



# Hospital Employee Health<sup>®</sup>



## Hospitals take their best shot to fight flu with new emphasis from JCAHO

*The pressure is on to improve vaccination rates*

### IN THIS ISSUE

- **Flu fight:** Two hospitals seeking higher annual flu immunization rates . . . . cover
- **Pertussis priorities:** HCWs need protection, say CDC panel and occ-med docs . . . . . 101
- **Short of shots?** Sterility issues at manufacturing plant again threaten vaccine supply . . . . . 102
- **Getting a lift:** JCAHO's fall prevention emphasis bolsters case for lift equipment . . . 103
- **Unsafe fumes:** Hospital cited for formaldehyde exposure . . . . . 104
- **Buyer beware:** NIOSH warns consumers about noncertified N95 respirators . . . . . 105
- **ED breakdown?** IOM panel calls for improvements . . . 106
- **Inserted in this issue:**  
— *JCAHO Update for Infection Control*

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

**R**amp up your flu vaccine campaign. This year, the heat is on for hospitals to improve their health care worker vaccination rates. Despite strongly worded recommendations from the Centers for Disease Control and Prevention (CDC) and missives from infection control and health care quality organizations, the rate of health care worker vaccination remains a tepid 42%.

Now, even surveyors from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be checking hospital flu vaccination rates. JCAHO's new standard requiring hospitals to monitor and improve their rates on influenza vaccination goes into effect in January 2007.

So what are you doing to increase your vaccination rates?

Many strategies are tried and true: educating health care workers about the risks of influenza to themselves and their patients; countering myths about flu vaccination; and making flu vaccination free and accessible. Some hospitals are asking health care workers who choose not to receive the vaccine to sign a declination statement; others are convinced that they can improve rates without adding a punitive tone or administrative burden.

### ***Current success no secret***

Nationally, the Veterans Health Administration succeeded in vaccinating almost 55% of its work force last year — about 10% better than the national average. Yet its success is no secret. The VA followed widely used strategies initially developed and refined by Kristin Nichol, MD, MPH, MBA, an influenza vaccination expert at the Minneapolis VA, and other occupational health leaders.

"The very successful facilities had done what everyone says they should," says **Michael Hodgson**, MD, MPH, director of the VHA's occupational health program — "information campaigns, mobile flu clinics, vaccination

**SEPTEMBER 2006**  
VOL. 25, NO. 9 • (pages 97-108)

**NOW AVAILABLE ON-LINE! [www.ahcpub.com](http://www.ahcpub.com)**  
For more information, contact (800) 688-2421.

available to all three shifts, and visible leadership.”

The tools and strategies are available as the VA Influenza Toolkit at [www.publichealth.va.gov/flu/flu\\_toolkit.htm](http://www.publichealth.va.gov/flu/flu_toolkit.htm). It includes a manual as well as posters and templates for buttons that can be used to promote vaccination.

“You have to do it in a way that makes it easy for employees and you have to provide ‘management incentives,’” Hodgson says. For example, as one network director performance measure — an accountability tool tied to an annual financial incentive for top managers — every facility must vaccinate 60% of employees.

“The managers are being asked to document

their plan for improvement and tracking, report their actual vaccination rate, examine what worked and what didn’t, and prepare to improve next year,” he says.

So far, the VHA has chosen not to use declination statements, and the VA manual does not contain a sample declination statement. Instead, the VA uses an annual survey to track vaccination rates and one-on-one interviews to identify reasons that employees decline vaccination, says Hodgson.

Accounting for the vaccination status of every employee, many of whom are vaccinated as veterans through their health insurance or through public sites, would be a time-consuming effort, without much documented benefit, Hodgson says.

For example, almost 15% of health care workers nationally have asthma and are likely to receive their flu shot from a private physician, he notes. So a hospital’s actual vaccination rate likely is higher than the number of doses they deliver.

Meanwhile, a high rate of vaccination provides “herd immunity,” or protection against an outbreak; it’s not necessary to reach 100% vaccination, he says.

Still, the VHA continues to strive for improved rates. “The goal is to ratchet up the penetration [of health care worker immunization], and we’ll see how far we get. Our goal is 80% by 2011,” Hodgson says.

## ***Campaign begins with a blitz***

Every fall, Wake Forest University Baptist Medical Center in Winston-Salem, NC, approaches the flu campaign with a blitz. It begins with a blast of publicity through the intranet, an internal newsletter, and e-mail. This fall, the medical center plans to add a message scrolling along the bottom of TV screens in employee areas.

Almost 100 “campaign coordinators” — mostly nurses — provide the vaccinations throughout the medical center, which encompasses four campuses, a medical school, 30 physician practices, 40 operating rooms, and numerous clinical centers. Employee health nurses also set up satellite sites and vaccinate in the employee health department.

The success rate: About 75% of 12,500 employees, volunteers, students, and physicians receive the vaccine.

“[Annual influenza vaccination] has become

**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](mailto:ahc.customerservice@thomson.com). Web site: [www.ahcpub.com](http://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.)

**Photocopying:** No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact Thomson American Health Consultants. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Thomson American Health Consultants also is approved by the California Board of Registered Nursing, provider number CEP10864. This activity is approved for 18 contact hours per year.

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

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.

Editor: **Michele Marill**, (404) 636-6021, ([marill@mindspring.com](mailto:marill@mindspring.com)).

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, ([brenda.mooney@thomson.com](mailto:brenda.mooney@thomson.com)).

Editorial Group Head: **Coles McKagen**, (404) 262-5420, ([coles.mckagen@thomson.com](mailto:coles.mckagen@thomson.com)).

Managing Editor: **Jill Robbins**, (404) 262-5557, ([jill.robbins@thomson.com](mailto:jill.robbins@thomson.com)).

Senior Production Editor: **Nancy McCreary**.

Copyright © 2006 by Thomson American Health Consultants. **Hospital Employee Health®** is a trademark of Thomson American Health Consultants. The trademark **Hospital Employee Health®** is used herein under license. All rights reserved.

