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Health care heroes weather Gulf Storm with guts and emergency planning

Advance planning makes the difference

Health care workers were heroes of Hurricane Katrina as they worked under grueling conditions to keep their patients alive despite lack of electricity, air conditioning and water, and sewer service.

Surviving the hurricane required more than guts and dedication. How hospitals fared depended on the level of emergency planning put in place before the hurricane hit.

Stories emerged after the hurricane of critically ill patients who died while awaiting evacuation and of doctors and nurses suffering from dehydration and fatigue. But there also were tales of ingenuity, courage, and professionalism amid dire circumstances. (See related article on p. 136.)

At Tulane University Hospital and Clinic in New Orleans, **George Jamison**, HCSP, CHCM, GC, director of facility services and safety officer, arrived at work at 7:30 a.m. the Saturday before the storm and began calling in staff and making additional emergency preparations. He didn't leave until the following Friday, on one of the last helicopters

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Special report: Needle safety and disaster preparedness

Five years ago, the Needlestick Safety and Prevention Act brought a new culture of sharps safety to hospitals around the country. In a special two-part report, *Hospital Employee Health* will explore the impact of this law. While thousands of needlesticks have been prevented, *HEH* found lingering barriers to compliance that leave health care workers at risk from blood-borne pathogen exposures.

HEH also pays tribute to the health care heroes who weathered two monster hurricanes — Katrina and Rita. We reveal how emergency planning, including caring for health care workers and their families, helps hospitals survive disasters. ■

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to evacuate patients and staff.

Not a single patient at Tulane died during the ordeal, Jamison notes proudly. (Two patients brought to Tulane from nearby Charity Hospital were dead on arrival, he adds.) Visitors, employees, and their family members also fared well.

Before the storm, Jamison and his colleagues had imagined the worst-case scenario — a key component of emergency planning. “You think of every hazard that could happen to you and you prepare for it,” says Jamison, who is a surveyor for the Joint Commission on Accreditation of Healthcare Organizations. **(For more information on emergency planning and the Joint Commission, see related article on p. 137.)**

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Every year, at the beginning of the hurricane season, Jamison stocks a supply of shaving cream, extra clothes, and food. Those are his small steps toward being prepared.

But getting the hospital in shape is a much more daunting task. As Hurricane Katrina approached, it began with a conference call with officials at HCA Corp., the Nashville, TN-based hospital governing body. Jamison conferred with the medical director, the chief nursing officer, the nursing director, the chief of the hospital police, and the head of dietary services.

The hospital called in employees for 1½ times its usual staffing, based on its patient load of about 136. The nurses were staffed for 12-hour shifts; physicians, medical residents, and interns also called in. At orientation, before they began work at Tulane, they were advised to have emergency plans. Now they had 24 hours to evacuate their families before reporting to work. The hospital was stocked with food and water.

Family members — and their pets — who did not evacuate were placed in the hotel across the street.

Meanwhile, on Saturday, Jamison called in his facilities team: three engineers, a maintenance manager, two electricians, one plumber, three general maintenance workers, a refrigeration specialist, the biomedical equipment director, and a technician, and the person who supported the hospital's medical gas supply. He told them all to bring extra clothes and a supply of food.

HCA began stocking supplies at staging areas around the Gulf Coast, with water, food, and linens that could be brought in.

Jamison already had imagined the potential of flooding that submerged the first floor. That flooding would swamp the generator, so he arranged for an additional, 2-megawatt generator to be placed on the mezzanine level. That generator was able to power two elevators, air conditioning, lighting, and medical equipment.

He brought in extra linens and moved the pharmacy, dietary services, and linens from the first floor. He placed huge bags of a kitty litter-type absorbent material on the floors. They were poured into red hazardous waste bags and placed in toilets when the sewage failed, allowing the hospital to maintain hygienic conditions.

Jamison also had about three portable gas generators. Each one was capable of supporting seven ventilators. Jamison wasn't counting on much outside help once the storm hit. “We actually stocked our supplies based on the thought that

we wouldn't get that much support from other agencies," he says.

Rescues amid gunfire, chaos

On Monday, after the hurricane passed, but before the levees broke, Tulane received 60 patients and their family members from the Superdome — a total of about 130 people. They were paraplegics, amputees, renal dialysis patients, and elderly people in poor condition. The hospital expected an emergency medical team to accompany them, but they came with no support, and no medical records.

Some family members of hospital employees were able to evacuate Monday afternoon, but by Monday evening, the flood waters had extinguished the hotel's generator. They were plunged into darkness as the city descended into chaos. Gunfire could be heard in the streets outside.

Some family members waded across the street and into the hospital. But Jamison needed to rescue his 79-year-old mother and two dogs. Tuesday evening, Jamison found a rubber rescue boat and, amid the staccato of gunfire, managed to bring his mother and dogs to safety.

Meanwhile, 13 critically ill patients arrived by boat from Charity Hospital. Everyone with nursing credentials — the chief operating officer, the nursing director, the employee health nurse, associate directors of nursing — pitched in to care for patients. When the generator failed from lack of fuel, they worked by flashlight.

Jamison notes the hospital maintained its policies and had a system to "set up command, take control, and communicate." The nurses calmed the patients.

"If you ever want to know what good nurses were made of, it showed there," he says. "It was truly a dedication of the nursing staff, some seasoned nursing and some junior nursing mixed together."

The day before Tulane ran out of fuel, Jamison asked for evacuation plans to begin. "It was actually around noon when I went in and told the COO and CEO and our [HCA] division president, who stayed with us the whole time, that I no longer could support the hospital," he says. "I thought by tomorrow at this time, we wouldn't have fuel. 'I'm telling you that, in my professional opinion, we need to start evacuation procedures immediately.' They contacted HCA corporate, and we started work."

On Thursday, when the elevators failed due to lack of electricity, most patients were already

positioned on the second floor, ready for transfer to the garage. Two patients had to be moved by hand — a 350-pound patient and a critically ill heart patient. Both survived the transfer.

Nurses continued to use the portable gas generators for patients on ventilators, but some still had to be manually "bagged" while they awaited evacuation.

Even the evacuation relied on advance planning. Jamison and his colleagues had considered how to turn the top level of the garage into an emergency helicopter landing pad. Bolts on four large lamp standards would need to be sawed off, and the lamps removed, but the garage was capable of holding the weight of the helicopter.

