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Landmark law requires Washington hospitals to buy lift equipment

$10 million fund supports purchase of one lift per 10 beds

Washington has become the first state in the nation to require hospitals to use patient transfer equipment "instead of manual lifting" as part of a safe patient handling program. The law, which easily passed the state House and Senate, with support from unions and the hospital association, is a landmark for the safe patient handling movement.

As other states consider measures to promote safe patient handling, health care worker advocates draw a parallel with the state-by-state campaign that led to a national needlestick prevention law.

"Momentum is building," says **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU). "This is synonymous with the first safer needle law we got passed in California in '98 that led to the federal law in 2000, after we passed 20 state laws.

"A very similar scenario is playing out here," he continues. "Hopefully, this won't take as long when enlightened employers realize how cost-effective these programs are."

Last year, Texas passed a law requiring hospitals to implement a safe patient handling program. Although it doesn't require the use of lifts or other devices, hospitals there have begun purchasing more ergonomic equipment, Borwegen says.

The Rhode Island, Florida, New Jersey, and Massachusetts legislatures also considered safe patient handling bills this year. A 2005 Ohio law provides no-interest loans to nursing home employers to pay for patient handling equipment and training, and a New York law established a voluntary two-year pilot project.

The Washington legislation differs from other efforts in one important way: It provides financial compensation to hospitals for purchasing patient transfer devices.

The law establishes a $10 million fund to provide a tax credit of up to $1,000 per bed to compensate for the expense of new equipment, and it directs the state's workers' compensation fund to

reduce insurance premiums for hospitals that implement the safe patient handling program.

That financial compensation, along with some wording changes, influenced the Washington State Hospital Association (WSHA) to support the legislation.

"We're the first state in the nation that provided funding for hospitals," says **Cassie Sauer**, the association's director of advocacy and public relations, noting that lift equipment is an expensive investment. "State legislatures around the country continue to pass unfunded mandates for hospitals."

Ergonomics regulations have a long, rocky history, but focusing solely on patient handling has been a successful strategy for health care worker unions.

After all, there are numerous studies showing that lift and transfer devices save money by reducing worker injuries. Nursing is one of the top 10 occupations suffering from the most musculoskeletal disorder injuries. And hospitals face a growing nursing shortage, which is exacerbated as an estimated 12% of nurses quit the profession each year due to back pain.[1]

"This is the ultimate low-hanging fruit," says Borwegen. "There are studies that show facilities save up to $10 for every $1 they invest in these programs. These are the most cost-effective ergonomic interventions that I'm aware of."

The U.S. Occupational Safety and Health Administration issued an ergonomics standard in 2000, but Congress rescinded the rule months later. Washington state developed a comprehensive ergonomics rule in 2002, which required employers to identify "caution zone jobs" and to reduce the hazards of musculoskeletal disorder injuries. Lifting 75 pounds or more once a day would have qualified as a caution zone job, which means hospitals would have been required to reduce the hazards of patient handling.

In a 2003 ballot initiative, Washington voters rescinded the ergonomics rule, which was strongly opposed by a coalition of businesses.

"They made it sound like if you supported ergonomics, you were in favor of people losing their health insurance. All these jobs would be leaving Washington state and people would be on the street without health insurance," recalls **Carter Wright**, communications director of SEIU 1199 Northwest in Seattle.

"It was much harder to distort the reality of what the problem is for health care workers," he says. "We had a really remarkable number of members of our union get involved in a really personal way [by contacting legislators]."

A mandate with money

The turning point for Washington's safe patient handling law came when the WSHA switched from opposing to supporting it. Wording was changed; so rather than requiring a "no manual lift" policy, the law requires a "safe patient handling policy."

That ensures that equipment wouldn't be required for patients who don't need it, such as infants or those who may be too vulnerable to injury, such as hip replacement patients, says Sauer. "The first version was too open-ended. It

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Washington law requires safe patient handling

According to the Washington safe patient handling law, hospitals must:

