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A monthly advisory for occupational health programs

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INSIDE

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ABOHN tackles certification rates, seeks to boost brand recognition

Computer-based testing will make exams more convenient

If you are an occupational health nurse and your signature is followed by "COHN" or "COHN-S," you know that the designation is not easily earned, and you undoubtedly derive some personal and professional satisfaction from being a certified occupational health nurse (COHN) or COHN specialist (COHN-S). So why doesn't everybody earn certification?

That's what the American Board for Occupational Health Nurses (ABOHN), the nation's only accredited occupational health nursing certification body, wants to know. ABOHN's board of directors are in the process of learning and processing the findings of a marketing and public relations study the board commissioned to learn why the numbers of nurses seeking COHN certification or recertification are down slightly.

"We, as an organization, like many nursing groups, are seeing a decline in the number of people practicing in our specialty; and a growing number of people retiring from occupational health nursing," points out ABOHN Chair **Mary Lou Wassel**, MEd, RN, COHN-S/CM, ARM, CSP. "As a result, our application numbers for certification and recertification have been declining for the past few years."

Wassel says that while one assumption could be that decreasing certification candidates means shrinking numbers in the occupational health profession, she does not believe that to be the case.

Untapped pool?

Wassel says ABOHN leaders believe that many nurses are practicing within the occupational health nursing scope of practice, but they "don't perceive themselves to be occupational health nurses and are unaware of the occupational health nursing specialty."

Wassel says the occupational health specialty is unique in nursing, in that many nurses working as on-site occupational health professionals may be alone at their worksites, with little chance for networking or mentoring.

"They may not be as connected [as nurses working in a group or hos-

pital setting],” she explains, a factor she experienced herself earlier in her career.

“I had the opportunity to work for a company in a position that was not titled as ‘occupational health nurse,’ but then I realized that that is what I was,” she recounts. “You can leave one of the more traditional nursing settings for an occupational health job and find yourself rather isolated. In my case, I was looking for colleagues and help with things like benchmarking. As a result, I joined a local chapter of AAOHN [American Association of Occupational Health Nurses]. It was through that connection that I learned more about the practice of occupational health nursing and about certification. So if you’re out there on your own, you might not know about occupational health nursing certification.

“Reaching people to let them know the resources that are available to them is our challenge.”

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ABOHN leaders have made public relations and outreach a priority for the board, and have hired a marketing consultant to help the board craft a dynamic strategic plan to communicate their message about certification. (*See box, “Occupational Health Nursing Certification,” page 3).*

According to ABOHN Associate Executive Director **Ann Lachat**, RN, BSN, COHN-S/CM, since its 1972 inception, ABOHN has certified 12,206 occupational health nurses. As of the end of 2006, the number of currently active certifications is 6,278. In 2004 that figure was 6,772, a drop of about 7% in two years.

ABOHN’s marketing partner has talked with nurses who are certified and non-certified, employers, and other key stakeholders. The firm created a benchmarking document from which it presented a day-and-a-half strategic planning session for ABOHN leadership at its January meeting. The benchmarking research revealed a current demand for occupational health nurses that exceeds the current supply of trained professionals.

“We are going to look openly at the organization to explore strategies to meet this demand, position ourselves in the future, and improve our brand recognition,” says Wassel.

Certification of value to nurse, employers

The benefits of certification, say leaders in the profession, are apparent.

“One of the things we found when we surveyed our members about benefits and compensation is that certified nurses made more money,” says AAOHN President **Susan Randolph**, MSN, RN, COHN-S, FAAOHN. “That’s certainly supportive of seeking certification and maintaining certification.”

The American Board of Nursing Specialties defines certification as the formal recognition of “the specialized knowledge, skills, and experience demonstrated by the achievement of standards identified by a nursing specialty to promote optimal health outcomes.”

Certification differs from licensure in a couple of ways — while licensure is required of anyone practicing nursing, certification is voluntary (except as required by employers), and typically represents the accomplishment of standards beyond those required by licensing boards.

“Anytime you have someone who’s certified,

that certification demonstrates advanced knowledge and expertise in occupational health nursing, and you have that body of knowledge that has been demonstrated through passing a national exam," Randolph adds.

Wassel says that many nurses who have achieved certification say they sought the designation for personal and professional reasons.

