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Expert says pandemic flu would be much worse than SARS outbreak

CDC guidance document urges preparedness

Hospitals need to ramp up their preparedness for pandemic influenza, a threat that is heightened by the continuing spread of avian influenza among birds and mammals in Asia, cautions the Centers for Disease Control and Prevention (CDC).

The U.S. Department of Health and Human Services issued a draft guidance document on pandemic influenza preparedness, with a section focused on hospitals (www.hhs.gov/nvpo/pandemicplan/annex2.pdf). Meanwhile, some hospitals are altering their fall influenza campaigns because of a delay in the distribution of about half the nation's flu vaccine. **(See related article, p. 135.)**

"It's worth remembering that there's been no other event in U.S. history that has killed as many people as the 1918 influenza pandemic," says **Ben Schwartz**, MD, senior science adviser in the National Vaccine Program Office, noting that 675,000 Americans died from the 1918 Spanish flu.

Better health care and antiviral medications could prevent many deaths, but the impact on the health care system from pandemic influenza would be severe, he notes. In fact, pandemic flu would make severe acute respiratory syndrome (SARS) look like a minor outbreak.

"An outbreak of influenza in a community may result in about one-third of the entire community becoming ill, whereas SARS caused fewer than 1,000 cases locally," he says. "There would, obviously, be a big difference in the impact of the two on the health care community."

Yet many hospitals have not focused their preparedness on pandemic influenza, Schwartz says. "When I talked with [hospital infection control practitioners] about pandemic flu, the response I got was that they had preparedness burnout. They were busy working on bioterrorism; they were busy working on SARS," he adds.

The draft guidance document outlines the similarities and differences between SARS and pandemic influenza. It recommends creating an all-hazards plan but maintaining distinct portions of the plan to address specific

hazards such as pandemic flu and SARS.

"One of the reasons for having a separate pandemic flu preparedness plan is to highlight what is important and what is unique about influenza," Schwartz explains.

How would you use limited resources during a pandemic influenza outbreak? That is a key question addressed in the preparedness document.

Your staff would be among your most critical resources. The CDC recommends hospitals coordinate their preparedness with state and local health departments and other health care facilities in the community. But you won't be able to count on help from other hospitals in your area or even around the country, Schwartz cautions. They all will be facing a similar crisis.

"Early in the pandemic before a vaccine is widely available, good health care is going to be the intervention that prevents people from dying," he says. "The question becomes, how do we maintain the capacity of the system?"

Hospitals may need to move health care workers from nonclinical to patient care areas. They may need to tap into student nurses, volunteers, and retirees, Schwartz adds. FluSurge software, a planning tool available from the National Vaccine Program Office web site (www.cdc.gov/flu/flusurge.htm), enables hospitals to estimate how many patients would be hospitalized and how many would need intensive care with pandemics of varying severity.

Meanwhile, hospitals need to consider how they would allocate scarce supplies of vaccines and antiviral medications.

"It will take months for those first supplies of vaccine to come off the line," says **William Schaffner**, MD, chair of the department of preventive medicine at Vanderbilt University School of Medicine in Nashville, TN, and a board member of the National Foundation for Infectious Diseases.

"Public health will be tracking exactly where influenza is going. It won't strike all parts of the world simultaneously," he says. "We'll have even more time to develop drugs and even vaccines. But there will be a time when there won't be enough vaccine, and there won't be enough drug to give everyone. We'll have to prioritize."

Antivirals may be effective as a prophylactic agent, but that isn't an efficient use, Schwartz explains. Health care workers would need to take it continuously to prevent infection, but could take it as soon as early symptoms appear to reduce the severity and duration of the disease.

Health care workers with more mild symptoms might work while sick, caring for a cohort of influenza patients, he says. Hospitals also need to consider who would get limited supplies of vaccines — how much would go to vulnerable patients and how much to health care workers.

"I think health care systems, as they do their pandemic planning, need to consider what staffing is required for effective patient care," Schwartz says. "If supplies of antivirals or vaccines are so severely limited that they would not be available for all health care workers, then health care systems need to be able to use what is available most effectively to maintain the essential functions."

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Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments call **Michele Marill** at (404) 636-6021.

Half the nation's flu vaccine for this season is delayed

Chiron contamination forces more testing

Contamination of some lots of this season's influenza vaccine has led to a delay in distribution of about half the nation's supply.

Chiron Corp. of Emeryville, CA, announced "a small number of lots" did not meet sterility specifications, and it would delay releasing its entire vaccine stock while further testing occurred. Chiron expects to deliver 46 million to 48 million doses of vaccine beginning in October.

Aventis Pasteur of Bridgewater, NJ, expects to deliver its supply of about 50 million doses from August to October. MedImmune of Gaithersburg, MD, will deliver about 1.5 million doses of the nasally administered FluMist in October. In all, the supply of flu vaccine this year will be the highest ever, according to the Centers for Disease Control and Prevention (CDC).

The Chiron delay will have a varying impact around the country depending on which manufacturer supplies a hospital. Some communities will need to postpone their influenza campaigns, says CDC director **Julie L. Gerberding**, MD, MPH.

What should you do if your vaccine supply comes from Chiron and you want an earlier vaccination of high-risk patients and their health care workers?

"The best thing for the hospital to do is to contact its vaccine distributor and identify how they might best be able to get earlier delivery of vaccine," Gerberding explains. "That's something that just generally gets worked out on a case-by-case basis. I also know that Aventis is planning to fulfill its commitment to the people who had already ordered vaccine, but it's going to then do its best to add additional supply to those places that are still waiting for their Chiron."

"At this very moment, people who have ordered the vaccine from Chiron need to look at their immunization program and begin to think about [how to handle the delay]," says **William Schaffner**, MD, chair of the department of preventive medicine at Vanderbilt University School of Medicine in Nashville, TN, whose own hospital receives its vaccine from Chiron.

Schaffner recommends setting priorities among patients and health care workers, vaccinating the most vulnerable patients and caregivers first.

Gerberding sought to assuage worries about the vaccine supply. "[W]e're expecting to have enough flu vaccine to assure that everybody who needs vaccination can receive it," she adds. ■

Hospitals already should be engaging in some preparedness functions, such as educating employees about influenza, the threat of a pandemic, and the importance of vaccination.

"Every year's influenza vaccination campaign can be thought of as a drill for what would happen with pandemic influenza," Schaffner notes. "The better, more efficient we make our routine influenza vaccination campaigns, the more prepared we will be in an emergent situation."

With an effective campaign, "everyone knows what to do. We all know how much vaccine to order, [and] how many needles and syringes we need," he says.

Vanderbilt also conducted two major drills testing the response to an outbreak. That came in handy when the hospital experienced a surge of influenza patients last year. "We quickly discovered that we had a backup in the emergency room," Schaffner points out. "We moved into our emergency planning mode phase I."

Chiefs of service were able to discharge patients to create more room for the onslaught of patients. The hospital did not need to go to phase II, which involves creating a special ward for the outbreak patients. "We were so pleased we had that plan in place and had drilled it," he adds. "It worked very well." ■

Model may be at fault if fit-tests are a failure

NIOSH to add criteria for respirator makers

Poorly fitting respirators may cause additional headaches for hospitals as they scramble to fit-test hundreds of employees to comply with U.S. Occupational Safety and Health Administration (OSHA) regulations.

The choice of respirator can make a big difference in how successful you are at fit-testing employees, according to a study by the National Institute for Occupational Safety and Health (NIOSH).[1] In fact, concerns over fit characteristics have influenced NIOSH to add new criteria to its respirator certification program.

By setting limits on the total inward leakage of masks — the amount of aerosol that comes in through the filter and face seal — NIOSH will essentially require better-fitting respirators. "We want to write a standard that is representative of

the best technology that is available today. That means some respirators will not make it because we will set the standard at the top," says **Rich Metzler**, MS, director of NIOSH's National Personal Protective Technology Laboratory in Pittsburgh.

A study of 18 models by NIOSH found a glaring difference in their basic fit characteristics.