### **Editorial Questions**

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

**THOMSON**  
★  
**AMERICAN HEALTH CONSULTANTS**

# Successful campaigns for vaccinating HCWs

1. Sending a letter, postcard or e-mail to employees prior to the start of the vaccine season, reminding them of the importance of vaccination, and where and when they will be able to get the flu vaccine.
2. Writing something in the employee newsletter or posting information on staff bulletin boards and providing fact sheets with pay stubs to dispel misconceptions and increase acceptance.
3. Increasing the number of sites where the vaccine is given. Use mobile carts to transport to different clinic areas, service meetings, grand rounds or near cafeteria entrances. This approach can minimize inconvenience as well as provide a means to advertise the vaccine availability.
4. Carts should be stocked with vaccine, safety syringes, vaccine information statements, sharps disposal containers, alcohol hand rub, alcohol wipes, adhesive bandages, documentation forms, and injectable epinephrine with orders for administration in the event of an acute hypersensitivity reaction.
5. Making appointments with services to attend service meetings. A schedule should be posted or e-mail sent to those in the service announcing that the vaccine is available at the staff meeting.
6. If your occupational health unit has a web site, adding information to the web site regarding flu shot locations and times.
7. In late November identifying employees not yet vaccinated and reminding them by e-mail or a phone call that the flu vaccine is available.
8. Working closely with the pharmacy to get your supply of vaccine for employees.
9. Modifying education materials from the Centers for Disease Control and Prevention and elsewhere to address risks to employees if they are not vaccinated.
10. Encouraging the facility director, service chiefs, and other managers to lead the way by getting their vaccine and encouraging their staff to get vaccinated.
11. Giving out buttons or stickers to all staff who are vaccinated showing that they have been vaccinated. It is an additional advertising strategy for both employees and patients to be vaccinated against influenza.
12. Sponsoring a kick-off event.
13. Adding an influenza reminder to occupational health's telephone recording. When employees call they can automatically be reminded about the availability of the vaccine. If the recording capacity exists, add specific information regarding dates, times, and locations for flu shots, as well as any other pertinent information. These reminders should begin Sept. 15 and conclude after the flu season has peaked, which usually occurs in February or March.
14. Extending hours that the vaccine is available to staff to include all shifts and days of the week. Plans must be made to have additional staff available during the extended hours of the clinic or available during off hours.  
If there is a vaccine shortage, using additional strategies if necessary to ensure those who are identified as needing the vaccine are targeted. If the shortage resolves, there also should be a mechanism in place to remind those not vaccinated that it is not too late to get the vaccine. ■

Source: Veterans Health Administration, Washington, DC; 2006.

part of our culture," says **Scott Spillmann, MD, MPH**, director of medical center employee and occupational health services.

In fact, it's a year-round effort. A broad-based task force includes administrators, clinicians, pharmacists, and representatives from the medical school, wellness program, marketing, and public relations; the trained vaccinators often are supervisors who provide the vaccine on every shift. Wake Forest maintains a web page dedicated to influenza vaccination and provides a hotline during the campaign to respond to employee questions or concerns.

The vaccinations begin in October. "We typically run the vaccination campaign until either we run out of vaccine or until the [flu] season

ends," says Spillmann.

The president and CEO of Wake Forest University Health Sciences, the medical school's dean, the hospital president and CEO, the board of trustees, and other administrators publicly get the vaccine and tout the campaign. "We have the support of every single top person in this medical center," Spillmann says.

The medical center emphasizes the core reason for employees to get the vaccine — to protect their patients and themselves. Every employee signs either an informed consent to receive the vaccine or those who decline are asked to sign a declination (see p. 100).

*(Continued on page 101)*

**TRIVALENT INACTIVATED INFLUENZA VACCINE (INJECTABLE)  
2005-2006 INFLUENZA VACCINATION PROGRAM • VACCINATION CONSENT/DECLINATION FORM  
WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER EMPLOYEE HEALTH SERVICES**

**> Please complete all questions and information/data collection sections of this form.**

Starting October 24, 2005, the influenza vaccine is offered free of charge as a benefit to **all** employees, students, and volunteers.

**INFORMATION ON PERSON TO RECEIVE 2005-2006 INFLUENZA VACCINE (PLEASE PRINT CLEARLY)**

Name (If you are an employee, print your name as it is in your employee records. If you are not an employee, print First Middle & Last names)				
Last 4 digits SSN	Birthday (mm/dd)	What is your association to the Medical Center? Please check all that apply.	<input type="checkbox"/> NCBH employee <input type="checkbox"/> WFUHS employee <input type="checkbox"/> NCBH volunteer <input type="checkbox"/> Other, specify:	<input type="checkbox"/> Medical Student <input type="checkbox"/> PA student <input type="checkbox"/> Grad Student
Work Ext./Day Phone	Dept. # (i.e. 952 or 105000)	Dept. Name		

Yes	No	(1-4 Permanent Contra-indications)
<input type="checkbox"/>	<input type="checkbox"/>	1. Are you allergic to eggs or egg products?
<input type="checkbox"/>	<input type="checkbox"/>	2. Are you allergic to Thimerosal (a preservative) other than contact lens sensitivity?
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you ever had Guillian-Barre Syndrome within 6 weeks of taking a flu shot?
<input type="checkbox"/>	<input type="checkbox"/>	4. Have you ever had an anaphylactic reaction to the influenza vaccine?
<input type="checkbox"/>	<input type="checkbox"/>	5. Are you allergic to latex?
<input type="checkbox"/>	<input type="checkbox"/>	6. Did you receive a flu shot last year?
<input type="checkbox"/>	<input type="checkbox"/>	7. If I could not get my flu shot from a campaign coordinator, I would go to Employee Health for my shot.

**> If you have had recent chemotherapy, radiation therapy, or steroids (except inhaled), these conditions may decrease the effectiveness of the vaccine. However, flu vaccination is still encouraged.**  
**> Because of increased risk of influenza-related complications, the CDC and the ACIP recommended flu vaccination for women who will be pregnant or breast-feeding during the influenza season.**

**> For nursing mothers and/or women concerned with pregnancy/reproductive issues, we have listed related links below for your information. We also encourage you to discuss these issues with your physician.**

- <http://www.fda.gov/cber/label/inflgla083105LB.pdf>
- <http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf>
- <http://www.cdc.gov/mmwr/pdf/rr/rr5408.pdf>

<input type="checkbox"/>	I am not able to receive the flu shot due to permanent contraindication 1-4 above.
<input type="checkbox"/>	I am not able to receive the flu shot today because I have a fever but I may re-evaluated later and may be able to take the vaccine at that time.
<input type="checkbox"/>	<b>Yes, I would like to have the influenza vaccination given to me.</b>
<input type="checkbox"/>	<input type="checkbox"/> This is the first flu shot I have ever taken.
<input type="checkbox"/>	I have had a flu shot already this year:
<input type="checkbox"/>	<input type="checkbox"/> Through the WFUBMC Influenza Vaccination Program
<input type="checkbox"/>	<input type="checkbox"/> Through another provider: Date Vaccinated: _____ Provider: _____
<input type="checkbox"/>	I realize I am eligible for the flu shot and that my refusal of it may put patients, visitors, and family with whom I have contact, at risk should I contract the flu. Regardless...
<input type="checkbox"/>	<b>No, I do not wish to have the influenza vaccination given to me.</b>
<input type="checkbox"/>	If NO, please check all the following that apply:
<input type="checkbox"/>	a. Fear of side effects (sore arm, tenderness)
<input type="checkbox"/>	b. Fear of injections
<input type="checkbox"/>	c. Fear of getting influenza from the vaccine
<input type="checkbox"/>	d. Other, specify: _____
<b>Signature:</b> _____	
<b>Date:</b> _____	

<b>For Office Use Only</b>	
Vaccine Manufacturer: <input type="checkbox"/> GSK <input type="checkbox"/> Aventis <input type="checkbox"/> Other: _____	Lot #: _____
Site: <input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid	Dose: 0.5 ml
Signature: _____	(RN/LPN/PA)    Date: _____

In the declination, the medical center asks employees why they chose not to be vaccinated. About 14% say they fear getting the flu from the vaccine — although the injectable vaccine is inactivated and cannot transmit influenza. “We try our best to dispel that [myth] every single year,” Spillmann says.