"They wanted to be certified to demonstrate competence because the specialty of occupational health nurses is so broad," she says. "A lot of times people will tend to be very skilled in one area of the practice they're engaged in on a daily basis, but other aspects they might not be as aware of or not be as familiar with.

"In studying and preparing for certification, people tell us they gained a new appreciation for the breadth of the practice, and also developed ideas of how they could expand upon or improve their practice."

Other reasons may be jobs that require certification either as a condition of hiring or as an indication of continued professional growth.

"It's a broad specialty and a challenging exam," with a pass rate in the mid 70 percent range, Wassel says.

It's about to become a more convenient exam, as the twice-yearly paper and pencil exam becomes a computer-based exam that will be available to candidates throughout the year at locations across the country.

"Now people will be able to apply, receive notice of eligibility, schedule themselves online, and take the exams at a time, place, and date convenient for them," says Wassel. "We have been working toward this goal of computer-based testing for a long time, and we're preparing to launch on our target date of March 1."

Computer-based testing, Wassel says, is one change the board hopes to will boost certification numbers.

"Many people have told us they have been waiting for computer-based testing, and the vast majority of feedback has been overwhelmingly positive," says Wassel, who says candidates for certification should feel less pressure than the twice-yearly tests might have caused.

"If you're preparing and people know about it, or your employer is encouraging you to take it, there could be pressure for the results [which arrived about six weeks later], but with the computer-based test, you get pass-fail results immediately."

Certification Type	Requirements
COHN — Certified Occupational Health Nurse **COHN-S** — Certified Occupational Health Nurse Specialist	• Licensed RN • 4,000 hours occ health work experience in the most recent 5 years • 50 contact hours of continuing education in the most recent 5 years • Bachelor's degree or higher (to earn COHN-S)
COHN-CM, COHN-S/CM — COHN or COHN-S with a specialty in case management	• COHN or COHN-S core credential • 10 contact hours of continuing education in case management in the most recent 5 years
COHN-SM, COHN-S/SM — COHN or COHN-S with a specialty in safety management	• COHN or COHN-S core credential • Current position with at least 25% safety activities • 50 contact hours of safety-related continuing education • 1,000 hours of experience in the most recent 5 years

In the event that the candidate does not pass, the new testing method means he or she won't have to wait six months to re-test. ■

For more information on certification, contact ABOHN, 201 E. Ogden Avenue, Suite 114, Hinsdale, IL 60521, phone (630) 789-5799 or toll-free at (888) 842-2646.

Men make inroads in female-dominated world

Male nurses make up 5% of occ health nurses

The number of men making nursing their career continues to be dwarfed by the number of women in the profession, but data show men are slowly increasing their presence in nursing, including occupational health nursing.

While more male faces, in a field traditionally populated by women, makes for interesting statistics, the reasons for it are not very mysterious, nurses say.

"It doesn't matter what race or sex you are, people want good jobs with good benefits, and occupational health nursing provides a great

opportunity for that," says **Richard Kowalski**, RN, MSA, COHN-S, who came into occupational health nursing 30 years ago, when he was an emergency department nurse with a young family. Kowalski, who spent almost 30 years in occupational health and management with General Motors in Michigan and is now a consultant, will make some small history in April, when he becomes the first male president of the American Association of Occupational Health Nurses (AAOHN). *(See profile, "New face set to lead AAOHN," p. 17.)*

"I don't think it's a gender thing — it's a question of good opportunities," he adds. "When people get more exposure to it, they see the opportunities to grow within different companies."

At the end of 2006, AAOHN data shows, of its total membership of 8,655, 7,879 (91%) are women, and 439, (5%) are men. (Some members did not indicate gender.) Three years earlier, at the end of 2003, total membership was 9,601, of whom 8,697 (90.5%) were women and 445 (4.6%) were men. *(See box to the right for a breakdown by age and gender.)*

From 2003 to 2004, 90% of registered nurse (RN) program degree recipients were women; by comparison, 51% of the U.S. population for that period was female.

"Male nurses make up around six percent of all RNs in the United States, and about 5.1 percent of AAOHN membership, so we're right in line with the national numbers," says current AAOHN President **Susan Randolph**, MSN, RN, COHN-S, FAAOHN.

Additionally, salaries continue to rise in occupational health nursing, and surveys of AAOHN membership indicate a high level of job security. Results of AAOHN's 2006 membership survey reveal that the average salary for AAOHN members is $63,472, with average salaries having increased 3.9% every year since 2001.

