Occupational Health Management™

A monthly advisory for occupational health programs

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IN THIS ISSUE

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JULY 2006
VOL. 16, NO. 7 • (pages 73-84)

Multicultural workplaces: Language not the only barrier to safety, health

Occ-health nurses called on to learn their communities

No matter how large or small it might be, today's workplace is far different than it was 40, 20, even 10 years ago, and that difference extends far beyond paperless records and robotic assembly lines.

American workplaces are now true reflections of the country's immigrant population, and no longer are citizenship and English fluency the prerequisites to working in the United States that they once were.

But as this diversity enriches our society and swells workforces, it also presents some unique health and safety questions for the occupational health nurse.

"The first thing I ask [when addressing a group of occupational health professionals] is how many of them speak another language, and it's surprising how many don't," says **Linda K. Glazner**, DrPH, RN, COHN-S, a consultant in Wisconsin. "Then I ask if there are other languages spoken in their plant, and if so, what are they? English is the [language] of the United States, but it would behoove us to appreciate and recognize other languages."

Posting safety rules in multiple languages is a start, as is establishing access to qualified interpreters. But languages are only part of the mix when your worksite is a blend of cultures and ethnicities.

Cultural definitions of health vary

In 1991, the American Nurses Association (ANA) issued a position paper setting out reasons why nurses should take diversity seriously, and in what contexts they should think about cultural differences and their effects on health.

Among the aspects of diversity that the ANA says nurses need to understand are:

- how cultural groups understand life processes;
- how cultural groups define health and illness;
- what cultural groups do to maintain wellness;
- what cultural groups believe to be the causes of illness;
- how healers cure and care for members of cultural groups; and
- how the cultural background of the nurse influences the way in which care is delivered.

"Culture is one of the organizing concepts upon which nursing is based and defined," the ANA stated in its position paper. (The paper, "Ethics and Human Rights Position Statements: Cultural Diversity in Nursing Practice," can be accessed at www.ana.org/readroom/position/ethics/etcldv.htm.)

Though language as a barrier to understanding safety and health information is one obvious challenge in a multicultural workplace, it is by no means the only one.

For example, members of one culture might define health and illness differently from members of another culture. The occupational health nurse might want to determine some basic definitions of health as they apply to his or her employee group:

- Is it being able to do what you want to do?
- Is it physical and psychological well being? *Physical* is defined as there are no abnormal functions of the body and all systems are without the abnormal functions that would cause a problem physically; *psychological* means that one's mind is capable of a clear and logical thinking process and association?
- Is it being able to perform normal activities, such as walking, without discomfort and at an optimum level?
- Is it something else?

Glazner says occupational health professionals "need to check our own pulse" and become aware of personal attitudes, beliefs, biases, and behaviors that may influence, consciously or unconsciously, both the care of patients and interactions with colleagues from other racial, ethnic, and cultural backgrounds.

"Every clinical encounter is cross-cultural," she comments. "Developing partnerships with our patients and maintaining 'cultural humility' can help us to learn and better understand the historical, familial, community, occupational, and environmental contexts in which our patients live."

One way for health care providers to "check their pulses" on diversity awareness is to take a cultural quiz created by the U.S. Department of Health and Human Services and Management Sciences for Health, a nonprofit scientific and educational collaborative that seeks answers to public health issues. The quiz (available at erc.msh.org/mainpage.cfm?file=3.0.htm&module=provider) provides multiple choices to a number of questions dealing with health care situations involving providers and patients of different cultures, with additional readings provided to assist in understanding right and wrong answers.

Cultural difference impact safety

In the work setting, culture can be a safety and health issue, Glazner points out. "The Midwest has a large [Chinese] Mung population," she explains. "Asians often are very polite, and won't say they don't understand something. They will nod their heads, and won't say they don't understand. And that's a safety issue."

She works with members of a Somali population, as well, and often encounters the Muslim belief that the body is a whole, and that simultaneous injuries or illnesses are related.

"So if you have a headache and you stubbed your toe at work, the headache might not be a work-related complaint but the toe injury is, and

Occupational Health Management™ (ISSN# 1082-5339) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Occupational Health Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (ahc.customerservice@thomson.com). Hours: 8:30-6:00 M-Th; 8:30-4:30 F.

Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864. This activity is approved for 18 nursing contact hours per year.

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This activity is intended for occupational nurses, occupational health managers and directors. It is in effect for 36 months from the date of publication.

Editor: **Allison Mechem Weaver.**
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@thomson.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@thomson.com).

