

FOR MORE THAN 25 YEARS

Hospital Employee Health®

Inserted in this issue: 2007 Reader Survey



IN THIS ISSUE

- **Safety first:** Report urges hospitals to protect HCWs from outbreaks even when transmission is uncertain cover
- **Pseudo-epidemic:** Hospital offers lessons on vaccination and flu preparedness 40
- **Tdap cost:** Despite its high cost, hospitals find value in vaccinating HCWs. 42
- **Smoke out:** 7 PA hospitals go 100% smoke-free 44
- **Extreme TB:** Extensively drug-resistant TB is 'practically untreatable' and poses new risks to HCWs. 45
- **Flu warning system:** CDC uses hurricane index to set community measures for pandemic influenza. 47
- **Inserted in this issue:**
— *The Joint Commission Update for Infection Control*

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

APRIL 2007
VOL. 26, NO. 4 • (pages 37-48)

SARS lesson: Err on side of infection control precautions to protect HCWs

Safety can't wait for science

Hospitals must act swiftly to protect health care workers from infectious diseases, even when the scientific evidence is unclear about transmission. Failing to do so put health care workers at greater risk during the emergence of severe acute respiratory syndrome (SARS) in 2005.

That is the conclusion of a stinging report from the SARS Commission in Ontario, Canada, with direct implications for preparedness for pandemic influenza. Safety should have superceded the debates over the use of N95 respirators vs. surgical masks, aerosol vs. droplet spread, and the need for fit-testing, concluded Ontario Superior Court Justice Archie Campbell, who served as commissioner of the Commission to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome (SARS).

Two nurses and a doctor died in the 2003 Ontario outbreak and 45% of the 375 probable cases were among health care workers.

"The point is not who is right and who is wrong about airborne transmission," wrote Campbell. "The point is not science, but safety. Scientific knowledge changes constantly. Yesterday's scientific dogma is today's discarded fable. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today."

"We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty. Until this precautionary principle is fully recognized, mandated and enforced in Ontario's hospitals, workers will continue to be at risk."

Campbell also endorsed stronger worker safety regulation in hospitals, including more inspections.

Linda Haslam-Stroud, RN, president of the Ontario Nurses Association (ONA), lauded the report as a "wake-up call for the government and the employers in Ontario." It also has received attention in the United States as hospitals gear up their pandemic influenza plans.

"It's an excellent description of the state of health care worker health

NOW AVAILABLE ON-LINE! www.ahcmedia.com

For more information, contact (800) 688-2421.

and safety, not just in Canada but in the U.S.," says **Bill Borwegen**, MPH, occupational safety and health director for the Service Employees International Union (SEIU). "There are perennial issues that have not been adequately addressed."

Nurses need to trust in protections

Clearly, pandemic influenza differs from SARS in important ways. Surveillance is likely to detect the first human-to-human transmission of a novel flu strain before it reaches North America. And while the SARS outbreaks occurred in hospitals,

Hospital Employee Health® (ISSN 0744-6470), including **The Joint Commission Update for Infection Control** and **Bioterrorism Watch**, is published monthly by AHC Media LLC, 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: customerservice@ahcmedia.com. Web site: www.ahcmedia.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 AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

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). Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).

Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).

Managing Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).

Senior Production Editor: **Nancy McCreary**.

Copyright © 2007 by AHC Media LLC. **Hospital Employee Health®** is a trademark of AHC Media LLC. 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.



influenza spreads widely across communities.

But the lessons of SARS still apply. Nurses continued to work during the SARS epidemic, despite their fears of becoming ill or infecting their family members. Yet when a second wave of cases occurred after public health authorities claimed the outbreak was over — despite concerns raised by frontline nurses — nurses lost the sense of trust that they were receiving adequate protection, says Haslam-Stroud. The ONA has sued the government of Ontario for failing to enforce health and safety standards at hospitals.

"The nurses in Ontario have very clearly said, 'You provide us the protection we need or we are not going to put our lives and our families' lives at risk [during pandemic influenza],' " she says. "We have learned the hard way with SARS that the government and employers unfortunately didn't take our protection as seriously as they should have."

U.S. nurses also are concerned about their protection from infectious diseases. Less than half (48%) of employees would be willing to report to work during a SARS outbreak, according to a survey of 6,428 workers from 47 health care facilities in the greater New York City area by researchers at the Mailman School of Public Health of Columbia University in New York. (**See Hospital Employee Health, November 2005, p. 139.**)

Yet health care workers did continue to work in Toronto, even as their colleagues succumbed to the illness. "I was amazed by the response of health care workers, mostly nurses, to step up to the plate and care for patients in the face of danger," says **Donald Low**, MD, FRCP, chief of microbiology at Mount Sinai Hospital, who was involved in the SARS outbreak containment. "It was not only in the early days of SARS, but also after there was thought to be transmission through precautions."

Still, the SARS experience may make health care workers wary if they felt they weren't adequately protected, Low says. Frontline workers need to be involved in the development of policies and procedures that would be used during future outbreaks of an emerging infectious disease, he says.

Employee health and infection control professionals will need to address this legacy of SARS as they plan for pandemic influenza, employee health experts say. "If [health care workers] don't feel that they're protected at work, if they think for a minute they'll take this home [to their families], they won't come to work," says **Gabor Lantos**, MD, PEng, MBA, president of

Occupational Health Management Services in Toronto.

Some hospitals failed to fit-test

Low acknowledges that mistakes were made in Toronto hospitals, particularly the failure to realize the importance of fit-testing the N95 respirators. But he insists that "the protection of all health care workers was taken seriously right from the beginning."

In fact, Toronto hospitals had consumed the available supply of N95s, he says. "If the outbreak had gone on any longer, there wouldn't have been any more to buy," he says. "We literally bought the last shipment."

When health officials realized that illness was spreading from a novel virus, the hospital immediately began using personal protective equipment and isolating patients in a negative pressure room.

But there was a delay in detecting the first cases and understanding their significance. The first Toronto victim of SARS flew home on Feb. 23, after staying in the Hong Kong Metropole Hotel, later identified as the site of global spread. A physician from Guangdong Province in China who had treated patients in an outbreak of atypical pneumonia was a fellow hotel guest — and he was ill.

"Mrs. K" developed a high fever and dry cough, and when she died at home in Toronto on March 5, her cause of death was listed as heart attack. Her son soon became ill, and he was brought to Scarborough Grace Hospital on March 7 by ambulance. (Two patients in the emergency department subsequently developed SARS.)

