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INSIDE

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Occ health, human resources: Natural partners, but expect some conflict

Confidentiality, employee fitness by far the biggest points for debate

In addressing health in the workplace, the partnership between occupational health and human resources is among the most important. But despite their shared objectives, many occupational health nurses (OHNs) and human resources (HR) managers find the relationship could be better.

The two specialties have so much in common and share so many of the same goals that sometimes the lines between the two can blur, leading to frustration on both sides.

Employee health and safety consultant **Elayne Preston**, RN, DOHS, COHN-S/CM, COHN©, says it is easy for OHNs and HR professionals to overstep each other's boundaries if they don't clearly understand each other's responsibilities and body of knowledge.

"Both the occupational health nurse and human resources are considered professionals, and I think that's where we have common ground," says Preston, who has spent time as an OHN working out of a hospital HR department. "As professionals, we share that you have to have a common, specialized body of knowledge; an agreement to perform to standards; we are represented by professional organizations; we are perceived by others as being professionals; we have a certification that is sort of a stamp that we've achieved a level of expertise; and we both have a code of ethics."

The code of ethics for HR, she points out, is very similar to that for OHNs, including requirements for confidentiality. "I sometimes have to remind HR professionals that we are similar that way," she says.

Similar goals lead to overlap

OHNs often work out of the same department as HR, and that closeness, coupled with the similarities of their work – both are usually members of the management team, both have some input into collective bargaining, both deal with issues regarding employee health and illness.

The similarities are enough that each might assume the other has the same goal in mind when specific incidents arise, when in fact the objectives of each might be different.

Some examples:

• The OHN might feel HR refers cases to him or her that are managerial, not medical. HR might view the advice given by the OHN as not practical to the employer's situation, or is not clear enough.

• HR wants to know what employees can do, not what they can't; OHNs want more effort directed at prevention, and finding alternate or light duty.

• OHNs feel HR and management expect them to divulge more information than confidentiality laws permit. HR managers are frustrated by what they sometimes perceive as OHNs blocking information they say they need to devise light-duty or alternate-duty assignments.

• The OHN's focus is on employee health and safety, keeping employees working and productive. The HR manager's aim is on business issues, including how to keep employees focused on achieving the employer's goals, increasing worker competency, and attracting and retaining staff.

"Basically, both professionals are concerned about the relationships between employees and employers," says Preston. "That's where our paths intersect."

That intersection can be seen in the selection and hiring process, when OHNs are conducting baseline medical examinations, identifying potential work limitations, and recommending placement.

"There is always room for discussion between nursing and human resources, particularly as it relates to hiring and establishing that workers who are hired are able to do that particular job and do it safely, without harm to themselves or their coworkers," says **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, president of the American Association of Occupational Health Nurses.

Sometimes, Preston adds, "the OHN has to be the one to say, 'I went over this employee's health and limitations, and I don't think they can do the job you just interviewed them for.'"

HR and OHNs also have to coordinate efforts when an established employee needs to be resituated due to an illness, injury, or exposure.

"The OHN does periodic health assessments, and for specific hazards, has to work with HR to make sure job placements continue to be safe," Preston points out.

"With the issue of attendance and fitness for duty, we're looking at things like medical certificates, trying to identify the likelihood that this employee can continue regularly and consistently. You might get employees referred by HR saying their attendance is really bad, and [asking what's] the likelihood that they can live up to their contract, what are their health issues, and is this an issue of accommodating a disability?"

When an employee's fitness for duty is evaluated, it usually falls to the OHN to translate that information into functional limitations that can be provided to the HR manager and the employee's supervisor, treading that fine line between providing information the company needs to know and protecting information that must be kept confidential.

"Then, there's what I call weird and wonderful workplace behavior, when an employee is doing something that is considered to be out of the

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ordinary, and HR looks to us to decipher whether there's a medical reason behind the behavior," Preston adds.

Confidentiality creates conflict

Confidentiality issues are the most common ground for tension between HR and OHNs. If an employee is exhibiting behavior and attendance problems, HR might initiate disciplinary action; but if substance abuse becomes suspected as the cause, discipline stops and medical intervention commences.

"This really re-routes the HR professional when that disclosure is made, because OHNs spearhead employers' recovery programs," Preston says.