Other attractions of an occupational health career, AAOHN members say, include:

More than seven out of 10 members receive dental, major medical, life, prescription drug, long-term disability, and short-term disability insurance;

The typical members have 75% of their health insurance program premium paid by their employers;

Three in four members report receiving a 401(k) retirement plan.[1]

Table 2

AAOHN: Number of Male Nurses Increasing

While men still represent a small percentage of the total occupational health nurse population (5%), their numbers relative to women have been rising in recent years, according to the Atlanta-based American Association of Occupational Health Nurses. As the table below indicates, about 10% of those nurses born between 1961 and 1970 are male, while only about 5% of those born between 1951 and 1960 are men. Here's the complete demographic breakdown (by gender and year of birth):

Born 1920 or earlier	**Born 1961 to 1970**
Members: 2	Members: 1,249
Women: 2	Women: 1,119
	Men: 116
Born 1921 to 1930	
Members: 57	**Born 1971 to 1980**
Women: 57	Members: 354
	Women: 323
Born 1931 to 1940	Men: 22
Members: 394	
Women: 387	**Year of birth not given**
Men: 5	Women: 486
	Men: 25
Born 1941 to 1950	
Members: 2,463	**Total:** 8,655
Women: 2,357	**Women:** 7,879
Men: 90	**Men:** 439
	Gender not specified: 337
Born 1951 to 1960	
Members: 3,354	*Source: American Association of*
Women: 3,148	*Occupational Health Nurses,*
Men: 181	*Atlanta.*

Men, women enter nursing for same reasons

According to the "Men in Nursing" study findings released in 2005 by the American Assembly for Men in Nursing (AAMN), California Institute for Nursing and Healthcare, and Coalition for Nursing Careers in California, men enter the field of nursing for most of the same reasons women do.[2]

"Men come to nursing for much the same reasons as their female counterparts, primarily to help others and for the growth opportunities the profession offers," the AAMN study concludes. "There were many comments about nursing being a 'calling', not just a profession, as well as numerous comments about being able to 'make a difference.'"

AAMN study respondents (some 500 male nurses) did not mention some of the same reasons for entering nursing that female nurses do, such as the influence of other health care profes-

sionals, parental influence, or an early awareness of nursing as a career possibility, a fact that the study authors attribute to men being a minority in nursing and nursing not traditionally considered a "man's job."

"There have been efforts for a while to increase the number of men in nursing, in general. Occupational health nursing is a choice that's attractive to men — and women — for a number of reasons," Randolph points out. "There's a lot of flexibility, opportunities for career advancement, involvement in a team approach and decision-making." ■

References

1. American Association of Occupational Health Nurses, Compensation and Benefits Study: A Statistical Survey of Job Profiles, Salaries and Benefits, 2006. Available online at www.aaohn.org/marketplace, or by calling (800) 241-8014, ext. 0.

2. American Assembly for Men in Nursing, Men in Nursing Study, 2005. Available online at www.aamn.org/MenInNursing2005Survey.pdf.

Profile

New face set to lead occ health nursing association

Richard Kowalski first male president in history

For the first time in its history, the American Association of Occupational Health Nurses (AAOHN) is preparing to install a male president. But that's not really how **Richard Kowalski**, RN, MSA, COHN-S, sees it.

"I don't look at [being an occupational health nurse and incoming president of AAOHN] as being a gender issue," he says. "I see it as challenges and opportunities."

Established in 1942, AAOHN is a 10,000-member association dedicated to advancing the health, safety, and productivity of workers by providing education, research, public policy, and practice resources for occupational and environmental health nurses. Until now, all its presidents and most of its board leadership have been women.

Kowalski, now an occupational health consultant whose special interest is case management, came into occupational health by accident, but for the same reason many other nurses enter the field — he had a young family to support, and he chanced upon an opportunity he felt was too good to pass up.

The former Vietnam combat medic was working as a nurse in the emergency department when he happened to be out with friends who were applying for skilled trade jobs with General Motors in northern Michigan. He was hired to be an onsite nurse for GM in 1971.

He became active in AAOHN shortly thereafter, joining the board in the late 1980s. His experience in AAOHN has given him an appreciation for the effect economics can have on the job security of occupational health nurses, as well as perspective on his own long and successful career with GM.

