FOR MORE THAN 24 YEARS

Hospital Employee Health®

THOMSON
AMERICAN HEALTH CONSULTANTS™

IN THIS ISSUE

■ **Declining the shot:** JCAHO issues a flu immunization standard. . . . . cover

■ **Passing the test:** Cutting back on annual TB testing at low-risk facilities. 87

■ **Silver celebration:** AOHP still working hard 88

■ **Breathing room:** Floor strippers in an unventilated room can mean problems. . . 90

■ **Beyond the lift:** Conference highlights ergonomic solutions beyond patient lifting 91

■ **Privacy is premium:** Confidentiality in employee health builds trust. 92

■ **Working wellness:** How one hospital launched a wellness program that worked 93

■ **Sign of the times:** Safe-lift logo can give patient-handling programs a boost. 95

Financial Disclosure:
Editor Michele Marill, Managing Editor Jill Robbins, Editorial Group Head Coles McKagen, and Consulting Editor MaryAnn Gruden report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AUGUST 2006
VOL. 25, NO. 8 • (pages 85-96)

JCAHO adds flu standard with no declination statements required

Declinations seen as obstacle to flu immunization

Hospitals must try to improve participation in influenza immunization of health care workers, but the Joint Commission on Accreditation of Healthcare Organizations won't require them to collect declination statements from employees who refuse the vaccine.

The new Joint Commission standard, which goes into effect Jan. 1, 2007, requires hospitals to evaluate why some employees do not receive the annual vaccine and to take steps to improve participation. **(For the Elements of Performance, see box on p. 87.)**

The standard follows recommendations by the Centers for Disease Control and Prevention (CDC) for hospitals to boost influenza immunization. The CDC has advised hospitals to ask employees to sign declination statements if they refuse the vaccine as a strategy to track vaccinations and improve compliance. **(For more information on the CDC's recommendations, see *Hospital Employee Health*, April 2006, p. 41.)**

"At a minimum, there has to be access to the vaccine on-site and there has to be an education program telling people why it's important," says **Robert Wise**, MD, vice president of JCAHO's division of standards and survey methods. "You have to evaluate the actual rate [of immunization] and the reasons for nonparticipation."

Influenza immunization of health care workers has come to the forefront as a patient safety issue. Nationally, only about 40% of health care workers receive the vaccine, according to CDC surveys.

"A fragile patient should not have to risk being exposed to a potentially deadly infection from a health care worker," Wise says.

Declinations: A burden with no benefit?

From nurses' unions to infection control experts, everyone agrees that health care workers should receive influenza immunization to prevent hospital-based spread of the disease. The specter of pandemic influenza

just magnifies the importance of vaccination.

But how should hospitals ensure that employees receive the vaccine each fall? There are a variety of strategies, but none has been as contentious nationally as the use of declination statements.

The Joint Commission received more comments on that potential aspect of the standard than any other issue, says Wise. Infection control organizations such as the Association for Professionals in Infection Control and Epidemiology and the Society for Healthcare Epidemiology of America endorsed the use of declination statements.

The American College of Occupational and Environmental Medicine argued that declination statements would divert resources that could be used for more positive methods to improve compliance.

The new standard gives hospitals flexibility to find other ways to address nonparticipation, says **William Buchta**, MD, MPH, medical director of the Employee Occupational Health Service at the Mayo Clinic in Rochester, MN.

"Hospitals could use declination forms, but the evaluation also could be accomplished by other means," Buchta says. For example, hospitals could study trends, conduct voluntary sampling surveys of those who did not get the vaccine, or ask employees for comments about why they did not get vaccinated, he says.

Declination statements would place a burden on employee health departments that are already stretched, says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, past executive president of the Association for Occupational Health Professionals in Healthcare, which also provided comments to JCAHO.

"It really would pull the limited resources that we have in our offices to tracking that [immunization] process rather than trying to educate employees and trying to come up with innovative ways to get more employees vaccinated," says Gruden, who is employee health coordinator at Western Pennsylvania Hospital in Pittsburgh. "We really wanted to focus on those positive efforts rather than a paper trail of declinations."

JCAHO provided the following comment in its rationale for the standard:

"One obstacle to effective vaccination is declination by health care personnel. Health care personnel may decline vaccination for many reasons. They may have been vaccinated elsewhere, have a medical contraindication, or have other personal reasons for declining the vaccine. Vaccination might also be declined because it is offered at inconvenient times or locations. Whatever the reason, it is important for organizations to identify why individuals do not participate in the vaccination program, work to overcome these reasons, and increase vaccination rates."

Who should you vaccinate?