The risk of transmission is very small from the live, attenuated virus used in the nasal vaccine, but that vaccine is not recommended for health care workers caring for severely immunocompromised patients, such as in a transplant unit. However, that vaccine is useful for the 3% who fear injections.

About 25% of those who declined the vaccine said they didn’t think they would get influenza or simply didn’t want the vaccine.

Although Wake Forest’s vaccination rate is almost double the national average, the medical center still hopes to take it higher. “We’re not resting on our laurels,” says Spillmann. “We’re not stopping here. We’re continually seeking ways to reach people, to educate people, to encourage people.” ■

## Hospitals merge pertussis vaccination with flu shots

*Recommendations call for immunizing all HCWs*

Hospitals began offering pertussis vaccines to their employees in an effort to protect vulnerable patients from a disease that is most contagious in its early stages, when it may go undetected.

The American College of Occupational and Environmental Medicine (ACOEM) urged hospitals to administer the vaccines “as soon as feasible” to health care workers with direct patient contact and noted that the costs will be more than offset by the benefits of preventing an outbreak ([www.acoem.org/guidelines/evidence](http://www.acoem.org/guidelines/evidence)).

Two federal advisory panels have endorsed the vaccinations, and the Centers for Disease Control and Prevention has issued provisional recommendations for the vaccination of health care workers ([www.cdc.gov/nip/vaccine/tdap/tdap\\_adult\\_recs.pdf](http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recs.pdf)).

“It’s an expensive recommendation, but this is a disease that still kills infants in this country,” says **Mark Russi**, MD, vice chair of ACOEM’s

medical center occupational health section and ACOEM liaison to the Healthcare Infection Control Practices Advisory Committee. HICPAC and the Advisory Committee on Immunization Practices endorsed the pertussis recommendation.

### **Cost of an outbreak**

A recent outbreak at Dartmouth-Hitchcock Medical Center in Lebanon, NH, highlights the potential for hospital-based spread of pertussis. This spring, 135 hospital employees were diagnosed with pertussis after the disease spread from one department. The hospital responded with a mass vaccination program and intensive monitoring.

More than 1,500 physicians and staff were screened and tested for pertussis, and more than 5,000 physicians, staff members, medical students, and volunteers were immunized against the disease over a four-week period. Health care workers in high-risk areas (such as the intensive care nursery) who were identified as having pertussis or who were awaiting test results were furloughed from work.

That led to the temporary closure of some hospital beds and cutbacks on operating room hours. Even today, physicians and staff entering high-risk areas sign in at entrances acknowledging they are symptom-free, according to a hospital spokeswoman.

An outbreak also occurred at the hospital in 2003, triggered by a nurse who worked with a cough that persisted for four weeks. Her teen-aged son, who also had a persistent cough, attended a school where pertussis cases had been identified. The hospital screened patients and employees and confirmed cases of pertussis in 10 of 117 employees in the hematology-oncology unit. Good infection control practices apparently prevented any of the unit’s patients from contracting the disease.<sup>1</sup>

A pertussis outbreak can place a significant burden on a hospital, notes **Tejpratap Tiwari**, MD, medical epidemiologist with the CDC’s National Center for Immunizations and Respiratory Diseases.

“Currently, if health care personnel have pertussis or if they’re suspected of having pertussis, the guidelines recommend that they stay away from work until at least five days of appropriate treatment are completed,” he says. “Health care personnel who are exposed to pertussis and are without symptoms should receive post-exposure prophylaxis but are allowed to continue working.

“Since we do not know how well Tdap vaccination prevents transmission, health care personnel who have received the newly licensed Tdap vaccine and who have unprotected exposures to pertussis should be given prophylactic antimicrobials. Alternatively, if the infrastructure in hospitals exists, they should be monitored daily for pertussis symptoms for 21 days without a course of antimicrobials. If respiratory symptoms appear during this period, then they can be treated early,” he says.

One study found that a Tdap vaccination program in hospitals is cost-saving, even when post-exposure prophylaxis is given to vaccinated health care personnel, Tiwari notes. The study estimated that for every dollar spent in a hospital vaccination program, there will be a cost-saving of \$2.38.<sup>2</sup>

### **Targeting HCWs who care for infants**

Hospitals are seeking to avoid outbreaks by offering the vaccine to employees. For example, Yale-New Haven (CT) Hospital has begun vaccinating new employees. “We’ve also targeted employees who have contact with infants as the highest priority group,” says Russi, who is director of occupational health at the hospital and associate professor of medicine and public health at the university’s school of medicine. “Over the course of the year, we will add pertussis vaccine to the flu vaccine campaign and offer it to [employee health] clinic patients.”

So far, employees have been receptive to the vaccine, he says, adding it is not associated with significant adverse effects.

Marshfield (WI) Clinic budgeted almost \$50,000 to vaccinate more than 1,500 employees at about \$32 per shot. That will encompass employees who may have contact with infants, including general internal medicine, pediatrics, family practice, and obstetrics. Eventually, the clinic hopes to offer the vaccine to all 7,000 employees, says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety.

Cunha is aware of the potential for hospital- or clinic-based outbreaks. “We have had cases of pertussis [among employees], but none of those were directly related to patient exposure,” he says.

Danville (VA) Regional Medical Center also is initially focusing on certain areas, include obstetrics, pediatrics, and neonatal units, the emergency department, outpatient clinics, laboratory, and

## **Concerns raised about flu vaccine supply, again**

*FDA investigates sterility problems*

**P**roblems with a major flu manufacturer have raised the possibility of another vaccine shortage or delay this fall. The FDA issued a warning letter to Sanofi Pasteur citing “significant deviations from current good manufacturing practices.”

FDA investigators said there were sterility failures in 11 vaccine lots manufactured between February 2006 and April 2006, and that the company had not sufficiently investigated those concerns. The FDA also cited other quality control and record-keeping deficiencies.

“At this time, the deficiencies noted in the inspection of Sanofi Pasteur’s Swiftwater, PA, manufacturing facility are not expected to significantly affect the availability of Fluzone for the 2006-2007 flu season, but we continue to review the progress made by the company,” the FDA said.

The Centers for Disease Control and Prevention in Atlanta projected that about 100 million doses would be available for 2006-2007, an increase of about 16% from last year. Yet it cautioned that health care providers should have contingency plans in case of supply disruptions.