"If we had not done proper preparation, that would not have been possible," he says.

HCA began arranging privately for helicopters, and flew in body armor for the hospital security force because of the dangerous conditions on the streets. They connected with ham radio operators in Tallahassee, FL, to help guide helicopters in a kind of air traffic control.

"We worked with anybody we could find to get helicopters," says HCA spokesman **Ed Fishbough**. "We started on it before the storm."

Eventually, HCA found 20 helicopters to use in the evacuation. But with 1,200 people to evacuate, it began slowly. Patients were brought from the swamped Charity hospital to be evacuated from Tulane. The small helicopters could take only one or two patients at a time.

"We found out the airport wasn't being used, [so] we started using it as a triage center," says Fishbough. "[It was an] eight-minute trip to the airport, two minutes on the ground and you're back. The government started to use Louis Armstrong [airport] as a triage center, as well."

The government rescue teams refused to take pets, and Jamison actually contemplated shooting his two boxers rather than abandoning them in the flooded hospital. But HCA offered to take pets as well as people.

"You can't ask people to come in and work and leave their pets behind," says Fishbough. "To them, that's part of their family."

On Thursday night, hospital police said they could not protect all the entrances to the hospital. Patients, employees, and family members moved to the garage, where they spent the night while security officers teamed up to guard the entrances. Everyone was evacuated by Friday afternoon, five days after the storm hit.

After the storm, Jamison moved to Snyder, TX,

to stay with his daughter. He immediately began working toward restoring the hospital facility.

Jamison's advice to other hospitals? Follow EC410, the Hazards Vulnerability Analysis standard of the Joint Commission.

"Exercise your plan to the nth degree," he suggests. "Actually call the people [on staff] and say, 'How well prepared are you?' Get [their emergency] names and phone numbers. When you have one of these drills, [think about] what would happen if you had to stay for four days. Could you? Would you?"

Jamison now knows the answer to that question is yes — for himself and his dedicated staff. ■

Chief nursing officer recounts Katrina efforts

HCWs put patients first in storm

[Editor's note: This e-mail was written by Pamela McVey, RN, CIC, chief nursing officer at Biloxi (MS) Regional Medical Center, to a chief nursing officer in Natchez, MS. McVey was formerly director of infection control/employee health at the hospital. She gave Hospital Employee Health permission to reprint this e-mail, and added this postscript: "We all understand that there is no 'getting back to normal.' We are now in the process of redefining what is normal. There is a great spirit here in the coastal counties of Mississippi. We'll be OK."]

Well, we just got our e-mail up and running. I hope this actually goes through to you. It must have been your prayers that saved us. If you came down here and saw firsthand the death and destruction on the coast from Ocean Springs to Waveland, MS, you would see that there is NO WAY that Biloxi Regional Medical Center should still be standing!!!

All of our staff, to the best of our knowledge, survived the storm as far as no major injury or death. Everyone is blessed to be alive. However, a large percentage of our staff have suffered catastrophic losses of homes and belongings. Many, many, many of us have lost absolutely everything we own, myself included. My home was in an area, in Pass Christian, that is so badly demolished, that the National Guard and EOC [Emergency Operations Center] cannot even get to it yet. Some of my pets were in a kennel in Pass Christian that more than likely no longer exists. Everyone continues to put

all of the personal loss behind them and tend to the patients, our first priority. It is only in the silence of a broken heart, when alone for a few minutes, or with a trusted co-worker, that the tears flow briefly. Then it's back to business. I do believe that most of the patients do not know the extent of the loss of the health care workers that are caring for them. And, they shouldn't know it. It should not be their burden.

You just would not believe it here. The city of Biloxi has no water, so we have had no water to run our air conditioners. Of course we have had mid 90-degree weather. Inside, it has to be well over 100 degrees. Of course, this also means that we cannot bathe or flush toilets. Think of 100 degrees, nobody bathing, and no toilets flushing. Can you spell "STINK"? We must constantly watch the staff for heat exhaustion in addition to watching the patients for the same thing. We have had only generator power; so needless to say, in order to conserve the generator power, there were frequent and extended times that the elevators were not working. (We have six floors in our hospital.)

We had been cut off from all outside communication. During the storm, we lost cable, so could not monitor the weather. Our EOC radio did not work, the phones went down, and the cell phones would work very sporadically. Windows in patient rooms started flying in and we had to evacuate the patients out of their rooms and into the hallways. As windows continued to fly in and ceiling tiles were ripped from the ceiling, glass was flying all over. We had to try to nail the doors shut, because after a certain time, the broken windows were trying to suck everything out.

We then had to evacuate the sixth-floor patients to the first floor. We no sooner got 38 patients from Med Surg down to the first floor, when it became apparent that the Gulf of Mexico was in our hospital loading dock, just about ready to lap over into the ER.

Things were flying off of our roof, patient rooms were leaking, not really from the roof, but the force of the wind, close to 145 mph, which was driving the rain straight through our bricks. Water was then seeping down onto the ceiling of the floors below and then that started the whole domino effect of ceiling tiles falling, things getting ruined by water coming through the ceiling, etc.

When the storm ended, we were all still alive. We didn't have any idea of what it looked like outside of our little world.

We finally were able to start getting in touch with corporate and once that happened and they

started getting a list of our needs, things got mobilized really fast. I can't say enough about HMA [Corp., owner of the hospital]! They are busting it, trying to get our every need met!

Our sister HMA employees are arriving to help and they are a godsend! Supplies and ice and fuel and clothes and chocolate and our every need is being seen to! You would just bust down and cry if you could see the response from our Mississippi division and all of corporate and our sister hospitals!

Homeland Security is here and there are federal police protecting our ER doors. The National Guard is here, [National Disaster Medical System] is here, and it is overwhelming to see all of this all in and around our beautiful little hospital.

Tonight, for the first time since the storm, we have some air conditioning going. We are not sure how long it will last, but we believe that as we sleep on the floors all over the hospital tonight, we'll get some sleep for the first time. We are running out of food and we do hope that a food truck will reach us tomorrow. It was supposed to have come yesterday and did not make it.