The Joint Commission also addressed other concerns in its final standard. As initially proposed, the standard would have applied to "staff, students, volunteers, and licensed independent practitioners." The final standard simply requires hospitals to immunize "at least staff and licensed

Hospital Employee Health® (ISSN 0744-6470), including **JCAHO Update for Infection Control** and **Bioterrorism Watch**, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Employee Health**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday, 8:30 a.m.-4:30 p.m. Friday EST. E-mail: ahc.customerservice@thomson.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $469. 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 1 month of the missing issue date. **Back issues**, when available, are $78 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 CEP10864. This activity is approved for 18 contact hours per year.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

Editor: **Michele Marill**, (404) 636-6021, (marill@mindspring.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen @thomson.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@thomson.com).
Senior Production Editor: **Nancy McCreary**.

Editorial Questions

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

THOMSON
AMERICAN HEALTH CONSULTANTS

JCAHO standard requires flu immunization of HCWs

Standard IC.4.15
Immunization against influenza is offered to staff and licensed independent practitioners.

Elements of Performance for IC.4.15

1. The organization establishes an annual influenza vaccination program that includes at least staff and licensed independent practitioners.
2. The organization provides access to influenza vaccination on-site.
3. The organization educates staff and licensed independent practitioners about the following:
   - flu vaccination;
   - nonvaccine control measures (such as the use of appropriate precautions);
   - the diagnosis, transmission, and potential impact of influenza.
4. The organization annually evaluates vaccination rates and reasons for nonparticipation in the organization's immunization program.
5. The organization implements enhancements to the program to increase participation.

independent practitioners."

"There are large hospitals where a student may happen to come in with a physician and be there for a day or two. Were we really expecting the organization to offer it to [every] student or volunteer? It was so important for this to be successful that we did not want to create burdens that really may not add much to the overall safety," says Wise.

The Joint Commission also will not require hospitals to cover the cost of vaccination, although the CDC recommends that the vaccine be offered free of charge. No other JCAHO standard addresses the issue of cost, notes Wise.

"There is a requirement that the organization make it accessible," he says. "You would have to have it on three shifts during the flu season." An evaluation might indicate cost as a barrier to vaccination and then the hospital might choose to reduce the cost to employees or make it free of charge, he says.

With the standard in place and a renewed emphasis on influenza vaccination of health care workers, Wise says immunization rates should rise. "Health care workers, when coaxed a little, will do the right thing," he says. ■

Freedom: Hospitals halt annual TB tests

Baseline only for low-risk facilities

The tedious job of tracking tuberculin skin tests for hundreds, or even thousands, of employees has ended for hospitals that rarely treat patients with tuberculosis.

In new guidelines released late last year, the Centers for Disease Control and Prevention (CDC) advised that hospitals that are "low risk" based on a risk assessment do not need to conduct annual TB screening. Without the burden of that task, employee health professionals have been able to focus on other projects, including injury prevention and wellness.

"It does free up an awful lot of time," says **Deborah Rivera**, RN, COHN, occupational health nurse supervisor at Children's Mercy Hospitals and Clinics in Kansas City, MO. "It was something we monitored very carefully. You wanted your compliance to be 100%, if at all possible, and we worked hard to do that. I'm glad it's gone."

Until this year, Children's Mercy conducted 7,000 to 10,000 TB tests a year, including two-step baseline tests. The hospital will continue to conduct two-step baseline tests on new employees, or a total of about 3,000 tests. The reduction will save an estimated $50,000, much of that in staff time.

In its 2005 *Guidelines for Preventing Transmission of* Mycobacterium tuberculosis *in Health-Care Settings*, the CDC classified hospitals as low risk if they had more than 200 beds and fewer than six TB patients in the preceding year, or if they had fewer than 200 beds and fewer than three TB patients in the preceding year.

Children's Mercy met the criteria, so Rivera brought the issue to the hospital's infection control committee and got the approval of the public health department. The hospital still provides annual education to employees about TB, monitors employee symptoms, and conducts an annual risk assessment.

If the risk status changes or transmission occurs, employees would need to have baseline, two-step tests if they have not had a TB test within the past 12 months, says **Paul Jensen**, PhD, PE, engineer director with the U.S. Public Health Service and the CDC's division of TB elimination. Employees who move to a new

setting, even if it is low risk and within the same facility, would need the two-step test, he says. (Different units, such as the emergency department, may carry different risk assessments.)

So nurses who "float" among different departments still may need annual TB testing even if they're in a low-risk facility, Jensen says. For other employees who transfer settings, the two-step testing could be avoided by using a TB blood test such as Quantiferon-TB Gold, he notes.

Now employees want TB tests

It seems strange to end annual TB testing, Rivera acknowledges. After all, conducting TB skin tests has long been a significant task for employee health — and one often reviewed by visiting surveyors from the Joint Commission on Accreditation of Healthcare Organizations.