However, no one yet connected this illness to the "atypical pneumonia" that China had reported or the outbreak in Hong Kong. "Mr. T" was not isolated until 21 hours after he arrived in the emergency department. In fact, even the following days, the hospital was slow in implementing the highest level of infection control measures, says Low.

"When it was recognized on March 13 or March 14 that we had a problem because of what happened in Hong Kong and what was going on in Hanoi (where SARS spread), that's when the alert should have been sounded," he says. "It was difficult convincing people that we had a big problem on our hands here."

On March 25, Scarborough Grace Hospital was shut down because of the SARS outbreak and on March 26, Toronto hospitals went into a Code

Orange, suspending nonessential procedures, restricting visitors, sending home administrative staff, and putting nurses on a work-home quarantine. Everyone still working in the hospitals wore gowns, gloves and N95s.

Meanwhile, infection control had received little attention and few resources prior to the SARS outbreak, and provincial laws on fit-testing were ignored, the SARS commission reported. Even during the SARS epidemic, some infection control practitioners continued to argue that the disease was spread by droplets and N95s were not necessary except during aerosol-producing procedures, the commission reported.

The SARS commission report questions the distinction between airborne and droplet spread, but says that scientific debate shouldn't dictate safety precautions. "The real problem is not the N95 respirator but the deep structural contradictions in hospital worker safety. These problems include a profound lack of awareness within the health system of worker safety best practices and principles," it says.

Today, Mount Sinai Hospital fit-tests employees annually, as do other Toronto hospitals. Throughout the province, new investments have been made in infection control and public health. "There is no question that there have been lessons learned and people are taking that to heart," Low says. "It's refreshing to see that kind of interest in public health and infection control again."

Outbreak averted in B.C.

One other lesson of SARS comes from Vancouver, where a prevailing culture of safety prevented a potential outbreak, the SARS commission concluded.

"Mr. C" had stayed in the Metropole Hotel, then visited Indonesia before returning to Vancouver on March 7. He was sick on the plane and went directly from the airport to the emergency department at Vancouver General.

He was immediately isolated in a curtained cubicle where beds are at least 2.5 meters from other patient beds. Within 15 minutes, he was placed on full respiratory precautions. Within 2½ hours, he was placed in a negative pressure room.

Vancouver had the advantage of more information about the spread of an atypical pneumonia in Asia. The hospital had a policy of using the highest level of precautions with an undiagnosed respiratory illness until there is further information, the report said.

British Columbia also had developed a pandemic influenza plan, which played a key role in preventing the spread of SARS, the commission report stated. The Workers Compensation Board issued guidelines on how to protect health care workers and conducted inspections of hospitals to make sure they were being carried out.

Only one nurse contracted SARS in Vancouver, and there was no nosocomial spread to patients or visitors.

"SARS taught us that we must be ready for the unseen," Justice Campbell concluded in his report. "That is one of the most important lessons of SARS. Although no one did foresee and perhaps no one could foresee the unique convergence of factors that made SARS a perfect storm, we know now that new microbial threats like SARS have happened and can happen again."

"However, there is no longer any excuse for governments and hospitals to be caught off-guard and no longer any excuse for health workers not to have available the maximum level of protection through appropriate equipment and training," he continued.

(Editor's note: The SARS Commission report is available at www.sarscommission.ca/report/index.html.) ■

Lessons from 'the pertussis epidemic that wasn't'

Dartmouth responded to pertussis scare

When a day care worker reported to employee health at Dartmouth-Hitchcock Medical Center in Lebanon, NH, with a severe, spasmodic cough that had lasted more than two weeks, an employee health nurse immediately thought of pertussis.

A lab worker reported similar symptoms, and soon there were other cases of concern. Some of them tested positive using PCR tests. The hospital posted advisories about respiratory hygiene and began screening employees and visitors for symptoms. The number of suspected cases rose, many of them conforming to the classic case definition for pertussis.

Within the next few months in the spring of 2006, the employee health department evaluated about 1,700 health care workers — 1,100 of them within a two-week time frame. With help from volunteer nurses and physicians, they administered

3,599 Tdap vaccines, which had recently been approved by the Food and Drug Administration, covering 72% of the hospital staff in mass immunizations. They gave out 1,364 treatment doses of azithromycin and the lab performed 1,041 PCR tests.

Employees were furloughed, home sick, or working with masks, while the hospital canceled some elective procedures and closed beds.

The efforts were a tremendous success: Dartmouth-Hitchcock effectively controlled a respiratory disease outbreak. But months later, the medical center received some stunning news. Not a single case of pertussis could be confirmed by culture, and only one case was confirmed through other testing. The New York Times dubbed it "the epidemic that wasn't."

The episode provides some important lessons for pertussis control, outbreak response, and pandemic influenza preparedness. While Dartmouth-Hitchcock hopes to fine-tune its response capabilities, the best decisions were made given the available information, says Robert K. McLellan, MD, MPH, FACOEM, medical director of Dartmouth-Hitchcock employee health and president-elect of the American College of Occupational and Environmental Medicine (ACOEM).

When faced with an outbreak that could prove fatal to vulnerable patients, as pertussis is for infants, occupational health and infection control must work together to implement swift and aggressive controls, he says.

"We're not just talking about a day or two of lost work [for employees]," he says. "We're talking about death as a potential outcome [for some patients]. As a team, we wanted to take this very seriously," says McLellan, who also is chief of the occupational and environmental medicine section at Dartmouth Medical School.

Why you should vaccinate HCWs

The Dartmouth case points out the benefits of pertussis vaccination of health care workers. While other respiratory diseases can cause severe cough, vaccinated employees would be much less likely to acquire pertussis. (The vaccine is about 85% effective.) That would shape decisions about outbreak control measures, says McLellan. (For more on how hospitals are handling pertussis vaccination, see related article on p. 42.)

But without vaccination, occupational health and infection control professionals must rely on

imperfect diagnostic tests.

Culture is the “gold standard” for detecting *Bordetella pertussis*, but pertussis is notoriously difficult to grow in culture. “In a medical center where infants may be at risk, you can’t wait two weeks to make decisions about how to manage it,” says McLellan.

