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IN THIS ISSUE

- **Safety gap:** Panel warns of an 'urgent need' to provide better protection for HCWs in a pandemic cover
- **Out sick:** CDC software can help you estimate absences during a pandemic 135
- **35-lb. max:** NIOSH recalculates the lifting limit 136
- **Get a lift:** OR now has its own algorithms and guidelines for safe patient handling .. 137
- **Gas warning:** Check for exposures to waste anesthetic gases, NIOSH says 140
- **Battling depression:** Interventions help employees overcome depression — and ultimately save money ... 141
- **Inserted in this issue:**
 - *The Joint Commission Update for Infection Control*
 - 2007 index of stories
 - CNE evaluation form for CNE subscribers

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IOM cites 'urgent' need for action to ensure HCW safety in flu pandemic

The weakest link in pandemic preparedness?

Not enough is known about how to protect health care workers in an influenza pandemic, and that lack of knowledge critically weakens the nation's preparedness, an Institute of Medicine panel has concluded.

The IOM experts determined that there is "an urgent need" for more research and better technologies for personal protective equipment and to raise the "employer and employee commitment to worker safety and appropriate use of PPE [personal protective equipment]." Hospitals need to develop a culture of safety, they said.

"Health care worker safety is essential for patient safety and patient care. Being prepared for an influenza pandemic places a priority on protecting the health care work force," the IOM experts stated.

Despite the urgent tone of the report, it garnered little attention when it was released in September. The IOM didn't issue a press release or hold a press conference, as it has with prior patient safety or nursing work force reports. Yet in an October meeting, the IOM Committee on Personal Protective Equipment for Healthcare Workers During an Influenza Pandemic sought to move forward by bringing together representatives from The Joint Commission accrediting body, labor unions, and federal agencies.

"The urgency really [leads to] the doorstep of the policy-makers, [who should] read this report and allocate resources to get the work done to protect the work force and the nation," says **Bonnie Rogers**, DrPH, RN, COHN-S, LNCC, a professor at the University of North Carolina School of Public Health in Chapel Hill and a member of the panel.

IOM panel members were "shocked" by the lack of scientific evidence regarding the transmission of influenza, says Rogers, who also is director of the North Carolina Occupational Safety and Health Education Research Center. But with a commitment of resources, many preparedness gaps could be filled as quickly as within one to three years, said panel chair

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Lewis Goldfrank, MD, chair of emergency medicine at the New York University School of Medicine and director of emergency medicine at Bellevue Hospital, NYU Hospitals and the VA Medical Center in New York City, in the report's preface.

"It is our belief that health care workers will feel secure only when the PPE that they are asked to wear is as safe and effective as the vaccines and medications they are asked to take," he said.

Many hospitals have stockpiled masks, respirators, and gloves for use during a pandemic. But a hospital's responsibility for ensuring the safety of

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Editorial Questions

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workers goes far beyond that, the IOM panel said.

"The institution needs to provide the equipment and the training and needs to make sure people are compliant," Rogers explains. Using safety equipment, including respirators when appropriate, should be as natural as buckling a seat belt when you get into a car, she says.

Employees' perception of the safety culture — how much the institution values worker safety — influences work practices, injury rates, employee satisfaction and even patient safety, says **Robyn Gershon**, MHS, DrPH, professor in the Department of Sociomedical Sciences at the Mailman School of Public Health at Columbia University in New York City. Gershon, an expert on safety climate, presented study findings to the IOM panel and is a member of the broader IOM Committee on Personal Protective Equipment for Workplace Safety and Health.

Health care workers will be more likely to report for work during a pandemic or other emergency if they feel adequately protected, she says. (See related article on worker absenteeism on p. 135.)

Hospitals should make sure that employees have a personal emergency plan so they know who will care for their children if they are called into work during a health emergency, she says. They should beef up their education and training and make sure that health care workers are fit-tested for respirators, she says.

"Fit-testing should be a priority now. You can't do it when everything is chaotic," Gershon says.