Employees also had grown accustomed to the annual screening. So paradoxically, employee health professionals who once spent hours reminding employees and following up on those who didn't get their tests now field requests from employees who still want the TB tests even if they're not required.

"Danville Regional Medical Center continues to offer annual TB testing to its associates, with almost all associates choosing to receive it," says **Peggy Taylor**, RN, COHN-CM, employee health nurse at the center in Virginia. "It seems like more so now than before, but it might be my imagination."

Employee health won't track down the employees to make sure they return for their test result to be read. But Taylor tells them, "'There's no point in my placing it if you're not going to get it read,'" adding that they usually do come back.

As at many rural hospitals, **Phyllis Radcliff**, RN, employee health nurse at St. Mary's Hospital in Streator, IL, once spent hours following up on employees who had failed to get their TB screens within the designated time. All of the hospital's 520 employees received annual TB tests, although the hospital hasn't treated a confirmed TB patient in at least five years.

"It had always been a battle getting everybody to do their annual TB testing," she says.

The hospital still conducts annual respirator fit-testing and provides TB education as a part of that. Employees may receive the annual TB test free of charge, if they want one, a policy that particularly benefits nursing students who need it for school, Radcliff says.

But with an end to mandatory testing, Radcliff says she will have at least a few extra hours a week to focus on improving employee health and preventing injuries.

Reference

1. Centers for Disease Control and Prevention. Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. *MMWR* 2005; 54(RR17):1-141. ■

AOHP at 25: Raising the profile of HEH

Challenges remain to cut hospital hazards

Twenty-five years ago, when hospital employee health was synonymous with tuberculosis testing, hospital hazards received little attention, and AIDS was called gay-related immune deficiency, a group of California nurses joined together with a mission. They were trying to protect hospital employees, and they needed each other's help.

They formed the Association of Hospital Employee Health Professionals as a way to network, share resources, and promote the prevention of hospital-based injury and illness.

Today, that organization thrives as the Association of Occupational Health Professionals in Healthcare (AOHP), with more than 900 members, 23 chapters, and members in almost every state. When AOHP celebrates its anniversary at its annual conference, to be held Oct. 4-7 in Sacramento, its founders and leaders will reflect on the successes as well as the challenges that remain.

Employee health professionals now deal with pandemic influenza planning, bioterrorism and emergency preparedness, the Family and Medical Leave Act, safe patient handling, wellness promotion and accident prevention, as well as the usual tasks of TB testing, immunizations, and pre-placement exams. And yet about 37% of employee health professionals have no clerical support, according to a survey conducted by AOHP in 2005.

AOHP continues to work to raise the profile of employee health. For example, AOHP officers send comments to federal agencies and the Joint Commission on Accreditation of Healthcare Organizations when they are considering changes in guidelines or standards. AOHP also is renewing its alliance with the U.S. Occupational Safety and

Health Administration (OSHA), which gives it a voice with that agency.

"Our goal as an association is to increase the national recognition of AOHP," says **Denise Strode**, RN, BSN, COHN-S/CM, executive president of AOHP and workers' compensation case manager for OSF SFMC Center for Occupational Health at Saint Francis Medical Center in Peoria, IL.

Starting from scratch

In the early days, employee health nurses worked with no guidelines or standards. If an employee reported a needlestick, they received some antibiotic ointment and a tetanus shot, recalls **Joyce Safian**, RN, FNP, PhD, one of the founders and the first executive president of AOHP. Safian will be the keynote speaker at the 25th annual conference.

As a young nurse just out of nursing school, Safian was working in the intensive care unit when a medical intern who had a needlestick admitted. He had developed fulminating hepatitis B and died within 24 hours. That tragic episode "never left my mind," recalls Safian, who later founded an occupational health clinic and is now president and CEO of North Bay Corporate Health Services Inc. in Santa Rosa, CA. "I recognized the importance and significance of what could happen to someone if they had a needlestick."

In 1978, Safian gave a presentation on "a comprehensive employee health program in a hospital" for the American Public Health Association conference. It was part of her master's thesis. She began fielding phone calls from employee health nurses seeking advice.

After much prodding, Safian agreed to help start an association, as long as she had the help of some other pioneers in the field, including Ann Stinson, Mary Alice Hall, Karen Gammelgard, and Cliff Strother.

Forty employee health professionals from northern California hospitals met together in 1981 and developed seven goals: to network, develop a professional continuing education program, publish a newsletter and a manual, sponsor research, provide consultation, develop political awareness and the impact of employee health on hospitals, and develop the role and recognition for the employee health professional.

Those goals remain much the same today.