Dartmouth-Hitchcock relied on the swifter PCR test to detect pertussis DNA. “The PCR test has the advantage of being rapid and sensitive. It can detect a small number of organisms being present,” says **Elizabeth Talbot, MD**, New Hampshire deputy state epidemiologist. “However, the PCR is not a standardized or FDA-approved method. There are many different approaches to conducting the PCR test.”

“What happened at Dartmouth-Hitchcock is not an isolated event. There are other settings that have struggled with making accurate rapid diagnosis of pertussis,” she says.

Dartmouth-Hitchcock acted appropriately, under the circumstances, Talbot says. “We’re forced to make a decision about the intervention before the diagnostics return a clear answer,” she says.

Occ-health needs surge capacity

Perhaps more importantly, the respiratory disease outbreak served as a real-life drill for pandemic influenza. Lesson learned: Hospital employee health will need surge capacity.

It was possible to manage symptom screening, illness evaluation and treatment, mass immunization, employee furlough and a respiratory hygiene program for thousands of employees in a short time-frame — but only with help from nonoccupational health nurses and physicians, says McLellan.

About 55 physicians offered to help and needed just-in-time training on occupational health protocols, he says. The hospital now is considering this as a part of an all-hazards approach — designing its emergency preparedness with just-in-time training of physicians that can be assigned to occupational medicine. “Much of the care could be routinized and any physician could be brought up to speed, but they need to be trained and provided a protocol,” McLellan says.

Occupational health needs to work closely with infection control, human resources, and safety to provide a framework for outbreak response. That team, in conjunction with hospital administrators, would form a Hospital Incident Command Structure with the authority to trigger the emergency response and assign doctors and

nurses to help occupational health, he says.

“When people think about managing a pandemic, the traditional public health planning focuses on how to take care of the community,” McLellan says. “[But] how are we going to take care of our staff? There is a huge need for staff surge and just-in-time training of people who will suddenly become occ health deputies.”

The pseudo-outbreak of pertussis also raised some potentially troubling issues about the employees’ approach to working while sick or on furlough after an exposure. Dartmouth-Hitchcock was able to send sick employees home after a symptom screen. But he notes, “We found that some employees we sent home because we thought they shouldn’t be in patient care environment were working in other health care environments.”

The Department of Health and Human Services guidelines for community mitigation in pandemic influenza call for people to stay home if someone in their household is sick during a pandemic or if they have been exposed. (**See related article on p. 43.**) What will that mean for health care workers?

“How are we going to retain employees in a setting of massive health care worker shortages, if we send them home but they’re actually capable of working?” asks McLellan.

Pandemic plans will need to consider such issues, as well as child care, pet care and elder care, he says. Policies will need to address how and when to conduct symptom screening and to send sick employees home. For example, employee health and infection control professionals may decide to allow symptomatic health care workers who are taking antiviral medications to work with cohorted influenza patients.

What sickened the HCWs?

If it wasn’t pertussis at Dartmouth-Hitchcock, what was it? “Most likely this was a potpourri of different respiratory pathogens, most likely viral,” says McLellan. Still, the symptoms were severe, he notes.

Dartmouth asked CDC to assist with the outbreak investigation and follow-up on the initial lab work. Of 134 suspect cases, 98 had been identified as pertussis by PCR and 36 by the classic case definition. When none of the cases resulted in a positive culture, Dartmouth asked for volunteers to have their blood drawn for serology testing. Of 39 serology cases, only one showed a moderate level of anti-pertussis antibodies.

CDC repeated PCR tests using two DNA targets

and found only one positive, says **Katrina Kretsinger**, MD, CDC medical epidemiologist. "Pertussis may have been circulating, but we don't believe that pertussis was the etiology of most of this illness," she says. The episode points out the need to improve diagnostics for pertussis, she says.

Meanwhile, Dartmouth managed to control a respiratory disease outbreak that had severe symptoms. "It was definitely an outbreak, it just wasn't an outbreak of pertussis," she says. "It showed that isolation, work furlough and improved infection control processes can halt respiratory illness outbreak of diverse cause."

It underscored the effectiveness of basic infection control procedures. "CDC's 'ask-for-a-mask' respiratory hygiene and cough etiquette campaign is so appropriate for so many diseases," says Talbot. ■

Coping with the cost of pertussis vaccine

Hospitals begin widespread vaccination

Hospitals are wrestling with the cost of complying with recent guidelines from the Centers for Disease Control and Prevention in Atlanta on pertussis vaccination of health care workers.

The CDC recommends vaccinating health care workers who have direct patient contact "as soon as feasible" if it has been at least two years since their last tetanus booster. Other health care workers should gradually receive the acellular pertussis vaccine (known as Tdap) as their tetanus booster, the CDC says.¹ The vaccine also contains tetanus and diphtheria toxoids, similar to the Td booster vaccine.

While many hospitals have not routinely paid for tetanus boosters for their staff, the CDC advises that Tdap should be offered free of charge. It costs about \$30 per dose.

"It just requires planning, and it requires having the support of your administration," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic in Nashville, who estimates that Vanderbilt will spend \$90,000 to vaccinate medical center and university employees. "We began planning for this when we first heard it was going to be approved. We put it in as a special budget proposal nine months before the upcoming fiscal

year," she reports.

A cost-benefit analysis showed that for every dollar spent on Tdap vaccination, hospitals would save \$2.38, based on the costs of controlling an outbreak, says **Katrina Kretsinger**, MD, medical epidemiologist and lead author of the CDC recommendations. "Vaccination can avoid a lot of problems with outbreaks in health care settings and all the costs those entail," she says.

Many hospitals did not previously provide routine tetanus vaccines to their employees because it is not considered an occupational risk. However, studies show health care workers are at higher risk for pertussis than the general population, making the vaccine a benefit both for employee health and patient safety. Adacel, manufactured by sanofi pasteur in Toronto, has been approved for adults ages 19 to 64. (**See summary of CDC recommendations on p. 43.**)

Protecting vulnerable patients

Most importantly, the cost of pertussis vaccination is weighed against the risk to vulnerable patients, particularly infants. CDC recommends prioritizing the vaccine by providing it first to health care workers who care for infants.

About 19% of pertussis cases and 92% of deaths occur among infants younger than one year old, the CDC reported. Infants receive the pertussis vaccine at 2, 4, and 6 months of age. "Until infants have finished those doses, they're quite vulnerable," Kretsinger says.