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Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

you have to help [the employee] differentiate between the two while respecting his or her beliefs," she explains. "That becomes a workers' comp problem."

Get to know your community

Glazner points out that many cities have several different ethnic population groups, and an occupational health nurse whose employees include members of those cultural groups should make an effort to become familiar with the cultures.

"In most places where there is a large population of people who don't speak English, there is a local association that offers resources that can help us as health care professionals," she points out. "And the easiest way to get to know another culture is to eat the food. It's hard not to gain a better understanding of people when you sit down and break bread with them."

Glazner relates that in an occupational health department where she worked in Los Angeles, six workers, including herself, did not celebrate Christmas. So the Jewish, Hindu, and Buddhist co-workers put together a rice potluck—rice being a common dietary denominator—and shared not only a meal, but insights into each others culture and history.

But Glazner and others experienced in multicultural workplaces caution against taking cookbook approaches to any sociocultural group, for risk of stereotyping and overgeneralizing about a people and their attitudes toward health and safety.

"Diversity is often greater within groups than between them," Glazner says. Health care needs to be evidence-based, flexible, authentic, and ethical, no matter who the patient population is, she adds.

Employers who are most successful at maintaining a productive, healthy, multicultural workforce are willing to be creative, flexible, and open-minded.

Rather than fighting the religious practices of a particular group that may differ from the majority, Glazner says managers should examine work practices to see if they can accommodate and compromise to satisfy everyone.

"During Ramadan, Muslims fast during the day, so some companies alter their work practices so the majority of those employees' work hours are at night, so they can work and eat at night rather than working during the day, when they have to go without eating," she points out.

Measures such as the one just described, or in dividing 30-minute breaks into multiple shorter breaks to accommodate ritual prayer during the workday "is not fighting the cultures, but accommodating the work culture and religious culture."

Use of English versus another language at work must be based on safety and not employee preference, she advises. In some hospitals, for example, employees who do not speak English as their first language are permitted to speak whatever language they want outside of patient care areas, but in areas of patient care, must speak English.

"You accommodate where you can, and if you can't you explain why and at least show that you recognize that this is something that is important," she says. ■

[For more information, contact:
***Linda K. Glazner**, DrPH, RN, COHN-S, CCM, CHES, FNP, FAAOHN, president, Linda K. Glazner & Associates, Wausau, WI. E-mail glazner2@aol.com.*
***Management Sciences for Health**, 784 Memorial Drive, Cambridge, MA 02139. Phone: (617) 250-9500. E-mail: erc@msh.org.]*

Health and safety for WWII vets through Gen Y

Five generations could be represented

Chances are, no matter what size your workforce, there are as many as five generations represented. The age difference between your youngest and oldest employees could be nearly 60 years, which presents challenges and opportunities for the occupational health professional.

"What we're seeing is that retirement is coming at a later and later age," points out **Arlene Guzik**, MSN, ARNP-BC, COHN-S, director of clinical services at Lakeside Occupational Medical Centers in Largo, FL. "It's the first time we've formally had all four generations in the workplace at the same time."

The issues that present are varied, and include differences in work ethics, interest in wellness, importance of health benefits, need for and mode of training, and attitudes toward authority. Just as the health concerns of a 22-year-old and a 67-year-old differ, so do the approaches to safety training and wellness in each group.

"We have to make sure our [wellness and safety training] messages are specific to addressing the needs of different generations," says Guzik.

Five generations under one roof

Each generation is fairly clearly defined as a group, but Guzik and others warn against overgeneralize groups by their birth date. Even so, a generation's age and shared experiences both shape their views on work and health, and guide occ-health directors in mapping health and safety plans.

Most generational experts agree on four distinct generations in today's workforce, though many add a fifth. Besides the time of their births, the generations are shaped by shared philosophies and the events of their times.

• **Matures, traditionalists, pre-boomers.** Members of this group were born before 1945, and grew up during the Depression and World War II. "They have been in the workforce a long time, and maybe have retired once and returned to work, either in different jobs or as consultants," Guzik says.

Matures are considered hard workers who are conservative, respectful of authority, loyal, disciplined, and mindful of adhering to rules.

• **Baby boomers.** The boomer generation was born between 1946 and 1964, and carry on many of their parents' characteristics. "Boomers are respectful of titles, group-oriented, don't like change, and live to work," says Guzik. Boomers' parents instilled in them a strong work ethic and a desire to give their children a better life. This working group includes record numbers of women, was the first TV generation, and is more liberal than the previous generation.