Word of the new organization (then known as AHEHP) spread quickly, and Safian heard from employee health nurses who wanted to join. At that time, the American Association of Occupational Health Nurses (AAOHN) didn't offer any targeted programs or services for hospital-based employee health. (AAOHN now has a large contingency of members in health care, offers health care-oriented sessions at its conferences, and has a relationship with AOHP.)

"Nobody really considered that hospital employee health was that important," Safian recalls. "We all knew it was because we were dealing with infections, communicable diseases, injuries. We were dealing with wellness programs, drug and alcohol issues. My days were completely filled. I could have worked 12-hour days."

When she started the employee health department at Santa Rosa Memorial Hospital, Safian had a used desk and an exam table. "I did everything. I even had to vacuum my own office. I wasn't considered that important."

By the time she left to start her occupational health clinic, the employee health department took up half a building and saw more than 40 patients a day.

Nurses in Southern California formed the second chapter of AOHP, and by May 1981, the fledgling organization already had 95 members. The first conference was held in October in Clear Lake, CA.

Hospital Employee Health newsletter formed shortly after AOHP and became an independent vehicle covering employee health issues in hospitals and information on the new organization and its mission. Chapters began to form elsewhere in the country. In 1983, AOHP gave its first research grant to an infection control nurse who developed a paper on "hospital personnel perspectives of the etiology of needlestick injuries and methods for their prevention" — discussing needle safety.

"It was a very dynamic and forward-thinking group who had a lot of experience and great plans for their profession," says **Kathy Harben**, the first editor of *HEH* and now enterprise communication officer for the Coordinating Office for Global Health at the Centers for Disease Control and Prevention.

Today, AOHP seeks to address both the beginning employee health nurse and the advanced professional at its annual conference. For example, this year's agenda includes sessions on implementing lift teams and other ergonomic interventions, using Quantiferon-TB Gold to replace TB skin testing, and a businesslike approach to return-to-work programs.

AOHP soon will release a resource guide on patient handling that focuses on the specific needs of acute care units. It was developed as part of the alliance with OSHA and will be available on both the AOHP and OSHA web sites.

"The complexity and sophistication of issues that the employee health professional is now addressing is mind-boggling," Safian says.

She will provide a historical perspective, and AOHP will present a timeline of its history. A gala event will celebrate the 25th anniversary, with dinner, dancing, a casino, and a speaker on "Humor at Work."

"We're hoping a lot of people will come and celebrate with us," says **Sandy Prickett**, RN, FNP, COHN-S, conference chair and employee health services coordinator/nurse practitioner at Marin General Hospital in Greenbrae and Novato (CA) Community Hospital. "As AOHP turns 25, I wanted [an agenda] that looks at the past as well as the present and future."

The internet has transformed the ability of employee health professionals to network and tap into resources. AOHP now has an e-mail listserv that enables members to discuss their concerns and share ideas.

But with all the changes in the past 25 years, many similar challenges remain. **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, past executive president and employee health coordinator at Western Pennsylvania Hospital in Pittsburgh, noticed familiar topics as she perused the brochure for the first conference.

"A lot of the issues we were dealing with 25 years ago are still issues today," she says.

(Editor's note: A conference brochure and other information are available at the AOHP web site, www.aohp.org.) ■

Workers become ill from floor strippers

Lack of ventilation creates a hazard

While getting your floors "hospital clean," you may inadvertently be exposing workers to a hazardous chemical that can cause respiratory, skin, and eye irritation, headaches, nausea, and even kidney or liver damage.

Floor strippers often contain hazardous solvents, such as 2-butoxyethanol and ethanolamine. If these are used inappropriately and in areas with poor ventilation, the air concentration may be high enough to cause symptoms not just among the cleaning staff, but in other workers in the space.

"This would mainly be a problem in enclosed areas like a file room or library," explains **Lawrence Raymond**, MD, SEM, professor of family medicine at the University of North Carolina in Chapel Hill and director of occupational and environmental medicine at Carolinas Health Care System in Charlotte.

Raymond investigated a cluster of ill workers in an unventilated file room that had been treated with undiluted floor stripper. Their symptoms persisted for months.

Meanwhile, the workers using the cleaning products are often some of the least educated in the hospital and may not understand the hazards. They aren't likely to ask to see the Material Safety Data Sheet.

"They don't know enough to know they're in danger. They are just trying to do their jobs the best way they can and get the wax or sealant off," says **Dawn Twenge**, BSN, RN, associate health nurse at Porter Hospital in Valparaiso, IN, which also had a cluster of workers affected by chemicals in a floor stripper.