- Create a safe patient handling committee by Feb. 1, 2007. They may assign the duties to an existing committee. At least half the committee members must be "frontline nonmanagerial employees who provide direct care to patients unless doing so will adversely affect patient care."
- Establish a safe patient handling program by Dec. 1, 2007, which includes a safe patient handling policy for all shifts and units.
- Conduct a patient handling hazard assessment that considers "patient handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas."
- Develop a method to "identify the appropriate use of the safe patient handling policy based on the patient's physical and medical condition and the availability of lifting equipment or lift teams." That includes circumstances in which certain devices would be medically contraindicated for particular patients.
- Purchase equipment by Jan. 30, 2010, that meets the minimum standards of one "readily available lift per acute care unit on the same floor unless the safe patient handling committee determines a lift is unnecessary in the unit; one lift for every 10 acute care available inpatient beds; or equipment for use by lift teams."
- Train hospital staff at least annually on policies, equipment, and devices.
- Evaluate the program annually, including its impact on musculoskeletal disorder injuries.
- Consider safe patient handling needs in architectural plans for construction or remodeling of a facility.
- Develop policies and procedures that allow an employee to refuse "to perform or be involved in patient handling or movement that the hospital employee believes in good faith will expose a patient or a hospital employee to an unacceptable risk of injury." ■

said hospitals would have to purchase needed equipment but didn't say what the equipment would be."

The final version requires one "readily available" lift per acute care unit, unless the safe patient handling committee determines a lift is not necessary, or one lift per every 10 acute care inpatient beds, or equipment for use by a lift team.

Most importantly, the bill provided the $10 million equipment fund. "This needs to be something that the state is investing in," says Sauer. The bill passed the state Senate unanimously and the House by a margin of 85-13 and was signed by Gov. Chris Gregoire on March 22.

The hospital association and Washington State Nurses Association will provide education about the bill and safe patient handling to help health care workers change their habits and learn to use the equipment, she says.

The bill affects the state's 98 hospitals and numerous nursing homes. "We believe that at least a third [of the state's hospitals] would already be complying with the mandate and probably [doing] more," says Sauer.

Reference

1. Stubbs DA, Buckle PW, Hudson MP, et al. Backing out: Nurse wastage associated with back pain. *Int J Nurs Stud* 1986; 23(4): 325-336. ■

Nursing grads may demand safer lifting

New curriculum brings change to schools

Future nursing graduates will come to their job interviews with new expectations and questions about safe patient handling.

A new curriculum has been introduced at some nursing schools emphasizing the use of lift and transfer devices, teaching nurses to use body mechanics only if a hospital fails to provide that equipment. Students are taught to ask about the hospital's plans to buy equipment and establish a safe patient handling program.

A draft version of the curriculum is available on-line at the web site of the National Institute for Occupational Safety and Health (NIOSH) at www.cdc.gov/niosh/review/public/safe-patient through May 30. A final version will be available on the NIOSH web site when the review is complete. It was developed through the Handle With Care program of the American Nurses Association, with a NIOSH grant.

This curriculum provides important new information for nursing students. Textbooks have continued to teach body mechanics as the appropriate method for patient lift and transfer, although the curriculum notes that numerous studies have

shown that proper body mechanics cannot prevent injury. The national licensing exam still includes questions about manual lifting, but also includes some about lifting with devices.

For nursing schools, this is a time of transition as they try to prepare students for a safer workplace but must acknowledge the current level of adoption at the nation's hospitals.

"We gave them the new curriculum and said, 'This is the latest information we have. We want you to know how to use the equipment. You have to follow your clinical instructor's lead. If you have to move a patient to a wheelchair and there are no lifts, here is the safest way to do it,'" explains **Lynne Shores**, PhD, MSN, BSN, RN, associate professor of adult health nursing at the Belmont University School of Nursing in Nashville, TN.

Teaching myths and facts on lifting

Nursing education could be a vanguard for changes in hospital practice, predicts **Nancy Menzel**, PhD, RN, COHN-S, associate professor at the University of Florida College of Nursing in Gainesville and an author of the curriculum.

After all, nurses who have relied on manual lifting throughout their careers often find it difficult to change their habits. "Practicing nurses have all been taught body mechanics," she says, and they are reluctant to dismiss it as ineffective.

Students have a chance for a fresh approach. The curriculum teaches nursing students some myths about lifting:

- **Myth:** Staff in great physical shape are less likely to be injured. **Fact:** "Studies have shown that many patient handling tasks are risky regardless of the person's strength and even those in great physical strength are at danger of being injured."
- **Myth:** Classes in body mechanics and lifting techniques keep nurses from getting hurt. **Fact:** "These approaches have not protected nurses from injury. You need more assistance than these techniques provide."
- **Myth:** Lifting equipment slows me down. **Fact:** "More modern equipment is designed with ease of use in mind."

The program provides an algorithm to help students determine the dependency level of a patient and the correct patient handling device. It describes the types of devices that are available, including ceiling lifts, beds that convert into chairs, and the HoverMatt that can be used for lateral transfers instead of draw sheets.