There are other barriers to respirator use. The N95 filtering facepiece respirators are uncomfortable and make it difficult to communicate with patients — or even to breathe.

"Health care workers are not really sure that these things really work. That's problematic because when you weigh that against all these barriers it's understandable why some people won't wear them in all instances," she says.

If health care workers understand how the respirators work, why they are necessary, and how to don and doff them properly, they will be more likely to be compliant, she says.

The panel also recommended that The Joint Commission enforce standards that "ensure the proper use of PPE is a priority."

The Joint Commission will respond to the report after its final release in January, says **Louise Kuhny**, RN, MPH, MBA, CIC, associate director for standards interpretation. But she noted that The Joint Commission has several standards that apply to worker protections and

pandemic preparedness.

For example, surveyors may ask employees about the hospital's plan for handling "an influx of infectious patients" — including the use of protective gear, she says. "Employee health issues are definitely addressed [by the standards]," she says. "We do write 'requirements for improvement' related to employee health."

Not enough known about transmission

Meanwhile hospitals need more guidance. What is the best personal protective equipment to protect against the spread of pandemic influenza? This basic question can't be answered without more information on the transmission of influenza, the panel concluded.

The National Institute for Occupational Safety and Health (NIOSH) and other agencies need increased funding to study influenza transmission and appropriate PPE, the panel said. "The basic research really needs to come first," says Rogers.

The IOM panel recommended the creation of an Influenza Study Network and collaboration between the U.S. Department of Health and Human Services and the World Health Organization to mount a global study of influenza transmission and prevention. Without that information, it's not possible to know the most likely route of transmission — contact, droplet, or airborne — or how best to protect workers, the panel said.

The panel also stressed that procedure or surgical masks are not personal protective equipment and cannot be used in place of respirators.

Bill Borwegen, MPH, occupational health and safety director of the Service Employees International Union in Washington, DC, lauded the panel for targeting the lack of scientific information about effective respiratory protection against infectious diseases. "For too long, we've relied on so-called expert opinion and qualitative judgments," he says. "The emphasis on evidence-based science is what's revolutionary."

The panel also called for better design and testing of PPE for health care workers.

The report could have far-reaching impact in shaping regulatory and research priorities, says **Les Boord**, director of the National Personal Protective Technology Laboratory at the National Institute for Occupational Safety and Health, which requested the report.

"It identifies a lot of issues and concepts for advancing the state of the art of personal protective

technologies for the health care worker," he says. "I think it's a very important and significant report."

(Editor's note: A pre-publication copy of the IOM report, *Preparing for an Influenza Pandemic: Personal Protective Equipment for Health Care Workers*, is available at www.nap.edu/catalog.php?record_id=11980.) ■

Pandemic plan: How many HCWs will be home sick?

Software predicts pandemic absenteeism impact

To prepare for an influenza pandemic, you've counted your ventilators and calculated your patient surge, sought options to add bed space and assessed the capacity of the emergency department. But have you estimated how many of your employees will show up for work?

FluWorkLoss software from the Centers for Disease Control and Prevention in Atlanta enables hospitals to estimate employee absenteeism based on the severity and length of a pandemic. The default program is based on a moderate pandemic similar to the one in 1968, with a 15% to 35% clinical attack rate. To test the consequences of a more severe pandemic, software users can change the rate of deaths, hospitalizations and outpatient visits.

Employers create scenarios. How long with the pandemic last? A short time frame (four weeks) means a higher peak of absences; a longer pandemic (up to 12 weeks) means the illnesses will be spread out.

You can alter assumptions about how many days employees will be out of work with the flu or how long some might need to be hospitalized.

"We really do encourage you go in and play endless 'What if's?'" says **Martin Meltzer**, PhD, senior health economist at CDC. During seasonal flu, sick employees typically stay home less than one day. During a pandemic, they may be sicker and employers may want them home for 24 hours or more after symptoms subside, for a total absence of at least five days. "The employees and the employers can see the impact of these [scenarios]," he says.