Because of concerns about the impact of a pertussis outbreak on vulnerable patients, some hospitals are considering making the Tdap vaccine mandatory. The American College of Occupational and Environmental Medicine has recommended vaccinating health care workers with direct patient contact "as soon as feasible," but did not address whether it should be voluntary or mandatory. (See www.acoem.org/guidelines.aspx.)

"There was a fatality in our system of a 5-month-old child," says **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic. "It didn't come from a health care worker. But that's enough incentive to me right now that we should make it mandatory," he adds.

There are some practical reasons why hospitals have not yet made the Tdap vaccine mandatory. With a sudden surge in demand, hospitals have received limited supplies. For example, Vanderbilt has received 1,000 doses a month for employees

and patients. It will take about 1,500 doses to cover employees who work in high-risk areas, such as obstetrics and pediatrics, estimates Swift. The university and medical center have about 20,000 employees.

"We are strongly encouraging health care workers in our children's hospital to participate," she says.

Preventing Pertussis in Health Care Workers

The Centers for Disease Control and Prevention offers this guidance for diagnosing and preventing pertussis among health care workers:

Clinical Case Definition:

A cough illness lasting at least two weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or posttussive vomiting, and without other apparent cause (as reported by a health care professional).

Laboratory Criteria for Diagnosis:

Isolation of *Bordetella pertussis* from a clinical specimen, or positive polymerase chain reaction (PCR) assay for *B. pertussis*.

Recommendation:

Health care personnel in hospitals and ambulatory care settings who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap. An interval as short as two years because the last dose of Td is recommended. Other HCP should receive a single dose of Tdap according to the routine recommendation; they are encouraged also to receive Tdap at an interval as short as 2 years. Priority should be given to vaccination of HCP who have direct contact with infants aged <12 months. Hospitals and ambulatory care facilities should provide Tdap for HCP and use approaches that maximize vaccination rates

Contraindications:

- History of serious allergic reaction (i.e., anaphylaxis) to vaccine components.
- History of encephalopathy (e.g., coma, prolonged seizures) not attributable to an identifiable cause within seven days of administration of a pertussis vaccine.

Precautions and reasons to defer Tdap:

- Guillain-Barré syndrome < six weeks after a previous dose of a tetanus toxoid-containing vaccine
- Moderate to severe acute illness
- Unstable neurological condition
- History of Arthus hypersensitivity reaction to a tetanus toxoid-containing vaccine administered <10 years previously. ■

Yale-New Haven (CT) Hospital had planned to offer the Tdap vaccine in the fall along with the flu vaccine but was unable to receive sufficient supplies, says **Mark Russi, MD**, director of occupational health. Instead, employees are receiving the Tdap vaccine with their annual tuberculin skin testing, he says.

Do vaccinated HCWs shed virus?

Although the vaccine is considered to be about 85% effective at protecting health care workers from acquiring pertussis, there are not yet any data on whether exposed individuals could still shed virus. Therefore, CDC still recommends providing antibiotic prophylaxis to health care workers who are exposed to pertussis.

Vanderbilt is participating in a study to determine how to respond to pertussis exposures of vaccinated workers. Vaccinated employees will be randomized to receive either placebo or antibiotics after a pertussis exposure, says Swift.

"They'll be rigorously tested after the exposure to see if they're shedding pertussis and asked about symptoms on a daily basis," she says. "If they have symptoms of pertussis, they are removed from the workplace and placed on antibiotics for treatment."

If hospitals can forgo giving antibiotics after an exposure, that could represent a significant cost savings. Almost 500 employees have been exposed to pertussis in the past three years at Vanderbilt, Swift says.

"We typically see from 12-20 events where a patient exposes multiple health care workers each year," she says. "Every time there's an exposure, we contact all of the exposed health care workers, we interview them, and we prescribe them antibiotics to prevent them getting pertussis."

In its vaccination recommendations, CDC provides some leeway for hospitals that want to avoid antibiotic prophylaxis of vaccinated employees. Daily monitoring of health care workers for signs and symptoms for 21-28 days after exposure "might be a reasonable strategy for post-exposure management," CDC says, noting that hospitals should "maximize efforts" to prevent transmission to infants or other vulnerable patients.

"Hospitals can choose to modify their post-exposure prophylaxis guidelines based on their best judgment and risk assessment," Kretsinger says.

Reference

1. Centers for Disease Control and Prevention. Preventing

tetanus, diphtheria, and pertussis among adults: Use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine. MMWR 2006; 55(RR17):1-33. ■

Smoke-free zone: Seven hospitals band together

No smoking at Bucks County, PA, campuses

The air is clear in public buildings, restaurants, and even many bars across America. So why should anyone light up even within a few steps of a hospital?

The seven hospitals in Bucks County, PA, decided that no one should — and they collaborated to become completely smoke-free. By July 4, employees, visitors, patients, vendors and contract workers will be prohibited from smoking anywhere on hospital property.

"Smoking causes so many diseases and so many preventable illnesses, we're making a statement to the community that we're walking the walk and talking the talk," says **Lynn Martinsen, MPH, CHES**, health risks program manager for the Bucks County Health Improvement Partnership in Langhorne, PA. "We should not allow people on the property to smoke."

"You shouldn't have an employee sitting outside smoking a cigarette while a newborn is being discharged and having their first exit to the world walking through a cloud of smoke," she says.

The Bucks County Health Improvement Partnership is a collaboration that began 14 years ago as a way to address health needs in the county. The CEOs meet regularly, and seven task forces address needs that have been identified in the community. For example, the hospitals support a clinic that provides free services in a disadvantaged part of the county. The partnership also launched a "Hearts and Soles" campaign to promote lifestyle changes to reduce the risk of heart disease and stroke.

So taking on smoking seemed a natural measure for the hospitals. They already restricted smoking to a designated area or smoking hut on the premises.

The new policy goes farther: "There will be no smoking on any property owned by any one of the seven hospitals. That includes vehicles. Employees no longer will be able to smoke within any vehicle owned by any one of the seven hospitals," explains Martinsen.

By coordinating their programs, the hospitals were able to increase awareness and share ideas. They also are following the lead of hundreds of hospitals. According to Americans for Nonsmokers' Rights (www.no-smoke.org), more than 600 hospitals have 100% smoke-free campuses.