• **Generation X.** Born between 1965 and the late 1970s, generation Xers grew up with two working parents and experienced the upheaval of the Vietnam era, economic downturn of the 1970s, and the first Gulf War. They grew up in the "instant" years that saw the advent of the microwave oven, remote controls, and automated teller machines.

They are less likely to follow rules and more likely to challenge authority. Unlike their parents and grandparents, they tend to change jobs frequently rather than plan a career with one employer. That last characteristic impacts employers and occupational health managers because it means more training as the workforce turns over.

"Generation X workers have more loyalty to themselves than to organizations, are more interested in their quality of life, expect instant results. While the boomers lived to work, generation X works to live, to have more money to spend on their social lives," Guzik explains. "There are a lot of very resourceful people, lot of entrepreneurs in this group."

• **Cuspers.** This group is described by some generational experts as those on the cusp between baby boomers and generation X, born between 1960 and 1968. They share characteristics of the generational groups that precede and follow them, noted for embracing the work ethic of their parents, but seeking a greater work–life

Working with a multi-generational work force

• Remember the commonalities among generations:
— Everyone wants to succeed.
— Everyone wants to feel valued.
— People want to be kept in the know about matters that concern them.
— All employees want clear communication about their employer's expectations of them.
• Although each employee may be motivated to perform well, the different generational groups may vary in their work style and expectations of the workplace
• Employees' reactions to factors such as change, new challenges, organizational politics are sometimes just different, not good or bad.
• Often these reactions can be better understood if you consider the generational age group of the employee.
— For example a "mature" has greater reverence for authority and may not verbally react to a policy change. However, a generation X or Y worker will ask "why?"
• Capitalize on individual and age group interests through:
— Special projects
— Committee work
— Social, team-building efforts
— Technology skills
— Ability to network or research solutions
• Work to develop a true peer environment, where different generational groups not only value what each brings to the table, but help their colleagues by sharing, teaching, and supporting each other.
• Reflect on your own values and beliefs that are influenced by the era in which you grew up.

Source: Duke University PAS faculty/employee assistance program, Durham, NC.

balance. They can act as a bridge between the older and younger generations in the workplace.

• **Generation Y.** The youngest faction in the workforce is generation Y, also known as "millennials," were born between 1980 and the early 1990s. They are technically proficient, multitaskers, and highly educated. They grew up with the Internet, so as a group are more technically proficient than their predecessors, and sometimes described as having short attention spans.

"They are very worldly, very educated, and like to have multiple choices," Guzik says. "They are a generation that if you tell them the expected outcome, they'll figure out how to do it."

Demands for health, wellness differ

The occupational health nurse should evaluate what the needs of his or her workforce are, and tailor wellness that targets the different generations as well as the employee population as a whole.

"Interests in wellness will vary by generation, and you need to look at the health benefits program, because each generation will have different expectations," says Guzik.

Health benefits are going to be most important to the older generations than to generation Y, so options will need to be available that satisfy a variety of needs.

"The majority of the boomers who have or will be having health problems want good benefits, good health care, and a good prescription drug program. They want wellness to focus on specific diseases, and how to address those specific issues from an education and resource standpoint," she continues. "Generation X and generation Y, on the other hand, want resources they will be able to use and tailor to themselves."

The younger working groups are less interested in health benefits and prescription drug programs, and more inclined to want cafeteria plans that they can pick and choose from. "They are more interested in fitness, education, and alternative medicine, and they like to learn on their own and to have internet resources," Guzik adds.

Consider generations in training plans

Business leaders and occupational health nurses facing the question of how to create safety training for 25-year-olds and 65-year-olds have to be creative to meet the different learning needs and motivations for each group.

Safety training is important for both the older and younger generations, but for different reasons.

"As the workforce becomes older, older people are trying to do the jobs they have done for the last 30 years, and they don't realize they sometimes can't do certain tasks the same way, and they need to be mindful of that," says Guzik. Workers may not be aware of the changes in their bodies as they age, and so need to be reminded. Addressing ergonomics and workstation accommodations will allow workers in that age group to continue being productive and healthy on the job.

Young workers, on the other hand, tend to sustain injuries when they're starting out and are unfamiliar with the potential risks in their jobs. The youngest workers — teenagers in the 14- to 17-year-old population — sustain the highest percentage of injuries, likely, experts say, because they are more likely to take risks or make bad decisions based on inexperience.

Younger workers — generations X and Y — are likely to respond best to training that is entertaining — visual and interactive. Older employees are more likely to benefit from traditional classroom instruction and exercises.