Employees also may stay home to care for ill family members or to take care of children who have been sent home as schools are closed. To estimate the impact of that, you may want to get some information on family caregiving responsibilities

by identifying how many employees listed dependents on their health insurance or by conducting an anonymous survey, Meltzer advises.

The FluWorkLoss software includes a measure for "cohabiting" adults, who may need to take care of a spouse or partner. However, it doesn't account for employees who may not show up for work out of fear of contracting the illness. Surveys of health care workers indicate that 50% may be not show up because of fear of risk to themselves or their family members.¹ Meltzer advises employers to add in a factor for that additional absenteeism.

While the software was based on data from previous pandemics, there are many unknowns and there's little data on how many days a worker might be absent while recovering from a pandemic strain of influenza or caring for a sick family member. For example, the software has a default value of 40 days to replace a health care worker who died from pandemic influenza. Users can change that to another value.

Despite its limitations, the software can be useful in providing a framework for various scenarios. "I hope people will start thinking of how they would replace [workers], how they would stretch out the force, what kind of cross-training they'll do," says Meltzer. "[They should consider] what are the most essential activities that need to carry on and what can be shut down."

(Editor's note: FluWorkLoss is available at www.cdc.gov/flu/tools/fluworkloss.)

Reference

1. Qureshi KA, Gershon RRM, Staub T, et al. Healthcare workers' willingness to report to duty during catastrophic disasters. *J Urban Health* 2005; 82:378-388. ■

NIOSH sets 35-lb limit as the max for safe lifts

Manual lifts of patients aren't safe

An 180-pound patient is partially dependent, able to lift only about half his weight. He's in a chair and needs help standing. How many nurses would it take to help him safely if they have no lift equipment?

The answer: Three. A new recommended weight limit for manual lifting for health care workers, calculated from the National Institute for

Occupational Safety and Health (NIOSH) Lifting Equation, sets the recommended maximum lift per nurse at 35 pounds.

If only two nurses helped the 180-pound partially dependent patient, they would each be lifting the equivalent of 45 pounds. Yet one nurse could help the patient with a sit-to-stand device, notes **Tom Waters**, PhD, research safety engineer in the NIOSH Division of Applied Research and Technology in Cincinnati.

"Almost all lifts of people are going to exceed the maximum recommended weight limit [for manual lifting]," says Waters, who created the original NIOSH lifting limit of 51 pounds for a static box under ideal conditions.

Needless to say, patients are not shaped like a box and usually aren't lifted under ideal conditions. An object should be held as close to the body as possible during a safe lift. In the health care calculations, however, Waters assumed that the health care worker would need to hold her arms at a 90-degree angle, with elbows by her side, for the best possible lift.

In fact, safe manual lifting is a matter of physics. The distance lifted, the vertical height, and the frequency of lifts are factors in addition to the weight. Lifting someone off the floor is one of the riskiest lifts that health care workers perform, Waters says.

Health care workers can use the lifting limit to determine when they need safety equipment. For example, if a nurse is holding a patient's leg to prepare it for surgery, how heavy is that lift? A leg weighs about 16% of total body weight, or about 39 pounds for a 250-pound person. If the patient weighs 250 pounds or more, the nurse will need to use equipment to lift the leg — or a second nurse will need to help hold it. (For more information on safe patient handling in the operating room, see article on p. 137.) "They need to have an awareness of the risk they're facing," says **Nancy Hughes**, MS, RN, director of the Center for Occupational and Environmental Health at the American Nurses Association in Silver Spring, MD.

When health care workers assess the need for lift equipment, they also need to estimate how much of the patient's weight they are bearing, she notes. "Just because there are two people [performing the lift] doesn't mean they're sharing the load equally," she says.

If a patient is combative or uncooperative, the lift limit would be even lower. The limit also applies to other lifts in health care, such as lifting heavy equipment, says Waters. "There is a maximum weight

limit [for a safe lift]," he says. "If you exceed that, you are putting yourself at risk."