"Being active and involved with the board has allowed me to see that with economic problems, there are nurses who come and go with some companies. I was lucky."

After a few years with GM, Koslowski became medical supervisor, then general supervisor, and finally managing supervisor (an executive position) in Saginaw. Seven plants and 10,000 employees were under his care, and he supervised medical departments that were staffed round-the-clock at each location.

While working in-house in occupational health was a stable job for Koslowski during his time at GM, even that has changed since his retirement three years ago. GM, like many other large employers, has found it more cost effective to outsource its occupational health services.

That is one reason that he believes case management is the area of occupational health most likely to grow in coming years.

"[AAOHN's] biggest challenge is going to be to help provide skills and education for our members to do their jobs, improve the jobs they are in, and if necessary, find new jobs," he says. "In occupational health, case management is going to be the biggest growing field because of the way companies are structuring their costs and benefits. It's cheaper for them to buy the services from a hospital or other vendor that specializes in case management."

The many faces of occ health attract

The attraction of occupational health to nurses looking to advance their career and expertise is that it is so many things, Kowalski says.

"It is health, business, wellness — there are a lot of facets to occupational health that you don't see in most other nursing jobs," he points out.

"You're able to develop not only your nursing skills, but other area of skill as well.

"I got a bachelor's in psychology and a master's in health administration [in addition to a nursing degree], so I like to say that because of occupational health I know the business side, the people side, and the medical side of nursing."

While the big-business structure of GM allowed someone in nursing to advance to an executive position, occupational health nurses at smaller employers can often find themselves in positions of important decision-making.

"Often, an occupational health nurse will find he or she is the only person at that company who is the go-to person on health care issues," he explains. "They become the medical expert.

"So nurses need to learn the business, so they can talk business as well as health care and see how the two go hand in hand."

AAOHN, he says, has been invaluable to him in learning how business and health care work together in different settings across the country. Besides providing networking opportunities, he says, nurses attend AAOHN meetings for continuing education "and to see what's out there."

"Being on the national board of AAOHN, I have met a lot of brilliant, talented nurses, and learned a lot from a lot of different people," he adds.

As president of the association Kowalski anticipates working with other associations in which AAOHN members have cross-memberships — for example, the Case Management Society of America.

"Our board converted to the Carver governance model a few years ago, and it has been great for us because we were able to have more opportunities for our staff to do things that are good for our members, under the direction of the executive directors," he says. "We can provide quickly what our membership needs, rather than sifting through big, old-fashioned committees that took too long for changes to go through the structure and get back to the membership."

Carver policy governance places emphasis on organizational purpose (the "ends") over the means by which those purposes are achieved. The executive board determines what results the membership should have, and then turns it over to staff to accomplish it, with the only limits on staff being to work within the board's pre-stated standards of prudence and ethics.

"That model has been great in improving things for our membership, and [current AAOHN President] Susan Randolph has done a wonderful job of implementing it," he says. "One thing I've seen in the last five years is that our board and staff are there to provide what the membership wants and what they need to help them with their profession."

Outgoing president **Susan Randolph**, MSN, RN, COHN-S, FAAOHN, says Kowalski's experience and knowledge are the most valuable tools he brings to the association presidency, but acknowledges that his gender can't hurt.

"He is one of a small number of men who have served as president of national nursing organizations, so he will bring a new face to occupational health nursing," she says. "He can be a role model, a spokesperson for men in occupational health nursing."

Kowalski and the 2007-2008 board of directors will be installed at this year's AAOHN Symposium and Expo in April in Orlando, FL. ■

Musculoskeletal pain hits 80% of sonographers

Sonographers' association seek answers, solutions

Musculoskeletal pain and injury has become so prevalent among medical sonographers that a large-scale survey found that up to 80% of sonographers work injured or work with discomfort. That percentage got the attention of federal worker safety agencies, a national sonographers association, and equipment manufacturers, who together are trying to make sonography a less painful career choice.

A series of local, national, and international surveys of diagnostic medical sonographers yielded results so consistent — and so unsettling — that "we don't go around trying to prove [the musculoskeletal injury rate] anymore. Now we're trying to address it," says **Joan P. Baker**, MSR, RDMS, RDCS, FSDMS, founder of the Society for Diagnostic Medical Sonography and an expert on musculoskeletal injuries (MSI) in sonographers.

A national consensus on work-related MSI in sonography in 2003 resulted in the creation of an industry standard addressing the problem.