"Our hospitals are the largest employers in the county," says **Lambert Tolbert, MEd, TSP** [tobacco smoke pollution] coordinator for the Bucks County Tobacco Control Project in Warminster, PA, which worked with the partnership on its efforts. "We hope to use [the initiative] to move [smoke-free policies] along in Bucks County."

Listening to smokers

The hospitals were resolute about their smoke-free plans — but they were also sensitive to the employees who smoke.

St. Luke's Quakertown Hospital, the first to go completely smoke-free, informed employees in May 2006 that the campus would be smoke-free as of Jan. 1, 2007. Some nonsmoking employees had actually been asking for the policy, which prevents employees from walking outside on their breaks to smoke in the parking lot or near entrances.

The hospital held a focus group and obtained feedback from smokers as the smoke-free plans were unveiled. The hospital's medical director, a former smoker, helped lead the meeting.

"Of course, the smokers were concerned," says **Shelley Maley**, director of human resources. "They felt their rights were being violated. They weren't happy about it. But they did say, if this is a rule, we'll follow it. We told them, 'If you don't want to quit smoking, you don't have to. But you can't smoke at work.'"

The hospital offered smoking cessation classes and promoted the policy at an employee health fair that coincided with the Great American Smoke-Out, an annual national campaign to promote smoking cessation sponsored by the American Cancer Society. On the menu: A "cold-turkey" lunch.

St. Luke's Quakertown also launched a marketing campaign, with signs at every entrance and on every trash can reminding visitors and employees of the policy. The hospital used resources from the Michigan Smoke-Free Hospitals program, created by the University of Michigan Health System. (For more information, see checklist on p. 45.)

Effective communication, including training of midlevel managers, is the key to success of a new smoke-free policy, says **Linda A. Thomas, MS**, program manager for the Tobacco Consultation

A Checklist to Implement a Smoke-Free Environment

The University of Michigan Health System's Tobacco Consultation Service in Ann Arbor created this checklist for hospitals that want to become 100% smoke-free. It also offers a CD free of charge to assist hospitals in creating a smoke-free environment. It is available at www.med.umich.edu/mfit/tobacco/requestSFE.htm.

- 1. Announce top management's commitment to create a smoke-free environment.**
- 2. Assign responsibility and authority for coordinating the implementation of the SFE to an appropriate member of senior management.**
- 3. Create a task force to plan implementation of the new smoke-free environment.**
 - Include people who smoke, nonsmokers, former smokers and representatives of any officially recognized employee organization.
- 4. Develop a timetable. Set a specific date to be smoke-free.**
- 5. Gather information, including:**
 - The medical, economic, and social effects of smoking.
 - Smoke-free policies implemented by other organizations.
 - Facilities (e.g., physical constraints or leases with other organizations that may influence policy decisions).
 - Employees (percentage of nonsmokers and smokers, level of enthusiasm).
 - Existing smoking policy.
 - Legal issues (legislation, regulation, union contracts, and other contracts).

- 6. Draft the implementation plan to phase in the smoke-free environment. Have it reviewed and refined by the appropriate individuals and groups.**
- 7. Announce the policy and implementation plan to all employees through a letter from the chief executive officer.**
- 8. Educate employees, patients and guests:**
 - Training sessions for managers
 - Feedback sessions for employees
 - Company newsletter, paycheck inserts, all staff e-mails
 - Signs, displays, leaflets
 - Fliers in patient appointment reminders
 - Fliers/posters in waiting areas
 - Notices in present designated smoking areas
 - News releases to local media
- 9. Offer smoking cessation programs to employees and their families at least six months prior to implementation day.**
- 10. Obtain insurance coverage of at least one cessation drug.**
- 11. Have the pharmacy carry cessation pharmaceutical inventories.**
- 12. Make changes to facilitate the smoke-free environment.**
 - Install "Smoke-free Area", "Smoke-free Environment — No Smoking in this Outside Location", or "No Smoking" signs.
 - Remove ash receptacles.
- 13. Enforce the policy from day one.**
- 14. Evaluate and refine policy.**
- 15. Be flexible and patient.**

Service at the University of Michigan Health System, which went smoke-free in 1999.

After Jan. 1, other Bucks County hospitals became smoke-free in a staggered fashion. In addition to St. Luke's, the hospitals are: Grand View Hospital, Warminster Hospital, Doylestown Hospital, St. Mary Medical Center, Lower Bucks Hospital, and Frankford Hospital.

"Each one had to take a period of time to meet and decide on these factors and what to offer their employees [for smoking cessation]," says Martinsen.

As more hospitals become 100% smoke-free nationally, the policy becomes more easily accepted, says Thomas. "In 10 or 15 years, people will say, 'I can't believe they ever allowed smoking around hospitals,'" she says. "We're changing norms."

(Editor's note: Information about creating a smoke-free

campus is available at www.med.umich.edu/mfit/tobacco/freeenvironment.htm and www.no-smoke.org/goingsmokefree.php?id=449.) ■

Drug-resistant TB poses new threat to HCWs

Strain is 'practically untreatable'

An extensively drug-resistant strain of tuberculosis (XDR-TB) is virtually untreatable and poses a threat to worldwide TB control. Protecting health care workers from this new threat will require vigilant adherence to infection control principles, TB experts say.

Currently, the strain is extremely rare in the United States, representing just 3% of the 1.2% of TB cases that are reported to be multidrug resistant. Yet a recent outbreak in South Africa among HIV-infected individuals revealed its deadly potential: the TB strain killed 52 of 53 infected patients in a single rural hospital.¹

XDR-TB is defined as TB that is resistant to isoniazid and rifampicin, the preferred drugs to treat tuberculosis, as well as at least one injectable second-line drug (capreomycin, kanamycin, and amikacin) and one fluoroquinolone.²

"You can just imagine that [if] any health care worker would become infected with one of these extensively drug resistant organisms, there's a very good chance of having a form of TB that's practically untreatable," says **Reynard McDonald**, MD, medical director of the Global TB Institute at the New Jersey Medical School in Newark.

Only about 10% of those who are TB-infected eventually develop the disease, but the risk is highest for the immunosuppressed, including people who are HIV-positive, transplant patients, or taking steroids.

The infection control precautions used for XDR-TB are the same as for other strains, says **Peter Cegielski**, MD, MPH, team leader for drug resistant tuberculosis in the international branch of the Division of TB Elimination at the Centers for Disease Control and Prevention in Atlanta.

However, because of the potential risk, "individuals who are particularly susceptible might want to take measures to work in areas where they're less likely to come into contact with TB patients," Cegielski notes.