The limits are not only good for workers, but help the hospital's bottom line, notes Waters. "There is evidence that programs relying on lift equipment can pay for themselves by preventing back problems for nurses," he says. ■

Easing 'dead weight' lifts of anesthetized OR patient

New guidelines offer algorithms

The patient lies on a gurney in the operating room and needs to be transferred and positioned onto the table. As OR nurses and techs assess this situation, one thing is clear: The anesthetized patient isn't going to be able to help with the transfer.

The operating room presents unique challenges when it comes to patient handling, from patients who are essentially "dead weight" to the need to maintain the sterile field. Even lifting and holding an arm or a leg for extended periods can be a hazard.

New algorithms and guidelines from the Association of peri-Operative Registered Nurses (AORN) in Denver provide tailored direction on how to assess patients and implement the appropriate safe patient handling. The guidelines were developed by a task force and guided by the work of the VISN 8 Patient Safety Center of Inquiry at the James A. Haley VA Medical Center in Tampa, FL, which developed the initial algorithms for safe patient handling.

New strategies emerge

The new guidance reveals a maturing of the safe patient handling movement as new algorithms and guidelines emerge for areas with special needs and circumstances. Orthopedics and rehabilitation will be the focus of upcoming guidance documents, says **Audrey Nelson**, PhD, RN, FAAN, director of the Patient Safety Center and a member of the task force.

"When we started, we were just looking at the most generic high-risk tasks and trying to apply them across long-term care, community and acute care settings," she says. "That will only get you so far. To really get to the root cause of injuries, You

need to go beyond the generic high-risk tasks."

Patient handling experts from the National Institute for Occupational Safety and Health (NIOSH) and the American Nurses Association also served on the task force.

Health care workers need to learn how to assess patient handling needs and need access to the appropriate equipment, says **Nancy Hughes**, MS, RN, director of the Center for Occupational and Environmental Health at the ANA in Silver Spring, MD.

"It is really important that each department look at their high-risk tasks and come up with solutions for the department," she says.

Seven high-risk tasks

For operating room nurses, safe patient handling means rethinking a variety of tasks. "Health care providers, particularly nurses, are going to take care of a patient at risk of their own health [if necessary]," says **Carol Petersen**, RN, MAOM, CNOR, perioperative nursing data set manager at AORN's Center for Nursing Practice. "If there are plans thought out ahead of time about how patients are moved and handled, including weight limits, we believe the nurses will be safer."

The task force listed the tasks in the operating room and prioritized them according to risk. They identified seven major high-risk activities: transferring patients, repositioning patients, lifting and holding patients' extremities, standing for a long period of time, holding retractors for a long period of time, lifting and moving equipment, and sustaining awkward positions.

The task force members then created a series of questions that could help guide health care workers toward the assistance they would need. The AORN guidelines make use of the new 35-pound manual lifting limit for health care developed by the NIOSH. (**See related article on p. 139.**)

For example, if the nurse is holding a patient's leg, does it exceed the 35-pound limit? Is there equipment that could be used to support it? Does it need to be held during the entire surgical prep? Does the person holding the limb need to be scrubbed?