I cannot say enough about the staff of BRMC! Through the entire 12-hour beating, this hospital was, even with moving patients all over to the best area of safety, one step ahead of the storm, and only one of our patients had any anxiety. She was a mom with a potential [pulmonary embolism], with a 4-day-old baby in her arms. That is a tribute to our staff that the patients never panicked because the staff never let on how scared they were. They were calm and confident, professional, and positive.

It has been, and remains, an experience like no other. Yesterday evening, I got my first chance to get out of the building and walk around a little bit. It is 100% totally overwhelming. It smells like death and destruction. It looks like someone dropped a big bomb on us. Almost everything is gone or has been moved to a new location.

Our ER and grounds look like a M.A.S.H. unit. There are injured people everywhere! Our morgue is filling up. There are not enough shelters for the stranded, hungry, thirsty people that are approaching our hospital hourly. We had a young man arrive to our ER and die today with a body temp of 108! We have snakebite victims, people who are already septic with *Vibrio* because of seven-hour swims clinging to trees after having been blown out into the storm.

Our nurses, doctors, techs, therapists, and everyone else has been fantastic throughout! The commitment and dedication to the great responsibility

of caring for the patients in our community who have been entrusted to our care and protection has been evident this week. It is an awesome and humbling experience to say that I am their chief nursing officer. With a lesser crew, we would not have survived as long as we have. I can't say that I wish this experience on anyone, but I do know, it is and will continue to be, a life-changing experience. God bless you and thank you for praying for us! ■

JCAHO: Small communities not well prepared

Hospitals should take role in planning

Even before hurricanes Katrina and Rita struck the Gulf Coast, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, worried that small communities were not doing enough to prepare for a disaster.

In a new report, the Joint Commission details 13 steps that communities should take to be prepared for a disaster. The guide is not just for hospitals, but it offers specific suggestions on the role hospitals can play in broader community planning.

Standing Together: An Emergency Planning Guide for America's Communities stresses the need to collaborate with other community entities, consider all possible hazards, and prepare for surge capacity, communication needs, and sufficient resources. (The guide is available at www.jcaho.org/news+room/press+kits/ems/emergency_planning_guide.htm. **For a list of the 13 steps, see box on p. 138.**)

A wake-up call

With Katrina, emergency preparedness made a difference in how well hospitals fared, says **Robert Wise**, MD, vice president of the Joint Commission's Division of Standards and Surveying Methods. But that was no surprise. The Joint Commission has been reviewing the impact of disasters on hospitals since Tropical Storm Allison flooded Houston in 2001 and forced a middle-of-the-night evacuation of Memorial Hermann Hospital, he says.

"If [Katrina] is a wake-up call, there have been a number of wake-up calls along the way," Wise says. "Hopefully, you don't need a hammer in the head to get up in the morning."

If your community is not at risk of hurricanes or earthquakes, there's no reason to feel off the hook, he says. Every community has a range of potential crises, from a major industrial accident to a terrorism attack. "There are some real risks associated with just being a city in the United States," Wise says.

Or, as it says in the planning guide, "Challenges abound, but perhaps the most threatening of these challenges is complacency."

Too often in smaller communities, there is no single voice for hospitals and they end up being left out of the local emergency planning committee. Wise advises hospitals to set aside their competitive nature and ensure they have a role in communitywide planning.

The Joint Commission developed the guide in partnership with the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University. It also convened two expert roundtable meetings in 2004.

Wise notes these lessons learned from past disasters:

- **Hospitals must be able to stand alone for at least 48 to 72 hours.**

In the immediate aftermath of a disaster, your hospital may be on its own — no water, power, transportation or other resources from the outside. You need to have resources, including equipment, medication, generator power, and water to survive.

Many hospitals are not prepared to provide for all their own needs, says Wise, who visited New Orleans about three weeks after Katrina hit.

"It's uncommon for emergency generators to handle all of the necessary utilities within a hospital," he says. "They often don't handle an HVAC. If you do not have your air conditioning or heating, it gets pretty miserable in there pretty quickly."

For example, the Ochsner Clinic Foundation in Jefferson Parish, LA, had well water as well as generator power and was able to stay open during and after the hurricane, says Wise.

- **Hospitals must take care of the personal needs of their staff.**

The disaster that is devastating the community is also devastating the lives of your staff — destroying their houses, scattering their loved ones, altering their lives.

"These community disasters have typically impacted the staff as much as it does the other victims. It has produced an unusual stress," says Wise.

JCAHO identifies 13 essential steps of emergency planning

These are 13 essential components of emergency planning, according to the Joint Commission on Accreditation of Healthcare Organizations:

1. Define the community.
2. Identify and establish an emergency management preparedness and response team.
3. Determine the risks and hazards the community faces.
4. Set goals for preparedness and response planning.
5. Determine current capacities and capabilities.
6. Develop the integrated plan.
7. Ensure thorough communication planning.
8. Ensure thorough mental health planning.
9. Ensure planning related to vulnerable populations.
10. Identify, cultivate, and sustain funding sources.
11. Train, exercise, and drill collaboratively.
12. Critique and improve the integrated community plan.
13. Sustain collaboration, communication, and coordination. ■

Hospitals that manage successfully during a disaster understand that they need to take care of their employees' needs, he says. For example, after Hurricane Charley hit Charlotte County, FL, one hospital sent crews to employees' houses to put up tarps and make repairs.

"[Hospitals] can have perfectly running generators and all the water and food, but if they don't take care of the staff — and the staff has to take care of their personal disasters — they will not be able to run the hospital," Wise says. "Your staff cannot feel endangered, cannot feel pulled away from their families."

- **Maintaining a communications system is crucial.**

Even if you make it on your own, you need contact with the outside world. Hospitals need an emergency communications system, says Wise.

For example, after Sept. 11, New York hospitals developed an 800 MHz phone system that would connect hospitals and the Emergency Operations Center. The closed-circuit system would not be affected by overloading on the public circuit. The phone system worked well during the Northeast blackout in 2003. ■

Will HCWs come to work during a disaster?

Barriers differ with SARS, snow storm

If a major disaster struck your community, how many of your employees would show up for work?