The U.S. Occupational Safety and Health Administration (OSHA) set a Permissible Exposure Limit of 50 parts per million (ppm) for 2-butoxyethanol, based on an eight-hour, time-weighted average. However, transient effects may occur at lower levels, OSHA said. The organization noted that skin absorption is a particular hazard. The National Institute for Occupational Safety and Health set a Recommended Exposure Limit of 5 ppm, as a time-weighted average, with the same notation about the risk of skin absorption.

Vapors cause headaches, dizziness

Porter Hospital had a new floor sealant that would last much longer than the old wax and keep the floors looking shiny and clean. But first, the old sealant needed to be removed.

It wasn't easy. The floor stripper should be diluted by a ratio of one part stripper to six or more parts water, but the employees figured more would work even better. They used three parts floor stripper to one part water.

As they worked in a vacant room, nurses and other employees asked them to keep the door closed so the vapors wouldn't spread into the hallway. The three-man cleaning crew began to have

headaches and dizziness and their legs were shaky.

When one employee came to Twenge with his symptoms, she began to investigate. She called the product manufacturer and spoke to a toxicologist who assured her the chemicals were just irritants at that exposure level.

The employees were examined by an occupational medicine physician, who conducted blood tests and found no adverse effects.

Twenge also conducted some monitoring by simulating the work environment with the door closed and the door open. In the closed room, even with a proper dilution, the monitoring showed exposures above the permissible level for 2-butoxyethanol, Twenge says.

The hospital now has a policy that the door stays open unless nearby patients, nurses, or other employees have respiratory problems that would be aggravated by the smell. If the door is closed but the window open, the cleaning staff can use a fan for ventilation. If both the door and windows are closed, the staff must wear powered air-purifying respirators.

The hospital also began to automatically mix the floor stripper with water at the correct proportion with a chemical dilution system to prevent employees from mixing it in stronger amounts than recommended.

"I think hospitals have a specific issue because of their culture, their space, and the kind of ventilation they have," says Twenge, who advises working together with the safety officer to lessen chemical hazards. "In industry, they just turn on a big fan that sucks everything out. You can't do that here. You have patients who have asthma in the next room."

Lack of ventilation caused a problem for seven clerical workers in North Carolina the day after treatment with floor stripper.

A contractor used an undiluted product that contained 2-butoxyethanol in an unventilated room that had shelves of files from floor to ceiling. Shortly after the workers arrived the next morning, they experienced eye and respiratory irritation, dry cough, and headache.

Within a few months, six of the seven workers developed hypertension and skin lesions that were identified as cherry angiomas.

Raymond assured the workers that the spots were not malignant, but he called the episode "worrisome." Adequate ventilation is the key to safe use of the chemicals, he notes.

If a worker complains of symptoms, there may be a broader problem of exposure, he says. "When you see an individual worker, you should really look beyond that worker. It's possible he or she is more sensitive to the particular chemical, but it's also possible he or she is representative of the others [who have not complained]." ■

Hospitals look beyond patient-handling hazards

Kaiser finds innovative solutions

While safe patient handling is gaining momentum across the country, hospitals are also turning their attention to other causes of costly musculoskeletal disorder (MSD) injuries — from housekeepers lifting loads of laundry to outpatient nurses helping patients onto exam tables.

"Approximately 60% of injury claims are related to sprains and strains. That's quite high," says **Corey Bain**, MPH, ASP, CHMM, REA, CIE, project manager for ergonomics with Kaiser Permanente's division of national environmental health and safety in Oakland, CA.

Kaiser has developed an ergonomics program that uses improvement goals and assessment tools as guides. Bain presented the Kaiser initiative at the HealthCare Ergonomics Conference sponsored by the Oregon Coalition for HealthCare Ergonomics and the Oregon Nurses Foundation, held in Portland in June.

The Oregon conference has become a West Coast parallel to the Safe Patient Handling and Movement conference sponsored each winter by the VISN 8 Patient Safety Center of Inquiry of the James A. Haley Veterans' Hospital in Tampa.

"Our coalition goal is [to address ergonomics in] any type of health care environment. It's broader than safe patient handling and movement," explains **Lynda Enos**, RN, MS, COHN-S, CPE, conference chair and chair of the Oregon Coalition for HealthCare Ergonomics, which brings together the hospital association, nurses' association, and other unions and employers. "We want to give people practical [advice]."

When an analysis of loss reports and injury trends point toward a problem, with some research, products can be found to lessen the hazard, Bain says. For example, Kaiser bought mop buckets that enable housekeepers to use foot pedals to ring out the mops. The pharmacy has assistive devices for opening caps and new cushioned matting on the

floor that is easy to clean, impermeable to fluids, but more comfortable to stand on.

In a broader effort, Kaiser also requires ergonomic design to be incorporated in the construction or remodeling of hospitals.