If more than one training option is offered, employment law experts say care must be taken not to exclude individuals based on age. Available options must be made available to all employees, in hopes that employees choose the training format that appeals to them most and from which they will therefore benefit most. ■

[For more information, contact:
***Arlene Guzik**, MSN, ARNP-BC, COHN-S, director of clinical services, Lakeside Occupational Medical Centers, 1400 E. Bay Drive, Largo, FL 33771.]*

OTC at work: OK at some sites, banned at others

NSAIDs, antacids among medications at issue

After going back and forth over the question of whether to provide employees certain over-the-counter (OTC) medications for everyday complaints such as headaches, muscle strains, and upset stomachs, Community Memorial Hospital in Menomonee Falls, WI, has opted to not stock OTC medications for its employees.

Shirley P. Rosien, RN, COHN-S, director of occupational health and wellness at Community

Memorial, says the decision boiled down largely to record-keeping and documentation requirements set forth by the Joint Commission on Accreditation of Healthcare Organizations.

"Being a hospital-based occupational health department, the regulations may be different than industry-based occ-health departments, but most of our issues relate to Joint Commission requirements," explains Rosien.

As an alternative, the hospital's outpatient pharmacy keeps a stock of commonly used OTC medications that employees can obtain.

No standard, but plenty of questions

At any time, a third or more of your worker population is likely to be taking OTC medication for a whole array of minor complaints, including cold symptoms, allergies, headache, muscle pain, or indigestion, surveys have shown. While company clinics at one time might have freely dispensed aspirin for headaches, employee health providers are taking a more careful look at what the risks might be to handing out medications on demand.

"There is no standard for administering meds at work," according to **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, clinical instructor in occupational health nursing at the University of North Carolina at Chapel Hill and current president of AAOHN. An occupational health nurse planning a system to dispense OTC medications should carefully consider a number of concerns, including what state regulations might govern the plan, what medications to make available, and how they should be administered. (**See table, right, for steps for setting up an OTC program.**)

Among the concerns voiced by occupational health providers about administering OTC medications at work include misuse by employees and potential interactions or side effects that could create safety risks for the employees taking the medication or their co-workers.

On one hand, if a company dispenses OTC medications, it knows what the employees are taking, and the employee's complaint is relieved, letting him or her continue to work and saving the company money. On the other, if the employee is taking prescription medications or OTC medications other than those dispensed at work, potential risks exist.

Occ-health nurses who dispense medications are responsible for the effects they have on the person taking them, so it's crucial that the nurse know what the condition is that the medication is

Administering OTC medication at work

1. The occupational health nurse should evaluate which OTC medications are currently offered and available at the work site. Ask the following questions:

• Are all of them necessary?

• Why are they offered?

• What are their ingredients?

Many OTC medications contain compounds that induce drowsiness, impair performance, and can contribute to work-related injuries. Some warn against operating machinery or driving. Some medications contain alcohol, caffeine, sugar, salt, or antihistamines.

2. Decide which medications are needed based on the types of worker complaints (e.g., headache, etc.), which medication(s) workers prefer, and what the possible cost of the medicine might be.

The nurse or person in charge of the program needs to know if a standing order for the medication is required. The Board of Nursing in each state would be able to provide guidance regarding the need for standing orders.

3. Explore the effects of the medication on the employee's job.

4. Consider the interaction of the medication with other medicines the worker may be taking. This may be other OTCs, vitamins, and prescription drugs for any number of ailments, such as hypertension, glaucoma, heart disease, diabetes, etc.

5. Consider effects of other variables:

• If the worker drinks alcohol, what effect might it have on the medication?

• What about herbal compounds or remedies?

Certain foods may interact with medicines. This could potentially make them less effective or could cause side effects.

6. Teach workers how to read labels on medications. Include where to find important information such as active ingredients, side effects, precautions, dosage, and indications for use. This education can save lives, decrease medication interactions, and promote self-care.

7. Written directions are helpful to guide workers' decisions, especially in light of diversity of workers and language differences.

Source: Susan A. Randolph, MSN, RN, COHN-S, FAAOHN

for, and what other drugs the employee might be taking at the same time.

Dispensing OTC medication not without risk

Some hospitals in the United States have stopped dispensing OTC medications to employees who request them for headaches, out of fear that the employee's diagnosis might be wrong. Anecdotes abound of employees with headaches being found to have subarachnoid bleeds; "dry eye" turning out to be contagious conjunctivitis; and "indigestion" actually signaling a myocardial infarction.