A snow storm would likely draw in just about anyone who could make it to the hospital, but in an infectious disease outbreak such as SARS, about half of your employees might be unwilling to work, according to a study published in the *Journal of Urban Health*.¹

"Different crises present the responder with different challenges and obstacles," and emergency plans need to address that reality, says lead author **Kristine Qureshi**, RN, DNSc, assistant professor of community health nursing at Adelphi University in Garden City, NY.

Some emergencies will tax employees' ability to report for work, due to childcare or eldercare responsibilities or transportation difficulties, Qureshi notes. In other disasters, some health care workers may simply be unwilling to work due to the perceived risk to themselves or their families, she says.

Qureshi and her colleagues at the Mailman School of Public Health of Columbia University in New York City surveyed 6,428 workers from 47 health care facilities in the greater New York City area. The survey encompassed a variety of acute care hospitals — both teaching and non-teaching facilities, ranging in size from fewer than 200 beds to more than 600 beds. It also included long-term care facilities and community clinics. The findings were consistent for all types and sizes of facilities, the researchers reported.

About half (48.9%) of employees said they would be able to report during a snowstorm, while most expected to be able to report for a mass casualty event (82.5%) or environmental disaster (80.6%). Barriers to reporting for work included transportation (33.4%), childcare (29.1%), eldercare (10.7%) and pet care (7.8%). Many also had health care problems (14.9%) that could affect their ability to report. That might include the need for treatment, such as dialysis, or for medications.

Hospitals should stress the need for personal emergency planning, including backup caregivers and emergency contacts that are updated annually, says co-author **Robyn Gershon**, DrPH,

associate professor at the Mailman School of Public Health.

They also should have emergency plans for providing care for employees' family members, she says. For example, a temporary childcare center could be set up, and elderly relatives may be able to help with the care of the children. Hospitals should also consider employees' needs for pet care, she adds.

"People don't want to be separated in a time of disaster. They want to know where their family is," Gershon says.

Willingness to report to work involves different barriers. Less than half of those surveyed said they were willing to work during a SARS outbreak (48.4%). They also were less likely to be willing to work during radiation (57.3%), smallpox (61.1%), or chemical (67.7%) events.

The reason: concern for their family or themselves.

"For those events where employees perceive they are at higher risk of injury to themselves or their family, they are less likely to be willing to report," says Qureshi.

Health care workers must believe that they are going to be safe at work, she says. "In the United States, we normally do not tell people when they're hired in health care that you have an obligation to respond, even if it's going to hurt or kill you."

Health care workers might be worried about being stigmatized during an infectious disease outbreak. During the SARS outbreak in Toronto, some health care workers reported that their children were ostracized as their friends' parents worried they might carry the virus, Gershon says. Nurses also were quarantined during the outbreak, allowed only to go home or to the hospital. They even wore respiratory protection at home when they were around their family.

The survey was conducted shortly after the SARS outbreak.

In some cases, the perception of risk may not reflect the true level of risk, Gershon reports. Hospitals may address perceptions of risk through education, she says. They also can improve trust by providing for adequate personal protective equipment and other worker safety provisions in emergency planning, she says.

Health care workers also were very willing to help out another facility during an emergency (79%), but that willingness depended in part on proximity. For example, only 17.5% said they would be willing to work in another state.

The recent Katrina disaster demonstrated the

willingness of health care workers throughout the country to pitch in. Some volunteered for medical support teams that traveled to the Gulf Coast. And in many communities, nurses and other health care workers volunteered to provide medical care and assessments to evacuees.

“Every person that I talk to within the system wants to help,” says **Sharon Marsden**, RN, employee health nurse at Seton Medical Center in Austin, TX, where nurses, social workers, and pastoral care staff were able to take time from work to care for evacuees at the Austin convention center.

Reference

1. Qureshi K, Gershon RRM, Sherman MF, et al. Health care workers' ability and willingness to report to duty during catastrophic disasters (Advance Access published on July 6, 2005). *J Urban Health* 2005; 82:378-388. ■

5 years after needlestick law

We're safer, but not safe enough

Market data show gaps in adoption

Five years after the Needlestick Safety and Prevention Act became law, hospitals have made a dramatic shift to safety devices, bringing about a decline of one-third to one-half in the rate of needlesticks among health care workers.

But amid this sea change toward a safer workplace, serious problems still exist. Virtually no operating rooms use blunt suture needles, a technology that has improved and is in widespread use in Japan. Some specialty areas, such as anesthesia and allergy, continue to resist the use of safety products. And cost and convenience continue to play a role, as with the use of conventional devices in pre-packaged kits and trays.

“It’s the first law in the world mandating safety devices. There’s no doubt it’s had a huge impact,” says **Janine Jagger**, PhD, MPH, a pioneer in sharps safety who is director of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville. Yet, she adds, “there are areas where the compliance has not been as good.”

Jagger and other sharps safety experts have turned their attention toward promoting sharps safety in these “residual areas.” They focus on education, better training, evaluation and selection

Market Penetration of Safety Devices

Hollow bore syringes and needles

Acute care (hospital)

FY 02: 46%
FY 03: 62%
FY 04: 71%
FY 05*: 79%

Alternate site

FY 02: 35%
FY 03: 39%
FY 04: 41%
FY 05*: 45%

*projected

(Note: These numbers reflect overall market penetration and not just Becton, Dickinson sales.)

Source: Becton, Dickinson & Co., Franklin Lakes, NJ.

Blood Collection Devices

Acute care (hospital)

FY 02: 74%
FY 03: 78%
FY 04: 82%
FY 05*: 83%

Alternate site

FY 02: 44%
FY 03: 52%
FY 04: 57%
FY 05*: 57%

*year to date

Source: Becton, Dickinson & Co., Franklin Lakes, NJ.

of new technologies, and even influencing manufacturers to improve their device offerings.

“People aren’t really using systematic evaluation,” says **June Fisher**, MD, director of the TDICT Project (Training for the Development of Innovative Control Technologies), which provides tools and training to health care facilities for sharps safety devices. She also is associate clinical professor of medicine at the University of California at San Francisco. “I’m hoping that people will be upgrading [devices] on an ongoing basis.”

Conventional devices still used

There’s plenty of room for improvement. Market data reveal the progress as well as the gaps in safer device implementation.

