of an on-line registration. The inconvenience would be almost unimaginable."

HHS picks up Congress' slack

For three years, Congress had the self-imposed mandate to enact legislation outlining comprehensive national health care privacy standards. It failed, and on Nov. 3, 1999, the government proposed its own standards for electronic medical records. Because Congress missed its Aug. 21, 1999, deadline, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Department of Health and Human Services (HHS) to issue final regulations by Feb. 21, 2000.

The standards would cover health care providers, health plans, and health care clearinghouses that transmit information electronically. Protection would start when the information becomes electronic and would stay with the information as long as it is in the hands of a covered entity. The regulations would allow patients access to information about how their medical information has been used and disclosed. "Redisclosure" could happen only with authorization from the patient.

"The regulations will require providers to become educated in the new privacy policy," says **Bruce Fried,** JD, partner and chair of the health law group at Shaw Pittman, an international law

firm in Washington. "They will have to train themselves and their staff as to how to be compliant. They will also have to build processes that protect the privacy of their patients."

The Washington, DC-based American Health Information Management Association (AHIMA) supports the proposed privacy regulation, says **Kathleen Frawley,** JD, MS, RRA, AHIMA's vice president for legislative and public policy services, because it is based on the "Code of Fair Information Practices" the association has supported for many years. "It places a number of obligations on the covered entities to maintain the privacy of individually identifiable health information," Frawley adds.

The regulations will affect access managers in several ways, she says. "When patients enter the delivery system, they will have to be given the 'Notice of Information Practices,' which will describe how the organization uses the information [it gathers on patients]," she says. "It's conceivable that a patient could come into the admitting office, and that [admitter] could provide the notice, which also has to be posted."

Also under the privacy regulation, access personnel will have to undergo training in privacy practices and be able to enunciate the policies and procedures involved, she says. "They must be familiar with the complaint mechanisms [for patients] within the organization and understand that violations could result in [the employees'] sanction or termination."

The patient complaint mechanism will be outlined in the Notice of Information Practices, Frawley notes.

"These are pretty landmark privacy requirements," she adds. "They certainly will pose challenges to health care organizations but at the same time will give patients some much needed protections."

Although the standards apply only to information transmitted electronically, Frawley says the protection extends to documents that are maintained or transmitted electronically and then printed out. "The protection also extends to documents that are originally paper and then become electronic. The paper record is protected."

In other words, she explains, "If the covered [health care] entity has a computer system, and information is entered there, it's covered."

She points out that issues such as leaving computer stations unattended are actually covered in another set of requirements — the standard for data security. The Notice of Proposed Rule Making for that standard was issued in August 1998, and the final rule was expected in December 1999, Frawley says. "That standard will cover the administrative, technical, and physical safeguards that an organization must take."

The two rules will work together, Fried notes. "Data security is largely a technology issue. The privacy requirements are the human side of the protection."

Fried expected the final standard for data security to be strict. "In my conversations with senior officials who are involved with this, they [say they] believe protecting medical privacy requires an even higher standard of security than the security that is available for large financial transactions taking place on the Internet."

Regulations don't apply to paper forms

HHS Secretary Donna E. Shalala acknowledges the limitations of the privacy regulations. "Under HIPAA, HHS does not have the authority to protect records that are maintained in paper form only," she has stated. "HIPAA also does not allow HHS to issue standards for records that are maintained by other insurers or by employers for workers' compensation purposes. The proposed rule does not establish appropriate restrictions on the use or redisclosure of such information by likely recipients, such as researchers, life insurance issuers, marketing firms, or administrative, legal, and accounting services."

Congress has the responsibility of passing legislation that covers paper medical records, too, says **Linda L. Kloss,** MA, RRA, AHIMA's executive vice president and CEO. "It remains incumbent upon Congress to pass comprehensive confidentiality legislation that protects all information equally — whether it's in paper or electronic format — and establishes a single, stringent national standard that serves as the law of the land."

In addition, only Congress can provide consumers with the right to take action in court when their medical information is used inappropriately.

Another concern is that the policy sets a federal floor, allowing states to develop more stringent privacy regulations. "We could end up with a hodgepodge of medical privacy regulations that would be difficult to administer," Fried says. Consumers would find they have different privacy protection depending on where they live. Organizations that operate over the Internet or across state lines would find the different levels of protection inefficient and chaotic, he adds. "I

think it's a difficult standard."

Fried points out, however, that the health care industry has time to prepare for the implementation of the standards. "The regulations that were published [Nov. 3] are proposed. The final regulations aren't due out until the end of February, and providers then have a two-year implementation period."

In addition, the February date is probably not even realistic, says Frawley, "in terms of the number of comments that will be received and the time needed to redraft." ■

Are patients at risk from the hospital environment?