Other worksite occupational health offices limit their involvement by providing one-time-only doses of OTC non-aspirin pain relievers, antacids, or anti-emetics.

Consumer Reports on Health in 2001 listed five hazards associated with use of OTC medications:

• Incorrect self diagnosis and subsequent treatment with an OTC medication that either alleviates symptoms and masks a more serious problem, or delays necessary treatment;

• Overdose resulting from increasing the dose past recommended parameters in an attempt to alleviate symptoms that do not respond to standard, non-prescription doses;

• Overuse caused by frequent and repeated use of some OTC medications can cause dependency. Rebound effect refers to when the drug wears off and the symptoms may be worse than those originally felt when the medication was initiated, creating a cycle of increasing drug use associated with worsening symptoms.

Overuse can lead to dependency or damage of major body organs, especially for individuals with histories of ulcers, gastrointestinal bleeding, hypertension, heart arrhythmias, kidney disease, or liver disease;

• Drug interactions can be mild, moderate, severe, or life threatening, and can occur with other OTC medications, prescription medications, herbal preparations, alcohol consumption, or illicit drug use; and

• Drug allergy may occur at any time, with any medication and can be life-threatening. ■

[For more information, contact:
***Shirley P. Rosien**, RN, COHN-S, director, occupational health and wellness services, Community Memorial Hospital, Menomonee Falls, WI. E-mail:* SROSIEN@communitymemorial.com.

***Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, clinical instructor, occupational health nursing, University of North Carolina at Chapel Hill. E-mail: susan.randolph@unc.edu.]*

ED docs at high risk for suicide

Many are reluctant to seek help

The bad news: Nearly three-quarters of ED physicians may experience depression at some point in their careers, and nearly half consider harming themselves. The worse news: Nearly half of those with such problems do not seek treatment.

These are some of the sobering statistics revealed in an article in the March 2006 issue of *Emergency Physicians Monthly* (www.epmonthly.com). In a survey of 108 emergency physicians, 73% of the respondents reported having experienced depression, and 41% of them did not seek treatment. In addition, 48% considered harming themselves in the course of the condition, and 85% did not report the illness to regulatory authorities, with several noting privately that to do so might jeopardize their ability to continue to practice.

Physicians are uniquely unwilling to seek help, says **Louise B. Andrew**, MD, JD, an emergency physician and a medical-legal consultant in Victoria, British Columbia, and the article's author. "There is a very real concern that medical boards might jump on us and say we shouldn't be practicing," she says. "You can't blame anyone for not wanting to be forthcoming if it could immediately cost them their livelihood."

Another impediment to seeking help is the "physician mentality," asserts **Jack Turner**, MD, PhD, FACEP, an emergency physician with Team Health, an organization in Knoxville, TN, that provides ED administrative and staffing services to hospitals. Turner also chairs his organization's Committee on Physician Well-Being and sits on the wellness committee of the American College of Emergency Physicians.

"Physicians think they can do everything," he says. "It's almost a strike against us to admit we are fallible somehow." Also, emergency medicine in general is more a lonely specialty, Turner reports. "We do not have the collegial support mechanisms most other specialties have — the

conversations around the doctor's lounge, sitting in our offices around lunch and chatting — and we often do not see other colleagues in the hospital," Turner adds.

Options appear limited

There are some options that may provide confidentiality, notes Andrew.

Some organizations offer employee assistance programs (EAPs) available to physicians, although the number of such programs she is aware of is "vanishingly small." And indeed, Andrew adds, physicians still may be reluctant to visit an in-house EAP "because they fear the licensing board or the employing entity will be notified." This fear exists despite that fact that EAPs are designed to maintain confidentiality, because even such a program may treat physicians differently for fear of liability in the event of patient injury.

Another option is your state's physician health program, she says. "A doctor can go to that organization without reporting directly to the licensure board, but the majority of physicians don't understand or don't trust this as an arm's-length arrangement," Andrew notes. "If you do go to a physician health program, and if they agree with you that you are depressed and that your patients' care might be jeopardized, they can force you into treatment or threaten to report you to the board if you do not comply."

Remember that any person who is depressed may not be thinking very clearly and may need some direction about their options, she says. "[The state's physician health program] actually would be a good place to go, because the doctors they refer to are used to treating doctors," she says. "Many doctors are reluctant to provide care to other doctors or to recognize illness, especially mental illness, in this population."

An ED director who suspects any kind of illness in a staff member should say, "You don't look so good. What's the problem? Is there anything I can do?'" he advises. "Let them know you're asking because you care about them, that you're there to help, and that they can be open with you," Turner says.