In acute care facilities, virtually all peripheral IV catheters (95%), which are attached to needleless IV systems, are safety-engineered devices, according to market conversion data compiled by the Healthcare Products Information Services in

San Jose, CA, and provided to *HEH* by Becton, Dickinson & Co. (BD) in Franklin Lakes, NJ. Yet in other health care settings, such as doctor's offices, clinics or surgery centers, about 18% still are conventional devices.

Syringes and blood collection devices were a prime target of safety programs as the problem of needlesticks emerged in the 1990s. But an estimated 21% of core hypodermic needles and syringes used in acute care hospitals still are conventional devices, according to projected FY 2005 data. Some may be used for pharmaceutical or other activities that don't involve the risk of blood-borne exposures. But in alternate care sites, less than half (45%) of the needles and syringes used are safety-engineered — a clear indication that sharps safety is lagging. (See charts, p. 140.)

Some medical specialties have been particularly unwilling to adopt safety devices. For example, in hospitals, only 59% of syringes and needles used in insulin administration and only 26% in allergy treatment were safety-engineered.

"The conversion to safety is highly dependent on behavior change," says **Amber Hogan**, MPH, manager of safety and health policy at BD, and some specialists have been more resistant to that change.

Hospitals should make sure that clinicians who work in multiple facilities do not bring conventional devices with them, says Hogan. For example, some anesthesiologists still will use a conventional needle to access a needleless IV system, overriding the safety feature. If an employee is stuck, the hospital will be liable for any costs associated with post-exposure prophylaxis or seroconversion, she notes.

"Hospitals need to establish and enforce rigorous internal protocol," says Hogan, who previously

worked with the Occupational Safety and Health Administration (OSHA) compliance division.

Disparities also are evident in blood collection, according to the market data. In acute care, the use of safety devices rose from 74% in FY 2002 to an estimated 83% in FY 2005. Yet in alternate care sites, only an estimated 57% of blood collection devices are safety-engineered. "Safety adoption is highly dependent on the type of facility in which [providers] practice," says Hogan.

In fact, the earliest sharps safety efficacy studies focused on phlebotomy devices, demonstrating the benefits of the technology, says **Gina Pugliese**, RN, MS, vice president of the Premier Safety Institute. "Phlebotomy poses one of the greatest risks of transmission of bloodborne pathogens," she says. "We have plenty of devices on the market. This should be 100% [adoption]. We should have crossed the finish line on this one."

The Service Employees International Union and advocacy group Public Citizen asked the Food and Drug Administration (FDA) to ban devices that don't meet safety criteria and to ban glass capillary tubes, which have been associated with bloodborne pathogen exposures.

In a Sept. 8 *Federal Register* notice, the FDA said the agency didn't have a "legal basis" for banning the devices. Instead, the notice said the agency would promote education, assist other organizations with voluntary "consensus" standards, and provide swift clearance of safer technologies.

"By allowing considerably more dangerous devices to stay on the market when equally effective, safer alternatives are available, the FDA has endangered the lives of hundreds of thousands of health care workers in this country," contended **Peter Lurie**, MD, deputy director of Public Citizen's

OSHA Bloodborne Pathogen Inspections and Citations

Year	Total Inspections	Complaints	Programmed Inspections	Violations
FY 01 federal:	30	21	65	3
state*:	26	11	42	13
FY 02 federal:	55	19	104	34
state*:	32	10	52	17
FY 03 federal:	44	17	85	26
state*:	25	10	84	13
FY 04 federal:	45	11	126	31
state*:	26	10	40	9
FY 05: federal:	40	8	97	29
state*:	11	7	30	3

*partial data

Source: U.S. Occupational Safety & Health Administration, Washington, DC.

Percutaneous Injuries by Device Type*

Hollow bore needles:

- Hypodermic needle/syringe: 29%
 - Winged-steel needle: 8%
 - IV stylet/catheter: 4%
 - Phlebotomy needle (vacuum tube): 3%
 - Other hollow-bore needles: 9%
- Suture needle: 18%
- Solid sharp object: 9%
- Scalpel: 7%
- Other/unknown sharp: 13%
- Glass: 1%

*Based on aggregate data of 37,717 injuries reported to National Surveillance System for Healthcare Workers (NaSH), Exposure Prevention Information Network (EPINet), Veterans Health Administration, Massachusetts Surveillance System to Sharps Injuries, 2000-2004.

Source: Centers for Disease Control and Prevention, Atlanta.

Health Research Group, in a statement.

Still, needle safety has led to changes in market forces and inspired voluntary actions. BD has removed a couple of conventional devices from the market, including a reusable blood tube holder (OSHA requires single-use holders) and a dose-sparing syringe that used a conventional needle attached to the syringe. Premier, a Charlotte, NC-based health care alliance that provides group purchasing, no longer offers any conventional phlebotomy devices or IV catheters, Pugliese says.

The operating room has been the most imperious to the adoption of safer technology. Few reusable scalpels (less than 5%) incorporate safety features to protect the blade, and only 59% of disposable scalpels in use are designed with safety, according to the market conversion data. (Most surgeons use the heavier, reusable scalpels.)

Less than 1% of all suture needles used in the United States use blunt technology that allows the penetration of muscle and fascia but not skin, says **Brian Luscombe**, group director of marketing for Syneture, a division of U.S. Surgical based in Norwalk, CT. In fact, suture needle manufacturers have historically promoted their sharpness.

Changes in blunt suture needle technology, including a special coating that improves their performance, could change their acceptability, he notes.

"We have just launched an initiative to promote blunt needle usage," Luscombe says. "There's

CE questions

17. According to George Jamison, HCSP, CHCM, GC, what level of staffing did the hospital have during Hurricane Katrina?
 - A. A skeleton crew of about half the usual staff for the patient load.
 - B. Routine staffing levels.
 - C. About 1½ times the usual staff for the patient load.
 - D. Most staff were unable to report during the hurricane.
18. According to the guide by the Joint Commission on Accreditation of Healthcare Organizations, what is "perhaps the most threatening . . . challenge" in emergency preparedness?
 - A. Hurricanes
 - B. Terrorism
 - C. Infectious disease outbreak
 - D. Complacency
19. During what disaster would health care workers be least willing to report to work, according to a survey by the Mailman School of Public Health at Columbia University in New York City?
 - A. Hurricane
 - B. Snowstorm
 - C. SARS
 - D. Chemical attack
20. According to market data from the Healthcare Products Information Services, what is the proportion of safety devices used in blood collection in hospitals?
 - A. 83%
 - B. 92%
 - C. 95%
 - D. 100%

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

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

definitely a recognition at this point that blunt needles can contribute to reduction in the incidence of needlestick injuries.”