Health care workers should be educated about the risk of multidrug-resistant TB and XDR-TB and reminded of the importance of rapid TB diagnosis, protective measures, and treatment of latent TB infection, he says.

How would you treat a health care worker with a known exposure to XDR-TB? That would be a troubling question, says McDonald. "If they were involved in the management of someone who clearly had XDR-TB and they converted their skin test after coming into contact with that patient, you [might] think their tuberculin skin

test conversion was related to XDR," he says.

"... If they were immunosuppressed, you most certainly would want to try to give them protection, but what in the world would you use? There is no data to guide you about what is appropriate treatment for these individuals," he says.

Meanwhile, public health officials seek better

CNE questions

13. According to the final SARS Commission report in Ontario, Canada, what is the most important principle that should guide protection of health care workers?
 - A. The scientific principle of disease transmission.
 - B. The epidemiology of a specific outbreak.
 - C. Regulatory principles.
 - D. The precautionary principle of placing safety before scientific certainty.
14. Why did Dartmouth-Hitchcock Medical Center in Lebanon, NH, detect pertussis in samples that could not be confirmed?
 - A. Errors in the lab resulted in false positives.
 - B. PCR tests are not standardized and pertussis culture is difficult.
 - C. Samples became contaminated, producing incorrect results.
 - D. The hospital used the wrong test.
15. According to a cost-benefit analysis conducted by the Centers for Disease Control and Prevention, what is the net savings of pertussis vaccination?
 - A. \$2.38 saved for every \$1 spent on vaccination.
 - B. \$4.14 saved for every \$1 spent on vaccination.
 - C. Break even (\$1 saved for every \$1 spent).
 - D. Tdap vaccination results in no net savings.
16. According to Americans for Nonsmokers' Rights, about how many U.S. hospitals are 100% smoke-free?
 - A. 100
 - B. 300
 - C. 400
 - D. 600

Answer Key: 13. D; 14. B; 15. A; 16. D.

COMING IN FUTURE MONTHS

■ California edges toward airborne disease standard

■ Update on flu: Did declinations work?

■ MRSA and health care workers

■ Should you use random drug screening?

■ Reducing injuries with a 'safety huddle'

surveillance data on multidrug-resistant TB to help assess and monitor the spread of XDR-TB. "It's critical that health care workers fulfill their responsibility for ensuring that tuberculosis cases are reported properly, including the results of test for susceptibility," says Cegielski. "It appears that the data we have are incomplete."

Overall, tuberculosis in the United States is at its lowest level since reporting began in 1953. In 2005, there were 14,097 cases, or a rate of 4.8 cases per 100,000 people. Multidrug-resistant TB also has declined significantly since CDC and others began combating a resurgence of TB in the early 1990s. However, the decline in TB cases has slowed significantly in recent years.

XDR-TB now has been detected in 27 countries, including Canada, Japan and Norway, and the World Health Organization has convened a Global Task Force on XDR-TB.

"We need to be continue to be vigilant [regarding] tuberculosis in health care settings, both inpatient and outpatient," says Cegielski. "Individuals with prolonged cough — more than two weeks — should be treated as potentially infectious cases."

XDR-TB threatens to derail the public health goal of eliminating tuberculosis in the United States and globally. "Clearly, better drugs and newer drugs are urgently needed," he says.

References

1. Gandhi NR, Moll A, Sturm AW, et al. Extensively drug-resistant tuberculosis as a cause of death in patients coinfected with tuberculosis and HIV in a rural area of South Africa. *Lancet* 2006; 368:1,575-1,580.
2. Centers for Disease Control and Prevention. Notice to Readers: Revised definition of Extensively Drug-Resistant Tuberculosis. *MMWR* 2006; 55:1,176. ■

Pandemic warnings could trigger closings

CDC, OSHA set categories for flu planning

Even a mild pandemic could result in school closings, cancellation of public gatherings, voluntary quarantines, and absenteeism of employees who must leave work to care for children or elderly relatives, according to interim guidance on community mitigation released by the Centers for Disease Control and Prevention.

A new Pandemic Severity Index, modeled after

the hurricane warning system but using a case fatality ratio as its measure, will be used to designate what interventions are needed. A Category 5 pandemic would be similar to the devastating 1918 pandemic, with a projection of more than 1.8 million deaths.

Categories 2 and 3, the mildest pandemics, could trigger school closings and other interventions, based on the characteristics of a pandemic within a specific community, the guidance says. (Category 1 would be similar to a more severe form of seasonal influenza with fewer than 90,000 deaths.)

Meanwhile, the U.S. Occupational Safety and Health Administration set risk categories for workers and told health care workers what they already know: They are at the highest risk for occupational exposure.

Employers should plan now to have respiratory protection for those high-risk workers and should cross-train at least three people for each essential position to maintain services during a pandemic, says **Amanda Edens**, deputy director of OSHA's directorate of standards and guidance.

"Employers may experience employee absences as well as interruptions in supplies," Edens says. "We recognize that a severe pandemic in our country could have a devastating effect on our nation's work force."

OSHA's guidance mirrors that of CDC, but gears its information to employers with information on administrative, engineering and work practice controls that can help protect workers.

"We recognize that a severe pandemic in our country could have a devastating effect on our nation's work force," OSHA administrator **Edwin J. Foulke Jr.** said in a press conference.

While school closings, "social distancing,"

CNE 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

voluntary quarantines and other "nonpharmaceutical interventions" may be disruptive, they can slow a pandemic and lower the peak number of cases, said CDC director **Julie L. Gerberding, MD, MPH**.

"This is an important goal because it will help save lives and it will also decompress the burden a pandemic places on our hospitals," she said.