Independent medical evaluations (IMEs) are part of many workplace employee health files, but ownership of those files — although clearly restricted by federal laws — can still be a bone of contention between the OHN and HR.

"A lot of my practice is working with HR, and maybe they identify the need for an IME, but the OHN is the keeper of the IME process so that we can keep the medical portion of the record confidential," she explains.

The role of translator, when handled well, can really be a bridge between HR and the OHN. Handled poorly, and it creates opportunities for conflict.

Medical jargon should be eliminated, whenever possible, when the OHN passes along information to HR or management. Managers seek simple, clear information and advice; if the information is being passed along to an HR manager who will then be passing it along to an employee's supervisor, the clearer and simpler it is, the less likelihood there will be for misinterpretation.

"I'm often asking the HR professional, 'What are the questions you need answered?' and I will include those in my letter to the medical evaluator," says Preston.

"And that takes quite a bit of trust on the part of the HR professional and management, because the company pays quite a bit for an IME, but never sees the report. All they get is what they're told by the occupational health nurse."

Denise Figueiredo, president of the National Human Resources Association, says that most "educated employers" know that there are limits to the amount of information they are entitled to from employee health records, but that doesn't mean they like it.

"There is pressure from upper management and management overall to have a return on investment and have the bottom line covered, and human resources is caught in the middle," Figueiredo explains. "[The HR professional] wants to be supportive of the employee, but there is that pressure from management for a return on investment."

Because employers need to have hard data on the cost savings their companies can realize from employee wellness, the HR/OH team can find themselves needing to work together to demonstrate the bottom line benefits, she adds.

"Management of some companies are committed to health and wellness, and really believe in it," she says. "And yet some still don't have a clue."

When the OHN shares office space with HR, special diligence must be paid to keeping medical files separate from personnel files. Preston says she has worked with companies where performance files were mixed in with occupational health and independent medical examination files, creating some messy confidentiality issues.

"When the HR professional has the same keys to the same files as the OHN, that never works," she advises.

Randolph says if the OHN reports to HR, both should learn early on what the expectations of each specialty are, and what each needs to run the best OH and HR program they can with the resources they have.

"The objectives of the occupational health nurse should be the same as human resources' and the company's," she says. "Their approaches might be different, but their goals should be similar."

Learn roles, build on shared goals

Preston says the better the HR and OH professionals understand each others jobs and boundaries, the easier it will be to work together toward joint goals and to work through situations where their efforts do not mesh.

OHNs should learn the roles of labor relations and HR, she urges. The core competencies of HR include a section on occupational health and safety, giving the two some common ground of knowledge.

Sharing case law resources and discussing new decisions having to do with occupational health and safety, labor relations, and arbitration is another way for the two disciplines to learn more about each other. Attending HR educational

events, and learning more about labor relations and the grievance and arbitration process is another.

But an important part of building a relationship with HR colleagues is knowing what each discipline's responsibilities and limits are.

"We need to be quite aware of our boundaries, where that line is in the sand, and be able to defend that line and communicate it clearly," Preston points out.

Even if the OHN reports to HR, the rules on confidentiality remain the same, and the OHN "runs sort of a balancing act," Randolph points out. While they are the exception, Randolph says there have been cases of OHNs losing their jobs for "insubordination" in refusing to divulge protected information.

"The OHN is trying to maintain the confidentiality of the records and what is required by standards, and balancing that against what human resources needs to learn to do their particular job," she continues. "Human resources has reasons for wanting to know this information, and so when you have a good working relationship with HR and you know where they're coming from and they know where you're coming from, there can be some understanding." ■

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Measles outbreak is threat to workplace

Check employee's vaccine records

Your nursing staff, already stretched thin, is about to take a hit. A measles outbreak has sickened a dozen people in your city, one of whom came into your ED before he was symptomatic. In an avoidable complication, several members of your staff whose measles vaccines were not up to date or effective now must stay home from work for 20 days.

This was the story at one Boston hospital in the spring, when a single measles case — a worker from India who came to work at a bank in the city's landmark John Hancock Tower — touched off an outbreak that felled 15 people across the city before waning in late June.

Highly disruptive to the hospital staff, yet highly avoidable if employees' vaccination histories were flagged.