Meanwhile, some other safety products haven't even been developed for certain applications. For example, there are no safety-engineered arterial catheters or biopsy needles.

“More intuitive products are needed, more products that operate like their standard counterparts, to maximize use,” says **Cathie Gosnell**, RN, MBA, clinical consultant of Premier Safety Institute.

Pre-packaged kits often contain conventional devices, including conventional syringes, violating the hospital's own policies about selection and use of safety devices. These may have been chosen by surgeons or anesthesiologists who are not well educated on safety, says Hogan. They are provided by medical supply companies that specialize in kit-packing, not by device manufacturers.

“Kits and trays are not standardized,” says Hogan. “They're customized based on what the customer requests.”

Are you likely to get an OSHA inspection or citation from these gaps in safety? That depends on where your hospital is located and whether your practices generate complaints from employees.

In the past five years, various federal OSHA regions and state OSHA programs have had special emphasis programs targeting the bloodborne pathogens standard. For example, in FY 2005, more than a third of the 97 federal OSHA citations were issued in Region 3, which encompasses Pennsylvania, West Virginia, Delaware, and the District of Columbia. (Virginia and Maryland, also in the region, run their own OSHA-approved programs.)

The number of “programmed,” or planned, federal OSHA inspections related to bloodborne pathogens exposure in hospitals rose after the revision of the standard in 2001 — from three in FY 2001 to 34 in FY 2002. (See chart on p. 141.)

Complaints actually have declined. In FY 2005, there were only eight inspections of hospitals based on complaints to federal OSHA related to the bloodborne pathogens standard. In FY 2001, there were 21.

Yet concern about sharps safety and exposures

has not waned — and isn't likely to, says **Dionne Williams**, MPH, an OSHA senior industrial hygienist who focuses on bloodborne pathogen issues.

“We have a hotline that answers calls on compliance issues. Bloodborne continues to be the No. 1 [standard] that people ask about,” she reports. “It's the top of our health standard, one of the top issues.”

The most frequent cause of a citation: Failure to use a safety-engineered device. Citations also are often issued for failure to update exposure control plans annually or to receive input from non-managerial employees.

Thousands of health care workers continue to suffer needlesticks annually. With underreporting and a lack of uniform national surveillance, it's impossible to know the full breadth of the problem.

But it's clear that while needlesticks have declined, they still pose a substantial workplace risk. An on-line survey published in *Nursing2004* found that one-quarter of nurses said they had at least one needlestick in the past year, but 42% said they did not report their needlesticks. About 40% of nurses said they used conventional devices at least some of the time.²

In September, the Centers for Disease Control and Prevention (CDC) in Atlanta held a conference with sharps safety experts to develop an “action plan” on sharps safety. Reducing needlesticks is one

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. ■

COMING IN FUTURE MONTHS

■ How needle safety became the norm

■ Not a quick fix: Safety in ORs

■ Looking for a root cause of needlesticks

■ Working toward a smoke-free workplace

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of the seven health care safety challenges of CDC's Division of Healthcare Quality and Promotion. It also is a goal of HealthyPeople 2010.

The meeting adjourned with the creation of smaller "working groups" on subtopics and a decision to meet again. There was no clear game plan for tackling the remaining barriers to implementation of sharps safety.

Perhaps the challenge of redirecting a workplace culture was exemplified by the design on the cover of the binders for the National Sharps Injury Prevention Meeting. It offered the maxim, "Sharps safety begins with you." The picture showed a conventional needle.

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1. Food and Drug Administration. Needle-bearing devices; Withdrawal of advance notice of proposed rule-making. *70 Fed Reg* 53,326-53,328 (Sept. 8, 2005).

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

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Hospital Employee Health®

New opportunities rise amid EH retirement

Time to show your value, experts say

Employee health professionals are beginning to retire, leaving opportunities for other nurses to move into the field and raising the value of the more seasoned, experienced practitioners.

About one in four (28%) employee health professionals have been in their positions for three years or fewer, according to the 2005 *Hospital Employee Health Salary Survey*. A shift in the experience level of employee health professionals also was apparent in a 2005 member survey conducted by the Association of Occupational Health Professionals (AOHP) in Healthcare in Wexford, PA, which showed the largest group of respondents had been in their position for one to five years.

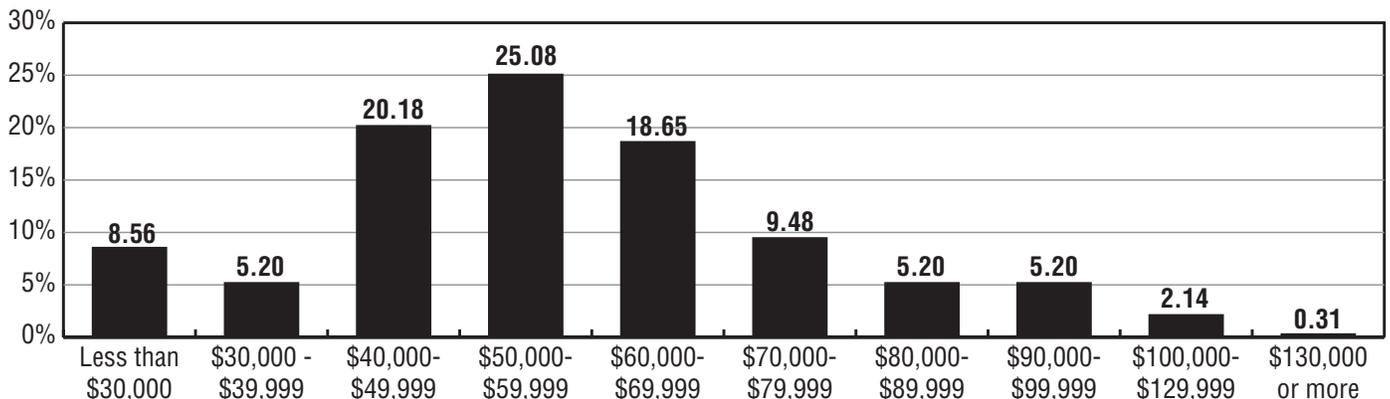
"We're starting to see a shift because of the

aging [of the work force]," says **MaryAnn Gruden**, president emeritus and community liaison for AOHP and employee health coordinator at Western Pennsylvania Hospital in Pittsburgh. "We have an influx of new faces in employee health."