(Editor's note: The CDC guidance on community mitigation is available at www.pandemicflu.gov/plan/community/community_mitigation.pdf. OSHA's Guidance on Preparing Workplaces for and Influenza Pandemic is available at www.osha.gov/Publications/OSHA3327pandemic.pdf.) ■

CNE 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. ■

To reproduce any part of this newsletter for promotional purposes, please contact:

Stephen Vance
Phone: (800) 688-2421, ext. 5511
Fax: (800) 284-3291
Email: stephen.vance@ahcmedia.com
Address: AHC Media LLC
3525 Piedmont Road, Bldg. 6, Ste. 400
Atlanta, GA 30305 USA

To reproduce any part of AHC newsletters for educational purposes, please contact:

The Copyright Clearance Center for permission
Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400
Fax: (978) 646-8600
Address: Copyright Clearance Center
222 Rosewood Drive
Danvers, MA 01923 USA

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	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	
Kay Ball, RN, MSA, CNOR, FAAN Perioperative Consultant/ Educator, K&D Medical Lewis Center, OH	Gabor Lantos MD, PEng, MBA President Occupational Health Management Services Toronto
William G. Buchta, MD, MPH Medical Director, Employee Occupational Health Service Mayo Clinic Rochester, MN	JoAnn Shea MSN, ARNP Director Employee Health & Wellness Tampa (FL) General Hospital
Cynthia Fine, RN, MSN,CIC Infection Control/ Employee Health San Ramon (CA) Regional Medical Center	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
June Fisher, MD Director Training for Development of Innovative Control Technology The Trauma Foundation San Francisco General Hospital	



Sign up for free infection control weekly e-mail alert today

Subscribers to *Hospital Employee Health* can join the *Hospital Infection Control Weekly Alert* e-mail list now. This alert is designed to update you weekly on current infection control issues that you may deal with on a daily basis. To sign up for the free weekly update, go to www.ahcmedia.com and click on "Free Newsletters" for information and a sample. Then click on "Join," send the e-mail that appears, and your e-mail address will be added to the list. If you have any questions, please contact customer service at (800) 688-2421. ■



The Joint Commission Update for Infection Control

News you can use to stay in compliance

Achilles heel of hand hygiene: Monitoring HCW compliance

Joint Commission seeks best practices on difficult issue

The Joint Commission is trying to solve the Achilles heel of hand hygiene: monitoring compliance by health care workers. As part of its increasing emphasis on infection control, the The Joint Commission is seeking innovative and cost-effective methods to address adherence to hand hygiene guidelines.

"The [Joint Commission is] trying to prepare a monograph of best practices for measuring hand hygiene adherence," says leading hand washing expert **Elaine Larson**, RN, PhD, FAAN, CIC, a principal in the project and a professor of pharmaceutical and therapeutic nursing at Columbia University in New York City. "People around the country are having a horrible time trying to figure out how to monitor it. It is so expensive. You can't pay somebody to observe all the time. Nobody really knows the best way to do it."

The Joint Commission continues to make hand hygiene a national patient safety goal, requiring compliance with the evidence-based recommendations in the hand hygiene guidelines issued by the Centers for Disease Control and Prevention (CDC) in 2002. The problem many infection control professionals are having, however, is meeting this 1A recommendation in the CDC guidelines: "Monitor health care workers' adherence with recommended hand-hygiene practices and provide personnel with information regarding their performance."¹

To improve the situation, The Joint Commission is looking for proven methods and strategies for monitoring hand hygiene compliance. "They try to use CDC guidelines for their standards, and CDC recommends having some kind of a monitoring plan," Larson says. "People are just at a loss at how to do it in a sustainable, cost-effective way."

The results of the project will be published in a free, educational monograph that recommends

promising practices for measuring hand hygiene compliance. The monograph, planned for publication in early 2008, will be the culmination of an 18-month project by the Joint Commission, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiology of America (SHEA), the World Health Organization (WHO), World Alliance for Patient Safety, the Institute for Healthcare Improvement (IHI), and the National Foundation for Infectious Diseases (NFID). Submissions will be confidentially reviewed by an expert panel under Larson's direction.

Gold standard not so golden

In general, the gold standard for hand hygiene adherence is considered to be direct observation and charting of compliance by an ICP or other health care worker. Organizations such as the Hand Hygiene Resource Center have created well-designed monitoring tools for this approach.² (See form, p. 3.) The Institute for Healthcare Improvement also recommends monitoring with direct observation by a trained observer using a standardized procedure and form. Independent observers are strongly recommended, preferably individuals who routinely are on the ward for other purposes and are not part of the care team, the IHI recommends.³ Independent monitoring can be reinforced with monitoring by the care team during routine multidisciplinary rounds, which permits immediate assessment and feedback, the IHI suggests. Observation periods should be 20 to 30 minutes, with the emphasis on observing complete encounters so that the proper measure of compliance can be obtained.

Emphasizing that self-reporting by personnel or patients is not a reliable measure of compliance, the IHI does note that adjunct measures to monitor adherence include tracking the volume of alcohol-based hand hygiene product used for a given time period. That is considered a less accurate strategy than direct observation, which is problematic in its own right. Problems include the expense of such labor-intensive monitoring and the influence of the well-known Hawthorne effect, which means essentially that observation tends to change behavior. Measuring compliance with hand hygiene practices during the delivery of care has long been complicated because of the resources needed to monitor the practices of many different care providers in numerous locations for meaningful periods of time. The absence of standardized approaches to measuring hand hygiene performance makes it impossible to determine whether overall performance is improving, deteriorating or staying unchanged as new strategic interventions are introduced. "Obviously, the gold standard is observation, but that changes behavior and it is very expensive," Larson says. "So the gold standard isn't even very good. There have been a number of proposals, including electronic monitoring devices. So the Joint Commission is sending out this invitation across the country for people who have found a good way to monitor hand hygiene to submit it as a best practice."

Must be applicable to soap, alcohol

The compliance tools will need to be applicable to both traditional hand washing practice and the use of alcohol hand rubs, which have become more predominant in health care since they were strongly emphasized in the CDC guidelines. While the alcohol hand hygiene dispensers are ubiquitous in health care settings, Larson is doubtful compliance has really increased. The historical view is that health care workers comply with hand washing only about 50% of the time.

"There are some studies coming out that indicate the alcohol [hand rubs] are taking off and they are starting to improve practice," she says. "People are using the alcohols more, but my sense is that they are not necessarily performing hand hygiene more often. They are just using the alcohol instead of soap. I'm not sure that it has really increased the bottom line rate of adherence. But the alcohol products are certainly being widely adopted across the country."

If the expert panel determines that a submitted

example has potential value to other health care facilities, the organization will be contacted for additional information and permission to include it in the monograph. Examples of promising practices for measuring compliance with hand hygiene guidelines are being sought from across a variety of settings, including hospitals, ambulatory care, home care, long-term care, and behavioral health. Organizations submitting examples are asked to include supporting documentation, such as published studies or summaries of results regarding the use of the method, as well as a sample of data in the manner it is displayed (i.e., charts or graphs).