"People were surprised that we had to isolate them from the 5th to 25th days of exposure, and it put some real strain on the emergency rooms and health departments [where they worked]," says **Anita Barry**, MD, director of communicable disease control for the Boston Public Health Commission. "But one guy was seen in two different hospitals. The first hospital didn't suspect measles, so when it was confirmed — even before the lab confirmation, when the physical findings suggested measles — the first hospital had people who had been exposed and had to be taken out of work. They had to do it, and it was a burden."

Measles not an eradicated threat

The rarity of measles outbreaks, coupled by the nearly universal vaccination of children in the United States, has led many to assume the threat of measles is almost non-existent. But global travel and the fact that measles is common in other countries means the disease should not be taken for granted.

The Boston outbreak was initiated by an asymptomatic single young man who flew to the city from India, and within a period of hours had unwittingly exposed a dozen coworkers. It's a threat that could easily be repeated, as workers coming into the United States on temporary work assignments are not required to prove they are vaccinated against diseases.

"There is a cohort of people in the United States who are susceptible to measles — people born too late to get the natural disease (before 1957), and people who were children when the vaccine was given in a way that was ineffective (1963-1967, roughly)," says Barry. Those born before 1957 were probably exposed to the disease naturally, had a mild outbreak, and are immune; children born after 1957 and through 1962 received vaccine that was effective; and children vaccinated since 1967 also received effective vaccine.

Symptoms of measles

Measles is the most infectious human disease; infectious particles can remain suspended in the air for up to two hours. The average incubation period from exposure to rash onset is 14 days (range 7-18 days. Symptoms include:

- Fever (as high as 103-105ºF)
- Cough
- Conjunctivitis
- Coryza
- Erythematous maculopapular rash (maculopapular eruption, often begins on face and spreads to the trunk and extremities, lasts 5-6 days)
- Mouth lesions (Koplik spots, characteristic but not always present)
- Average incubation from exposure to rash is 14 days (range 7 to 18 days)
- Infectious particles can remain suspended in air for up to two hours

Also:

- Loss of appetite
- Diarrhea (especially in infants)
- Generalized lymphadenopathy

Source: Centers for Disease Control and Prevention, Atlanta, GA.

"Those who received the vaccine from 1963 through 1967 think they're protected, but they're probably not," she adds. During that time, some children received a killed-virus vaccine, rather than the live virus that is in effective vaccine. Also, immunoglobulin was given along with live-virus vaccines during that time, rendering the vaccine ineffective.

Occupational health nurses, Barry says, "might have a susceptible cohort [at their worksites] and not know it."

Susceptible cohorts were at work at the Boston bank and hospital; consequently, hundreds of people were forced to stay home until the incubation period passed or they were proved to not be susceptible.

"We had an unfortunate confluence of events," says Barry. "We had someone coming from outside the United States from an area where measles occur, working in a place where people work relatively close together, and having a susceptible cohort who thought they were vaccinated for measles. Introduction from outside the U.S., which is common, plus environment, plus a susceptible pool in one place."

Employees in 30s and 40s susceptible

Health officials are warning that anyone born after January 1, 1957, should have two valid doses of a measles-containing vaccine that they received after they were at least 12 months old. Children immunized before their first birthday might not be protected, as maternal antibodies could neutralize the vaccine.

"If someone in your workplace can't produce records [showing they are protected], they need to be revaccinated," says Barry. That means two doses of measles vaccine for those born after 1957, and anyone born outside the United States who has not been vaccinated.

People born before January 1957 should have serology documenting that they are immune — either by exposure or vaccine —or should have at least one dose of vaccine, Barry says.

"It's surprising to people," she points out. "Many of our cases are in their 30s and 40s, and they had had their shots. But they got the ineffective vaccine."

Especially in the health care setting, but also in any workplace, if someone comes in with the

Measles immunization guidelines

The Centers for Disease Control and Prevention and the Massachusetts Department of Public Health recommend:

- Carefully assess all patients presenting with febrile rash illnesses and report such cases to their local Board of Health; and
- Ensure that all staff and patients are up to date with their measles, mumps, rubella (MMR) immunizations;
- All children <12 months of age are encouraged to get their first dose of MMR vaccine as soon as possible;
- All individuals born in and after 1957 should have two doses of MMR vaccine (regardless of country of birth);
- Individuals born in the United States before 1957 are usually considered immune — but, they may wish to receive a single dose of MMR vaccine to increase their likelihood of protection against measles (Exception: Health care workers born before 1957 should have one dose of MMR vaccine);
- Individuals born outside the United States before 1957 should have one dose of MMR.