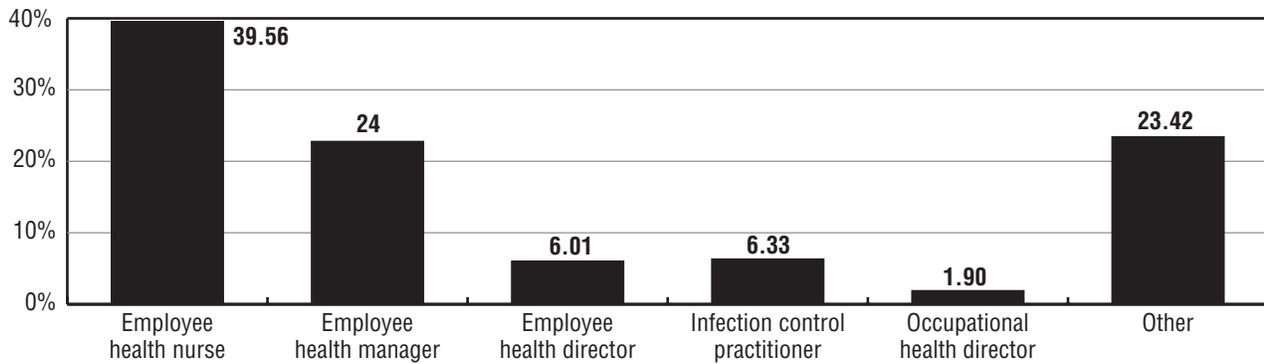
The salary picture in employee health has remained stable. Most employee health professionals (56%) received a raise of 1% to 3%, although a significant number did better than that. About 21% of EHPs received a raise of 4% to 6% and another 6% received raises of 7% to 10%, while 15% received no raise at all.

There were 330 respondents to the *HEH* survey. They were more likely to work at a nonprofit hospital in a rural or medium-sized city and at a hospital

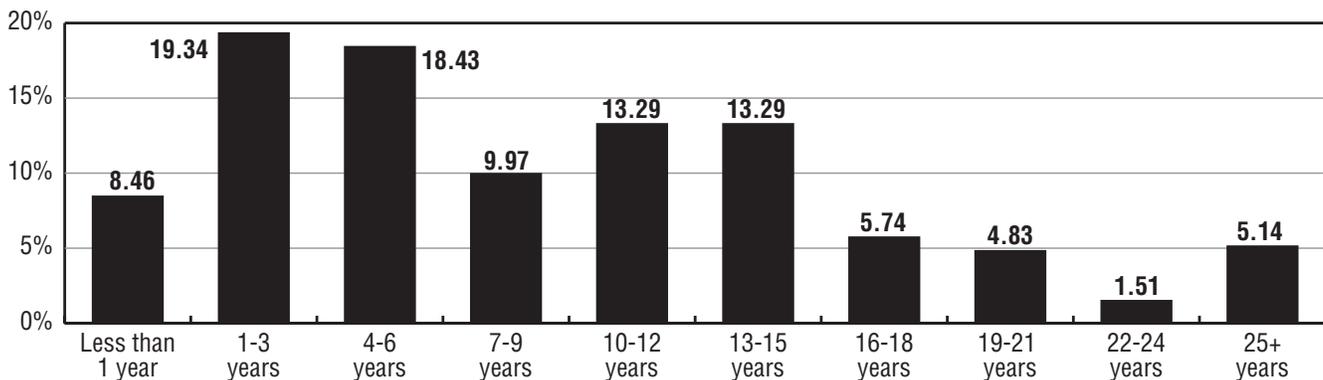
What is Your Annual Gross Income?



What Is Your Current Title?



How Long Have You Worked in Employee Health?



with 300 or fewer beds. The most prevalent salary ranges were \$40,000 to \$50,000 (reported by 20%) and \$50,000 to \$60,000 (reported by 25%).

Broaden your scope

Employee health continues to attract seasoned health care professionals. About half of survey respondents were older than 50 years, and 61% had worked in health care for more than 25 years. That experience is becoming even more valuable as employee health expands to encompass a broader set of responsibilities, employee health experts say.

At Children's Healthcare of Atlanta, **Jean Randolph's** title changed from employee health to occupational health manager, representing a different perspective on the job. She is involved with family and medical leave, disability, workers' compensation, ergonomics assessment, and injury prevention, among other duties.

"We're doing many more things than we ever did before," says Randolph, RN, COHN-S/CM, MPA. "Like every other facet of nursing, we're being asked to broaden our scope as much as we can."

Her work contributes to the hospital's bottom line, as she tries to control employee health care costs. For example, employees with chronic conditions such as diabetes and hypertension receive education and disease management. The department is even promoting work-life balance with a new program called Club MED (Motivate, Explore, and Discover) that aims beyond traditional wellness.

During lunch hours and on weekends, the hospital is offering classes on gardening, cooking, and scrapbooking. The hospital encourages employees to develop their personal interests and to spend time with their families. "We want them to recognize that family time is important to your life as well," says Randolph.

Randolph hopes to engage employees with topics they enjoy, but she also plans to incorporate such elements as health risk appraisals. Wellness programs help employees stay well and stay fit, and they serve as a retention tool, says Randolph.

Some employee health professionals may feel that wellness programs are a frill — something they will never have time to develop. But you have to move beyond the basic tasks of pre-placement physicals, TB testing, and immunizations, Randolph says.

“You’ve got to bring your value to people,” she says. “You can’t be in this job just to pass out Band-Aids and aspirin.”

Employee health also can play a more prominent role in hospital planning. For example, Randolph also chairs the emergency management committee in her hospital, acting as a liaison with the community.

“Occupational health nurses are the perfect people to be responsible for emergency management within their institution,” she says. “They should have relationships with outside agencies and they should have [had some education with] curriculum in emergency management.”

How can you take on additional responsibilities when you’re understaffed even for the basics?