The agency asks health care facilities to prepare for both best- and worst-case scenarios: “[D]evelop plans for expanding outreach and infrastructure to vaccinate more persons than last year and develop contingency plans for the timing and prioritization of administering influenza vaccine, if the supply of vaccine is delayed and/or reduced.”<sup>1</sup>

Vaccination efforts should continue through December, “and possibly later.” If there is a shortage, the live, attenuated influenza vaccine (available as FluMist for nasal administration) “should be used preferentially for all healthy persons aged 5 to 49 years (including health care workers) to increase the availability of inactivated vaccine for groups at high risk,” the CDC says.

### **Reference**

1. Centers for Disease Control and Prevention. Prevention and control of influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2006; 55 (Early Release):1-41. ■

the hospital's child care center. Employees have reported mild side effects from the vaccine, including pain and redness at the vaccine site, and a little malaise and fever, says **Jacob Moll**, MD, MPH, medical director of outpatient clinics/employee health.

For now, the hospital is not vaccinating employees (or patients) 65 years or older unless there is a specific request from a physician, says Moll. ADACEL, the Tdap vaccine manufactured by Sanofi Pasteur, is licensed by the FDA for use among adults ages 19 to 64.

The CDC is recommending the Tdap vaccine for employees who have not received the Td vaccine within the past two years. The recommendation involves only a one-time, single dose, but as more data become available, that recommendation may evolve and health care workers may eventually need another booster, Tiwari says.

Even employees who have had confirmed pertussis should be vaccinated, he says. "Neither pertussis vaccination nor previous disease confers lasting or lifelong protection," he says. "The immunity wanes over a five- to 10-year period."

## References

1. Boulay BR, Murray CJ, Ptak J, et al. An outbreak of pertussis in a hematology-oncology care unit: Implications for adult vaccination policy. *Infect Control Hosp Epidemiol* 2006; 27:92-95.

2. Calugar A, Ortega-Sanchez IR, Tiwari T, et al. Nosocomial pertussis: Costs of an outbreak and benefits of vaccinating health care workers. *Clin Infect Dis* 2006; 42:981-988. ■

# Safe lifting fits JCAHO fall prevention goal

*Assessment, safer lifts are part of program*

If you're still trying to convince your hospital administration to invest in a safe patient handling program, here's a compelling reason: Lift equipment may help prevent patient falls. And the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has a special interest in fall prevention.

As a 2007 National Patient Safety Goal, JCAHO is requiring hospitals to implement a fall reduction program. Assessment of fall risk, medication use, and environmental measures such as bed

alarms are key parts of fall prevention. So is ambulation, and lift equipment or the use of lift teams may help patients gain mobility. For example, a sit-to-stand lift can help patients who have some weight-bearing capabilities.

The Joint Commission doesn't specify that hospitals should purchase equipment. But that clearly is a component of patient transfers, says **Carol Ptasinski**, RN, MSN, MBA, senior associate director of standards interpretation.

"There should always be some equipment in place that would assist the staff in safe transfer of the patient," she says.

Assessing a patient's fall risk also involves an assessment of the patient's dependency and lift and transfer needs, she says. That assessment should be reevaluated when the patient changes medication, has surgery, or periodically during the patient's stay.

The VA Patient Safety Center of Inquiry at the James A. Haley Veterans Hospital in Tampa, FL, has developed algorithms that include an assessment of patient handling needs, which would be incorporated into a falls assessment.

Integrating safe patient handling with fall prevention also could help build support from nurses, says **Audrey Nelson**.

"Nurses have the idea that they always have to put the patient first," she says. "It's easier for them to buy into something where they think it would have an importance [to patients]."

## Ceiling lifts provide support

At the Central Arkansas Veterans Healthcare System in Little Rock, patient safety practitioner **Mary E. Watson**, MSN, RN, APRN, BC, quickly saw the connection between fall prevention and safe patient handling.

The Joint Commission specifies the need to safely transfer patients, she notes. "If you are transferring the patient safely, then you are going to prevent injuries to staff that may occur if they were improperly transferred," she says.

Similarly, assessing and documenting a patient's transfer needs would include employee safety as well, she says. "It's a safe patient handling issue and not simply an exercise in assessment," she says.

Watson is integrating the assessment of fall risk with the patient transfer assessment, using the VA's algorithms. Her two-hospital system also is putting ceiling lifts in almost every patient room, which can be used for patient transfers

and repositioning. Physical therapists can put the harness on patients and use the ceiling lift as a backup when the patients first begin to walk in their rooms, says Watson. "If they start to collapse, they're in a harness."

With lift equipment, nurses may provide more prompt and frequent transfers because they don't have to wait for co-workers to help, notes Nelson. In a retrospective study of 24 rehabilitation and long-term care units in Florida, she and her colleagues found patient outcomes improved with the implementation of a safe patient handling program, which incorporated both ceiling and floor lifts.

They compared residents in the units for the two years before and after the program was implemented. The residents had lower levels of depression and urinary incontinence, and improved in their activities of daily living. They were awake more hours during the day, and they had fewer falls.

The improvement was particularly noteworthy because resident functioning would be expected to decline during a four-year period, notes Nelson, whose study is not yet published.

"You're fighting an uphill battle to show an improvement," she says. "There were some variables that stayed the same, and we felt that was a good finding as well."

More research is needed on the link between fall prevention and safe patient handling, Nelson says. Beyond patient safety, research also reveals patient attitudes toward mechanical lift devices. In one survey, Nelson found that patients actually preferred the lift devices. "Nurses think if they don't touch the patient, that it's not good nursing care. Patients say there are good touches and touches that are not dignified. It's not a "caring touch" if multiple caregivers are struggling to lift a patient, she says. ■

## OSHA cites hospital on formaldehyde

*Path lab is source of complaint*

Concerns about formaldehyde exposure in a laboratory of New York Hospital Queens led to \$112,500 in fines and two citations for alleged "willful" violations from the U.S. Occupational

Safety and Health Administration (OSHA).

Lab workers, including pathology assistants and oral pathology residents, were exposed to formaldehyde while cutting specimens in the "grossing room" of the pathology lab. According to OSHA, formaldehyde exposure can cause irritation to the eyes, nose, and throat, and asthma-like respiratory problems.

An OSHA inspection found that the hospital did not promptly monitor the employees' exposure and did not ensure that employees working with a formaldehyde solution participated in a training program, which resulted in citations for "willful" violations, the highest level that can be issued by the agency. According to OSHA, a willful violation is "one committed with an intentional disregard of, or plain indifference to, the requirements of the Occupational Safety and Health Act and regulations."

"They are the most severe category and they are given relatively infrequently," says OSHA spokesman **Ted Fitzgerald**.

OSHA also issued citations for three "serious" violations. The agency said the hospital did not administer a medical disease questionnaire or provide medical surveillance to employees experiencing "signs and symptoms indicative of possible overexposure to formaldehyde."