Kaiser's northwest region in Portland has a goal of reducing the number of ergonomic-related injuries by 50% from its 2002 level. The goal of a 20% reduction in the first year came easily with the implementation of lift teams, says **Marilyn Terhaar**, RN, MSN, HEM, Kaiser's northwest regional workplace safety consultant.

"We found that repositioning patients in the hospital was one of our biggest [causes of] injuries," she says. "Instituting a lift team helped us reduce our injuries."

The next year's goal of a 15% reduction was harder to achieve, and the region attained only 14%. This year, the goal again is 15%.

To reduce injuries in outpatient clinics, the Kaiser region purchased lightweight mobile lifts to assist patients out of cars. A physical therapist designed a training program with a video to help employees reduce twisting, turning, and awkward postures that lead to injuries, says Terhaar.

The region also purchased exam tables that are electronically adjustable and can be lowered to 18 inches from the floor. Employees no longer have the strain of helping patients mount a step and climb to an exam table.

To keep employees current on their knowledge of the equipment, employee health and safety professionals conduct mock surveys. Kaiser also puts strong emphasis on labor management teamwork. Labor representatives work with managers to reduce injuries in a specific area, Terhaar says.

Employee input means greater employee buy-in — and greater success, she says. "It has to be their process." ■

Put a premium on privacy in employee health protocol

Give info on need-to-know basis

One employee has a medical file detailing a back injury that occurred at work. Another is a diabetic and consults with the employee health staff but never had a work-related problem.

Their records raise different privacy issues, but for employee health professionals, one truism holds: Only give supervisors the information that they need to know.

Employees often feel uneasy about the confidentiality of information maintained by employee health, notes **Marilyn Piek**, RN, MSN, COHN-S, CCM, RMHC, director of employee/corporate health services at Palomar Pomerado Health, a hospital district in northern San Diego County.

"If we ever want to get to proactive wellness and safety, we have to create a comfort level of confidentiality," she says.

Piek has worked to build that trust by making it clear that her department shares information only on a need-to-know basis. For example, if an employee fills out a health risk appraisal as a part of the wellness program, only one employee health nurse reviews that information and communicates with the employee. Employee health is not a part of the human resources department and the health information is separate from human resources files.

In fact, the employee's medical file is kept in a locked room, and each worker's compensation claim, which has different privacy considerations, is kept in a separate file, says Piek.

"A manager can't walk into the employee health department and demand to see an employee's medical record," she says. "They can ask questions about things they feel they need to know. It's up to the department protocol what information can be released."

For **Rosemary Bootes**, RN, CNP, MSN, MBA, nurse practitioner at Alliance Employee Health at Health Alliance, a six-hospital system in Cincinnati, demeanor also is important. She is consistently neutral when addressing any health issue, from a minor first-aid treatment to a life-threatening condition such as HIV.

"I'm very guarded about disclosing information, whether it's completely innocuous or not," she says. "If I'm very cavalier about information, then the moment I'm not cavalier, you think it's something serious — and I've already given you information."

Supervisors simply receive information on whether the employee has any job restrictions, she says. "All they need to know is how it's going to affect this individual's ability to do the job."

Here are some specific privacy issues faced by employee health professionals:

- **HIPAA:** Some employee health information is covered by HIPAA (Health Insurance Portability and Accountability Act) privacy provisions, which restrict access and require employee consent before it is shared. For example, personal

health information obtained in a pre-placement exam but unrelated to work duties would be protected by HIPAA, Piek notes. Health information obtained in an employee health clinic to treat personal issues such as hypertension also would be protected. In general, employee health information should be treated with the same sense of confidentiality as that of other patients, says Piek. "We need to realize that the employer is not the owner of the medical information, the patient is."

• **Needlestick reporting:** Incidents are reported on U.S. Occupational Safety and Health Administration (OSHA) logs without identifying the employee. Lab tests are treated with the same privacy considerations as other patient records, and are released only to the employee health practitioner who is treating the patient. Because of sensitivity about possible HIV or other bloodborne pathogen exposure, some hospitals use codes instead of names and send the tests to an outside lab to further protect employee identity.

• **Workers' compensation claims:** Workers' compensation claims are not covered by HIPAA regulations, and information on those work-related injuries and illnesses will be shared with the insurer and case manager. The workers' compensation insurer may request information on similar injuries — for example, to determine if an employee with a back injury had previous work-related or nonwork-related back injuries. If the claim is for work stress, the workers' compensation investigator may delve deeper into the employee's personal health history, notes Piek.

"Many employees do not realize that information beyond their employee health file may be examined by the workers' comp claims adjuster," she says.