Three models performed well right out of the box, without fit-testing, the study found.[1]

With some models, only one or two out of 25 test subjects were able to pass a fit-test, says **Chris Coffey**, PhD, chief of the Laboratory Research Branch in NIOSH's Division of Respiratory Disease Studies in Morgantown, WV. In fact, combined with a margin of error in fit-testing, even those who passed with poorly fitting respirators may not have adequate protection.

"Fitting characteristic is an important facet," he says. "At one point in time, people thought if you

Hospitals feel the pain of annual fit-test rule

Most have few EHPs, many fit-tests

Do you feel overwhelmed by the annual fit-testing rule? You're in good company. Most of your peers at hospitals around the country rank the difficulty with compliance as a 7 out of 10 or worse, according to a survey by the American Association of Occupational Health Nurses (AAOHN) in Atlanta.

At most hospitals, employee health professionals are on their own with this burden — and they only have a staff of three or fewer to accomplish it, the survey found.

"It validates what we've been hearing from members who have these concerns," says AAOHN president **Susan Randolph**, MSN, RN, COHN-S, FAAOHN, clinical instructor in the Occupational Health Nursing program at the University of North Carolina at Chapel Hill. "We're looking for ways to help them comply and have an effective program."

Annual fit-testing continues to be a controversial issue nationally. In late November, the Centers for Disease Control and Prevention (CDC) plans to hold a stakeholder meeting to discuss fit-testing issues. The CDC's draft tuberculosis guidelines have been held up by disagreement between some CDC divisions and the National Institute for Occupational Safety and Health (NIOSH) over wording on fit-testing. The current draft calls for periodic fit-testing, while NIOSH supports the annual fit-testing required by the U.S. Occupational Safety and Health Administration.

AAOHN contacted 2,196 hospital-based occupational health nurses by e-mail. They received a response from 714 to the on-line survey, a response rate of 33%. Most of the respondents (72%) work in nongovernmental, not-for-profit hospitals; 70% of them reported a high level of difficulty complying with the rule.

Federal government hospitals were those least affected by the fit-testing rule. Some 43% of those hospitals have a more than five-employee health staff, and 72% fit-test fewer than 500 employees.

Yet it's common for hospitals to fit-test a large portion of their staff. Almost a third (32%) of respondents said they are fit-testing between 1,000 and 5,000 employees. About a quarter (26%) fit-test between 500 and 999 employees, and 28% fit-test between 100 and 499 employees.

That task is most difficult when employee health professionals have little or no help. Just more than half (52%) reported that employee health is solely responsible for fit-testing, while 28% worked with individual departments and 20% worked with an outside vendor or provider.

Doing it alone is a position **Lori Schaumleffel**, RN, COHN-S, ARM, coordinator of Employee Health Services at Mercy Hospital of Folsom, CA, is accustomed to. She is the only employee health professional in her hospital, and she has clerical help for just eight hours a month.

"I'm not unusual. There are lots of folks in larger facilities [doing it alone]," she says. Now, with the new rule, "my responsibility is to fit-test everyone in the facility who needs to be fit-tested," notes Schaumleffel.

She can't pawn off the duties onto managers. "My managers are spread very thin. I don't think that's unusual, that the managers have already a huge amount of work to do in regards to compliance issues. Adding fit-testing, which requires equipment and space and time, is more difficult for the manager to accomplish."

Schaumleffel has begun fit-testing about 250 employees — about two-thirds of the hospital staff. The high-risk staff, such as those who work in the ICU, emergency department (ED), and respiratory therapy, are receiving their updated fit-tests first. California is requiring compliance for high-risk staff by Oct. 18 and for lower-risk staff by Jan. 18.

Some other employee health duties will have to be set aside while she accomplishes the fit-testing. Meanwhile, she hopes the AAOHN survey leads to a sharing of "best practice" information on fit-testing. "The survey opens up discussion to help us learn from each other," she adds.

(Editor's note: Further information on the AAOHN fit-test survey is available from the web site at www.aaohn.org.) ■

passed the fit-test, you got an adequate level of protection, that fit-tests were basically 100% accurate. We've shown that may not be the case. Tied with poor fitting characteristics, you can end up with a respirator that doesn't protect adequately even if you passed the fit-test."

Yet both Coffey and Metzler emphasize that fit-testing still is important to make sure an individual respirator provides adequate protection for a specific employee.

"Our goal is to improve the fitting characteristics of the respirator so a larger portion of the population will receive a better-fitting respirator, but it does not eliminate the need for the individual to be fit-tested," Metzler says. "Even the good-fitting respirators had an improvement [in fit in the study] when the fit-test was done."

In the study, Coffey and his colleagues tested 18 models on 25 test subjects with varying face sizes. They used Simulated Workplace Protection Factor values — a test of total leakage while performing certain exercises — to evaluate respirator performance. The researchers also compared the effectiveness of different fit-test protocols, including Bitrex, saccharin, (both qualitative) and the quantitative Portacount.

The small sample size and survey population limits the study's scope. There are more than 165 models of N95 filtering facepiece respirators. But here are some findings:

- **There is no perfect fit-test.**

  Some employees will pass a fit-test although the mask really doesn't provide the protection for which the N95 filtering facepiece respirator was designed, and some will fail although they actually fit properly. The amount of "beta" (falsely showing adequate protection) and "alpha" (falsely showing inadequate protection) error differs with different fit-test methods.
- **Qualitative fit-testing has a higher error rate.**

  Because it's subjective, some employees may simply say, "I think I taste something." You may want to vary the concentrations of the substance you're using to see how it effects the pass-fail rate, Coffey suggests. Research is needed on how varying the concentrations of the test agent affects the pass/fail rate, he says.
- **You can't tell just by looking at a respirator whether it will fit.**

  "Some of them looked like they did fit," Coffey points out. "The leaks were small enough that you couldn't tell just by putting them on someone's face and saying, 'This one will do well, and this one will do poorly.'"

Quick Q&A: Expert answers EHPs' fit-test questions

(Employee health professionals face logistical issues as they scramble to fit-test hundreds of employees. Hospital Employee Health *posed some common fit-testing questions to respiratory protection expert* ***Roy McKay****, PhD, director of the occupational pulmonology services program at the University of Cincinnati College of Medicine.)*

Question: What is the most common error you see in performing qualitative fit-testing?
Answer: Not following proper procedures resulting in test results that may be incorrect. For example, not squeezing the hand bulb properly resulting in insufficient generation of aerosol, not continuing the test for the proper length of time, improper use of the hand held nebulizer bulb.

Question: How many employees can be properly fit-tested at one time?
Answer: One.

Question: In qualitative fit-testing, is Bitrex or saccharin more effective — or are they equally effective?
Answer: On a population basis, they are essentially similar, although some individuals may not taste one or the other equally.

Question: How can you prevent employees from having a lingering taste of Bitrex or saccharin after the fit-testing is complete?
Answer: Tell employees to rinse their mouth with water and use a wet face cloth to wipe the face and lips.

Question: What steps should you take to prevent room contamination with the testing substance, which may affect subsequent tests?
Answer: Be sure to use a room that has adequate ventilation.

Question: If an employee is documented to be able to taste saccharin, is it necessary to repeat sensitivity testing every year?
Answer: Absolutely.

Question: Is the train-the-trainer approach, when employee health professionals train department managers to fit-test their own employees, an effective strategy?
Answer: Yes, if training program is conducted properly.

Question: OSHA recently approved a new fit-testing protocol. Does this apply to the N95 filtering facepiece respirators that many hospitals use?
Answer: The new protocol is to be used only with the controlled negative-pressure method of fit-testing, which is not applicable to filtering facepiece respirators.

(For information on courses on fit-testing and respiratory protection, go to www.drmckay.com.)

- **Choosing a better-fitting respirator could make your fit-testing process smoother.**

For example, 76% of test subjects passed the Portacount fit-test with the MSA Affinity Ultra, a model that provided almost five times the required level of protection even without fit-testing.