Source: Massachusetts Department of Public Health, Boston.

symptoms of measles, isolation and protection measures must be taken immediately, and completely. (**See Symptoms of measles, page 89**.)

"We had a number of cases where people came into a health care facility and they were masked, but then they sat in a waiting room with other patients," Barry relates. "Measles is airborne. When someone comes in with suspected measles, you need to have a system where the person is immediately masked and put in an airborne isolation room. You have to remember that second step of getting them into an airborne infection isolation room."

The good news, Barry points out, is that people can protect themselves against measles. (**See Immunization guidelines, page 89.**)

Occupational health nurses "need to make sure their current and new staff are protected against measles," she urges. "Another story we heard, not uncommonly, from the health care facilities here is that they know about their new employees, but their veteran employees don't know their status. So they had to come out of work, and that was hard on the facility. So think about your current people." ■

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Mumps outbreak sparks public health debate

Hospitals should check employees' immune status

An outbreak of mumps in Iowa has led hospitals to re-examine the immunization records of health care workers, with some checking for serologic evidence of immunity in employees who have had an exposure.

With more than 975 reported cases of mumps in Iowa alone and the disease spreading throughout the central states, the Centers for Disease Control and Prevention (CDC) has advised health care workers to have two doses of the MMR (measles, mumps, rubella) vaccine.

"If you have not received two doses of the mumps vaccine, it is very important that you get your second dose," CDC director **Julie L. Gerberding**, MD, MPH, said in a press conference, emphasizing the importance of health care worker immunization. The CDC is using MMR doses from the national stockpile, as well as donated doses from the manufacturer, Merck, to supplement the states' supply.

Health care workers who contract mumps should stay home until they are symptom-free, public health authorities advise.

The Iowa Department of Public Health previously had advised hospitals to review the immunological status of their staff, says **Patricia Quinlisk**, MD, state epidemiologist. Employees should have had mumps or two doses of the mumps vaccine, which usually is given with measles and rubella vaccines in the MMR, she says.

Hospitals in affected areas have responded with employee health efforts. The University of Iowa Hospitals and Clinics in Iowa City is testing the titers of employees who have been exposed and giving them a second MMR vaccine if they only had one. Health care workers with direct patient care responsibilities in high-risk areas also have received a second dose of MMR if they had only one.

A few health care workers have contracted mumps despite the vaccine, probably due to the small margin of vaccine failure, says **Cheryl Person**, RN, BSN, nurse manager of the University Employee Health Clinic. So far, all exposed health care workers who were tested had a positive titer, showing evidence of immunity, she says.

The mumps outbreak has puzzled public health officials and led to greater scrutiny of vaccine effectiveness and vaccination policies. Iowa typically has about five cases of mumps a year. But the state is now ground zero for the largest epidemic of mumps in the United States since 1988, according to the CDC.

"We're trying to figure out what is contributing to this. We don't have all the answers," Quinlisk says.

She notes that the vaccine is about 95% effective — that still leaves five people per hundred who are susceptible to the disease. Also, Iowa began requiring two doses of the MMR vaccine for schoolchildren in 1991. Many Iowans, including some health care workers, may have received only one dose of the vaccine.

Gerberding also reassured health care providers that the MMR vaccine is effective. "I really want to emphasize that while we are of course investigating the outbreak and we will learn more about the efficacy of the vaccine in this particular setting, we have absolutely no

information to suggest that there is any problem with the vaccine," she said.

Air travel contributed to spread

The outbreak began in December with two confirmed cases of mumps in college students at an eastern Iowa university. Another case was confirmed in mid-January, and by February, cases were appearing on college campuses throughout the state. Cases also have been reported in nearby states, including Kansas, Nebraska, Illinois, Minnesota, Missouri, Wisconsin, and Oklahoma.