NIOSH report on MSI among sonographers

To address the high rate of musculoskeletal injuries among diagnostic medical sonographers, the National Institute for Occupational Safety and Health (NIOSH) recommends the following controls to help reduce the number of injuries:

Equipment

• Provide adequate work space for personnel, sonography equipment, the patient table, and other equipment.

• Ensure that sonography equipment is fitted with a high-resolution screen that has a high refresh rate (85 Hertz or higher), a noninterlaced monitor and an easily adjustable "brightness control" to reduce eye strain. Position the equipment monitor directly in front of the sonographer.

• Position the keyboard to allow the arm to be in a relaxed position with the upper arm close to the body (minimal flexion and abduction) and the elbow at a 90° angle. A laptop computer may enable the sonographer to achieve a favorable position with respect to the patient. However, be aware that laptops can present other problems because the keyboard and monitor cannot be positioned separately, which make them difficult to handle at the bedside.

• Use a posture-enhancing adjustable chair to accommodate the sonographer through adjustable footrests, seat heights, and lock and release casters. Casters should allow for rolling between patients and the ultrasound machine when necessary, yet prevent rolling backwards when performing necessary procedures.

• Use motorized adjustable tables (including those equipped with drop-down side rails) to optimize the positions of the patient and the sonographer.

• The table should be as narrow as possible (preferably 24 to 27 inches wide) to allow for proximity to the patient and to reduce the amount of shoulder abduction needed to reach the patient's far side.

Work Practices

• Decrease the duration of static posturing:

• Vary postures throughout the day.

• Sit or stand, depending on the exam.

• Decrease hand-grip pressure:

• Alternate the scanning hand and vary the grip used.

• Take short breaks.

• Loosen grip on the transducer.

• Minimize awkward and extreme postures.

• Increase tissue tolerances through exercise and adequate rest.

Scheduling

• Schedule different types of exams for each sonographer in a workday to decrease strain on musculoskeletal tissues specific to one type of exam.

• Limit the number of portable exams to help minimize those tasks with higher number of pinch grips and increased static or awkward postures.

• Consider a maximum number of scheduled exams for sonographers. Take into account existing ergonomic conditions and equipment, the type of exams performed, experience of the sonographer, and the duration of the individual exams. Because of the complexity of each diagnostic situation, it is difficult to specify an allowable limit to the number of exams per day. Until better information is obtained, take into account the total examination time per day (more exams of shorter duration or fewer exams of longer duration).

Training

• Periodic training and reassessment regarding the above ergonomic interventions should include the following:

• Setting up the equipment, bed, and chair

• Modifying the equipment positioning during scanning

• Positioning patients

• Using adaptive equipment or devices, such as cushions and wedges and the patient's limbs for resting the elbows during scans

• Taking rest breaks during the procedures

•Maintaining good physical fitness and conditioning

• Optimal handling of specialized tests such as trans-vaginal examinations

• Having symptoms promptly evaluated by a licensed health care provider

(Source: Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. "Workplace Solutions: Preventing Work-Related Musculoskeletal Disorders in Sonography," September 2006. Available online at www.cdc.gov/niosh/docs/wp-solutions/2006-148.)

In late 2006, the National Institute for Occupational Safety and Health (NIOSH) issued a "Workplace Solutions" paper addressing MSI and sonography, an action Baker says is notable.

"The NIOSH publication is important in that as a profession, we believe, there are 100,000 to 125,000 sonographers practicing in the United States, so by size, on a national scale our profession probably wouldn't hit anyone's radar screen. We're not as large a profession as nurses, or teachers," Baker points out. "But we're grateful that NIOSH looked beyond the number in our profession and looked at the percentage within the profession that is injured, and that's when sonography got NIOSH's attention for high incidence of injury." *(See box on page 19 for NIOSH's guidelines for reducing MSI.)*

In pain half their careers

Butler says that the studies conducted prior to the 2003 consensus conference showed that the average respondent to the surveys had been a sonographers for 11 years, and that those who reported having worked with pain or injury (approximately 80%) said they had been suffering the discomfort for about five years.

"So we can say that those who have been suffering discomfort have been in pain for half of their careers," she says.

And while it would have made for a simpler fix if the studies had pinpointed one or two causes for the pain, the data showed "a very multifaceted problem," Butler adds.