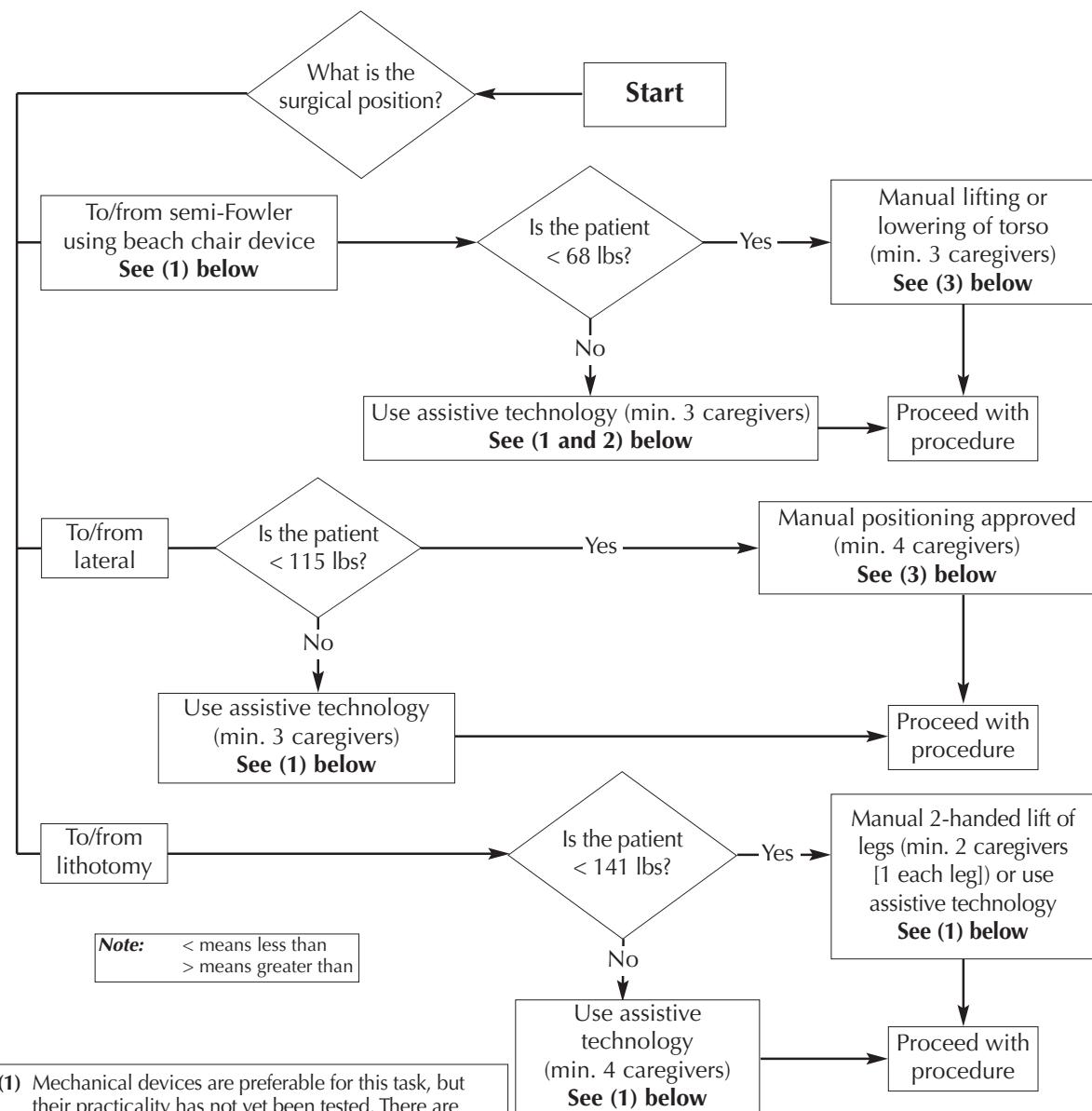
The use of patient handling equipment will require a change in the usual practice in the OR. The OR team, including physicians, need to be educated about the risks of manual lifting and the safe lifting methods and equipment.

"This is something that needs to be supported

(Continued on page 139)

Ergonomic Tool #2

POSITIONING/REPOSITIONING THE PATIENT ON THE OR BED INTO AND FROM THE SUPINE POSITION



- (1) Mechanical devices are preferable for this task, but their practicality has not yet been tested. There are special slings and straps that can be used with mechanical devices. For example, turning straps can be used to turn a patient to and from lateral or supine, or limb support slings can be used to lift the legs to and from lithotomy. More research is needed.
- (2) Use the automatic semi-Fowler positioning feature of an electric table if available.
- (3) One of these caregivers could be the anesthesia provider to hold the head and maintain the airway.

- During any patient handling task, if any caregiver is required to lift more than 35 lbs of a patient's weight, an assistive device should be used.
- The number of personnel to safely position the patient should always be adequate to maintain the patient's body alignment.
- A separate algorithm for prone-to-jackknife is not included because this is assumed to be a function of the table.