Yet the overall pass rate for all 18 models with the Portacount was 16%. **(For a list of the models tested and their performance without fit-testing, see box, below.)**

Reference

1. Coffey CC, Lawrence RB, Campbell DL, et al. Fitting characteristics of eighteen N95 filtering-facepiece respirators. *Journal of Occupational and Environmental Hygiene* 2004; 1: 262-271. ■

N95 Filtering Facepiece Respirators Performance

Model	Simulated Workplace Protection Factor*
MSA Affinity Ultra	48.0
3M 8110S/8210	16.6
3M 1860/1860S	13.7
North 7175N95	7.2
Moldex 2200N95/2201N95	6.1
Willson N9510F	5.6
MSA Affinity Plus	5.2
Gerson 2737	4.9
Willson 1410N95	4.5
Aearo Safety Pleats	4.4
3M 8512	4.1
Moldex 2300N95/2301N95	2.7
Willson N9520F	2.7
Survivair 1930	2.4
Moldex 2207N95	2.1
U.S. Safety ADN95	2.0
Moldex 2700N95/2701N95	1.9
3M 8212	1.3
All 18 Models	2.9

* Simulated Workplace Protection Factor, a test of performance that means 95% of wearers of that respirator can expect to have a total penetration value below the 95th percentile total penetration value.

N95 Filtering facepiece respirators have an Assigned Protection Factor of 10, which means they filter out all but one-tenth of an aerosol.

Source: National Institute for Occupational Safety and Health, Pittsburgh. 2004.

Work environment may hasten nurse retirement

Flexibility, accommodations would help

Work stress and dissatisfaction with the work environment may hasten the retirement of aging nurses, according to a study by the Center for American Nurses, an Austin, TX-based affiliate of the American Nurses Association.

Almost half (47%) of 4,000 nurses surveyed said the relationship with nursing management or administration caused them to think about leaving. Nurses also cited staffing concerns and "the effect of organizational shift from patient to finance or other [issues]" as reasons they might leave.

Yet nurses said they would consider postponing retirement if they could have flexible schedules or a phased retirement with shorter hours or fewer days worked. More than one-third (37%) of the nurses surveyed said they plan to retire between 2015 and 2020.

"Most nurses retire from the bedside at 52 and from the profession at 62," says **Claire Jordan**, RN, MSN, president of the Center for American Nurses, noting that the average age of nurses is now 46. "We are barely six years away from looking at 50% of the nurse work force leaving the bedside."

To retain nurses, hospitals need to alter the work environment to make it more suitable for older workers, she says. "Nurses have jokingly said to me, 'I guess we'll keep working if it'll pay for our total hips and our total knees,'" Jordan adds. "The lifting issue is a big issue for nurses."

The need for accommodations came out in focus groups conducted by the Center for American Nurses. But most nurses said administration had not made any changes in scheduling or work environment to take into account the aging work force.

"Twelve-hour shifts in nurses over 52 just becomes almost impossible," Jordan points out.

Meanwhile, hospitals won't be able to fill their nursing needs just with new recruits, she cautions. "Obviously, one of the best ways to prepare for this shortage is to prolong the working life, to change the plans for retirement. We are trying to work up an agenda for all the acute-care employers [to retain nurses]."

The aging work force also has a major impact on nursing injuries and workers' compensation.

(Continued on page 143)

JCAHO Update for Infection Control

News you can use to stay in compliance

Joint Commission recognizes Pittsburgh hospital for quality and infection control in patient safety

A common language changes patient safety culture

A multifaceted patient safety program that included a focus on infection control has garnered a Pittsburgh hospital a 2004 John M. Eisenberg Patient Safety and Quality Award.

The awards are given out annually by the Joint Commission on Accreditation of Healthcare Organizations and the National Quality Forum.

The University of Pittsburgh Medical Center (UPMC) in McKeesport, PA, was honored for "innovations in patient safety and quality at a local or organization level."

Program focus

The program features teaching/learning packets that focus on key areas such as infection control, patient falls, and rapid clinical response to a change in patient status.

"We have a nursing education department that is primarily responsible for formatting the learning packet once the topic has been identified," says **Doris Gaudy**, RN, MS, senior director of patient services.

"Many experts within our institutions contribute to the information that is placed in the learning packets. We try to do the learning packets in a way that they are very informative but simple, because time is a precious commodity," she explains.

Health care workers, who must sign off on them after the course is completed, see the learning packets as having "a lot of merit" she notes.

"The signatures at the end of the packet help us in two ways," Gaudy points out. "One, when you sign your name to something, it brings to it a certain level of accountability. Secondly, the teaching/learning packet is used to provide [medical] education credits."

According to **T. Michael White**, MD, senior vice president of value and education at UPMC McKeesport, the infection control component of the program includes an emphasis on hand hygiene; standard and transmission-based precautions; prevention and early diagnosis of *Clostridium difficile* infections; appropriate antibiotic usage; and prevention of central line-associated bacteremia.

The focus on *C. difficile*, for example, is yielding early signs of improvement, White says. **(See *C. diff* strategies, p. 140.)** Reports of both *C. difficile* and associated colitis conditions are in decline, he notes.

"I won't say that this is statistically significant, but they are moving in the right direction," White adds.

Education to prevent patient falls

In addition to infection control, the teaching/learning packets used in the program are designed to prevent patient falls and improve the clinical response to a change in patient status.

The latter includes an educational emphasis on "calling for help early" by physicians, nurses, and therapists in the institution.

Clinicians have been taught to summon a clinical team to the bedside whenever a patient experiences a significant, unanticipated change in status.

"The concept is a very simple one," White

Patient safety program focuses on *C. diff* infections

High index of suspicion key

An award-winning patient safety program at the University of Pittsburgh Medical Center in McKeesport, PA, includes a focus on preventing troublesome *Clostridium difficile* infections. Among the key points for clinicians to consider are:

- *C. difficile* often is a hospital-acquired infection that can be spread from person to person.
- *C. difficile* can cause antibiotic-associated diarrhea and colitis.
- *C. difficile* colitis may present as a life-threatening sepsis syndrome with impressive leukocytosis, and a paradoxically unimpressive abdomen without diarrhea.
- The key to diagnosis is a high index of suspicion.
- For the hospitalized patient on antibiotics who develops diarrhea —- think *C. difficile.*
- When you have a high index of suspicion for *C. difficile*, it is important to send specimens to the lab for toxin ASAP.
- The major tools to prevent *C. difficile* include:
  — meticulous hand hygiene with antibacterial soap and water
  — effective contact isolation precautions (note: precautions pertain to visitors, too)
  — appropriate antibiotic usage (type and duration)
  — addition of yogurt or equivalent (e.g., Lactinex) to diet for patients receiving antibiotics
- Treatment (e.g., metronidazole) may be started as soon as *C. difficile* is suspected and will not interfere with diagnosis.
- Agents that slow the colon (e.g., lomotil) should not be used in *C. difficile* cases.
- *C. difficile* can be complex and the timely involvement of the GI, ID, and/or surgery consultant often is in order.
- Upon discharge, patients who have received antibiotics in the hospital or who have been diagnosed with *C. difficile* must be educated to call for help early if diarrhea develops at home. ■

says. "Instead of waiting to call the crisis team when a patient is near death, we call the crisis team early when [patients] have a change in status. Our institution has gone from calling for help or a code about six times a month to about 35 times a month.

"The [patient] survival rate has gone from about 50% to 95%. But of course, we are getting there much, much earlier," he explains.

"The number of true codes has diminished, and the survival rate [for those] has improved as well," White notes.

Developing a common language

Another patient safety approach in the program centers on preventing patients from falls that can increase morbidity and extend hospital stays.

"We recognized that nationally and regionally falls were a major issue," White says, noting that patient falls are now designated as "failure mode" to prompt investigation.

As with the other facets of the program, prevention of patient falls requires knowledge and involvement — using a common language — among physicians, nurses, pharmacists, and therapists. Contributing factors to falls include medication and syndromes of confusion (delirium/dementia), the program emphasizes, he adds.