But hands-on practice also is an important component. Vendors have loaned or donated equipment to the 29 pilot schools of nursing.

"We're hoping vendors will see the advantage of training students on their equipment.

A recruitment and retention tool

Still, it will take time for nursing schools to make this shift. Although there are about 580 schools of nursing that offer a baccalaureate program and about 1,500 nursing education programs nationwide, only 29 nursing schools have participated in this project.

Those schools attended the Safe Patient Handling and Movement Conference, sponsored by the Patient Safety Center of the James A. Haley VA Medical Center in Tampa, FL. As part of the program, the schools agreed to work with the state nursing organizations, says **Nancy Hughes**, RN, MHA, director of the Center for Occupational and Environmental Health at the American Nurses Association.

"Once you have a few schools of nursing talking enthusiastically about it, it will spread," she says.

Hospitals recognize value of programs

Meanwhile, hospitals have begun to recognize the value of safe patient handling programs not just for injury prevention, but for retention and recruitment, says Hughes.

"We're finding that the nurses that have worked at facilities with safe patient handling and movement are looking for that in their next position," she says. "They won't go to a facility that doesn't have it. There's no reason to have the injuries when the equipment is available."

Nursing students may have similar feelings after they've been exposed to safer methods of lifting and transferring patients. Shores encourages her students to ask about ergonomic equipment.

She tells them, "When you interview, I would encourage you to ask, 'Do you have safe patient handling policies that include equipment? Is that on your short-range plan for the next few years?' Use that as part of your decision making. Would you like to continue to pursue a job there?"

Wooing nursing graduates in the future may require something more than just body mechanics, Shores says. ■

Will vaccine protect HCWs before a pandemic?

Researchers seek partial immunity from vaccine

Could health care workers receive some vaccine protection from avian influenza even before a global pandemic occurs?

Researchers are investigating whether an H5 vaccine could provide "priming," or partial immunity, that would strengthen a response to future, more specific vaccines. If so, world health experts would consider the possibility of vaccinating health care workers or other high-priority groups prior to a pandemic, but the safety of the vaccine would have to be clearly established, said **Margaret Chan**, MD, the World Health Organization's assistant director-general for communicable diseases.

"We have to be absolutely clear that in the absence of an H5N1 outbreak affecting humans in big numbers we need to look at the trade-offs. If we are not going to do good, we would not wish to do harm," she said at the International Conference on Emerging Infectious Diseases held in Atlanta in late March.

Chan warned that the potential for H5N1 pandemic influenza is greater than ever, within its rapid global spread among wild birds and poultry and genetic evolution of the virus. It took two years for H5N1 avian influenza to spread to 15 Asian countries. But in the past three months, a time of intense surveillance, the virus was detected in another 20 countries in Asia, Europe, and Africa, she noted.

As of March 21, there were 184 human cases identified in eight countries, with 104 deaths. There has been no evidence of sustained, human-to-human transmission.

"The pace with which it has spread is reason for concern," said Chan. "We have never seen this in the history of avian influenza. We are receiving reports of sporadic human infection. . . The risk of pandemic is great."

Two distinct genetic strains of H5N1, termed "clade 1" and "clade 2," have caused infection in humans. Animal studies have shown that the two strains are distinct enough to require a separate vaccine, said **Nancy Cox**, PhD, chief of the influenza branch of the Centers for Disease Control and Prevention (CDC).

"What we have found so far is that there is some cross-reactivity, but it certainly isn't at the level we would like," she reported.

Cox acknowledged that the virus could continue to mutate beyond the two clades. Clade 1 caused human disease in Vietnam, Thailand, and Cambodia in 2003, and clade 2 was identified in human cases in Indonesia in 2005.

"The expectation is that the immunologic priming of an individual with an H5 vaccine, whether there was a perfect match or not, would provide some measure of protection," she said. "That assumption is not proven, but it's based on what we've seen with the regular seasonal influenza viruses when they undergo antigenic drift."

Mask recommendation could change

Meanwhile, world health experts acknowledge that recommendations about mask use could change as they learn more about the disease.

Decisions about respiratory protection hinge on the science of influenza transmission — whether it is airborne or droplet-borne, said **Marty Cetron**, MD, director of the CDC's Division of Global Migration and Quarantine.

"The science around it is uncertain. It's an area of active, ongoing debate," he said. "The guidance is dynamic."