OSHA stated that an environmental engineering firm conducted monitoring and registered vapor levels of 5.52 ppm; the short-term exposure limit for formaldehyde is 2 ppm over a 15-minute period.

The hospital also was cited for failing to repeat the monitoring when there was a change in personnel or change in the HVAC system and failing to notify affected employees of the monitoring results. **(For a summary of OSHA requirements related to formaldehyde, see box on p. 105.)**

New York Hospital Queens has contested the findings, citations, and penalties, says **Camela Morrissey**, vice president of public affairs and marketing. "We believe that we're going to be able to provide the necessary evidence to have any citations and penalties removed," she says.

The OSHA inspection originated with an employee complaint that was not union-related. Nonetheless, the Service Employees International Union plans to meet with hospital administrators to discuss the formaldehyde exposures, says **Steve Schrag**, Eastern Region Hazmat Program coordinator for the union. "My goal is to get the problems fixed," he says. ■

## Protecting employers from formaldehyde exposure

(Editor's note: In a fact sheet, OSHA offers a summary of its formaldehyde standard. This is an excerpt. The complete fact sheet is available at [www.osha.gov/OshDoc/data\\_General\\_Facts/formaldehyde-factsheet.pdf](http://www.osha.gov/OshDoc/data_General_Facts/formaldehyde-factsheet.pdf).)

Airborne concentrations of formaldehyde above 0.1 ppm can cause irritation of the respiratory tract. The severity of irritation worsens as concentrations increase.

Some of the key provisions of the OSHA standard require employers do the following:

- Identify all employees who may be exposed to formaldehyde at or above the action level or STEL (short-term exposure limit) through initial monitoring and determine their exposure.
- Reassign employees who suffer significant adverse effects from formaldehyde exposure to jobs with significantly less or no exposure until their condition improves. Reassignment protection can continue for up to six months until the employee is determined able to return to the original job or unable to return to work — whichever comes first.
- Implement engineering and work practice controls to reduce and maintain employee exposure to

formaldehyde at or below the eight-hour TWA (time-weighted average) and the STEL. If these controls cannot reduce exposure to or below the PELs (permissible exposure limits), you must provide your employees with respirators.

- Label all mixtures or solutions composed of greater than 0.1% formaldehyde and materials capable of releasing formaldehyde into the air at concentrations reaching or exceeding 0.1 ppm. For all materials capable of releasing formaldehyde at levels above 0.5 ppm during normal use, the label must contain the words "potential cancer hazard."
- Train all employees exposed to formaldehyde concentrations of 0.1 ppm or greater at the time of the initial job assignment and whenever a new exposure to formaldehyde is introduced into the work area. Repeat training annually.
- Select, provide, and maintain appropriate personal protective equipment. Ensure that employees use this equipment such as impervious clothing, gloves, aprons, and chemical splash goggles to prevent skin and eye contact with formaldehyde.
- Provide showers and eyewash stations if splashing is likely.
- Provide medical surveillance for all employees exposed to formaldehyde at concentrations at or above the action level or exceeding the STEL, for those who develop signs and symptoms of overexposure and for all employees exposed to formaldehyde in emergencies. ■

## NIOSH warns users about uncertified N95s

*New products — and claims — flood market*

A growing demand for N95 filtering facepiece respirators has created a booming market — and concerns about the marketing claims of new products.

The National Institute for Occupational Safety and Health (NIOSH) has become more vigilant about checking the status of respirators marketed as NIOSH-certified, says **Heinz W. Ahlers, JD, MS**, chief of the technology evaluation branch at NIOSH's National Personal Protective Technology Laboratory in Pittsburgh.

"Right now, we are certifying a lot of N95 respirators. People are trying to get ready for avian influenza," says Ahlers. But amid that onslaught of new products, some do not live up to their

claims, he adds.

NIOSH issued a user notice to alert consumers that the Nano Guard respirator, marketed by 2H Distributors incorrectly displayed a NIOSH logo indicating it was certified by the agency. It is not.

On its web site, 2H Distributors asserts that the NanoMask uses a new technology and is "the only mask proven to be 99.9999% effective

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

The **September/October** issue of *Bioterrorism Watch* is available on-line at [www.ahcpub.com](http://www.ahcpub.com), exclusively for subscribers of *Hospital Employee Health*.

Copies of the issue will be available in html and PDF formats for easy reading. Just log on to print out your copy. To take the CE test on-line, go to <http://subscribers.cmeweb.com/>. Each issue will test separately. If you have questions, please call customer service at (800) 688-2421. ■

against avian flu and other viruses and bacteria.”

The manufacturer, Emergency Filtration, intends to apply for NIOSH certification “in the near future,” according to its web site. “It was important to validate the nanoparticle-enhanced filter against bacterial and viral contaminants and NIOSH was not able to provide this biological validation,” it stated.

NIOSH also revoked the certificate of approval for two respirators sold by Crews Inc., of Memphis, which carried the model numbers RPN951 and RPN952 and the approval codes TC-84A-4172 and TC-84A-4173. The company provided misleading information about the respirators, which are manufactured in China by a company that does produce masks under NIOSH certification, Ahlers says.

Ahlers’ advice to hospitals: Make sure your N95s are NIOSH-certified, and buy more than one model from more than one manufacturer to offer options that fit your population.

NIOSH certification tests the filtering capabilities of the respirator. NIOSH is developing a Total Inward Leakage test to determine the fit capabilities of N95s. Manufacturers then will be required to meet minimum criteria for fit, says Ahlers. ■

## Stress cripples HCWs in emergency department

*IOM report calls for protections*

The nation’s emergency care system is in crisis, and the solution must include protections for the health care workers who struggle to make it work, according to an Institute of Medicine report, “Hospital-Based Emergency Care: At the Breaking Point.”

“You can’t build a better emergency care system without a healthy and safe work environment and a strong work force,” says IOM panel member **Brent R. Asplin**, MD, MPH, medical director of Regions Hospital emergency department (ED) and department head of emergency medicine at Health Partners Group and Clinics in St. Paul, MN. “The emergency care system rests on the foundation of all the dedicated individuals, from pre-hospital care [of first responders] to the variety of specialists who support the emergency department.”

The ED poses higher risks of stress, violence, and infectious disease than other units in the hospital, notes Asplin. Those workers are the backbone

## CE questions

9. According to Michael Hodgson, MD, MPH, director of the Veterans Health Administration’s occupational health program, the VHA tracks its influenza immunization rates through:
  - A. an annual survey of employees.
  - B. pharmacy records.
  - C. declination statements.
  - D. managers’ reports.
10. According to Tejpratap Tiwari, MD, medical epidemiologist with the CDC’s National Center for Immunizations and Respiratory Diseases, health care workers who are exposed to pertussis should:
  - A. receive a Tdap vaccination.
  - B. receive antimicrobials or be monitored for symptoms.
  - C. be furloughed.
  - D. receive a chest X-ray.
11. According to Carol Ptasinski, RN, MSN, MBA, senior associate director of standards interpretation for the Joint Commission on Accreditation of Healthcare Organizations, an effective fall reduction program should include:
  - A. the purchase of ergonomic equipment.
  - B. the use of lift teams.
  - C. assessment of patients’ lift and transfer needs.
  - D. new policies on patient ambulation.
12. An Institute of Medicine panel found what condition plagues most emergency departments and contributes to greater risk for patients and employees?
  - A. Overcrowding
  - B. Inadequate training
  - C. Contamination by hazardous materials
  - D. Disease transmission

Answer Key: 9. A; 10. B; 11. C; 12. A.