Changing the culture

"The teaching/learning packet itself is nice, but the [overall] concept has helped change our culture here," White continues. "What we have found is that if we can develop a common language among our professionals — get everybody on the same page — it actually [leads to] behavior changes."

For example, educators at the hospital have drawn specific attention to the fact that *C. difficile* colitis may present as a life-threatening sepsis syndrome with impressive leukocytosis, and a paradoxically unimpressive abdomen without diarrhea.

Such a condition might be missed until it worsens, but now it is the subject of a common clinical language and an interactive patient safety culture, White adds.

"Nurses began to ask doctors, 'You know this white [blood cell] count is very high. Do you think it could be that syndrome?'" ■

2005 patient safety goals warn of sound-alike drugs

Infection control goals remain intact

New patient safety goals for 2005 by the Joint Commission on Accreditation of Healthcare Organizations include preventing patient falls and avoiding potentially fatal mix-ups with similarly named drugs.

Remaining unchanged from 2004 are the two key infection control patient safety goals:

1. Comply with current Centers for Disease Control and Prevention hand hygiene guidelines.
2. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goals include patient falls reduction

Effective Jan. 1, 2005, the patient safety goals also include a new emphasis on reducing patient falls.

Infection control professionals have focused on this area before as an important noninfectious adverse outcome.

The Joint Commission's new patient safety goal calls for hospitals to "assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks."

Much emphasis is placed on medication in general, with the Joint Commission adding a goal for 2005 that calls for hospitals to "accurately and completely reconcile medications across the continuum of care."

That goal states that "during 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient.

This process includes a comparison of the medications the organization provides to those on the list.

A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization."

In addition, the Joint Commission calls for hospitals to "identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs."

The Joint Commission notes that many drug names can look or sound like other drug names, which may lead to potentially harmful medication errors.

Communication issues exacerbate problem

Increasingly, pharmaceutical manufacturers and regulatory authorities are taking measures to determine if there are unacceptable similarities between proposed names and products on the market. But factors such as poor handwriting or poorly communicated oral prescriptions can exacerbate the problem, the organization states.

To prevent potentially deadly interactions or inappropriate care, the Joint Commission lists the following tips:

- Maintain awareness of look-alike and sound-alike drug names as published by various safety agencies.
- Clearly specify the dosage form, drug strength, and complete directions on prescriptions. These variables may help staff differentiate products.
- With name pairs known to be problematic, reduce the potential for confusion by writing prescriptions using both the brand and generic name.
- Include the purpose of medication on prescriptions. In most cases, drugs that sound or look similar are used for different purposes.
- Alert patients to the potential for mix-ups, especially with known problematic drug names. Advise ambulatory care patients to insist on pharmacy counseling when picking up prescriptions, and to verify that the medication and directions match what the prescriber has told them.
- Encourage inpatients to question nurses about medications that are unfamiliar or look or sound different than expected.
- Give verbal or telephone orders only when truly necessary, and never for chemotherapeutics. Include the drug's intended purpose to

ensure clarity. Encourage staff to read back all orders, spell the product name, and state its indication.

- Consider the possibility of name confusion when adding a new product to the formulary. Review information previously published by safety agencies.
- Computerize prescribing. Use preprinted orders or prescriptions as appropriate. If possible, print out current medications daily from the pharmacy computer system and have physicians review for accuracy.
- When possible, list brand and generic names on medication administration records and automated dispensing cabinet computer screens. Such redundancy could help someone identify an error.
- Change the appearance of look-alike product names on computer screens, pharmacy and nursing unit shelf labels (including automated dispensing cabinets), and pharmacy product labels, and medication administration records by highlighting, through bold face, color, and/or tall man letters, the parts of the names that are different (e.g., hydrOXYzine, hydrALAzine).
- Install and utilize computerized alerts to remind providers about potential problems during prescription processing.
- Configure computer selection screens and automated dispensing cabinet screens to prevent the two confused drugs from appearing consecutively.
- Affix "name alert" stickers to areas where look- or sound-alike products are stored (available from pharmacy label manufacturers).
- Store products with look- or sound-alike names in different locations in pharmacies, patient care units, and in other settings, including patient homes. When applicable, use a shelf sticker to help locate the product that has been moved.
- Continue to employ independent double-checks in the dispensing process (one person interprets and enters the prescription into the computer and another reviews the printed label against the original prescription and the product prior to dispensing).
- Encourage reporting of errors and potentially hazardous conditions with look-alike and sound-alike product names and use the information to establish priorities for error reduction. ■

JCAHO, CMS are merging hospital quality measures

Common measures manual available

The Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare & Medicaid Services (CMS) are working together in completely aligning current and future common hospital quality measures in their condition-specific performance measure sets.

Common measures manual

The current hospital quality measures are included in the Joint Commission's ORYX Core Measures and CMS' 7th Scope of Work Quality of Care Measures on heart attack, heart failure, pneumonia, and surgical infection prevention.

CMS and the Joint Commission have released and made available on their web sites a common measures specification manual, which includes a data dictionary, measure information forms, algorithms, and other technical support information. (The specification manual can be found at www.jcaho.org/pms/core+measures/aligned_manual.htm.)

The intent is to achieve total identity of common measures by the time that data collection for January 2005 patient discharges begin.

Reduce costs for hospitals

The intended measure alignment will make it easier and less costly for hospitals to comply with existing CMS and Joint Commission requirements for data collection and reporting, according to a Joint Commission release.

The measures that are in the four Joint Commission and CMS hospital measure sets, which presently are in use, calculate the same way, but there are differences in the format of the specifications for data elements, types of cases excluded, calculation algorithms, and other measure dimensions. ■

(Continued from page 138)

Here are three common ailments associated with aging — near-vision loss, arthritis, and back injuries — and examples of how hospitals can approach them:

1. Near-vision. Nurses need to see the fine print — on I.D. bracelets, orders, prescriptions, and labels. Yet as they age, near-vision suddenly may become a problem.

At Pitt County Memorial Hospital in Greenville, NC, nurses have a vision screening every year with their TB skin tests, bloodborne pathogen education, and immunization update.

In fact, the hospital is expanding the screenings into a health screen, offering glucose and cholesterol testing and a health risk appraisal.

Pitt County Memorial uses the Titmus Vision Screener to check near-vision, although a simple screen also could be accomplished with a Jaeger chart, says **Pat Dalton**, RN, COHN-S, occupational health project specialist.

"[The screens] do help us to identify people who are beginning to have problems. We are able to identify the near-vision problems that you begin to get with aging," she says.

The job duties determine the near-vision requirements, Dalton notes. At the first sign of decreased near-vision, employee health will simply ask the employee to check on it. If the problem is more significant, it may reach an action point. Employee health would alert the manager to make sure that the vision check occurred.

Meanwhile, a quality improvement team is reviewing the use of abbreviations, such as qid. Some will be eliminated to prevent confusion, Dalton says. The use of computers to relay orders also has reduced the risk of miscommunication. "The reading is much more legible," she adds.

2. Arthritis. Chances are, many of your employees already suffer from arthritis. And as the work force ages, those numbers increase dramatically.

In 2002, some 43 million Americans had a diagnosis of arthritis, according to the Centers for Disease Control and Prevention (CDC). Another 23 million report chronic joint pain but don't have a diagnosis, says **Teresa J. Brady**, PhD, OT, senior behavioral scientist with CDC's arthritis program.

"Arthritis is already in the workplace; employers don't need to wait for the aging of the population," she explains. "But we do predict that the problems related to arthritis are going to increase dramatically over the next 25 years."

That is especially true for nurses, with an average age of 46. Osteoarthritis commonly develops between the ages of 45 and 64. "The nursing population is aging themselves into the most common point of onset for degenerative, or osteoarthritis," Brady notes.