Currently, the CDC recommends using surgical masks as barrier protection against influenza — whether it is seasonal or pandemic. Higher levels of protection, such as an N95 filtering facepiece respirator or powered air-purifying respirator (PAPR), would be appropriate for protection during aerosolizing procedures, the CDC says.

The WHO recommends the use of respirators such as the N95. "HCWs working with [avian influenza]-infected patients should select the highest level of respiratory protection equipment available, preferably a particulate respirator," its guidelines state. "Surgical and procedure masks do not offer appropriate respiratory protection against small-particle aerosols (droplet nuclei) and should not be used unless particulate respirators are not available when dealing with airborne transmitted diseases."[1]

Reference

1. World Health Organization. Avian influenza, including influenza A (H5N1) in humans: WHO interim infection control guideline for health care facilities. Geneva; Feb. 9, 2006. Accessed on-line at: www.who.int/csr/disease/avian_influenza/guidelines/infectioncontrol1/en/index. html. ■

Pandemic influenza plan: You can't do it alone

Hospitals to share supplies, staff

Every year is a mini-drill for pandemic influenza. Hospitals vaccinate thousands of health care workers against seasonal flu, set priorities amid shortages or delays in vaccine supply, and put renewed emphasis on hand hygiene and respiratory etiquette.

But if (or when) pandemic influenza strikes, traditional flu planning won't be good enough. Hospitals will need a unified approach to prevent transmission, respond to the ill and worried well, and to protect health care workers.

"We're strongly encouraging the facilities to communicate with each other, even to start thinking about how they would share resources — not just supplies, but also staffing," says **Deborah Levy**, PhD, MPH, lead, health care preparedness in the Division of Health Care Quality Promotion at the Centers for Disease Control and Prevention in Atlanta.

Harborview Medical Center in Seattle is one example of a hospital that is working with its neighbors (and competitors) to prepare for a possible pandemic with better communication and regional coordination.

"It is imperative that health care organizations organize together to plan for any kind of pandemic or disaster situation," says **Chris Martin**, BSN, RN, administrative director of emergency services and chair of the disaster committee. "We all are going to need each other."

In a worst-case scenario, extrapolated from U.S. government estimates, a pandemic could hit King County (Seattle) with 11,000 deaths, more than 50,000 people needing hospitalization, and 1.2 million people sick.

"We would be so far above and beyond what our capacity is, there is no way we could meet that need," she says.

There are no simple answers to such dire circumstances. But by joining together, King County hospitals are preparing as best they can. The hospitals plan to share supplies and equipment, such as antiviral medications or ventilators. They are pooling grant money they receive from the Health Resources and Services Administration to respond to disasters. They may even share staff, Martin says.

"We are hoping to hire a regional resource center person, to work with hospitals and [other health care] entities to really be able to put together the plans and policies we need to share these resources," she says. "It makes more sense for us to pool our money rather than for each hospital to make their [separate] decisions about what they want to purchase."

The hospital is working with distributors to keep the regional stockpile, so it can be rotated and will not become out of date — and it could be easily distributed in time of need. Harborview is the disaster control hospital for King County, which means that it would coordinate the routing of patients to area hospitals so none are overloaded.

Meanwhile, the regional emergency preparedness committee meets every month and conducts periodic tabletop drills. **Kathy Maher**, RN, MSN, manager of employee health services, is part of the emergency preparedness committee. She provides input on employee needs, from protective equipment to disaster preparedness education.

Here are some of the issues that hospitals must consider in their pandemic influenza planning.

- **Priorities for vaccination.**

Although the CDC has recommended priority tiering of vaccine, each hospital needs to define specifically who would be the first to receive the vaccine, notes Maher. At Harborview, the top priority would encompass first responders, emergency department personnel, and the public safety personnel who control entry to the emergency department. Respiratory therapists and housekeepers and facility engineers who would maintain the rooms of pandemic influenza patients also would receive the first vaccines.

Direct care providers in the units caring for hospitalized flu patients, including nurses, physicians, hospital assistants, and lab personnel, would be top priority as well.

Martin notes that ambulatory care clinics play a key role in the Harborview plans. Ill patients may show up at the clinics rather than the hospital. And those clinics may provide some surge capacity if hospitals become overwhelmed, she says.

- **Administration of antivirals.**

According to the Harborview pandemic influenza plan, which is available on-line (http://depts.washington.edu/ictrain/influenza/influenza.htm), employees who are exposed to avian influenza will receive seven to 10 days of prophylaxis with oseltamivir.