• **Accident investigation:** At Palomar Pomerado Health, supervisors must conduct accident investigations, which include an interview with the injured employee. However, this discussion focuses on the incident and not the health effects. The supervisor also may discuss the accident with other employees to determine if there have been similar "near-misses" or to seek ideas about prevention. The employee's name and specifics about the injuries should not be discussed, however, says Piek.

• **Pre-placement exams:** Seek only what you need to know to determine the ability of the newly hired employee to perform his or her job duties, advises Piek. At Palomar Pomerado Health, the medical history questionnaire asks, "Do you have any physical, medical, or mental conditions that would make you unable to perform the job duties for which you are applying?" and "Have you ever had any medical conditions that caused you to miss time from work?"

"We are hoping for honest disclosure during that process," she says. The health system also conducts physical exams to evaluate the employee's ability to perform job functions.

• **Electronic communication:** Don't put personal medical information in an e-mail unless you use encryption, Piek advises. E-mail advisories may tell employees that they are due for a TB test or influenza immunization. They may be used to briefly alert a supervisor that an employee has been cleared for duty or has job restrictions. "We're very careful about what we put in an e-mail," she says. "None of the details of that clearance should be discussed." ■

Change for life: Wellness wins over employees

Hospital promotes healthy competition

Promoting health is an obvious goal for a hospital; but often the efforts extend only outward, to the community, not internally to the hospital's own employees.

Garden City (MI) Hospital (GCH) decided to broaden its mission of wellness. After all, about half of the hospital's 1,427 employees are between the ages of 40 and 59. Staying fit would mean a higher quality of life as they age — and a better working life as well.

The GCH campaign — Great Changes for Healthy Employees — provides employees with annual health screenings, stress management programs, and the "Pedometer Challenge" that promotes walking as exercise. It has identified employees with serious medical conditions, such as hypertension, and enabled others to make lasting lifestyle changes.

"We thought we could not only boost morale with something fun and different for employees but improve health," says employee health nurse **Michelle Schulze**, RN, BSN. The participation and enthusiasm from employees has been even greater than she expected.

"We feel like we've been able to make a difference," she says. "There's a direct effect on employee job satisfaction, injuries, and [reductions in absenteeism]."

GCH began with a wellness fair, a basic wellness tool offered by many hospitals. What made this fair extraordinary was its scope; the hospital offered much more than the standard blood pressure and cholesterol screening and health assessment.

A podiatrist brought a computerized mat on the floor that indicated the pressure points as a person walks. It can be used to identify any dysfunctions. "If you're weight-bearing on your foot in an unusual way, they can develop orthotics," Schulze explains.

The cardiology department conducted EKGs and scheduled follow-up visits if there were any abnormalities. A massage therapist provided free neck and shoulder massages. The hospital-affiliated home health agency offered information on services that employees might need for an elderly relative. Employees also could receive bone density evaluations.

Every hour, Schulze and her colleague, employee health nurse **Catherine Chamberlain**, RN, BSN, drew a ticket for door prizes, such as a gift certificate to a local restaurant or a water bottle with the GCH logo. Hospital administrators visited the fair to show support for employee wellness.

Employees loved it. "It was so exciting to read the comments because they were so positive," Schulze says.

The fair was just the beginning. "After we did the wellness fair, we were trying to figure out how to increase employees' activities," says Schulze.

Schulze and Chamberlain wanted to create a true lifestyle change, so they devised the Pedometer Challenge. The goal: Each participating employee would walk 5,000 steps a day for 100 days. The program was inspired by the American Heart Association recommendation to walk 10,000 steps a day, and the Michigan Steps Up campaign promoted that and other healthy lifestyle changes.

The employee health nurses promoted the Pedometer Challenge as a healthy competition for individuals or teams. They planned to track the "steps" on a road map to show how far the employees had collectively walked. They bought about 75 pedometers and put the sign up in the cafeteria.

Within 45 minutes, the pedometers were gone and more employees were arriving asking to enroll. In all, 382 employees participated — or about 27% of the staff. "We really were not prepared for the volume. It was overwhelming," says Chamberlain.

CE *questions*

5. In its new standard on influenza immunization, who did the Joint Commission on Accreditation of Healthcare Organizations say should receive the vaccine?
A. All hospital employees
B. Employees involved in direct patient care
C. Staff, students, volunteers, and licensed independent practitioners
D. Staff and licensed independent practitioners

6. According to Paul Jensen, PhD, PE, what type of TB screening do employees need if they move to another setting in the hospital, even if it is low risk?
A. A two-step baseline TB skin test or a TB blood test.
B. A single TB skin test or blood test.
C. A questionnaire and medical evaluation.
D. They do not need any further testing or evaluation.