What can you do about it? Here are some basic steps, she advises:

- **Minimize repetitive bending or lifting.** Overuse of a joint, particularly after an injury, can increase the risk of osteoarthritis, she says. For example, repetitive knee-bending has been linked to osteoarthritis, she says.
- **Refer employees for evaluation if they have chronic joint pain.** Rheumatoid, or inflammatory, arthritis responds well to early, aggressive medical treatment.
- **Offer education on arthritis.** The Arthritis Foundation in Atlanta offers an Arthritis Self-Help Course at locations around the country — www.arthritis.org or (800) 283-7800. Contact the arthritis coordinator in your state health department, which has federal grant money for arthritis activities (www.cdc.gov/nccd php/arthritis/states.htm).
- **Encourage weight control.** People who are overweight or obese have an increased risk of developing osteoarthritis.

3. Back injuries. When **JoAnn Shea**, MSN, ARNP, director of employee health and wellness at Tampa (FL) General Hospital, met with the senior management to ask for lift teams to reduce patient-handling injuries, she had a compelling argument. About half of the hospital's nurses are older than 40. The hospital's most severe injuries occurred among employees older than 45.

She presented four cases of patient-handling injuries, which cost the hospital between $350,000 and $500,000 each. Only one of the four was able to go back to work, and she had to take a non-nursing job. The others were totally disabled. All were older than 40.

The worst injury was to a nurse who was trying to move a 500-pound bariatric patient with the help of just one other employee. "It's sad, because she was a very good nurse," Shea adds. "She tried to get help but there wasn't enough help. She was moving the patient over to a stretcher." The nurse suffered a herniated disc, had three back surgeries, and remains disabled.

The administration approved the lift team. It costs about $200,000 in salaries and benefits per year, and Tampa General has spent about $750,000 on ergonomic equipment. The hospital has ceiling

lifts in the rehab unit, skilled nursing facility, and half the rooms in the rest of the hospital.

But the investment has paid off. Workers' compensation costs declined by 29% last year. In two years, patient-handling injuries dropped by 62%. "Our lost workdays went down, our restricted workdays went down," Shea says.

Tampa General also will be able to retain nurses who may have left because of the physical demands of the job. Shea surveyed nurses to see how they felt about the lift teams. "A lot of them said, 'I don't think I could continue to work without the lift team at my age. Now, my back doesn't hurt every day when I go home.'

"If you want to keep your experienced nurses in clinical nursing, which is where the shortages occur, then we have to provide the tools for them to be able to do their job safely," she adds. ■

Why JCAHO cares about hospital ergonomics

'Environment of Care' targets worker safety

The Joint Commission on Accreditation of Healthcare Organizations wants you to use ergonomic interventions.

That is an argument your hospital administration will have a hard time ignoring as you promote the use of tools, equipment, and training to reduce patient-handling injuries among your staff.

The Environment of Care standard says facilities should provide a safe environment for patients, staff, and visitors. To underscore the point about safe working conditions, the Environment of Care newsletter recently highlighted ergonomics with a two-part series on the hazards of repositioning.

Specifically, surveyors may look for compliance with standards that require hospitals to identify risks and develop processes to minimize them, as well as a human resources standard that requires staff training.

Surveyors have been educated about ergonomic hazards as they relate to the Environment of Care standard, says **John Fishbeck**, RA, associate director of the Joint Commission's division of standards and survey methods.

In the new style survey, surveyors track patients through their care and may ask their caregivers about ergonomics, such as, "What have you been told about how to safely move or reposition this patient? Have staff up here had any injuries related to lifting or ergonomics issues?" he adds.

The Joint Commission's interest in ergonomics can provide justification for an investment in ergonomic equipment, says **Deborah Fell-Carlson**, RN, COHN-S, loss control consultant with SAIF Corp. in Salem, OR, a nonprofit workers' compensation insurer.

"The Joint Commission clearly wants a safe environment for everybody," she says. "If we're not providing a safe environment for everybody, then we're really not providing what Joint Commission is intending."

Hospitals can use ergonomic indicators as part of the performance improvement process that is required by the Joint Commission.

"The Joint Commission's 2004 rules require one failure mode effects analysis every year [that is] reported to the board, Fell-Carlson says. "Some of the facilities are using that to evaluate the cause and effect of safe patient handling strategies."

At the hospital at which she previously worked, Fell-Carlson used the overall lost workday case incident rate as a benchmark. Using the Bureau of Labor Statistics formula, she determined that the hospital's lost workday incident rate was 6.3 per 100 full-time employees (FTE), compared to an industry average of 4.4 **(The industry average is available at http://stats.bls.gov/iif/oshwc/osh/os/ostb1244.txt; the hospital sector is SIC code 806. For the BLS formula, see box, p. 145.)**

The hospital developed a comprehensive ergonomics program, which included the analysis of workstations by an occupational therapist, education of staff on the use of patient-handling equipment, and the purchase of new devices. The hospital bought repositioning devices, total body lifts and stand-up lifts to help patients ambulate.

With the interventions, the lost workday incident rate dropped to 1.3 per 100 FTE. "It really did show that what we were doing was very effective," Fell-Carlson says.

At Samaritan Lebanon (OR) Community Hospital, a safety team conducts safety tours every month in a different department, marking areas of concern on a hazard log. Ergonomics is included in that hazard review, says **Joseph R. Haralson**, CHE, vice president for ancillary/support services.

Managers are required to address the hazards identified within 30 days, and the hazard log is a regular item on the safety committee's monthly agenda. Items remain on the hazard log until they have been resolved, he says. A quarterly status of

Calculating LWD Incidence Rates

- ✔ Lost workdays (LWD) = Number of injuries and/or illnesses resulting in lost time or restricted work.
- ✔ Employee hours = Total number of hours worked by all employees in one year
- ✔ LWD incidence rate = $\frac{\text{\# LWD cases x 200,000}}{\text{\# employee hours worked}}$

Source: U.S. Bureau of Labor Statistics, Washington, DC.

the environment report, including a safety report, is presented to the board.

During a Joint Commission survey in May, surveyors made positive comments about the hazard log and reporting process, Haralson explains. "That was exactly what they wanted to see, a chain of communication and coordination between all levels of the organization."

Ergonomics may arise in Joint Commission surveys based on the new tracer methodology, which tracks the care of specific patients, he says.

"Let's say they pulled a chart and it happened to be a patient who weighted 350 pounds. Then I would say they would probably have a lot of questions about ergonomics, employee safety, and lift devices," Haralson explains.

Training also is important to the Joint Commission. Twice a year, Samaritan Lebanon holds safety fairs for employees. They travel from station to station, receiving an update about ergonomics, security, needle safety, hazardous materials, and other safety issues. Employees must answer a quiz to demonstrate knowledge of the safety information, he says.

The Joint Commission, always a strong influence, has an even larger role to play in the absence of a regulatory standard on ergonomics.

"Anytime we can integrate occupational health and safety into an organization's current work, their current priorities, it breaks down some of the obstacles that are preventing them from doing this," says **Chuck Easterly**, loss control manager at the SAIF Corp.

Oregon OSHA decided not to pursue an ergonomics rule, but wanted to focus on the hospital and construction industries to reduce musculoskeletal disorder injuries, he says.

A committee of labor, hospital, and insurance representatives formed the Oregon Coalition for Healthcare Ergonomics. The coalition recently held a conference to discuss "real-world solutions for people who are in the real world."

Fell-Carlson spoke at the conference about using ergonomics to demonstrate process improvement in the Joint Commission's Environment of Care standard. "[Hospital administrators] frequently say, 'We would love to do that, but . . . we don't have the money; we don't have the resources; we've got to do these things first. We'll get to it after the survey.'" Instead, they can focus on ergonomics as part of Joint Commission compliance, she says.

"People say the Joint Commission is for patient safety. But everywhere the Joint Commission says patient safety, they also say patients, staff members, and visitors," Fell-Carlson adds. ■

Latex allergy update: Is powder-free carefree?

Fewer problems reported with improved gloves

With low-protein, powder-free latex gloves available, has the issue of latex allergy been resolved? For some hospitals, changes in products have reduced new employee sensitivities almost to zero. Other hospitals are still seeking alternatives to latex to create a latex-safe environment.