Hospitals also should be aware that administration of vaccine or antivirals to the general public

Surveillance and Monitoring of HCWs and Exposure Management

[Editor's note: This excerpt from the Harborview Medical Center's (HMC) plan addresses the surveillance of health care workers who are exposed to patients infected with avian influenza. So far, there have been no cases of avian influenza detected in the United States in birds or people.]

All persons entering the Level 3 Isolation room must sign the Avian Influenza Contact Log, which will be collected by Infection Control. This log will be initiated and posted by the charge nurse in the area. Screening and follow-up will be coordinated between Infection Control, Employee Health, and Public Health. Employee Health will maintain a list of staff who have contact with any patient and perform provider screening.

Staff who have cared for patients with avian influenza and adhered to infection control precautions should perform self-checks at least daily for: fever, respiratory symptoms, and/or conjunctivitis until seven days following the last contact with any patient suspected or confirmed with avian influenza.

Staff who had unprotected high-risk exposures to patients with suspect or confirmed avian influenza should be monitored twice daily for development of fever, respiratory symptoms, and/or conjunctivitis (eye infection) until seven days after last exposure to the patient.

• Unprotected high-risk exposure is defined as presence in the same room as a probable avian influenza-infected patient during a high-risk aerosol-generating procedure or event and where infection control precautions were either absent or breached.

• Health care workers who have cared for patients with avian influenza should report any fever event and, if ill for any reason, should be removed from patient care. They should should seek medical care and, prior to arrival, notify their health care provider that they may have been exposed to avian influenza. In addition, employees should notify Employee Health or Infection Control at HMC.

With the exception of visiting a health care provider, health care workers who become ill should be advised to stay home until 24 hours after resolution of fever, unless an alternative diagnosis is established or diagnostic tests are negative for influenza A virus. ■

may need to take place at health care facilities rather than the public health department, advises Levy. The antivirals need to be administered within 24 to 48 hours of onset of symptoms, and public health departments may not be able to cope with an onslaught of ill patients, she says.

Hospitals also will need security to protect the supplies of antivirals and vaccine, she notes. "Definitely there are issues around pandemic flu that require a different sort of planning," she says.

• **Support services for employees.**

Imagine a scenario in which schools are closed and large gatherings of people are prohibited to prevent spread of disease. Now you have key employees with child care issues. Don't expect to simply bring those children into the hospital, even if you have a child care center, says Levy.

After all, if area day care centers and schools are closed, so is yours.

Meanwhile, employees may need emotional support as they cope with difficult circumstances. For example, if the need surpasses the number of ventilators available, employees will need to decide which patients receive that life-saving treatment.

Harborview asks its employees to develop a personal disaster plan that would include pandemic influenza. The hospital also emphasizes communication and has chaplains and social workers available to discuss issues with employees.

• **Respiratory protection.**

Harborview has 185 powered air-purifying respirators (PAPRs), which are the primary protection used by employees caring for tuberculosis patients. However, in the case of pandemic influenza, PAPRs may create some disinfecting issues that don't exist with tuberculosis (which is not spread by fomites).

So, Harborview plans to stockpile about 1,000 N95 filtering facepiece respirators. Some top-priority employees, such as those in the emergency room, will receive initial and annual fit-testing. The hospital also will have a plan to conduct fit-testing on an as-needed basis, says Maher.

Current CDC guidelines call for droplet precautions unless the patient is undergoing an aerosol-generating procedure. But a pandemic could be prolonged, and respiratory protection guidelines could change.

"This is something that would extend for several waves, maybe for six to eight weeks," says Levy. Planning for pandemic influenza will require a different approach than for sudden disasters, such as an earthquake, hurricane, or bomb attack. ■

HCW sickline: 'Please press 1 for fever'

Clusters could signal an outbreak

The first sign of an outbreak in your hospital may come from your employees. A cluster of sick workers in one unit raises an alarm. Is this just a seasonal spike in illnesses — or is a disease being spread within your hospital?

During the SARS scare, health care worker symptoms were closely monitored as a kind of "sentinel" for emergence of the disease. Now, pandemic influenza planners are asking hospitals to develop a method for detecting signs and symptoms of influenza among their staff.

Here are some examples of "sickline" surveillance systems hospitals have adopted to pick up on patterns in employee illness.

Leaving a sickline message

The sickline at Regions Hospital in St. Paul, MN, began after a gastrointestinal outbreak. A nurse manager noticed that a couple of her patients had diarrhea — and a few of her employees were out sick with similar symptoms. An investigation revealed that they were all afflicted with a highly contagious norovirus.