(Editor's note: For more information on this initiative, contact Linda Kusek, project coordinator, Consensus Measurement in Hand Hygiene Project, the Joint Commission, at lkusek@jointcommission.org.)

References

1. Centers for Disease Control and Prevention. Guideline for hand hygiene in health care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002; 51(RR16):1-44.
2. The Hand Hygiene Resource Center at www.handhygiene.org/educational_tools.asp.
3. Institute for Healthcare Improvement. *How-to Guide: Improving Hand Hygiene A Guide for Improving Practices among Health Care Workers* On the web at: <http://www.ihi.org/ihi/about>. ■

Loud and clear: Plain language protects patients

White paper on improving health literacy

As part of an increasing emphasis on patient empowerment and education, infection control professionals have seen arcane terms such as "nosocomial" de-emphasized in favor of clearer language.

That same trend is cutting across all fields of medicine, which has a long tradition of obscure nomenclature that seems increasingly out of touch with today's patient safety movement. In that regard, the Joint Commission warns that far too often, ordinary citizens are placed at risk for unsafe care because important health care information is communicated using medical jargon and unclear language that exceed their literacy skills, according to a call to action released by The Joint Commission

(Continued on page 4)

Hand Hygiene Monitoring Tool

Patient Care Unit/Dept.: _____ Day of Week: _____ Date: _____

Initials of Monitor: _____ Time: _____ AM/PM to _____ AM/PM

Healthcare Worker (HCW) Type:

1 = Physician
 2A = House Officer
 2B= Medical Student
 2C= PA
 3 = Physician Support Staff
 4 = Nursing/Nursing Support
 5 = Continuing Care/Social Worker
 6 = Pastoral Care
 7 = IV Team

8 = Physical Medicine Staff
 9 = Environmental Services Worker
 10 = Patient Transporter
 11 = Radiology Tech.
 12 = Respiratory Therapist
 13 = Dietitian
 14 = Traypasser
 15 = Other

Key:

HW = Hand Wash
 HA = Alcohol Hand Antiseptic
 Y = Yes
 N= No
 N/A = Not Applicable
 D = Bed closest to door
 W = Bed closest to window

BED LOCATION (→)	D	W	D	W	D	W	D	W	D	W	D	W
CONTACT PRECAUTIONS: Y, N, N/A												
HEALTH CARE WORKER TYPE (→)												
OPPORTUNITY REQUIRING HAND HYGIENE INTERVENTION												
Before Patient Contact												
After Contact With Patient's Skin												
After Contact With Patient's Gown/Linen												
After Contact With Inanimate Objects in Pt. Rm.												
Before IVD Care												
After IVD Care												
Before IVD Insertion												
After IVD Insertion												
Before Wound Contact												
After Wound Contact												
Before Mucous Membrane Contact												
After Mucous Membrane Contact												
Before Body Fluid Contact												
After Body Fluid Contact												
Housekeeping/Environmental Activities												
Gloves Removed & Activity Not Observed												
OUTCOME												
Hand Wash												
Alcohol Hand Antiseptic												
No Action - Missed Opportunity												
Gloves (Y/N)												
Gowns (Y, N, N/A)												

Comments: _____

in its newest public policy white paper, "*'What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety.'*" The paper frames the existing communications gap between patients and caregivers as a series of challenges involving literacy, language, and culture, and suggests multiple steps that need to be taken to narrow or even close this gap.

"Effective communication is a cornerstone of patient safety," says **Dennis S. O'Leary, MD**, president of The Joint

Commission. "If patients lack basic understanding of their conditions and the whats and whys of the treatments prescribed, therapeutic goals can never be realized, and patients may instead be placed in harm's way." The detailed solutions developed by a special Joint Commission Expert Roundtable focus on making effective communications a priority in protecting the safety of patients; addressing patient communications needs across the spectrum of care; and pursuing public policy changes that promote better communications between health care practitioners and patients. Failure to provide patients with information about their care in ways that they can understand, The Joint Commission report warns, will continue to undermine other efforts to improve patient safety. "Breakdowns in communication between patients and caregivers can significantly impair the ability of physicians to diagnose and treat medical problems," says **Ronald M. Davis, MD**, chair of the Joint Commission expert roundtable on health literacy and director of the Center for Health Promotion and Disease Prevention at Henry Ford Health System, Detroit. "Everyone who has a role in health care — specifically including practitioners, employers, and regulators — must work together to pursue strategies for improving communications with patients that will result in safer, more effective care."

The Joint Commission already promotes the involvement of patients in their care through its ongoing Speak Up™ educational campaigns. In addition, expectations regarding patient engagement and involvement in care decisions are stipulated in Joint Commission accreditation standards and its National Patient Safety Goals. But health literacy problems, which often go unrecognized and unaddressed by health care practitioners, undermine the ability of health care organizations to comply with the intents of the accreditation standards

and safety goals that seek to protect patients' safety.

"What is clear to you is clear to you," says **Toni Cordell**, expert panel member

and nationally known speaker on the topic of health literacy, who struggles with dyslexia.

"Every patient should be a full partner in his or her medical decisions. This requires crystal-clear communication that is done with compassion and mutual respect," she says.

The Joint Commission report on strategies for addressing health literacy and protecting

patient safety contains 35 specific recommendations that cover a wide range of important improvement opportunities including, among others:

- The sensitization, education and training of clinicians and health care organization leaders and staff regarding health literacy issues and patient-centered communications.
- The development of patient-friendly navigational aids in health care facilities.
- The enhanced training and use of interpreters for patients.
- The redesign of informed consent forms and the informed consent process.
- The development of insurance enrollment forms and benefits explanations that are "client-centered."
- The use of established patient communication methods such as "teach-back."
- The expanded adaptation and use of adult learning centers to meet patient health literacy needs.
- The development of patient self-management skills.
- Health care organization assessment of the literacy levels and language needs of the communities they serve.
- The design of public health interventions that are audience-centered and can be communicated in the context of the lives of the target population.
- The integration of the patient communication priority into emerging physician pay-for-performance programs.
- The provision of medical liability insurance discounts for physicians who apply patient-centered communication techniques.

(Editor's note: A complete copy of *The Joint Commission white paper, "'What Did the Doctor Say?: Improving Health Literacy to Protect Patient Safety'* is available at www.jointcommission.org.) ■