That a tough dilemma for many employee health professionals. You’ll need to partner with others at the hospital and even use volunteer resources, says Gruden.

She has just 1.8 FTE (full-time equivalent) employees in her department — herself and a part-time nurse. She has no clerical support. She serves 2,500 employees, plus medical students and volunteers. (About 37% of employee health professionals report that they have no clerical support, according to the AOHP survey.)

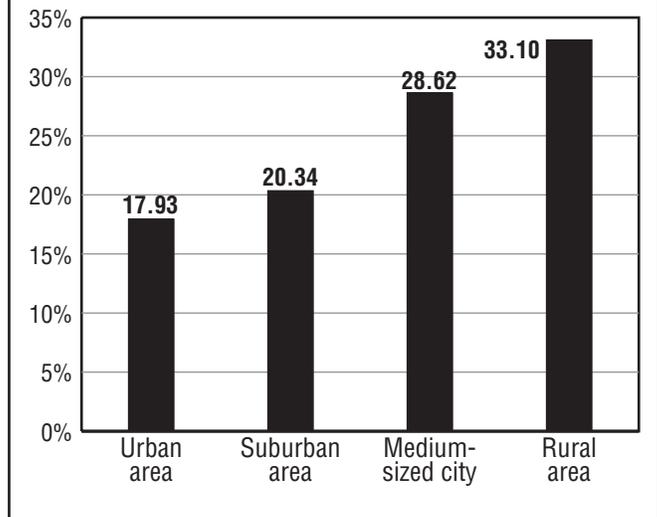
She and her nurse have learned how to work together efficiently. “We’re a team. If we have to get it done, we get it done,” says Gruden.

But she also depends on others at the hospital. Every fall, nurses volunteer to help administer flu vaccines to the staff. Managers also allow nurses to take time off their units to help with TB testing every January.

Meanwhile, if she has a question about the Family and Medical Leave Act, Gruden knows who to contact in human resources. She works closely with colleagues in infection control, safety, and risk management.

“You don’t work in a vacuum. You’re interdisciplinary,” she says. “You need to know where to go to tap into the resources you need.”

Where is Your Facility Located?



Through collaboration, you also inform others about the importance of employee health. After all, your work extends beyond the employee health clinic. By providing services such as ergonomic assessments and blood pressure checks, you raise your profile to the staff and administration.

“You have to think outside your box so you can find a way to have time to do some of the other things,” say Randolph. “Even if it’s just making yourself visible doing hypertension screenings, you’ve got to do that.”

Education and networking are key

Employee health professionals also need to build adequate career tools to do their jobs. That means networking, continuing education, and certification, employee health experts say.

At first, when nurses move into employee health, they may view it as another clinic for patient care, with employees as patients, says **Georgia Knuth**, RN, MS, COHN-S/CM, executive director of the American Board for Occupational Health Nurses in Hinsdale, IL.

“Many people continue to do the same kind of one-on-one treatment of patients that they did in a different arena,” she says. “An occupational health nurse looks at the exposures that are there in the work environment. They’re doing more upper-level decision making.”

AOHP offered “Getting Started” courses at its annual conference in October, and the American Association of Occupational Health Nurses in

Atlanta offers on-line courses as well as sessions at its annual conference in May. (More information is available at www.aohp.org and www.aaohn.org.)

The National Institute for Occupational Safety and Health also supports 16 university-based education and research centers around the country, which offer courses in occupational health nursing. (See www.niosh-erc.org.)

When you get beyond the basics, occupational health certification demonstrates that you have reached a level of experience and competency in the field and is a good marketability tool, says Knuth.

"Certification is extremely important," agrees Gruden. "It validates your competency in the specialty."

The HEH survey found that 14% of respondents had the COHN-S certification, a decline from 19% in 2004. AOHP also found a decline in certification in its member survey, from 81% in 2000 to 48% in 2005.

That may simply reflect the influx of new employee health professionals, says Gruden.

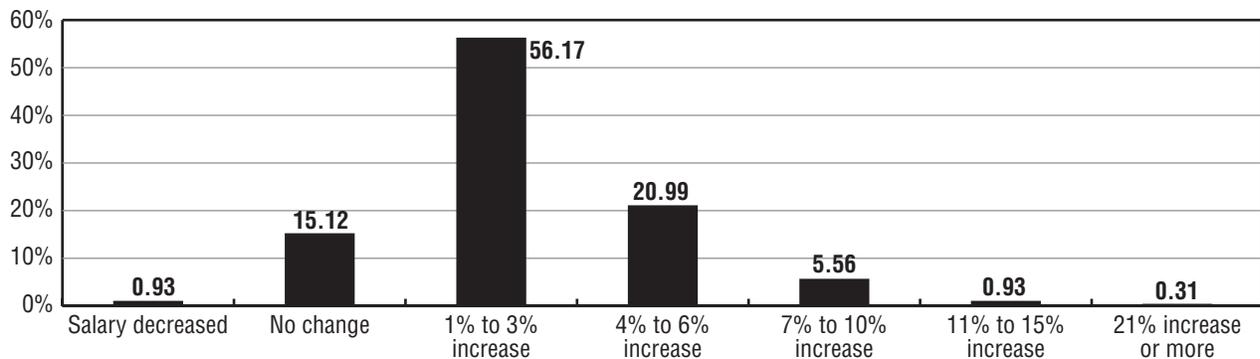
COHN certification requires 4,000 hours of occupational health work experience in the past five years and 50 contact hours of continuing education in occupational health in the past five years.

Continuing education and professional organizations help employee health professionals stay current in their field, says Gruden. "There's just so much that's changing," she says. "There's really a need to stay on top of the issues and be able to respond to those issues as they come up."

At many hospitals, employee health is staffed with only one specialist, or with a nurse who has responsibility for both employee health and infection control. AOHP and AAOHN provide networking opportunities with colleagues at other hospitals through local or state chapters.

"You don't have to be alone," says **Susan Randolph**, MSN, RN, COHN-S, FAAOHN, president of AAOHN and a clinical instructor in the Occupational Health Nursing Program at the University of North Carolina at Chapel Hill. "There's a whole network of people available to share ideas and to provide guidance." ■

In the Last Year, How Has Your Salary Changed?



What Is Your Highest Degree?