After the hospital got the outbreak under control, employee health and infection control professionals began talking about how such outbreaks could be detected more quickly. "We decided we really didn't have a good way to track sick calls because they go to [different] people," says **Mary Brodehl**, RN, nurse manager of employee health services.

The sick call line, a dedicated voice mail in the employee health office, began in late 2004. The hospital focused the program on nursing and dietary workers — employees who have close patient contact and have exposure throughout the hospital. When those workers call in sick, they are transferred to the voicemail and prompted to leave their name, phone number, unit, job description, and symptoms.

Every morning, someone in employee health listens to the messages and logs them on a spreadsheet. Employee health categorizes the illnesses as respiratory, gastrointestinal, musculoskeletal, or other. It takes about 20 minutes to half an hour to log the calls, Brodehl says. While it varies with the season, the call line averages 20 calls a day.

The sick call line is confidential, notes Brodehl. Employees are encouraged to simply say "mental health day" if they are taking a day off but aren't really sick, she says.

Employees are comfortable with the system and have been cooperative. "It's part of the culture now," she says.

'If you have a sore throat, press 1'

If three nurses in the same unit have similar symptoms for three days, infection control steps into action at Maine Medical Center in Portland. The cause may be an illness circulating in the community, but it still points out a need for greater vigilance, says **Maggie Kelley**, MSN, NP, COHN-S, director, employee health services.

For example, the hospital recently saw a rise in gastrointestinal symptoms, and Kelley sent out a notice urging staff to use "exemplary" hand hygiene. Fortunately, the trend abated.

Nursing staff members call an 800 number to report unscheduled absences. Using a touch-tone phone, they press "1" if experiencing an illness or "2" if they are calling for another reason. After pressing "1," the caller is prompted to respond by pressing "1" for yes and "2" for no for the following symptoms: fever, nausea/vomiting/diarrhea, stiff neck with headache, rash, cough, sore throat, nasal congestion or sneezing, or conjunctivitis. A nurse manually records the responses onto a confidential tracking tool. So far, two spikes have been detected involving nausea/vomiting/diarrhea.

The program doesn't incorporate the hospital's entire staff of about 5,400, though that is the goal if a fully automated data collection system becomes available, Kelley reports. "In the interim, nursing representation across the 'house' gives us an overall impression of staff illness trends," she says.

"We're trying to establish our baseline so we can compare year to year," says Kelley. "Our infectious disease specialists are comparing the trends to see if the employee trend is the same as [in] the community. If we see something off track, it prompts us to evaluate further."

If hospitals across the country collected surveillance data on employees, that could provide an early alert system to minimize disease spread, says Kelley. "It could also be a useful tool for early identification of potential novel viruses," she adds.

Baystate Health System in Springfield, MA, wants to know if employees have the flu. This

limited sickline ramps up each year with the start of the flu season, usually in December or January. It stops when the cases drop to a trickle, usually by March, reports **James Garb**, MD, director of occupational health and safety. It encompasses the health system's 9,400 employees at three hospitals.

Baystate System sniffs out the flu

The Baystate's sickline began about two years ago when the influenza vaccine was in short supply. The health system had purchased a supply of amantadine. "We wanted to know when we should consider prophylaxis [rather than just] treatment," says Garb. "If we saw several nurses with influenza-like symptoms, we might offer prophylaxis to the rest of the staff on the unit.

"We've had enough vaccine and we do not have a stockpile of amantadine at this point," he says. "But with all the talk about pandemic influenza, we thought we'd continue what we have in place."

Employees either can fill out a survey on the health system's intranet or can call the nurse line. Those nurses have been trained to collect information on influenza symptoms among employees. They ask about fever higher than 101° F, headache, muscle aches or pains, sore throat, and cough. Employees identify their unit but do not need to give their name.

"We're very focused," says Garb. "We don't ask them to report any other types of symptoms. We're just looking for influenza symptoms.

"We ask if they had the flu vaccine, and if they did, how far before the onset of their symptoms," he says. "I try to categorize the symptoms into two different groups. If someone just had a sore throat and no fever or myalgia, then that's not influenza."

If they have influenza symptoms despite having the vaccine, Garb records that as a vaccine failure. He acknowledges that the method is crude; some employees may have an influenza-like illness that is not actually influenza. But it gives a picture of possible influenza activity.

At the peak of the flu season, the surveillance picks up about 40 cases per week. So far, it hasn't identified any clusters in a particular department, says Garb. But with the concern about avian influenza, Baystate plans to continue the system.