ICPs use rounds, committees to assess risk

With patient acuity on the rise and many hospitals trying to extend the life of aging facilities through renovations and expansions, the risk of infection posed by the health care environment is becoming an increasing concern for infection control professionals.

"I think that overall the patients in the hospitals are sicker and most of the hospitals are older," says **Raymond Chin**, MD, hospital epidemiologist at Sharp Memorial Hospital in San Diego. "In order to keep pace with medical technology, they have had to either retrofit, add, or renovate."

Health care delivery changes and consolidations also have led to renovations and new construction as hospitals combine and rework their clinical missions. Such construction can result in environmentally linked outbreaks, such as airborne *Aspergillus* infections in bone marrow transplant patients during renovation projects.[1] "These [environmental concerns] have been borne out of outbreaks, where controls were not in place," says Chin, a member of the Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee (HICPAC). Chin is one of the key HICPAC members working on new environmental infection control guidelines, which are expected to be completed in the coming year. **(See related story, p. 10.)**

In addition to construction projects, experts remind that the health care environment poses day-to-day risks that may go undetected without systems in place for routine review of the facility. While the significance of the role of the health care environment in the spread of infection has been debated for years, it is clear that some airborne (i.e., *Aspergillus*) and waterborne (i.e., *legionella*) pathogens pose an infection risk to patients. On the other hand, routine environmental culturing has been generally discouraged, and most ICPs have neither the time nor the resources to give inordinate attention to the health care environment.

"There are limited resources available to infection control, and those really need to go where the risk is greatest," says **Andrew Streifel**, MPH, REHS, hospital environment specialist at the University of Minnesota in Minneapolis. "I believe, for example, that maintaining the ventilation system is more important than making sure that you use a powerhouse disinfectant on the floor."

In general, ICPs should be aware that the more immunocompromised the patient population is, the greater the possible risk of an environmental role in infection with such pathogens as airborne fungi, notes Streifel, a frequent environmental consultant to hospitals and co-author of a recent review article.[2] "I think that is the case," he notes. "As I dig in my compost pile, I might sneeze from it, but I don't think it will create a problem for me. But if I had a white [cell] count of less than 100, it might become a real risk factor. So it's really very important, from my point of view, that hospitals taking care of [immune-compromised] patients can verify that the environment is reasonably safe."

Insidious sources

Of course, infected and colonized patients and the health care workers that treat them can contaminate environmental surfaces and equipment with such nosocomial pathogens as vancomycin-resistant enterococci. In that regard, patient sources and the unwashed hands of health care workers are still likely to be the primary routes of transmission in hospitals. But less obvious environmental sources also can be present, he notes.

"The majority of the organisms that do infect our patients are from people, and it's important to recognize that, but there are conditions where the environment becomes contaminated," says Streifel. "I'm [consulting] at a children's hospital now where the janitor's utensils have been implicated in the spread of opportunistic fungi."

Streifel tracked down the problem to water

damage around a sink in the janitorial closet. Mold and fungi growth had resulted, contaminating mops, brooms and other cleaning utensils that workers took into patient rooms, he noted. Indeed, an increasingly common environmental problem in hospitals — and also a possible source of mold and airborne fungi — is water damage and degraded cabinet materials beneath sinks. Ironically, many of the sinks were added to ease compliance with the cardinal rule of infection control: hand washing.

"In some respects, infection control is responsible for this in an indirect sort of way," he says. "They insist that we have sinks everywhere. I think that's very appropriate, but then administration and construction planning puts in very cheap biodegradable sinks — generally plastic laminate — and that stuff degrades." To solve such problems, hospitals should use molded sinks of ceramic, stainless steel, or plastic that are not subject to water damage, he recommends.

Ideally, ICPs should have systems in place that allow input into such matters from the outset, bringing any concerns to the fore before problems develop. For example, a multidisciplinary committee was formed at Children's Hospital in Dallas to deal with ongoing environmental concerns, says **Pat Metcalf**, RN, infection control director at the hospital. A subcommittee of the infection control committee, the panel meets monthly with representation that includes members of infection control, engineering, administration, and facility services.

Implications a construction person won't see

"There are so many issues in the hospital, and just having this committee helps us all be aware of what is going on," she says. For example, having the committee in place enabled early review and discussion of a planned indoor fountain in a hospital atrium area. Fountains and whirlpools have been shown to be a source of aerosolized *legionella* or other waterborne pathogens, which can cause pneumonia and other serious infections in immunocompromised people who inhale them. To prevent such an occurrence, Metcalf ensured that infection control concerns such as routine disinfection of the water and maintenance of the fountain were addressed before the project went forward.