## CE instructions

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

of emergency care and need support, he says.

"Much of the progress that is occurring in the ED today is because the professionals working in it refuse to let it fail, despite, in some circumstances, overwhelming odds," says Asplin, who also is vice chair of emergency medicine at the University of Minnesota in St. Paul.

The vulnerability of workers became clear in the SARS epidemic in Canada, which began with an outbreak in the ED of a Toronto hospital. An elderly woman became ill and died at home after a visit to Hong Kong. Her son, who had cared for her, was admitted to the ED with pneumonia.

The close proximity of patients in the ED contributed to nosocomial spread. Ultimately, 128 cases were linked to the initial ED case, including 47 infected health care workers.<sup>1</sup>

"In most emergency departments, by the time a truly potentially dangerous airborne pathogen like SARS or smallpox or [pandemic] influenza was identified, the likelihood would be that the whole emergency department would essentially be contaminated," Asplin says.

### **Improving the ED through redesign**

Redesign of the emergency department — both physical structure and processes — actually can relieve some of the stress and hazards, says Asplin.

For example, delays in patient flow create stress for ED workers and increase the risk of infectious disease transmission. The IOM report cites a study showing that 91% of the nation's EDs report overcrowding as a problem. Often, patients have received the care they need from the ED but are waiting for an available inpatient bed, says Asplin.

The IOM panel urged the Joint Commission on Accreditation of Healthcare Organizations to establish a standard to address ED overcrowding and the "boarding" of patients in the ED.

The IOM also recommended that "hospitals adopt robust information and communications systems to improve the safety and quality of emergency care and enhance hospital efficiency." An electronic medical record can give ED personnel quick access to patient information and

reduce the paperwork burden, Asplin says.

In fact, ED operations should be evaluated overall to improve efficiency. Can registration take place at the bedside? Can some minor care occur during triage? Are all the required tasks still necessary and providing value? "Focus on tasks that add value and take away tasks that don't," says Asplin.

At Harbor-UCLA Medical Center in Torrance, CA, ED physicians meet monthly to discuss ED issues. To address the physical stress of night shifts, the physicians decided to shorten the shift by one hour, from 11 p.m. to 7 a.m. to midnight to 7 a.m., says **Marianne Gausche-Hill**, MD, director of pre-hospital care and a member of the IOM panel.

The medical center is constructing a new ED — with ceiling lifts, she says. Technology reduces stress, from software that tracks patient flow to lift devices and gurneys that are easier to push, says Gausche-Hill, who also is a clinical professor of medicine at the University of California at Los Angeles.

Redesigning the ED can protect workers and patients elsewhere in the hospital. The airflow of an ED should be separate and distinct, Asplin advises. "One mistake we've made in emergency care systems is not treating our emergency

### **Correction**

The July 2006 issue of *Hospital Employee Health* should have said, according to 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 have a safety feature. The safety feature was not activated in 70% of those cases.

In the August 2006 issue, *HEH* incorrectly stated that the Association for Professionals in Infection Control and Epidemiology (APIC) supports the use of declination forms in influenza vaccination programs for health care workers. While APIC endorses mandatory flu vaccination for health care workers, it does not take a position on declination forms. ■

## **COMING IN FUTURE MONTHS**

■ Making the transition to Quantiferon-TB Gold

■ How to avoid common record-keeping errors

■ Giving ergonomic relief to sonographers

■ A vaccine for H5N1 avian influenza?

■ The link between nurse staffing, patient safety, and worker safety

departments as essentially airborne isolation units," he says.

Security is another major concern for emergency departments. ED personnel sometimes treat rival gang members side by side, or care for a gunshot victim while worrying that the perpetrator may come by to finish the job, says Gausche-Hill.

The IOM panel suggests assigning multiple caregivers to a violent-prone patient and/or having two entry points to ED exam rooms.

It is commonplace for EDs to have security guards. Some also have metal detectors and surveillance cameras. At Regions Hospital, employees and physicians carry devices that allow them to communicate with colleagues in the department — and push a panic button if they need immediate help.

Sufficient staffing and adequate patient flow also can create a better environment for patients and staff, says Asplin.

"You're never going to take the stress out of emergency care. If you did, a lot of people who are working in the emergency care system wouldn't be interested in it. It does attract people who are interested in a high-paced and sometimes high-stress environment," he says, but adds, "We've met and exceeded the stress threshold for many of the workers, and it is time to reduce it."

## Reference

1. Varia M, Wilson S, Sarwal S, et al. Investigation of a nosocomial outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto, Canada. *CMAJ* 2003; 169:285-292. ■

## 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. ■

## EDITORIAL ADVISORY BOARD

**Consulting Editor**  
**MaryAnn Gruden**  
MSN, CRNP, NP-C, COHN-S/CM  
President Emeritus  
Association Community Liaison  
Association of Occupational  
Health  
Professionals in Healthcare  
Coordinator  
Employee Health Services  
West Penn Allegheny Health  
System  
Western Pennsylvania Hospital  
Pittsburgh

**Kay Ball**, RN, MSA, CNOR,  
FAAN  
Perioperative Consultant/  
Educator, K&D Medical  
Lewis Center, OH

**Cynthia Fine**, RN, MSN, CIC  
Infection Control/  
Employee Health  
San Ramon (CA) Regional  
Medical Center

**June Fisher**, MD  
Director  
Training for Development of  
Innovative Control Technology  
The Trauma Foundation  
San Francisco General Hospital

**Guy Fragala**, PhD, PE, CSP  
Consultant/  
Health Care Safety  
Environmental Health  
and Engineering  
Newton, MA

**Janine Jagger**, PhD, MPH  
Director  
International Health Care Worker  
Safety Center  
Becton Dickinson Professor of  
Health Care Worker Safety  
University of Virginia  
Health Sciences Center  
Charlottesville

**Gabor Lantos**  
MD, PEng, MBA  
President  
Occupational Health  
Management Services  
Toronto

**JoAnn Shea**  
MSN, ARNP  
Director  
Employee Health & Wellness  
Tampa (FL) General Hospital

**Denise Strode**  
RN, BSN, COHN-S/CM  
Executive President  
Association of Occupational  
Health Professionals  
Clinical Case Manager  
OSF Saint Francis Center  
for Occupational Health  
Peoria, IL

## 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](mailto: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](http://www.ahcpub.com/online.html).