Air travel may have escalated the spread and could ultimately lead to outbreaks across the country. The CDC reported that two travelers — one going from Waterloo, IA, to Washington, DC, and the other from Tucson, AZ, to Cedar Rapids, IA — may have exposed other air passengers to mumps between March 26 and April 2. A 2005 epidemic in the United Kingdom, involving about 56,000 cases, also may be linked to the Iowa outbreak — the viruses in the outbreaks share the same genotype.

As of late April, Iowa had reported 975 confirmed, probable or suspect cases of mumps, a disease characterized by fever, headache, fatigue, and the telltale swelling of the salivary glands. About 25% of the Iowa cases have been among college students, with a median age of 21. About 20% to 30% of the cases may be asymptomatic, the CDC reports.

Before the vaccination became routine, "nearly everyone in the United States experienced mumps," the CDC says. Although complications are rare, the disease can lead to inflammation of the testicles or ovaries, meningitis or encephalitis, spontaneous abortion or deafness.

Until this outbreak, mumps was not a major vaccination concern. It is included in the MMR vaccine and routinely administered, but its vaccine partners, measles and rubella, were considered a greater potential hazard. "We haven't had a problem with mumps for years," says **William Bellini**, PhD, chief of the CDC's Measles, Mumps, Rubella and Herpes Virus Branch.

If most people have had either the mumps or the vaccine, why did an outbreak occur? Does this indicate that the vaccine is not effective?

Some 64% of those with reported cases of mumps in Iowa had received two doses of the MMR vaccine, while 10% had received only one dose. But that doesn't necessarily reflect a vaccine failure, public health authorities say.

"It doesn't mean the vaccine's not working," Quinlisk says. "It just means the vaccine is not 100%." A significant outbreak can occur even with just five out of every 100 people susceptible to the disease despite vaccination, she says. "The best thing we can do is make sure everybody is fully vaccinated. You're going to slow down if not stop the spread," she says.

Still, the sudden spread of mumps has raised a number of public health questions. "We're wondering why we're seeing that now, [and] why we haven't seen it before," says Bellini.

The CDC is looking into the possibility of waning immunity. Some colleges and universities required an additional dose of MMR before matriculation, but some smaller colleges did not, he says. Gerberding noted that so far the CDC does not see evidence of waning immunity. "If waning immunity were a primary problem, we would expect much older people to be affected," she said. "So we are looking into this as one of several possibilities, but I think right now with what we know about this vaccine's efficacy, what we know about the undervaccinated people in this age cohort, and what we know about the sociology of life in some of these [college] community settings, we have ample explanation for why the virus is spreading the way it is."

Meanwhile, there have been no outbreaks in hospitals, day care centers, or K-12 schools, Gerberding noted. "Fortunately, we are not seeing outbreaks right now in schools or in younger children in large part because they have a higher degree of two-dose coverage."

"The biggest lesson learned is that this could happen anywhere," says Quinlisk, who notes that Iowa's record of vaccination is similar to that of other states. "Now is a really good time to make sure that college campuses, health care workers, and the general population are vaccinated." ■

Hospitals may not be ready for major disaster

Part of problem is funding to train staff

Even though national initiatives to improve bioterrorism, epidemic, and natural disaster preparedness have strengthened communities' overall public health readiness, hospitals' ability to handle sudden surges of patients during a mass emergency remains a concern, particularly

due to shortage of funds to train staff, according to a study by the Center for Studying Health System Change (HSC).

The researchers present their findings in the July/August edition of the journal *Health Affairs* (www.healthaffairs.org).

"Hospitals, and to a lesser extent other health care providers, have improved their ability to respond to public health threats, but observers are not confident of their ability to handle large-scale emergencies," the author write. Some hospitals report "funding wasn't sufficient to make adequate investments, particularly for improving information systems and training staff.

"Several hospitals reported that finding time and money to train staff was an ongoing concern, particularly given staff turnover."

Another unfunded mandate?

Studies identifying critical and vulnerable institutions in the event of a major catastrophic event never fail to mention hospitals. The recently released National Strategy for Pandemic Influenza strategy report, prepared by the Department of Homeland Security, states that hospitals and health care personnel are at high risk due to exposure in the event of an influenza epidemic. The plan and calls on all employers, both public and private, to take steps now to protect continuity of operations and employees in the event of a pandemic — a tall order when your place of business is where all the sick people go, and not easily done without substantial training and preparation.