Here are the experiences of several hospitals as they address the problem of latex allergy:

- **Disbanding the latex task force.**

At Tampa (FL) General Hospital, about 100 employees a year once complained of sensitivities to latex gloves. Some of them developed latex allergies, either with skin or respiratory reactions. But the switch to powder-free, low-protein gloves, even in the operating room, virtually has eliminated the problem.

"Now I have maybe one employee a year who has a true latex allergy," says **JoAnn Shea**, MSN, ARNP, director of employee health and wellness. "They're not severe. It's usually more of a dermatitis." Shea involved both staff and doctors in the glove decisions. Her task force included managers, staff nurses, educators, and infection control. "I probably had about 30 people look at the gloves and decide what to evaluate," she says.

Price was an important consideration because the hospital uses about 105,000 boxes of latex gloves a year. A drop in price in the powder-free latex as well as nitrile gloves enabled the hospital to make the switch. The hospital is eliminating vinyl exam gloves because of concerns about durability and will use only latex and nitrile.

With the elimination of powdered gloves, a latex allergic surgical tech was able to return to the operating room, Shea notes. Employees with asthma reported that their symptoms improved, and fewer employees complained of dermatitis. A few employees have reacted to accelerants in the latex, but they are able to wear the gloves with cotton liners or with a different brand, she says.

The change in gloves also fit in with an overall evaluation of latex use in the hospital, explains Shea. The hospital has sought latex-free products and has exam carts with latex-free items for use with allergic patients.

Tampa General continues to evaluate new employees for latex allergy, but the latex task force has disbanded. Going powder-free "has made a remarkable difference," Shea says. "We don't meet anymore because we resolved our issues."

- **Moving toward a latex-free environment.**

When Baystate Health System in Springfield, MA, set up a latex allergy task force in 1997, the long-term goal was to shift from latex to nitrile gloves. "Each year, we look at the numbers and reassess the situation," says **James Garb**, MD, director of occupational health and safety.

Every year, some employees are newly identified as allergic to latex, despite the hospital's use of low-protein, powder-free gloves. In 2003, eight employees became latex-allergic. In the first half of 2004, two employees were identified with latex allergy. The three-hospital system has 6,000 employees. "As a percentage it's not great, but it has a huge impact on these people's lives for the ones who do develop allergies," Garb says.

With the dropping cost of nitrile, he was able to request a switch from latex gloves, a change that will cost an additional $134,000. About 90% of exam gloves would be nitrile, while some employees would be able to continue to use latex. The hospital system also uses a small proportion of vinyl exam gloves.

Garb expects some employees will have sensitivities to the accelerants used in nitrile gloves. "We'll try to have some glove options that have different type of chemicals. If you have a problem with one glove, you'll try another one — just like with hand soaps." As more hospitals use nitrile, the cost likely will continue to decline, he adds. "I think we should be trying to minimize exposure to latex even though the gloves are better [quality] than they were years ago."

- **Staying on the (latex allergy) alert.**

Mayo Clinic in Rochester, MN, considered disbanding its latex allergy task force. After all, years

CE *questions*

17. According to Ben Schwartz, MD, senior science adviser in the National Vaccine Program Office, when would it be appropriate for health care workers to work while sick with influenza?
    A. if their respiratory symptoms aren't severe and their fever isn't over 100°
    B. if they've had symptoms for at least 3 days
    C. if they are caring for a cohort of influenza patients during a pandemic
    D. It is never appropriate for health care workers to work while sick with influenza.
18. According to NIOSH research, choosing a respirator with better fit characteristics means that:
    A. More employees will pass their fit-tests.
    B. Fit-tests are not necessary.
    C. Fit-tests will be less accurate.
    D. Hospitals should use quantitative fit-tests.
19. According to Teresa J. Brady, PhD, OT, senior behavioral scientist with CDC's arthritis program, which increases the risk of osteoarthritis?
    A. working 12-hour shifts
    B. stretching and reaching
    C. workplace stress
    D. repetitive bending or lifting
20. What is the Joint Commission's position on ergonomics?
    A. It's a matter handled solely by OSHA.
    B. It hasn't been scientifically proven to be work-related.
    C. It should be addressed through the Environment of Care standard.
    D. It's considering an ergonomics standard.

Answer Key: 17. C; 18. A; 19. D; 20. C

CE objectives

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- describe how those issues affect health care workers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■

of coordinated efforts virtually had eliminated new cases of latex allergy.

"We just don't get complaints anymore, but we've decided to keep the vigilance up," says **William Buchta**, MD, MS, MPH, medical director, employee/occupational health service.

With no federal standards on allowable protein levels in latex gloves, the Mayo Clinic set up its own testing of the allergenicity of the gloves. More recently, Mayo has favored neoprene and vinyl exam gloves. "We encourage the synthetic," Buchta notes. Employees aren't always pleased with the switch. "It was a culture change. People like the feel of latex. It feels more natural," he says.

Surgeons have been allowed to continue to use powder-free latex gloves — within some parameters, as they aim to use only products with low latex antigen. "We just try to limit the number of types so we have some control over the product," Buchta adds. "It used to be that any surgeon could order whatever glove they wanted. We can't allow that."

He still sees cases of contact dermatitis, but often that is caused by repeatedly taking the gloves off and washing the hands. He also screens new employees for latex allergy.

Meanwhile, the task force meets quarterly to talk about latex allergy issues related to both employees and patients. "We try to keep the awareness up that this is always going to be an issue," Buchta says. "We just have to keep it under control." ■

CA governor vetoes first-ever zero-lift bill

He cites burdens of new lift team mandate

California Gov. **Arnold Schwarzenegger** vetoed a bill that would have made his state the first in the country to require hospitals to use lift teams. The state legislature passed a bill requiring hospitals to adopt a zero-lift policy by using specially trained lift teams and lift equipment for patient handling. "General acute-care" hospitals in California would need to conduct a needs assessment and implement the program as of Jan. 1, 2006. The bill exempted rural hospitals.

Schwarzenegger said in a statement, the "well-intentioned" mandate was too costly and burdensome. "Although I cannot support AB 2532, I encourage hospitals to review their lift policies to determine the extent to which they can develop lift teams and purchase machinery to assist in lifting patients. I also encourage hospitals to consider incorporating modern lift technologies into new construction and significant renovation projects, including their seismic retrofit activities," he said.

The California Nurses Association made a major push for the bill, as thousands of nurses wrote the governor and urged him to sign it. It also had the support of Kaiser Permanente, the state's largest hospital provider, which reported a 39% reduction in back injuries over a three-year period with the use of lift teams. The bill requires lift teams to use lifting devices "unless specifically contraindicated for the patient's condition."

However, the California Healthcare Association, the state's hospital association, opposed the bill, citing a high cost of compliance. The University of California (UC) hospitals criticized it for not providing enough flexibility. "UC opposes the bill because a zero-lift policy in law sets an unrealistic and unattainable standard that could place patients at risk or delay care," UC said in a statement. ■

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- A quest for wellness: Why one hospital offers a range of services
- Update on new ergonomics resources and tools
- Are HBV and HCV being transmitted in ambulatory care?
- Advice on treating contact dermatitis

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How do you make the most of your job — and your career — after a long tenure in the nursing profession?

Go beyond your nursing experience and think in a businesslike way, create value for your organization, and align your goals with those of the hospital, employee health experts say.