NIOSH says sonographers are at risk for developing work-related musculoskeletal disorders such as inflammation of the tendons (tendonitis) or tendon sheaths (tenosynovitis), bursitis, muscle strains, and pathology of the nerves in the upper extremities, neck, and back.

The causes include gripping transducers too firmly (carpal tunnel syndrome); awkward postures and reaching (back and neck pain, bursitis, tenosynovitis, degenerative disc disease); pressure to the elbow from faulty workstation equipment (cubital tunnel syndrome); and other fault workstation equipment or use of equipment (eye strain).

"Once you realize the problem, you have to turn to education," Baker says. "Obviously, [sonographers] know they are having this trouble, but don't know a way out of it, so what we — SDMS and others — have been doing all we can to educate sonographers on risk factors for injury and how to minimize them."

Equipment manufacturers have been involved in efforts to reduce the incidence of MSI since the 2003 consensus conference.

"Redesigning equipment is very expensive, so manufacturers need to know it will impact customers worldwide, so the result of the studies [which included sonographers from around the world] made it possible for them to see the scope of what they are dealing with," she says. Consequently, manufacturers participated in drafting the industry standard.

Finally, SDMS is working with schools to teach new sonographers how to avoid some of the MSIs experienced by those already out of school and working.

"We want to teach them the right way to do it, but that is hard because their teachers don't always work the right way themselves," Butler points out. ■

For more information

- Consensus Conference on Work-Related Musculoskeletal Disorders in Sonography. Society of Diagnostic Medical Sonography; May 13-14, 2003. Notes available online at www.sdms.org/msi.
- Joan P. Baker, MSR, RDMS, RDCS, FSDMS, director of marketing and partner, Sound Ergonomics LLC, Kenmore, WA. Phone: (877) 417-8151.

Chick-fil-A president drives employees to run marathon

Emphasis on fitness impacts job performance

There are employers who grudgingly agree to employee wellness and health initiatives, and then there's Chick-Fil-A restaurant president Dan Cathy, who recruited 202 employees to train for and run in the Walt Disney World Marathon and Half-Marathon with him in January.

"When leadership on top rallies the troops, that's when everything happens," says exercise physiologist **Elizabeth David**, wellness director for Chick-Fil-A, a family-owned, Atlanta-based chain of more than 1,240 chicken restaurants.

"[President Dan Cathy] ran the Disney marathon in January 2006 with his son and two friends, and he came back and said, 'Elizabeth, I want 100 people to run the marathon with me

next year," David recalls.

"I said, 'Yes, sir,' and then I thought, 'Oh my goodness, how are we going to do this?'"

That Cathy's wish for 100 employees to run the marathon was met and doubled comes as no surprise to David. Wellness — or "wholeness," as Chick-Fil-A calls it — is a theme integrated throughout the company's relationship with its employees and franchise operators.

"Chick-Fil-A cares so much about their employees, and about every aspect of their lives," David explains. "It's everything — exercise, financial health, and relationships."

Corporate culture of wellness

David came to work as the company's wellness director in 2004, when Chick-Fil-A partnered with Cooper Aerobic Centers. At first a one-person operation, the wellness program now employs three full-time and three part-time employees, including a registered dietician/nutritionist and a physiologist.

A 2,000 square-foot exercise facility gave way in 2005 to a 12,000 square-foot center designed "to create an environment so irresistible that it leads to a healthy lifestyle," she explains.

That gave the 600 employees in the Atlanta area motivation and resources, but what of the other 50,000 nationwide?

"Our challenge is getting out across country. . . how to motivate nationwide," David says. "This marathon was our first big push nationwide."

The marathon was the centerpiece event of the "2006 Mooooove Challenge," a campaign to get Chick-Fil-A employees and their families to commit to getting cardiovascular exercise by setting goals of entering local athletic events (walks, 5K races, bike races). Employees anywhere in the country access the program via a website with resources, training hints, and links to wellness staff.

"We're working on more ways to reach them," David adds. "A newsletter that's not read won't motivate anybody."

The marathon idea motivated employees company wide, even if they did not work toward entering the race.

"Everyone who participated [in the Mooooove Challenge] had to implement changes in their lives, and to hear people tell about losing 40 or 50 pounds, their blood pressure decreasing, their children and spouses more active — it's easy to see that this has greatly affected their lives," says David.