"The implementation of transmission interventions to protect personnel with such responsibilities is crucial," the federal plan report states, "And organizations can additionally reduce risk by dedicating specific space and personnel for the care of patients with influenza and reducing or eliminating the connectivity of such areas and providers with the rest of the organization."

Training and drilling staff on transmission interventions takes money and space, both of which are in short supply in some places, the *Health Affairs* authors report.

"The recent federal funding has helped communities enhance public health capacity, but communities are worried that they won't be able to sustain public health improvements made since 2001 if funding continues to decline," says **Andrea B. Staiti**, an HSC health research analyst and co-author of the study. "Hospital officials also face a daunting array of possible threats, from chemical to nuclear to biological, which are challenging even to the best of planners. The predicament was voiced by one emergency department director, who wondered, 'How much do you really prepare for the unknown? How many victims do you plan for?' No one can really tell us." ■

JCAHO: Patient contact? Flu vaccine mandated

Vaccines must be provided; employees can say no

As expected, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) has issued an infection control standard that requires accredited critical access hospitals, hospitals, and long-term care facilities to offer influenza vaccinations to staff, including volunteers and licensed independent practitioners with close patient contact.

The standard becomes an accreditation requirement January 1, 2007, and addresses a concern shared by health care professionals across the board — the low (less than 40%) influenza vaccination rate among providers. It stops short of mandating that health care providers with close patient contact be vaccinated, a move that would have met stiff resistance.

"This is an important first step toward improving influenza vaccination rates within the health care community, which will enhance the health and safety of patients in their care and health care workers themselves," according to **William Schaffner**, MD, vice president of the National Foundation for Infectious Diseases and chair of Vanderbilt University School of Medicine's department of preventive medicine.

"We hope in the future this standard will be expanded to encompass various strategies to increase health care worker vaccine uptake, such as signed declination," Shaffner adds.

While nursing organizations and other groups had clearly stated opposition to mandatory vaccines for health care workers, the JCAHO standard fell short of what other groups, including hospital pharmacists represented by the American Society of Health System Pharmacists, who wanted flu vaccines to be mandatory for everyone except those in whom the vaccine is contraindicated, abhorrent on religious grounds, and employees who signed declination forms.

Influenza causes approximately 36,000 deaths and more than 200,000 hospitalizations annually in the United States. The JCAHO standard, suggested in early 2007 and open to comment before the final standard was announced in June, follows closely the Centers for Disease Control and Prevention (CDC) recommendations for flu vaccination in health care workers in close contact with patients.

Will convenience boost compliance?

JCAHO issued the standard in response to recommendations by the CDC making the reduction of influenza transmission from health care professionals to patients a top priority in the United States. While the CDC has urged annual influenza vaccination for health care workers since 1981, the CDC's *"Morbidity and Mortality Weekly Report"* published earlier in 2006 calls for stronger steps to increase influenza vaccination of health care workers.

"Preventing the spread of the flu protects patients and saves lives. Encouraging health care workers to be vaccinated can play a vital role in stopping the transmission of this potentially fatal infection," says **Robert Wise**, MD, vice president of JCAHO's division of standards and survey methods.

According to JCAHO, health care–associated transmission of influenza has been documented among many patient populations in a variety of clinical settings, and infections have been linked epidemiologically to unvaccinated health care workers. Typically, fewer than 40% of health care workers are immunized each year.

Aiming to increase awareness and education efforts, as well as to boost vaccination numbers by simply making the vaccine free and convenient to health care workers, the new Joint Commission standard requires organizations to:

- Establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- Provide access to flu vaccinations on site;
- Educate staff and licensed independent practitioners about flu vaccination; non-vaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission, and potential impact of influenza;
- Annually evaluate vaccination rates and reasons for non-participation in the organization's immunization program; and
- Implement enhancements to the program to increase participation. ■

Bringing troubles to the job: How OHNs can help

Life events, conflict outside work can affect job

It is rare that any person can leave his or her troubles at home and not let it affect life at work. Psychosocial stressors such as grief and loss, family responsibilities, financial burdens, domestic violence, and health problems may cause employees to present to the occupational health nurse (OHN) with physical ailments that, with some investigation, can be attributed to stress.

The OHN can identify employees whose stressors are threatening their job performance — and perhaps their well-being — and offer helpful assessment and referral if he or she knows what to look for.