"It's a tool that would probably be moderately sensitive in picking up something if it were out there," he says. ■

Patient safety is key for employee health workers

Employees are patients, too

Employee safety is patient safety. After all, those employees are *your* patients, and by improving their work environment and teaching them about safety measures, you help them protect *their* patients.

That is the main message of **Barb Maxwell**, MHA, RN, COHN-S, CCM, CWCP, division director of company care for the HCA West Florida division in St. Petersburg, who will speak at the upcoming annual conference of the American Association of Occupational Health Nurses (AAOHN). **(For more information on the conference, see editor's note, p. 58.)**

Demonstrating that link between overall patient safety and employee safety also can enhance your value as part of risk management, safety and other hospital operations, Maxwell says. "We're no longer Band-Aid nurses," she says. "[Occupational health is] a profession within itself, and we need to evolve to another level to touch upon our patient population."

For example, influenza immunization of health care workers has become a hot patient safety concern, as a way to protect vulnerable patients from the serious complications of influenza. Fatigue also has been identified as a contributing factor in medical errors. Employee health professionals can educate employees about the dangers of fatigue from long shift work and can raise concerns with management about employees who work an extended stretch of long shifts.

Meanwhile, employee health nurses need to face up to patient safety issues of their own, says Maxwell. For example, they often allow employees to drop in if they have health concerns. But that means that the employee health nurse is constantly interrupted, which could lead to errors, such as miscommunication of orders, she says.

"It doesn't matter if they're with another employee or if they're writing up a report," she says. "It distracts the health professional from their medical tasks."

Instead, employee health professionals should ask for a courtesy phone call so they can prepare to see the employee/patient, she says. Maxwell offers other patient safety issues to consider:

- **Make sure you have complete information**

on your employee/patients. Always check for allergies before providing even an over-the-counter medication. Be aware of interactions. For example, patients on digoxin could have a reduced effect from their medication if they eat quantities of licorice, and thus could be at risk for atrial fibrillation. By asking appropriate questions and checking medical history, you also are modeling a patient safety process for employees, she says.

• **Don't work outside your scope of practice.** Employee health nurses are accustomed to working with autonomy, notes Maxwell. But don't cross the line to actual solo practice. Be aware of what your state nurse practice act allows, and make sure you function under the purview of a medical director.

• **Keep track of near-misses.** Perhaps a medication error was discovered at the last moment, or an employee didn't receive proper care instructions while being managed for a workers' compensation claim. There should be a mechanism for examining errors and near-misses so you and others can learn from them, says Maxwell.

"We need to move from pointing blame and focus on the process of safety," she says. "We need to look at error-prone situations and near-misses. It takes a collaborative approach to reduce errors."

[Editor's note: The AAOHN 2006 Symposium & Expo will be held from May 9-11 in Albuquerque, NM. More information is available at the AAOHN web site, www.aaohn.org/education/symposium-expo/index.cfm, or from AAOHN headquarters. Phone: (770) 455-7757.] ■

Hospital saves by spending on employee health

Wellness program builds HCW loyalty

The market for nurses in Southern California is vicious. Hospitals try to entice them away from competitors by offering signing bonuses, car payments, and even closing costs on home purchases.

Rather than chasing workers with incentives, Huntington Hospital in Pasadena took a different tact. The hospital builds loyalty by addressing the issues that matter most to employees: their personal health and their work/life balance.

"We wanted to be an employer of choice," says **Debra Ortega**, vice president of human resources. "That didn't just mean dollars and cents. That

CE *questions*

17. What is the ratio of patient handling equipment required by the new Washington state law?
A. One lift per 10 inpatient acute care beds.
B. One lift per 15 inpatient acute care beds.
C. One lift per 20 inpatient acute care beds.
D. No specific ratio is required.

18. A new patient handling curriculum in nursing schools will teach students:
A. how to use proper body mechanics.
B. myths and facts about safe patient handling.
C. why hospitals should implement lift teams.
D. about state laws on safe patient handling.

19. The H5N1 virus has evolved into two "clades," or genetic strains. What impact does that genetic diversity have on preparedness efforts?
A. The new group is more easily transmissible among humans.
B. The new group attacks only birds.
C. It is more difficult to develop a vaccine that will provide adequate protection.
D. There is no impact on preparedness efforts.

20. According to Deborah Levy, PhD, MPH, hospitals preparing for pandemic influenza must:
A. talk to each other about sharing resources.
B. stockpile enough antivirals and N95s for hospital use.
C. send their preparedness plans to the CDC.
D. choose an area hospital that will become the "flu" hospital.