What motivates Cathy is a deep religious faith (Chick-Fil-A restaurants have always closed on Sundays so that employees could spend the day with their families and attend church) and a more practical goal.

"It's like when you know your parents love you and care for you, you will do everything you can to show your parents you appreciate and care for them," David explains. "We have something like a 97% retention rate for employees in the home office. Everyone who works for the company feels very appreciated, and when that is the case, it's paid back by the performance of the employee." ■

Source

• Elizabeth David, exercise physiologist, Chick-Fil-A, Inc. Address: 5200 Buffington Road, Atlanta, GA 30349. Phone: (404) 765-8038. Email: elizabeth.david@chick-fil-a.com.

Bloodborne pathogens, breathing issues 2007 target

The Association of Association of Occupational Health Professionals in Healthcare (AOHP) will take on bloodborne pathogen exposure, safe patient handling, and respiratory protection as its public policy issues for 2007 through 2009. AOHP membership named the three topics as the top public policy issues of concern to them in the coming two years.

Bloodborne Pathogen Exposure — AOHP advocates for a policy in which individual states remove the current statutory requirement for special written consent for HIV testing, so that exposure source testing in the case of a blood or body fluid exposure involving a health care worker can be expedited. AOHP will continue to push for safer sharps policies. The association says 57 health care workers in the United States have been documented as having seroconverted to HIV following occupational exposures, and of those, 26 have developed AIDS. Another 140 are reported with possible, though unconfirmed, seroconversion.

Timely testing of the source patient can shorten the time that HIV anti-viral prophylaxis is needed, eliminate the need for follow-up testing,

and reduce the level of worker anxiety over the exposure, according to AOHP.

Safe Patient Handling — AOHP supports the use of lift/assist devices as the primary method for the prevention of back injuries, and calls for mechanical equipment to be provided for patient lifts, transfers, and repositioning.

Back injuries and other musculoskeletal disorders related to patient handling are the leading cause of workplace disability for nurses and other direct patient care providers. Each year approximately 40,000 nurses report illnesses from back pain, representing more than three-quarters of a million lost workdays annually due to back injuries among nurses, and lifting is the cause for many of those injuries and lost workdays, according to AOHP.

Respiratory Protection — AOHP will advocate, during the next two years, for increased research, training, and education relating to respiratory protection from tuberculosis and other airborne respiratory transmissible diseases. Efforts will be directed toward enforcing, at the state and federal levels, regulations requiring annual respirator fit testing and training. ■

(For more information on AOHP and its two-year policy platform, visit www.aohp.org.)

Soap and water still a good way to clean hands

New products like antibacterial soap and hand sanitizers clamor for attention, but plain old soap and water is still a good way to clean hands, according to the *Harvard Health Letter*.

In studies reported in the January 2007 issue, washing hands with soap and water for 15 seconds reduces bacterial counts by about 90%. But the authors note that even people who are conscientious about washing their hands often make the mistake of not drying them properly — wet hands are more likely to spread germs than dry ones.

Today, almost half of the hand soaps on the market have an antibacterial additive, and debate continues as to whether use of antibacterial soaps is worsening the problem of antibiotic resistance. Even if antibiotic resistance weren't an issue, results from studies suggest that antibacterial soaps available to consumers don't add much to hand hygiene. The findings are a useful reminder that antibacterial soaps aren't the all-purpose germ fighters that many people think they are.

Alcohol-based hand sanitizers have the advantage of not requiring water or towels, but shouldn't be relied on as the only cleanser in a health care setting, the authors say. To be effective, the rubs need to come into contact with all surfaces of your hands. For that reason, the Letter report states, studies have shown that using small amounts is really no better than washing with plain soap and water. ■

Poll: Nurses take top spot for ethics, honesty

Americans continue to consider nurses the most honest and ethical of professionals, according to a 2006 Gallup poll. The annual poll on professional honesty and ethical standards has seen nurses take the No. 1 spot for eight consecutive years. Pharmacists ranked second in the poll, and physicians ranked fourth. In order, the professions ranked the top 10 in terms of honesty and ethics were nurses, pharmacists, veterinarians, physicians, dentists, engineers, college teachers, clergy, policemen, and psychiatrists. The lowest-rated professions tended to be those connected with sales or big business, along with lawyers, elected officeholders, and news reporters.