"[For example,] how long will it be before there is considerable microbial growth in the fountain and we need to think about draining the water?" she asks. "There were just a lot of implications that a construction person isn't going to think about."

In addition to a standing committee, another approach to address ongoing general environment issues is to use a rounds concept like that devised by **Mary B. Jones**, RN, CIC, coordinator of infection control at Pinnacle Health System in Harrisburg, PA. The project was borne out of a collaboration between the committees for infection control, environment of care, and nursing performance improvement, she explains. The result was an infection control environmental rounds program that involves a walk-through inspection and use of a checklist form. The rounds are used to assess and measure compliance with such criteria as general unit appearance and infection precautions. The program is essentially an ongoing form of risk assessment, she notes.

"It gives us a mechanism in which inspection, evaluation, and correction of environmental issues can be uniformly addressed," Jones says. "We are a very common visible entity. When I first started in infection control, a very wise individual — my first boss — said there is not one area in the health facility in which you don't belong. Of course, with courtesy. But I have that attitude as I go around and do the infection control environmental rounds. We're not perceived as police, but rather part of the team."

To emphasize that aspect, ICPs conduct the survey every other quarter, and clinical units are asked to do their own self-assessments in the alternating quarters. An area that was identified early as a potential problem was rolling stock like wheelchairs and IV poles. No department had taken "ownership" for the cleaning and maintenance of the equipment, so protocols were put in place assigning those responsibilities. While the program enables some monitoring of basic infection control measures and environmental issues (i.e., hand washing, accumulating dust), it also creates a mechanism for raising concerns about more "silent" issues such as air flow.

For example, Jones has established reporting mechanisms that call for hospital technical services to routinely ensure that air flow in negative-pressure rooms (i.e., for tuberculosis isolation) is vented to the outside and does not recirculate. Conversely, positive air pressure is maintained in operating rooms to ensure that air flows out and away from vulnerable surgical patients. "We

HCWs in genetic trials should be trained, followed

In lieu of national consensus guidelines for infection control and gene therapy, individual clinicians have reviewed the literature and devised preventive measures. The following recommendations were developed by **Martin Evans**, MD, hospital epidemiologist at the University of Kentucky Chandler Medical Center in Lexington, and colleagues.[1]

Each gene therapy vector must be evaluated individually, considering such factors as the likelihood the viral vector may replicate, patient shedding, mode of transmission, and people at risk for secondary infection, they noted. Precautions should be determined for each study by committees that include representation from such departments as biosafety, infection control, and pharmacy. Additional recommendations are summarized as follows:

Health care workers

• Health care workers with known immunocompromising conditions should be discouraged from working on gene-therapy protocols.

• Workers should undergo formal training by infection control staff in conjunction with employee health staff and the principal investigator of the study. Educational materials should include information about the vectors, procedures, known and unknown risks, and potential transmission of agents to the general public. Use of standard precautions and personal protective equipment should be reviewed. The importance of hand washing should be emphasized. Isolation precautions for the patient should be described.

• The employee health service should be made aware of the study and of the individual health care workers involved. There should be arrangements, as needed, for 24-hour postexposure evaluation and management. Pertinent immunization should be made available if possible.

• Surveillance should be performed on clinical, pharmacy, and laboratory personnel to determine if cross-transmission of vectors occurs. Protocols should be developed for the collection and testing of baseline sera or other appropriate specimens. Testing should be performed periodically during the study to determine if cross-transmission occurs.

Outpatients and admitted patients

• Patients should be treated only in areas approved by the institutional biosafety committee or alternative authority. These areas and their waiting rooms should be physically separated from areas frequented by immunocompromised patients who are not part of gene-therapy protocols.

• If possible, rooms should be private, with a sink and commode in the room.

• An appropriate transmissions precautions sign (airborne, contact, etc.) should be posted on the door.

• Patients should be restricted to their rooms during treatment. All tests and procedures requiring patient transport from the room that are not necessary for the study should be postponed if possible. When volunteers leave the room for tests or procedures, they should wear isolation garb if recommended by the institutional biosafety committee.

• Dedicated equipment (stethoscopes, sphygmomanometers, thermometers, etc.) should be available. These items should be disinfected appropriately before being reused.

• Linens should be placed in fluid-resistant bags and handled with standard precautions.

• All meals should be served with disposable dinnerware and trays in the room.

• Visitors should be strictly limited to immediate family (adults only). Visitors should follow the isolation precautions recommended by the institutional biosafety committee.

• Care must be taken to prevent spills of the vector or aerosolization (such as expressing liquid from a syringe).

• Kits specific for the agent should be readily available to manage spills.