This approach may release the physician's reluctance to talk, says Andrew. "It's so unusual for people to show they care about doctors," she notes. "Sometimes the surprise brings a sense of relief, and they think: 'Oh my God, someone really cares!' and let down their defenses."

Creating more opportunity for dialogue between doctors would also help, Turner suggests. "Rather than just having meetings to discuss business, have meetings to discuss the experiential things they do: the difficult cases, those that affected them emotionally," he says. "It may help relieve the cumulative stress."

Turner suggests that a topic a month be selected, such as what to do if you find a colleague who is impaired. "Then, maybe next month, 'What happens if one of us becomes depressed? What do we do? How we help?'" he says.

"You could have a general inservice: education about the signs and symptoms of depression, or other illnesses in physicians," Andrew suggests. "It may not be the least bit unreasonable to have one session of CME a year on impairment."

Where do you get facilitators for such sessions? A good resource is the American College of Emergency Physicians' (ACEP's) practice management department, says Andrew. "There is a superb speakers' bureau on wellness topics," he adds.

Be vigilant: Sharps safety still tops OSHA citations

Injuries occur with safety devices

Despite widespread conversion to sharps safety devices, hospitals are more likely to be cited for violations of the bloodborne pathogens standard than any other standard.

OSHA issued 136 citations to hospitals in FY2006. Sharps injuries also contributed to the overall high rate of injury among hospitals.

In 2006, OSHA sent letters to 105 hospitals, cautioning them about their rate of six or more injuries or illnesses resulting in days away from work, restricted activity, or job transfer. The average rate for hospitals is 3.4, and the average for all industries is 2.5.

"What we're seeing there is not only the nonuse of engineering controls, but also [problems with] work practice," says **Dionne Williams**, MPH, senior industrial hygienist.

For example, in one case, a facility was cited for a needlestick that occurred when an employee put an unprotected sharp in her pocket. She needed to carry it to a sharps container down the hall because no container was available in the patient care area. As she pulled it out of her pocket, she accidentally stuck another employee. The hospital needed to

have sharps containers available for immediate disposal, says Williams.

The hospital also is responsible for monitoring work practices to make sure safety devices are being used properly, she says. Safety rounds, in which employee health or safety professionals observe everyday activities, can identify problems with work practice, she says.

Hospitals should develop a safety culture that encourages employees to discuss potential problems in a nonpunitive environment and "to be vigilant about things they see," says Williams.

More than half (57%) of sharps injuries occur with the use of safety devices, and about 70% of those were not activated, according to the EPINet data compiled from about 48 hospitals by the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville.

With the rapid growth in the use of safety devices, it's not surprising that they would be involved in a higher proportion of needlesticks, says **Jane Perry**, MA, associate director of the center. Hospitals should evaluate injuries to determine whether better training is needed or perhaps a switch to a device with a different safety mechanism, she says.

Other standards frequently cited by OSHA include personal protective equipment (PPE) , hazard communication, and respiratory protection. For example, in the past year, hospitals have been cited for failing to have an available eye wash station.

"Everything in the health care facility isn't going to fall under the bloodborne [pathogens standard]," says Williams. "It's important for hospitals to make sure they're ensuring PPE for other types of hazards."

Although OSHA has been prohibited from enforcing the annual fit-testing requirement related to tuberculosis and N95-filtering facepiece respirators, hospitals must follow the other requirements of the respiratory protection standard, such as annual training.

Hospitals also have significant hazards in nonclinical areas, particularly related to facility and equipment maintenance. Among the top 10 most-cited standards involve lockout/tagout, woodworking, and cadmium.

One type of violation is missing from the list. The general duty clause of the Occupational Safety and Health Act has not been used to enforce ergonomics-related hazards, despite the high number of musculoskeletal disorder injuries in health care due to patient handling.

"Because there's no standard, it makes it incredibly difficult for us to be able to cite," says Williams. "We do inspect hospitals when we get complaints, but the bar is raised very high as far as documenting for citations. We do issue hazard alert letters, which is the next best thing to get some action." ■

Workers traveling? Think health and safety

Occ-health nurse should help with planning

International travel has become an almost routine component of business as more and more corporations extend their interests globally. For the occupational health nurse, this means not only keeping tabs on workers at the home office, but those whose work takes them to potentially hazardous parts of the world.

Most business travelers assume they might need shots before they travel, but the employee's current health as well as conditions where he or she is traveling are factors for the occ-health nurse to consider, says travel medicine consultant **Gail A. Rosselot**, MS, MPH, NP, COHN-S, president of Travel Well of Westchester, NY.