7. What issue was just emerging as the Association of Occupational Health Professionals in Healthcare (AOHP) formed 25 years ago?
A. Needle safety and AIDS
B. Ergonomics
C. Monitoring of chemotherapeutic agents
D. Tuberculosis

8. Floor strippers that contain hazardous chemicals such as 2-butoxyethanol may cause symptoms in workers when they are:
A. used without proper ventilation.
B. used in concentrations stronger than recommended.
C. Allowed to saturate the skin
D. All of the above

Answer Key: 5. D; 6. A; 7. A; 8. D.

CE instructions

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

Throughout the challenge, participants received small rewards to encourage them to keep walking. At the end, there were more prizes, including awards for the teams and individuals that had "traveled" the farthest. In all, the employees logged 101,777.2 miles.

Partnering for success

Creating a wellness program has been a challenge for two part-time employee health nurses who job share. They must plan and manage the events while still managing the usual pre-placement exams, TB screening, immunizations, and injury prevention activities.

How do they do it? With a little help from fellow departments; they have learned to partner with others in the hospital and make use of other resources. For example, when they wanted to sponsor a program on managing holiday stress in December, they called upon the Employee Assistance Program. A psychologist who provides counseling to employees developed a special "lunch and learn," and a pharmaceutical representative provided the food.

Different departments donated gift baskets for the prizes at the wellness fair. For example, physical therapy offered lotions and a massage. The fire department, whose emergency responders work closely with the hospital, donated smoke detectors.

The budget had been slim. It only cost about $5,000 for them to coordinate the Pedometer Challenge. (Employees purchased the pedometers.) Schulze and Chamberlain created the marketing for their program and even have developed their own posters.

The payback has been rewarding, literally. Both Schulze and Chamberlain have been honored as employees of the month. And the employee health department has gained a higher profile, both among administrators and employees. Some employees come by once a week for a blood pressure check.

"We've become involved in their lives and their health issues," says Schulze. "We feel like all our efforts have been so well received." ■

Sign signals safe lifting practices practiced here

Symbols designed to change behavior

Signs are everywhere in a hospital: *No Smoking. Authorized Personnel Only. Caution: Radiation.* So can one more sign protect nurses' backs?

The green "Safe Lifting Environment" sign features a hand pushing a button and a stick figure sitting on a lift. It signals the use of patient-handling equipment to reduce musculoskeletal disorder (MSD) injuries.

The symbol was created by Liko Inc., a Franklin, MA-based vendor of patient handling equipment, as a nonproprietary emblem (without a Liko logo) to be used freely by anyone who needs to boost compliance with a safe-lifting program.

"Our experience says that people don't automatically do what we want them to do — but they will stop at the end of the street if there's a stop sign," says **Dan Gilmore**, Liko's director of marketing.

The sign defines the environment, says Gilmore. "We're establishing boundaries where safe lifting really should be practiced," he says.

Several hospitals already have used the signs

CE objectives

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

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

COMING IN FUTURE MONTHS

- JCAHO fall prevention standard may give a boost to lifts
- Study: Impact of occupational injuries is underappreciated
- Do ED staff need greater protection?
- Boosting productivity with the right info system
- Update on employee immunizations

as a tool to promote awareness. The logo is available on lapel pins, buttons, and drink tumblers.

At the University of Connecticut Health Center in Farmington, the logo provides a visual image of the patients' lift needs. The logo is on the white boards attached to each patient's bed, where nurses and aides can find information about what assistive device should be used with the patient.

"It's a communication device," says **Patti Wawzyniecki**, MS, an industrial hygienist who specializes in ergonomics. "We're trying to get people to use the aides and equipment on a more regular basis."

Liko also has established a web site (www.safeliftingportal.com) to spread information about safe lifting, with tools to help hospitals implement a safe-lifting program. The logo is available on that site. It also provides a "cost savings calculator" that employee health professionals can use to estimate the potential benefit of injury reduction. Its resources include information on safe patient-handling legislation in various states, a newsletter with updates, and a sample safe-lifting policy.

"We wanted to create a clearinghouse where people could go to access information on safe lifting," Gilmore says. ■

Correction

The July issue of ***Hospital Employee Health*** incorrectly stated the proportion of needlesticks caused by safety-engineered devices. According to the EPINet data compiled from about 48 hospitals by the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville, about a third (32%) of needlesticks occur with needle devices that do not have a safety feature. The safety feature was not activated in 70% of those cases. ■

BINDERS AVAILABLE

HOSPITAL EMPLOYEE HEALTH has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail **ahc.binders@thomson.com**. Please be sure to include the name of the newsletter, the subscriber number and your full address.

If you need copies of past issues or prefer on-line, searchable access to past issues, you may get that at **www.ahcpub.com/online.html**.

If you have questions or a problem, please call a customer service representative at **(800) 688-2421**.