• All waste should be placed in red biohazard containers, handled as regulated medical waste, and incinerated. Personnel handling waste should wear disposable latex gloves. The room should be decontaminated according to the institutional biosafety committee recommendations when the patient leaves.

• Infection control staff should be notified if a gene therapy patient is referred to the hospital for studies, admission, or readmission. Patients admitted to the emergency department should be placed in an isolation room on contact precautions unless advised otherwise by infection control staff.

Reference

1. Evans ME, Lesnaw JA. Infection control in gene therapy. *Infect Control Hosp Epidemiol* 1999; 20:568-576. ■

were able to have that regular monitoring initiated specifically because of the infection control rounds," she says. "We were finding that it appeared to be appropriate, but we wanted to make sure that it was well-documented."

In addition, having the rounds program in place proved important as extensive renovations began at the four-hospital system, she notes.

"Because of the visibility we had with the infection control environmental rounds, we were able to easily slide into the 'construction environmental rounds' without any issue whatsoever," Jones says. "We made certain that there was negative [air] pressure in the construction areas and that the barriers were in place prior to construction. If there were difficulties, we made sure they were corrected immediately and the work was halted until they were corrected."

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1. Carter CD, Barr BA. Infection control issues in construction and renovation. *Infect Control Hosp Epidemiol* 1997; 18:587-596.

2. Vesley D, Streifel AJ. "Environmental Services." In: Mayhall, ed. *Hospital Epidemiology and Infection Control*. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999, pp. 1,047-1,053. ■

NEWS BRIEFS

New OSHA directive could reduce needlesticks

An updated compliance directive from the federal Occupational Safety and Health Administration (OSHA) is expected to lead to more citations for facilities that fail to evaluate and purchase safer needle devices. The directive, released on Nov. 5, 1999, should help educate compliance officers on the 1991 bloodborne pathogens standard.

According to OSHA, the directive will ensure consistent inspection procedures are followed and takes into account the wider availability of improved devices and better treatment following exposure to bloodborne diseases such as HIV, hepatitis B, and hepatitis C.

The revised directive emphasizes the importance of an annual review of the employer's bloodborne pathogens program and the use of safer medical devices to help reduce needlesticks and other sharps injuries. However, OSHA makes it clear that it does not advocate the use of one particular medical device over another. The directive also highlights basic work practices, personal protective equipment, and administrative controls.

The emphasis on engineering controls results from OSHA's request last year for ideas and recommendations on ways to better protect workers from contaminated needles or other sharp objects.

OSHA administrator **Charles Jeffress** reported that nearly 400 health care facilities and workers contributed comments. "They told us that safe medical devices already available are effective in controlling hazards and that wider use of such devices would reduce thousands of injuries each year."

The revised directive also includes detailed instructions to compliance officers on inspections of multi-employer work sites, such as home health services, employment agencies, personnel services, physicians, and health care professionals in independent practices, and independent contractors.

Also included in the directive are decontamination requirements, guidelines on hepatitis vaccinations and post exposure treatments, and employee training.

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The directive is available on the OSHA home page at http://www.osha.gov. You can also obtain copies from the agency's publications office by calling (202) 693-1888. ▼

Fellowship opportunity offered to nurse execs

Nurse executives who want to help shape the health care system of the future should consider applying for a Robert Wood Johnson Executive Nurse Fellowship. The three-year fellowships are open to senior-level nurses in executive roles in health services, including patient care service, integrated delivery systems, health plans, and other health organizations engaged in organizing and delivering health care; public/community health; and nursing education.

Approximately 15 Executive Nurse Fellows are selected each year. Fellows remain in their current position while participating in the program. Each is awarded a $15,000 leadership development account to support self-selected learning activities, independent study, and access to an electronic communications network. In addition, the program provides matching funds up to $15,000 each year for the first two years of the program to support a required comprehensive leadership project in the Fellow's home institution.

The deadline for receipt of applications by the national program office is Feb. 1, 2000. For an abstract or the full text of the Call for Applications, visit The Robert Wood Johnson Foundation Web site at http://www.rwjf.org/grant/jgrant.htm. Look for "List of Open Calls for Proposals." ■

Alternative medicine newsletter offers nursing tool

American Health Consultants, publisher of *Patient-Focused Care and Satisfaction* and *Alternative Medicine Alert*, is pleased to announce the publication of a new monthly newsletter for nurses on alternative medicine and holistic nursing. Beginning in January 2000, each issue will contain review articles of specific alternative therapies and modalities; abstracts and commentary from current medical and nursing journal articles; and columns on controversies in holistic nursing, applying therapies to clinical nursing practice, and legal and ethical issues surrounding holistic nursing and alternative medicine. Subscribers will be eligible to receive approximately 12 contact hours of nursing continuing education credits at no extra charge.

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