OSHA in 2002 issued a technical bulletin, "Safety and Health During International Travel," in which it recommended that employers identify employees who travel internationally and refer them to qualified health care professionals for obtaining travel information and vaccinations, but does not mandate that employers provide those services or vaccines.

Occupational health nurses, should identify all international travelers in their workplaces and establish a policy that sets out what pre-travel preparations those travelers should receive. The policy should be applied consistently to employees at all sites and employment category, Rosselot adds.

Prevention starts with an educated nurse

Although vaccines are the first thing that most people think of when contemplating travel to a country where disease is an issue, most travel health concerns are not vaccine preventable. Injury, illnesses, and recurrence of prior health problems are all risks when traveling, and almost all can be prevented with pre-travel preparation.

"Vaccines are important, but there are many more prevention measures that are much more important," Rosselot says.

The responsibility of knowing what the health and safety risks are for employees traveling abroad naturally falls to the occupational health nurse, and it can be a constant challenge to keep up with. The risks and disease threats change almost daily in some areas of the world, and there are few opportunities for formal or ongoing training, because the information changes so rapidly.

Despite the challenge of keeping up with the ever-changing field of travel health, the occ-health nurse should push employers to provide resources for them to stay abreast of the potential health risks to their traveling employees.

Most information is web-based, so it can be quickly updated, but some occ-health nurses don't have ready access to the Internet at work.

"It's not enough to have a plan and policy. The person delivering the message to employees has to be adequately educated, and most nurses know this and quickly realize when they're out of their element," Rosselot says. "Most employers are reluctant to provide the resources necessary for them to train, but it's worth it for nurses to push for it."

Once a policy is in place, it should be disseminated early and often. New hires and newly promoted employees should be sent a letter describing the company's business travel policy, with encouragement to visit the company nurse long before the trip is imminent. Rosselot says she encourages nurses to send the letters home in any materials that might be seen by a spouse who could act as an additional reminder to the business traveler.

If there is a positive outcome of the SARS and avian influenza outbreaks, Rosselot says, it is the heightened recognition they have brought to the need for precautionary travel medicine.

Plan before packing

While some business travelers will show up at the nurse's door with bags packed and ticket in hand, some advance preparation is far preferable to cover as many anticipated risks as possible.

Rosselot suggests the nurse get to know the patient and any inherent risks in his or her background. Ask about the traveler's current health, any medicines being taken, and the duration of the time away.

"Once you have the employee there, you have your baseline, and then you become a partner with that person throughout the time they travel," she suggests. "You are their partner for prevention, and it's a rewarding part of the job."

If the traveler will be gone for a long period of time (many weeks or months), preventive care such as dental checkups and physical exams should be scheduled; the occupational health nurse may need to help facilitate "rush" appointments, and Rosselot says having a network of practitioners who can be called on in emergencies is helpful in these cases.

"The plan follows the general outline for occupational health: pharmacological and non-pharmacological risk reduction," she says. "That's what we're talking about—reducing risk for injury and illness."

Pre-travel preparation includes educating the traveler so that he or she can maximize self-care on the road if prevention measures don't work, and reducing their exposure to potential risks.

"The bottom line for employers is the bottom line, and that means keeping the trip successful from a business point of view. A sick traveler who has to stay in bed, get medical treatment on the road, or return home early is not a successful business traveler," Rosselot points out.

The nurse's challenge, then, is to prioritize the known risks and customize a prevention plan that is realistic. Downloading and printing out reams of information about tropical diseases that might be encountered could make for interesting reading on the plane, but too much information can overwhelm and unnecessarily scare the traveler, Rosselot cautions.

Practical information that applies to that traveler is more likely to be retained and of benefit. Risk minimization — hiring a driver or taking a cab rather than renting a car and driving — deserves plenty of attention from the occupational health nurse.

Accidents — motor vehicle accidents, drownings — are the #1 cause of morbidity and mortality in people traveling abroad, says Rosselot. And underlying health problems (versus exotic diseases) are the more frequent cause of hospitalization.

"You have to prioritize and identify what the real risks are to that employee, and weed out the less likely risks," she says.

"Certainly corporate travelers can be told not to rent a car on their own and not to participate in certain activities, like corporate bungee-jumping with the clients."

Some companies elect to make corporate travel contingent upon the employee being evaluated

by the company doctor or nurse before getting on the plane, or checking in every year with employee health.