"It is humbling for nurses to again be rated so highly for honesty and ethical behavior," said **Pamela Thompson**, CEO of the American Organization of Nurse Executives. "I believe this is an example of the remarkable connection nurses have with the public whom they serve, and a validation to nurses for the values that underscore their practice." ■

Joint Commission changes name

The Joint Commission on Accreditation of Healthcare Organizations has launched a new brand and logo, and is now known

simply and formally as The Joint Commission. In announcing its new identity, The Joint Commission says the new brand reflects the accreditation board's continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care. The "Jayco" extranet also has a new name — The Joint Commission Connect. For more information, visit the website at www.jointcommission.org. ■

Nanotechnology poses occ health challenges

Workers are 'canaries in a coal mine,' expert says

Workers are "canaries in the coal mine" when it comes to the potential health, safety, and environmental effects of nanoscale materials, which are considered by many in the occupational health field as a high priority for concern due to the lack of knowledge about the microscopic particles. This is the warning from **Andrew Maynard**, PhD, chief scientist of the Woodrow Wilson Center's Project on Emerging Nanotechnologies (www.nanotechproject.org).

"The good news is that international concern over how to ensure safe nanotech workplaces has resulted in some progress," Maynard says. "The bad news is that critical questions about worker safety — and about broader environmental, human health, and safety issues — remain unanswered."

The work of Maynard and colleagues in nanotechnology research appear in a *Journal of Nanoparticle Research* special issue, published in January 2007 as a special journal issue devoted to nanoparticles and occupational health. (Available at www.springerlink.com/content/p13817kll818.)

Areas of specific progress that Maynard and his coauthors highlight in their article include new instrumentation capable of better measurement of airborne nanostructured particles, innovative ways of controlling exposure to airborne nanoparticles, and the effectiveness of filters in removing nanometer-diameter particles from the air.

Nanotechnology is the ability to measure, see, manipulate, and manufacture things usually between 1 and 100 nanometers. A nanometer is 1 billionth of a meter; a human hair is roughly 100,000 nanometers wide. In less than a decade, nanotechnology is predicted to result in $2.6 trillion in manufactured goods annually. Already, there are almost 400 manufacturer-identified nanotechnology-based consumer products on the market, including computer chips, automobile parts, clothing, cosmetics, and dietary supplements. (A list is available at www.nanotechproject.org/consumerproducts.) The number of jobs

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. ■

COMING IN FUTURE MONTHS

- Employees with eldercare issues
- Color-coding bridges language barriers
- EAP by phone
- Eye protection update

involved in making nano-enabled products will rise from about 50,000 today to more than 10 million in 2014, nanotechnology research indicates.

"Greater resources and attention are needed now on nanotechnology occupational health and safety research in order to ensure safe nanoworkplaces today and in the future," Maynard says. ■

Bonus Book

FREE White Paper for you!

AHC Media appreciates the faith you have placed in us to provide you with practical, authoritative information. As a token of our gratitude for your support, we would like to provide you with the free white paper, The Joint Commission: What Hospitals Can Expect in 2007. From new National Patient Safety Goals to new standards to a new data management tool designed to help hospitals identify areas for improvement, 2007 is shaping up as a year of innovation and change for the Joint Commission on Accreditation of Healthcare Organizations and the facilities it accredits. This special paper is written specifically to explain the new standards so that you can plan appropriately.

To get your free copy of The Joint Commission: What Hospitals Can Expect in 2007, type in http://www.ahcmediawhitepaper.com into your browser, and follow the instructions.

Thank you again for subscribing! ■

CE *questions*

5. True or False. In occupational health nursing, both licensure and certification are required for practice.
A. True
B. False

6. According to a recent AAOHN member survey, which of the following is/are reason(s) that both male and female nurses seek to work in occupational health?
A. Availability of benefits such as dental, major medical, life, prescription drug, long-term disability, and short-term disability insurance
B. Employer-paid health insurance program premiums
C. Attractive salary and job stability
D. All of the above

7. To reduce the risk of musculoskeletal injury, sonographers are advised to do which of the following?
A. Maintain static postures throughout the day
B. Increase hand-grip pressure
C. Alternate the scanning hand and vary the grip used
D. Always sit during examinations

8. According to the Society for Diagnostic Medical Sonography, musculoskeletal pain or discomfort is reported in what percent of sonographers practicing in the United States?
A. 25%
B. 40%
C. 65%
D. 80%

Answers: 5. (b); 6. (d); 7. (c); 8. (d)