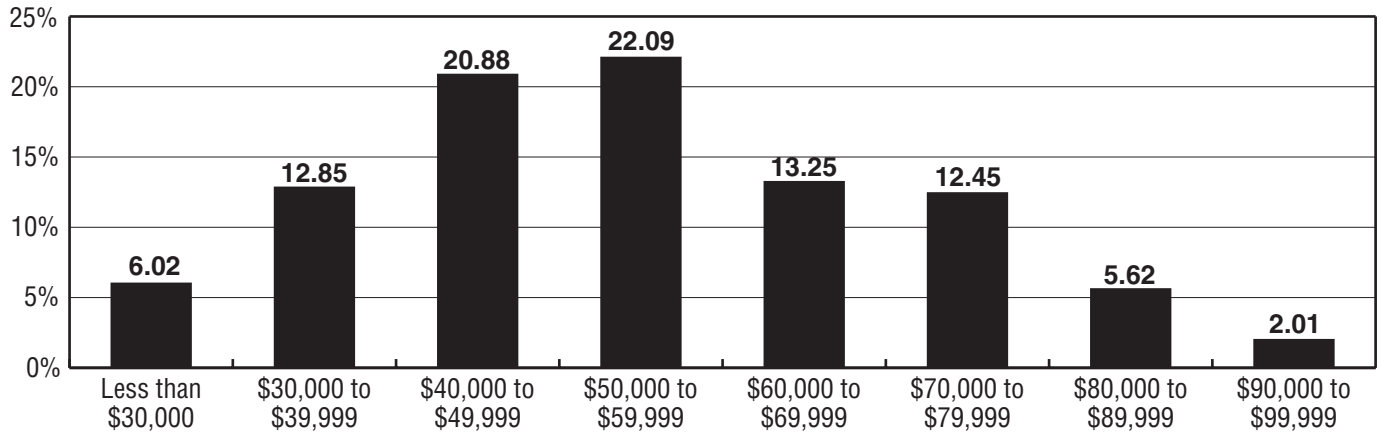
"I've seen many nurses who have been in these roles for many, many years," says **Arlene Guzik**, MSN, ARNP-BC, who taught a workshop on "Maximizing the Value of Your Occupational Health Program" for the American Association of Occupational Health Nurses in Atlanta.

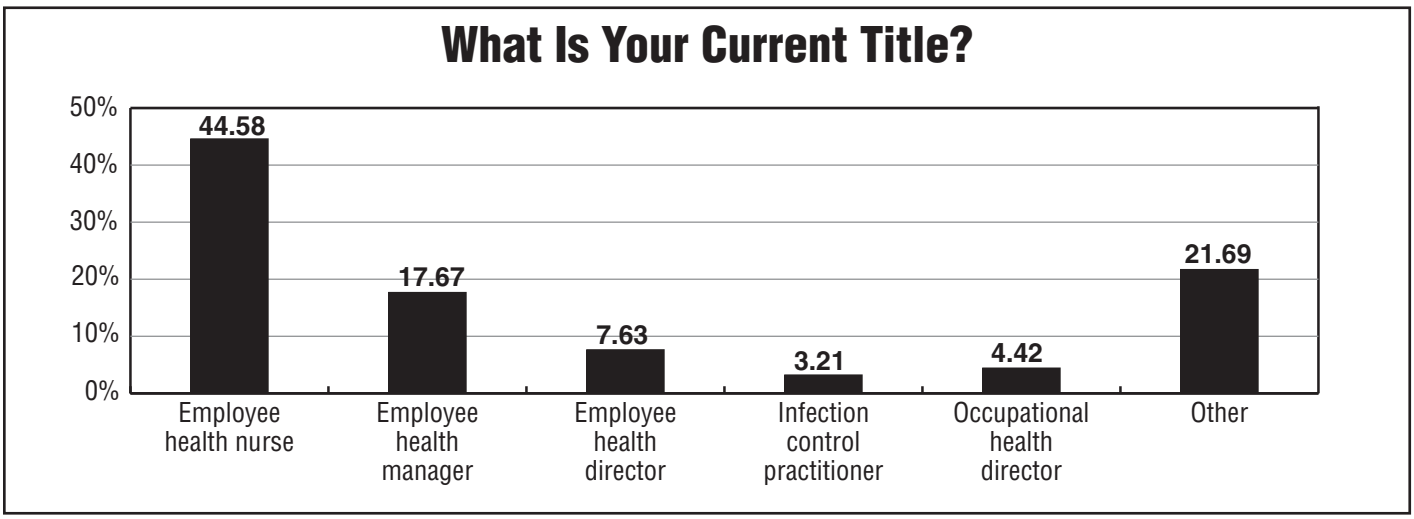
"They have not changed with the times. They continue to provide the same services they provided, the same way they provided them, many years ago. They're seen just as a nurse," says Guzik, who is director of clinical services at the Lakeside Occupational Medical Centers in Largo, FL, and president of the Florida State Association of Occupational Health Nurses.

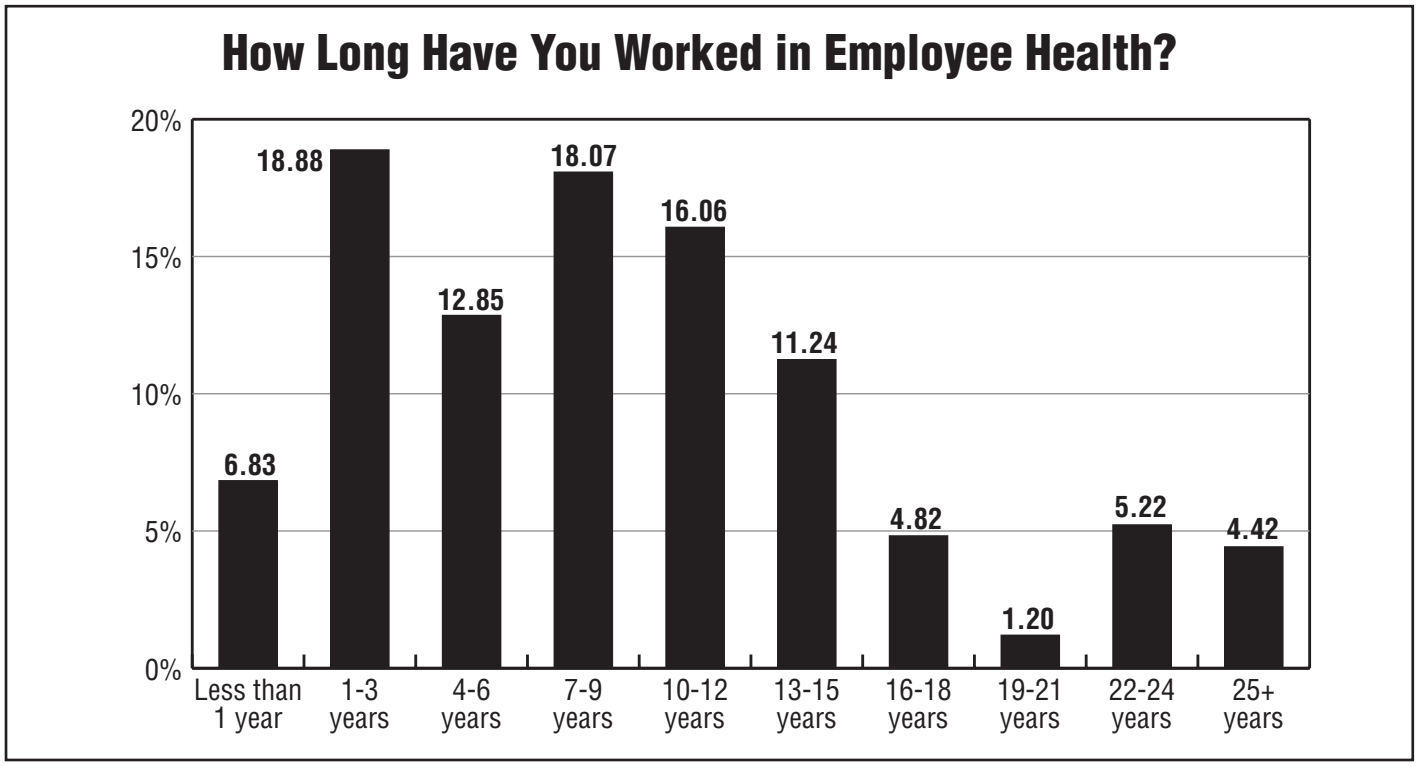
Instead, employee health nurses need to demonstrate "effectiveness beyond the clinical effectiveness," she says.