"My perspective is that people will bring their personal problems into the workplace — it's unavoidable," according to **Betsy Gilbert**, PhD, RN, assistant professor at Seattle University College of Nursing. "The main things occupational health nurses will encounter will be the reactions to normal life events — stress related to life changes; life phases, including birth and death; grief and loss; interpersonal issues; violence; reactions to the job."

Sometimes, the employee's behavior and demeanor clearly suggest the stress he or she is under. But often, the stress manifests itself in ways that are not as easily deciphered.

"Knowing the effects of all these is one of the big things that an occupational health professional can concentrate on," says Gilbert. "Knowing a little about how they affect people, whether it's shock, anger, depression, a period of lower productivity."

Life events can pile on

Even events as universal as the birth of a child and a child leaving home, marriage and divorce; and the aging of parents can inflict tremendous amounts of stress.

"All the stress reactions have the same physiological symptoms — gastrointestinal symptoms, muscular symptoms, emotional systems," Gilbert points out.

When an employee approaches the OHN complaining of a stomach ache, "it would be a nice opportunity to ask about stressors," she continues. Doing so is important because the real malady is

the stressor, not the stomach ache, Gilbert points out.

"Don't stop with treating just the stomach. You can help people connect the dots [between their physical complaint and stress that might be contributing to it] in the spirit of the whole-person view. People with injuries even might have stressors that are preoccupying them and contributing to their injury, so you might be able to help them understand that," says Gilbert.

One troubled employee might be dealing with a really acute stressor; another might be a chronic worrier. Each will be affected differently by the events occurring in their lives.

Health care workers may be particularly affected by life stresses, because as professional caregivers they often end up with the lion's share of family responsibilities, for example, when parents get older.

"They might find themselves caring for older family members and children – the idea of the sandwich generation – and that can put a lot of demand on someone," says Gilbert.

Interpersonal issues require resolution

Interpersonal stressors may come from outside work or may involve coworkers, but regardless of the setting, conflict is a normal human occurrence. It helps if the OHN can provide advice, resources, and referrals for resolving conflict, Gilbert suggests.

The health care environment lends itself to interpersonal stress, with high-demand jobs, frequent situations over which the employee has little control, and stress affecting coworkers, patients, and visitors.

"Health care tends to be more stressful, so there's the importance of the occupational health nurse having the skills to solve interpersonal problems, since the work involves so many relationships with coworkers, managers, clients, families, and the organization," Gilbert points out.

Interpersonal relationships turn violent for health care workers more commonly than in other professions. Health care workers are among the most likely to be the target of violence on the job so the OHN working in the health care setting needs an armament of resources and knowledge on the subject. (**See resources list, right.**)

When violence happens away from work but the effects — physical or not — are seen in the workplace, the OHN can elicit information on how to help by doing a routine domestic violence screening. The mnemonic RADAR, developed by the Philadelphia Family Violence Working Group, can provide some guidance:

- Routine screening —It is important to establish privacy, safety, and rapport. Never ask about abuse if a partner, friend, or relative is in the room. Never use a friend or family member as an interpreter when asking about abuse.
- Ask direct questions — For example: *We all fight at home. What happens when you and your part-*

Resources

Stress
- MedlinePlus: Stress, www.nlm.nih.gov/medlineplus/stress.html
- Stress Management for the Health of It, www.cdc.gov/nasd/docs/d001201-d001300/d001245/d001245.html
- Tips to Reduce Stress, www.ncfh.org/pateduc/en-stress.htm
- International Society for Traumatic Stress Studies, www.istss.org
- NMHA Stress — Coping with Everyday Problems, www.nmha.org/infoctr/factsheets/41.cfm

Violence and Conflict Resolution
- National Coalition Against Domestic Violence, www.ncadv.org
- Violence Against Women Online Resources, www.vaw.umn.edu
- Workplace Resource Center: Online Briefings, workplace.samhsa.gov/OnlineBriefings/ebriefs/schlenger.html
- Association for Conflict Resolution, www.acrnet.org

Anxiety
- American Institute of Stress, www.stress.org
- Anxiety Disorders Association of America, www.adaa.org
- Freedom From Fear, www.freedomfromfear.com
- Mind Tools, www.mindtools.com/smpage.html
- Posttraumatic Stress Disorder Alliance, www.ptsdalliance.org/home3.html

Depression
- Depression and Bipolar Support Alliance, www.dbsalliance.org
- Mental Help Net, www.mentalhelp.net
- National Mental Health Association, www.nmha.org NIMH, www.nimh.nih.gov
- Suicide Prevention Resources Center, www.sprc.org
- American Foundation for Suicide Prevention, www.afsp.org/index-1.htm

ner fight? Have you ever been in a relationship in which you felt you were treated badly? Are you here today as a result of battering?