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

## Calendar reminder

The Association of Occupational Health Professionals in Healthcare will hold its 25th annual conference Oct. 4-7 in Sacramento, CA. More information is available on the AOHP web site, [www.aohp.org](http://www.aohp.org).



# JCAHO Update for Infection Control

*News you can use to stay in compliance*

## JCAHO standard targets resistance to HCW flu vaccinations

*Does new standard have teeth?*

Having made infection control and patient safety top priorities in recent years, the Joint Commission on Accreditation of Healthcare Organizations is now taking on the thorny issue of flu vaccinations for health care workers in a new standard that becomes effective next year.

It appears the Joint Commission has no immediate expectation for hospitals to meet some benchmark immunization rate, but does expect the standard to begin pushing national rates out of the anemic 40% range.

"The current rates are abysmally low," says **Robert Wise**, MD, JCAHO vice president of the division of standards and survey methods. "The standard is set up essentially as a CQI project, where the organization has to have a program, has to evaluate its rates, has to understand why there is a problem, and it has to improve it. This is a standard now; [noncompliance] would be a problem."

The Joint Commission standard requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers and licensed independent practitioners with close patient contact. The standard will become an accreditation requirement beginning Jan. 1, 2007, for the critical access hospital, hospital, and long-term care accreditation programs. Organizations will be required to:

- establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- provide access to influenza vaccinations on site;
- educate staff and licensed independent practitioners about flu vaccination; nonvaccine control measures (such as the use of appropriate

precautions); and diagnosis, transmission, and potential impact of influenza;

- annually evaluate vaccination rates and reasons for nonparticipation in the organization's immunization program;
- implement enhancements to the program to increase participation.

### **JCAHO follows CDC action**

The Joint Commission developed the standard in response to recommendations by the Centers for Disease Control and Prevention (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, CDC guidelines published earlier this year call for stronger steps to increase influenza vaccination of health care workers.<sup>1</sup>

In issuing the standard, JCAHO cited estimates that influenza causes 36,000 deaths and more than 200,000 hospitalizations on average in the United States a year. Furthermore, health care-associated transmission of influenza has been documented among many patient populations in a variety of clinical settings, and patient infections have been linked to unvaccinated health care workers.

In two separate studies in geriatric long-term care facilities, total patient mortality was significantly lower in those sites where health care workers were vaccinated compared to sites where routine vaccination was not offered to health care workers (10% vs. 17% and 14% vs. 22%)<sup>2,3</sup>. Increased rates of health care worker vaccination also correspond with a significant

decrease in the incidence of health care-associated influenza.

“It has been demonstrated epidemiologically that patients are getting flu from health care workers,” Wise says. “One of the particular problems is that by the time that the health care worker is symptomatic they have already been infectious for a couple of days. The only way to deal with that is to get the vaccine. If you tell someone to stop coming to work when they have symptoms, it is not going to work. It is too late.”

### ***Will standard change historic problem?***

In recent years, the Joint Commission has issued tougher standards and patient safety goals focused on infection control, but it is an open question whether JCAHO has built enough momentum to take on the entrenched resistance to seasonal flu vaccination by health care workers. Moreover, many of those recalcitrant workers are nurses, the very backbone of the health care delivery system. The reasons typically given for refusing vaccination are the perception that they pose no risk to patients, fear of vaccine side effects, fear of needles, or belief that the vaccine causes the flu. While there are elements of the health care work force that remain suspicious of the safety of the annual influenza vaccine, such fears remain unsupported by scientific evidence. On the contrary, a study comparing receipt of flu vaccine vs. placebo revealed no significant difference in side effects.<sup>4</sup>

In an age of patient safety — which the Joint Commission is now emphasizing in many of its standards and accreditation activities — there is a glaring disconnect in having large numbers of health care workers unvaccinated every flu season. “Certainly people have looked at it from an employee health point of view — all the time lost from work, etc.,” Wise says. “But one of the areas that the CDC has particularly [emphasized] is transmission from the health care worker to the patient.”

But does the Joint Commission standard go far enough to really solve the problem?

The Association for Professionals in Infection Control and Epidemiology has come out in favor of mandatory seasonal flu vaccinations for patient caregivers; the Society for Healthcare Epidemiology of America is calling for workers to sign off on declination statements if they turn down the shot; and the Centers for Disease Control and Prevention also puts declination statements on the table as an option.<sup>5</sup>

The CDC language is somewhat equivocal, noting “the independent contribution of signed declination statements to improving HCP [health care personnel] vaccination has not been studied. However, obtaining declination statements from health care workers who refuse vaccination for reasons other than medical contraindications can assist facilities in identifying personnel who might require targeted education or other interventions to overcome barriers to vaccine acceptance. In addition, collection of such information will allow health care facilities to determine what proportion of their staff are reached and offered vaccine.”

The Joint Commission’s new standard requires hospitals to offer flu vaccine but stops short of requiring declination statements. Instead, hospitals are to annually evaluate vaccination rates and reasons for nonparticipation and implement program enhancements to improve participation.

### ***The declination dilemma***

“Declination statements are not required,” Wise explains. “That was one of the most hotly debated issues. The question was whether declination statements truly added to improving the rates or do they just add a burden on the hospital.”

Rather than filing a declination form for individual workers, hospitals can assess reasons for noncompliance through surveys, he notes. “It’s a lot less burdensome.”

Indeed, he adds the Joint Commission does not see enforcement of the standard to be a complicated matter. “You either know your rates or you don’t. You need to know your [immunization] rates,” Wise says. “You need to demonstrate what are potentially the issues about why you do have a better rate. Then you need to do something to enhance the program to increase it.”

JCAHO had a major impact on hand hygiene practices in the nation’s hospitals after it made CDC recommendations for alcohol hand rubs a national patient safety goal. “That is a particularly powerful one, at least from a process point of view,” Wise says. “If you go into almost any hospital now you will see the alcohol hand rub containers. The CDC has done two surveys and is finding that well over 90% of all hospitals are now using alcohol-based hand rubs. The issue that has come up is, are we able then to go from that process indicator to an outcome? Are the people really using the [hand hygiene] material? There has not been really a good method yet to

measure that. People are taking a look at that inside the Joint Commission.”

At any rate, we will now see if a similar impact holds true for flu vaccination. And given the regulatory nature of the times, there is always the possibility that flu immunization rates could be reported as a process measure in state and federal laws regarding hospital quality. “Whether it will [carry the same importance] as MRSA [methicillin-resistant *Staphylococcus aureus*] infection or something like that, I leave it up to the experts,” Wise says. “But it is an important process measure that may [reflect] the overall culture of the organization.”