Answer Key: 17. A; 18. B; 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 **June** 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. ■

means helping with the challenges that face the health care worker on a daily basis."

Huntington began with a survey of employees to identify their priorities. They responded that the health plan was their most important benefit.

So while other hospitals were restraining their health plans to cut costs, Huntington redesigned theirs to add benefits. The hospital offers a PPO, which allows employees to see specialists without a referral. Employees receive a greater benefit if they receive their health care from the hospital.

To offset the additional costs — as much as $16 million — the hospital has created a disease management and wellness program to help employees gain control of their health. They also developed a concierge service to help employees handle those stressful and time-consuming errands and chores that take up their off-duty time.

"We wanted people to think, 'What would I lose if I left Huntington?'" says Ortega. "The plan has been a huge success for us. We listened to them and it really was a partnership. That's how the wellness program came about."

Huntington launched its wellness program on Valentine's Day 2005 with a health fair. More than 1,000 employees participated in health screenings that included cholesterol and blood pressure checks and early detection of diabetes. "We found one person who could have had a stroke within hours had he not come and been sent to emergency," recalls **Patti Bennett**, director of human resources.

Vendors promoted healthy products and the hospital served up healthy food, while employees had the opportunity to take a confidential risk assessment at computer kiosks. The hospital discovered that a significant number of employees have serious medical conditions, including cancer, asthma, coronary heart disease, congestive heart disease, back pain, and diabetes.

Employees can opt to receive monthly phone calls to help manage their conditions. For those with minor health risks, the calls may just involve motivational coaching to lose weight or exercise more. Those with serious conditions may receive calls from a nurse or licensed dietitian.

An outside contractor manages the program and maintains employee confidentiality. That is important so employees don't feel they're being watched, says Bennett. So far, about 30% of those eligible for the service have signed on, says Bennett. Even a modest improvement in disease management could bring significant savings in medical costs — along with lower absenteeism and better outcomes for the employees, she notes.

After all, Huntington Hospital pays 100% of its employees' insurance premiums and highly subsidizes dependent coverage. The cost to employees hasn't gone up in four years.

"I think our employees are very, very grateful," she says. "We don't want to have to increase [the cost to employees] because that's very important to them. We need these programs to keep those costs under control."

Concierge service relieves stress

Stress also can contribute to lower morale, higher injury rates, and poorer health. So Huntington Hospital has incorporated a concierge" program to help employees maintain a better work/life balance.

The hospital paid Errand Solutions in Chicago to set up its program on-site. Employees pay for the individual services, such as car wash, dry cleaning, shoe repair, or watch repair. One employee forgot his wife's anniversary until the last minute. Within two hours, the concierge had obtained a dinner reservation and a dozen roses.

COMING IN FUTURE MONTHS

- Floor stripper causes headaches, dizziness, nasal irritation
- Secrets of a successful flu vaccine campaign
- Coping with FMLA: How to manage leave requests
- Beyond latex: Can you prevent contact dermatitis?
- A new way to build a safety culture

During the holidays, the concierge service wrapped some 1,300 presents — at no charge to employees.

"They have said, 'You don't know how you've changed my life. I no longer have to run errands on Saturday. I can spend time with my kids,'" says Ortega. "One employee has a handicapped husband. It's a huge help. She has to work full time and take care of her husband."

These programs have helped build loyalty. Turnover has declined from about 15% to 10%. That means fewer costs in hiring temporary staff to fill in and recruiting new nurses. "Employees really feel that there is a partnership here," says Ortega. ■

Edwin Foulke confirmed as new OSHA head

Edwin G. Foulke Jr., a South Carolina attorney who represented businesses in their dealings with the U.S. Occupational Safety and Health Administration (OSHA), received U.S. Senate confirmation as the new OSHA administrator. Jonathon Snare had been serving as acting administrator since John Henshaw stepped down in December 2004.

Foulke previously served as chairman of the Occupational Safety and Health Review Commission from 1990 to 1994 and on the commission from 1990 to 1995. The independent commission hears appeals of OSHA citations. In his Senate testimony, Foulke stressed the continued need for OSHA outreach and assistance, particularly to small employers that don't have a comprehensive safety program. He also said he supports "strong, fair, and effective enforcement." ■

Go on-line for this month's *Bioterrorism Watch*

The **May/June** issue of *Bioterrorism Watch* is available on-line at www.hospitalemployeehealth.com, exclusively for subscribers of *HEH*.

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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. ■