- Document your findings.
- Assess patient safety and discuss an emergency plan.
- Review options and referrals.

Stressors causing or exacerbating a mental health crisis for your employee can present in suicide attempts, violence against self or others, or the first or an acute appearance of a major mental disorder. Even if an employer provides an employee assistance program, the OHN is often the first line of help in a crisis. "The role of the occupational health nurse has to do with understanding that psychosocial issues may affect a person's work, and you're in a unique position to assist with screening and resource placement," observes Gilbert. "Workers look to occupational health nurses for help, even if an EAP available. Nurses are always the people workers want to talk to."

Stages of Change Model

Precontemplation
Not yet acknowledging that there is a problem behavior that needs to be changed

Contemplation
Acknowledging that there is a problem but not yet ready or sure of wanting to make a change

Preparation/Determination
Getting ready to change

Action/Willpower
Changing behavior

Maintenance
Maintaining the behavior change

Relapse
Returning to older behaviors and abandoning the new changes

Adapted from Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. *Am Psychol* 1992;47:1102-1104.

If a mental health issue is suspected, Gilbert offers another mnemonic — FRAMES — to guide the OHN in making the appropriate referrals:

Feedback. Make a direct statement of personal risk, impairment, and observations. "Confront them with reality and inform them that, based on your experience, if people don't get help, here's what we know can happen," Gilbert suggests;

Responsibility. Make it clear that the responsibility for change and taking the next steps are up to the client;

Advice. The OHN provides advice on where to go from here;

Menu. The nurse provides a choice of ideas for self-help, treatment, and other options for solving the problem or, in the case of substance abuse, quitting;

Empathy. Use an empathetic approach, projecting a willingness to help;

Self-efficacy. Foster an optimistic, empowering attitude that emphasizes the clients' strengths. "You can do this" is the message Gilbert says the OHN should reinforce.

Employee's willingness to change

The nurse's approach to the employee, regardless of the stress in his or her life and its effects, should be keyed whenever possible to how open the employee is to change. Can he or she delegate care of a parent? Is the person in denial about an abusive relationship? Is he or she eager to quit a substance addiction?

A model proposed by Prochaska (see table, left) suggests that when it comes to change, people go through changes in attitude toward change. A person in the precontemplative stage might be resistant to the idea of change just now, while someone in the action stage might approach the nurse about getting help.

"Look at where that person is, and try to interact at the right level," advises Gilbert. "There is lots of self-help available for anxiety and stress management, but for depression, people need extra guidance and support in recognizing it and getting help with follow-through."

Health care workers might need additional coaxing to recognize and address problems.

"The fact is that they're not immune to these problems, including substance abuse, but sometimes health care workers feel they are sort of immune or untouchable," she points out. ■

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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 letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

CE *questions*

5. An employee exhibits symptoms that cause you to suspect he or she might have measles. The correct protective measure(s) to take is/are:
A. mask the person
B. place the person in an airborne infection isolation area
C. either A or B
D. both A and B

6. The recently released Joint Commission for Accreditation of Healthcare Organizations (JCAHO) standard on influenza vaccines for employees with patient contact mandates that all employees in close contact with patients receive the immunization.
A. True
B. False

7. RADAR is a mnemonic designed to guide in assessment and referral for:
A. domestic violence
B. substance abuse
C. mental illness
D. life change issues

8. Regarding the disciplines of human resources and occupational health nursing, which of the following statements is true?
a. The certification standards for occupational health nursing contain a human resources component.
B. The certification standards for human resources contain an occupational health component.
C. Human resources managers and occupational health nurses are interchangeable.
D. None of the above is true.

Answers: 5. D; 6. B; 7. A; 8. B