## References

1. Centers for Disease Control and Prevention. Influenza Vaccination of Health-Care Personnel Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) *MMWR* 2006; 55:1-16.
2. Carman WF, Elder AG, Wallace LA, et al. Effects of influenza vaccination of health-care workers on mortality of elderly people in long-term care: A randomized controlled trial. *Lancet* 2000; 355:93-97.
3. Potter J, Stott DJ, Roberts MA, et al. Influenza vaccination of health care workers in long-term care hospitals reduces the mortality of elderly patients. *J Infect Dis* 1997; 175:1-6.
4. Margolis KL, Nichol KL, Poland GA. Frequency of adverse reactions to influenza vaccine in the elderly: A randomized, placebo-controlled trial. *JAMA* 1990; 264:1,139-1,141.
5. Talbot TR, Bradley SF, Cosgrove SE, et al. SHEA Position Paper: Influenza Vaccination of Healthcare Workers and Vaccine Allocation for Healthcare Workers During Vaccine Shortages. *Infect Control Hosp Epidemiol* 2005; 26:882-890. ■

## Nurses charge JCAHO lax on staffing standards

*Raises risk of hospital-associated infections*

The Joint Commission on Accreditation of Healthcare Organizations is embroiled in a legal battle with the American Nurses Association (ANA) over the issue of hospital staffing levels.

The ANA, the New York State Nurses Association (NYSNA), and the Washington State Nurses Association (WSNA) recently filed a lawsuit in a U.S. district court against the Department of Health and Human Services (HHS). The nursing

groups seek to remedy perceived violations of laws that require minimum standards for participation in the federal Medicare program. Specifically, the groups claim that HHS allows hospitals that fail to meet federal nurse staffing requirements to participate in Medicare, thereby endangering patients. The lawsuit seeks to prevent HHS from allowing JCAHO, which accredits 82% of all hospitals, “to use its own, minimal standards” for nurse staffing in its accreditation of hospitals. As part of the lawsuit, the NYSNA and the WSNA claim that hospitals in both states have failed to hire and assign enough nurses to meet HHS standards for participation in Medicare, and this failure has resulted in nurses working in situations that “jeopardize the health and safety” of nurses and patients.

“The number of Medicare patients is increasing at the same time nurse staffing shortages are growing,” says **Verlia Brown**, MA, RN, president of the NYSNA. “This is a dangerous combination. It is critical that hospitals adhere to the highest possible nurse staffing standards for the sake of nurses and patients.”

According to the lawsuit, HHS has “unlawfully delegated its authority to JCAHO by allowing it to use standards that are not equivalent to standards set by HHS for participation in the Medicare program.” The lawsuit seeks a court order to require that HHS assures that JCAHO uses standards that are “at least equivalent” to HHS standards. The lawsuit asks the court to order the following actions to prompt adherence to HHS regulations while ensuring continuing access to health care services:

- require HHS to comply with the registered nurse staffing regulation;
- require HHS to designate provisional approval of hospitals that rely on JCAHO accreditation for participation in the Medicare program.

### ***Demanding RNs at the bedside***

HHS and JCAHO guidelines both include requirements for nurse supervisory personnel. But HHS requirements also call for nurse staffing levels that ensure the “immediate availability” of a registered nurse for the bedside care of any patient. In addition, HHS requires that staffing schedules be reviewed and revised to meet patient care needs and nursing staff absenteeism. The lawsuit charges that JCAHO’s standards are “devoid” of any requirements for the immediate availability of nurses to provide bedside care to patients and also do not address with sufficient

specificity the requirements of staffing plans.

“Plaintiffs and the public are harmed by a failure to require adequate staffing on medical/surgical units where registered nurse-to-patient staffing ratios of 1:8 result in patients being 31% more likely to die within 30 days than those in units with RN-to-patient ratios of 1:4, and complications such as urinary tract infections, pneumonia, shock, and gastrointestinal bleeding are much more prevalent,” the suit charges.

Indeed, clinical investigators have found that inadequate health care staffing can spark nosocomial outbreaks when rising patient census or acuity outstrip nursing resources. Though it can be difficult to establish a clear epidemiological link between such conditions and subsequent infections, the general consensus is that staffing problems — particularly if they occur in conjunction with an increase in patient acuity — may undermine aseptic technique, catheter care, and hand washing compliance by harried health care workers.

JCAHO infection control standard IC.9.10 requires hospital leaders allocate adequate resources that include sufficient staff as reflected by “numbers, competence, [and] skill mix.” In response to the lawsuit, JCAHO emphasized that its accreditation standards meet or exceed HHS requirements. Moreover, numerous HHS validation surveys demonstrate the adequacy of Joint Commission standards in the area of nurse staffing, JCAHO said in a statement.

In addition, the new survey process, “Shared Visions — New Pathways,” pays particular attention to the important role of nurses by shifting the focus from survey preparation to continuous improvement of operational systems that directly impact the quality and safety of patient care. Moreover, the Joint Commission argues that it has established “cutting-edge staffing standards that create a framework for measuring and improving nursing care.”

Hospitals may participate in the Medicare program either through JCAHO accreditation or through accreditation by a state agency approved by HHS. A 2004 U.S. Government Accounting Office (GAO) report concluded that JCAHO had “unacceptable performance” in identifying hospitals that did not comply with Medicare requirements, the ANA charges. Prior to 2006, JCAHO accreditation surveys were scheduled. The GAO acknowledged that by conducting unannounced surveys beginning this year, JCAHO likely would improve its performance.

## References

1. Fridkin SK, Pear SM, Williamson TH, et al. The role of understaffing in central venous catheter-associated bloodstream infections. *Infect Control Hosp Epidemiol* 1996; 17:150-158.
2. Haley RP, Bregman DA. The role of understaffing and overcrowding in recurrent outbreaks of staphylococcal infection in a neonatal special-care unit. *J Infect Dis* 1982; 145:875-885.
3. Kidd F, Heitkemper P, Kressel A. A neonatal intensive care unit outbreak of *S. aureus* associated with inadequate staffing. Abstract S74. Presented at the Conference of the Society for Healthcare Epidemiology of America. San Francisco; April 18-20, 1999. ■



## JCAHO, APIC publish infection control book

*Workbook aspect encourages planning*

Joint Commission Resources (JCR) — a division of the Joint Commission on Accreditation of Healthcare Organizations — has collaborated with a leading national infection control group to publish a workbook.

Published in collaboration with the Association for Professionals in Infection Control and Epidemiology, the *APIC/JCAHO Infection Control Workbook* addresses the challenging infection control issues in a variety of health care settings. The workbook includes detailed explanations of Joint Commission infection control requirements, answers to commonly asked questions, and checklists and tools to help organizations improve infection control practices. The workbook format encourages organizations to develop action plans to address infection control issues found in their own self-assessment.

The *APIC/JCAHO Infection Control Workbook* is available through the JCR for \$95 using order code IC-SA-01SJ. To order publications, call JCR customer service toll-free at (877) 223-6866, 8 a.m. to 8 p.m. CT, weekdays, or visit [www.jcrinc.com/infomart](http://www.jcrinc.com/infomart) to order on-line. ■