"When you see someone in private practice in an outpatient setting, you don't have a lot of control over their trip, but their employer does," says Rosselot. "The Peace Corps, for example, will not pay out a dollar in insurance benefits if a volunteer is hurt or killed riding a motorcycle. The employer can say that if you do certain things, it's at your own risk."

Traditional travel advice — don't drink the water, don't eat raw fruits and vegetables, and avoid areas where mosquitoes are plentiful if malaria is a risk — still holds true, and many travel medicine clinicians suggest a baseline tuberculosis test before travel to at-risk areas and one upon return.

Cover pharmacological measures

Immunizations are the obvious first-line pharmacological measures to review for a business traveler. Some vaccines can be given once, and as late as the day of travel. Others need repeat doses, usually a total of three, so if the first shot is given just before departure, the nurse may need to locate a health resource at the destination for the immunization to be completed.

Travel medications that cover traveler's diarrhea (which affects up to 60% of travelers in some settings) and malaria should be included in a medical kit that accompanies the traveler. Basic first aid supplies should also be included, as should a broad-spectrum antibiotic in case travel diarrhea is acquired. With any medications, the traveler should be thoroughly familiarized about how and when it should be used.

Another pharmacological strategy is to monitor and evaluate the employee's health while he or she is traveling. This is particularly important if there is a chronic or serious health issue with that person. The nurse might choose to have the patient call in at scheduled times during the trip, or if a medical resource is available at the destination, the traveler could be monitored on location.

"When they come back, do a follow-up and find out how they did," Rosselot suggests. "Ask what they used in their medical kit, what risks they encountered, and what worked for them and what needs to be improved. This tells you if you're meeting your goals for traveling employees, and also looks good in year-end reports."

Rosselot says it's a horrible thing to consider, but since the first outbreaks of avian influenza two years ago, she has made it a point to talk with business travelers about making sure they don't find themselves unable to return home.

"I talk about avian flu to every traveler, whether they're gong to countries that have reported outbreaks or not, because it's a global issue," she says. "I tell them that if they become aware of sustained human-to-human transmission, they should get themselves home immediately, and that's it. I'm not concerned with Tamiflu, I am concerned with people being locked out [outside U.S. borders]."

Among the United States' contingency plans should avian influenza or other disease become pandemic is to close its borders, to try to limit or slow the spread as much as possible. This won't happen overnight, but airports could quickly become overwhelmed and air travel could be crippled in the ensuing panic.

"I tell travelers that if they become aware of a situation, they should get to the airport immediately and get on line for a flight home," says Rosselot. "If someone is stranded outside our borders, it's unthinkable, but we don't have any magic bullets here in the U.S. We're just as vulnerable to the spread as anyone else, and trying to control our borders is all they'll be able to do."

Pandemics are not the only threat travelers should be advised to watch for. Political unrest and natural disasters — such as approaching hurricanes — are worthy of attention. "Don't ruin their travels by dwelling on the negative," Rosselot advises nurses. "Just tell them to keep their wits about them and stay aware." ■

[For more information, contact:
***Gail A. Rosselot**, MS, MPH, NP, COHN-S, president, Travel Well of Westchester, 140 Todd Lane, Briarcliff Manor, NY 10510. E-mail: garosselot@aol.com.]*

CE Objectives / Instructions

The CE objectives for *Occupational Health Management* are to help nurses and other occupational health professionals to:

- Develop employee wellness and prevention programs to improve employee health and productivity.
- Identify employee health trends and issues.
- Comply with OSHA and other federal regulations regarding employee health and safety.

Nurses and other professionals 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, you must complete the evaluation form provided in the June issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE *questions*

1. Which of the following is NOT among the recommendations issued by the American Nurses Association regarding nurses and diversity?
a. Nurses should understand how cultural groups understand life processes
b. Nurses should consider how cultural groups define health and illness
c. Nurses should ignore their own cultural background when caring for patients of different cultures.
d. Nurses should be familiar with what cultural groups do to maintain wellness

2. Which of the following is NOT considered a characteristic of workers born during the baby boom era?
a. Respectful of titles
b. Work to live
c. Don't like change
d. Group-oriented

3. Which of the following risks is/are associated with use of over-the-counter medications?
a. Incorrect self diagnosis, leading to masking of serious problem
b. Overdose resulting from exceeding recommended parameters in attempt to alleviate symptoms
c. Overuse leading to dependency and rebound
d. All of the above

4. The most serious risks faced by international business travelers can be avoided through use of appropriate vaccines.
a. True
b. False

Answers: 1. C; 2. B; 3. D; 4. B