The 2004 *Hospital Employee Health* Salary Survey reveals the challenge that employee health nurses and managers face. About 20% of respondents reported they received no raise in the past year, while only 10% reported flat salaries in 2003. *HEH* analyzed the responses from 249 employee health professionals around the country. Most of them (73%) work at nonprofit hospitals, and more than

What is Your Annual Gross Income?







half (56%) are located in a medium-sized city or rural area.

Those who received a raise were most likely to get just a modest one; 46% reported receiving raises of 1% to 3%. Many respondents may have reached a ceiling after years of service at their hospitals. About 50% were 51 or older, and 63% have worked in health care for 25 years or longer.

In many cases, employee health nurses may be stuck in a middle ground. They don't receive the special incentive bonuses given to nurses who work in clinical care, yet they don't have the title and salary of a department manager, says **Denise Strode**, RN, COHN-S/CM, executive president of the Association of Occupational Health Professionals in Healthcare, based in Wexford, PA.

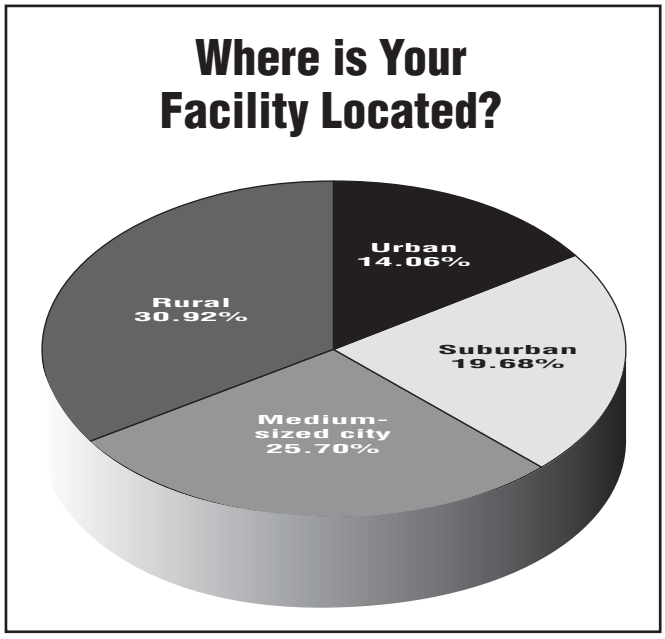
"A lot of times you are functioning as a manager because you have the full responsibility of the program, but if you aren't supervising anyone, you can't be called a manager," says Strode, who is clinical case manager at the OSF SFMC Center for Occupational Health at Saint Francis Medical Center in Peoria, IL.

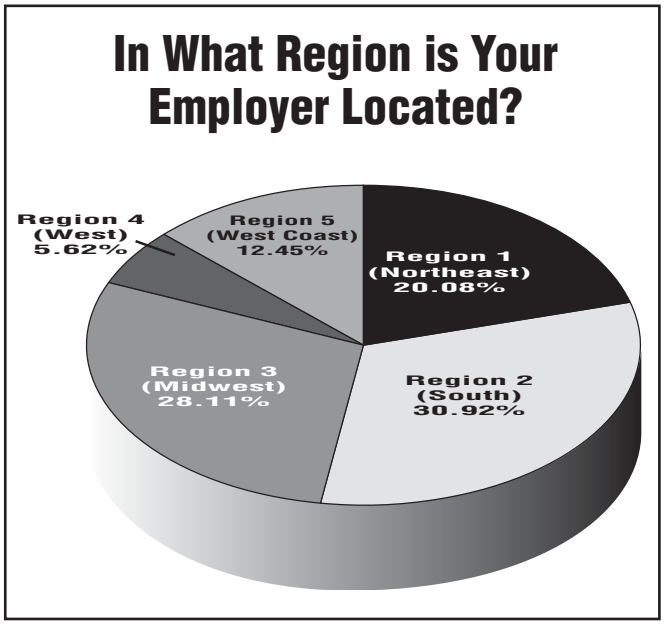
What can you do about that? "I would remind everyone to look at their job description and have input into that," she adds. "I rewrote mine and put as many action and managerial type words [as I could]." That didn't translate into an immediate raise for Strode, though she felt better having an action-oriented position.

She later became a case manager and had another opportunity to write her own job description. Because a case manager is on a higher pay scale than an RN, Strode has a higher earning potential.

The *HEH* Salary Survey found that 52% of employee health nurses earn between $40,000 and $60,000. By contrast, most employee health managers (53%) earn between $60,000 and $80,000. The highest paid employee health professionals work in suburban areas and live on the West Coast.

Getting a raise may be difficult in lean times for hospitals. But you can enhance your visibility and your value to your organization — and eventually better pay may follow, employee health experts say. Here is some of their career advice:





✔ **Conduct an organizational assessment.**

"We really have to step back and do a careful analysis of what we hope to accomplish and look at it strategically so we then can demonstrate positive outcomes," says Guzik. You want to know who the important players are in the organization. Analyze costs, including the costs of the employee health service, workers' compensation claims, and regulatory compliance. "Sit back and develop the strategic goals you wish to accomplish with the partners who will help you accomplish those goals," she says.

✔ **Challenge yourself to add value.**

When you've been in your position for a long time, you may drift into "maintenance mode," Guzik cautions. "You develop your policies, your procedures, your standards. You educate; you communicate. Then once that's accomplished, you hit a plateau," she says.

"The most important thing is not to be satisfied sitting on top of that plateau. It becomes comfortable; but when you become comfortable you become vulnerable." Instead, you need to be creative and innovative, and set new goals — even in a cost-cutting environment, Guzik says. "The business world today demands that we do more with less across the board," she says.

✔ **Take the time to build relationships**

Do you want to know more about the hospital's finances and how your work affects the bottom line? Or understand more about legal ramifications of what you do? Invite someone from finance or the legal department to lunch, or just ask him or her for a few minutes of his or her time to talk. "Take the opportunity to have lunch with people in your organization. Don't go to lunch with the same people day after day," Guzik advises.

You also should find people who share your goals and can help you promote your programs and proposals, says **Pat Dalton**, RN, COHN-S, occupational health project specialist at Pitt County Memorial Hospital in Greenville, NC.

She has been in occupational health nursing for 36 years. "You've got to have an ally, somewhere along the line. It might be a physician. It might be a new medical director. It might be the chairman of infection control or safety or risk management."

For example, when Dalton wanted to establish an alternative staffing program for nurses on work restrictions, she first went to the vice president of nursing with her idea and gained support. Eventually, she and the vice president presented the idea to top administration and the hospital's board. Don't work alone, she advises. But make

sure you bring your proposals to people who have the power to make them happen. "You can't do things in a big way unless you start at the top and know your support comes from there," she says.

✔ **Boost your skills.**

At Inova Health System in Fairfax, VA, employee health is a part of human resources.

Diane Dickerson, RN, MS, COHN-S, CPHR, director of Employee Occupational Health Services, wanted to understand the human resource perspective, so she earned a master's degree in human resource management and development.

"I wanted a broader scope or a broader knowledge of the scope of HR and how all the puzzle pieces have to fit together," she says. You're not looking at [just] one person's needs, you're looking at a whole organization."

The degree didn't lead to an immediate raise, but Dickerson eventually was promoted from employee health manager to director.

If you want to know more about another area, such as budgeting, don't wait for your hospital to send you to a seminar, Guzik adds. "We have to be motivated to do those things on our own — otherwise, you are not perceived to be professional and motivated to change yourself. We have to take the initiative to continue to learn, continue to grow, to move beyond our comfort level so we can speak the language of other people in the organization."

✔ **Market yourself.**

Do your employees think of you as a trusted professional who's there for them? Do your administrators know what you do and how you work to prevent injuries and lower costs? They will if you make them aware of accomplishments.

Strode enjoys building relationships with employees and going beyond regulatory compliance or injury surveillance. "I always think of the employees as my patients. I want them to know I'm here for their health," she says.

Strode also advises employee health professionals to get out the word, for example, by putting articles on employee health in the hospital newsletter.

"We've been trying so hard to empower our nurses. Publicize yourself and all that you do," she adds. ■