Used with permission from AORN Guidance Statement: *Safe Patient Handling and Movement in the Perioperative Setting*, 2007, p 16. Copyright © AORN, Inc., 2170 South Parker Road, Suite 300, Denver, CO 80231. All rights reserved.

by the whole institution," says Petersen.

(Editor's note: The AORN safe patient handling guidelines are available for \$39 from the AORN bookstore at www.aornbookstore.org/.) ■

Patchwork of safe lift laws evolving state by state

Minnesota is the latest of eight states

A patchwork of safe patient handling state laws is evolving around the country, presenting a wide range of requirements for hospitals.

The mildest measures encourage safe patient handling or set up study committees. The toughest require employers to assess risks and purchase the appropriate equipment to reduce them.

Only one thing is certain: More patient handling laws are likely to emerge with each legislative season, typically beginning in January.

"The drum roll continues," says **Bill Borwegen**, MPH, occupational health and safety director at the Service Employees International Union (SEIU) in Washington, DC. "We're continuing to follow the model that we used to put safer needles in the hands of health care workers, which resulted in a dramatic reduction in needlesticks."

As an increasing number of states passed sharps safety laws, pressure grew to develop a national law that would create a uniform standard. So far, the state laws on safe patient handling have not provided much momentum behind a national bill, which has not even been the focus of a hearing.

In California, which led the way for sharps safety, Gov. Arnold Schwarzenegger recently vetoed a safe patient handling bill for the fourth time.

"It is frustrating that stopping injuries to nurses and patients from manual lifting, as critical as it is, has not been elevated to the level of importance it deserves," says **Anne Hudson**, RN, a back-injured nurse from Coos Bay, OR, who formed the Work Injured Nurses Group (WING USA) to advocate for safe patient handling and co-edited the book *Back Injury Among Healthcare Workers: Causes, Solutions, and Impacts* (CRC Press/Lewis Publishers, 2003). "Even though there are literally thousands of people now working on this around the country, it seems that halting preventable injuries from lifting people is still

not at the very top of the priority list."

Minnesota was the most recent state to enact safe patient handling legislation. By the summer of 2008, all licensed health care facilities must have a safe patient handling committee that includes frontline workers and a safe patient handling policy. They

State Laws on Safe Patient Handling

- **Texas SB1525**, enacted July 17, 2005: The first state to mandate implementation of a policy for safe patient handling and establishment of programs by hospitals and nursing homes. However, the law does not require the purchase of equipment and applies only to nurses.
- **Washington HB1672**, enacted March 22, 2006: The first state to require hospitals to provide lift equipment as part of their policy for safe patient handling. The law provides financial assistance through tax credits and reduced workers' compensation premiums.
- **Hawaii House Concurrent Resolution No. 16**, passed April 24, 2006: Calls for health care facilities to provide safeguards to minimize musculoskeletal injuries by nurses and calls for the legislature to support policies in the American Nurses Association's "Handle With Care" campaign.
- **Rhode Island H7386 and S2760**, enacted July 7, 2006: Requires hospitals and nursing facilities to achieve the maximum reduction of manual lifting except in emergency situations.
- **Ohio HB 67**, enacted March 21, 2005: Created a workers' compensation loan fund for interest-free loans to nursing homes to purchase lift equipment and implement a "No Manual Lifting" policy.
- **New York A07641 and S04929**, enacted Oct. 18, 2005: Created a two-year "Safe Patient Handling Demonstration Program" to collect data on injuries and describe best practices.
- **Maryland HB 1137**, enacted April 10, 2007: Requires hospitals to establish a safe patient lifting committee with equal representation from managers and employees and to develop safe patient lifting policies.
- **Minnesota HF 122**, enacted May 25, 2007: All health care facilities must minimize manual lifting using safe patient handling equipment. A \$500,000 fund enables facilities to apply for a hardship grant for assistance in purchasing safe patient handling equipment.

Source: Anne Hudson, WING USA (Work Injured Nurses Group), Coos Bay, OR.

must conduct audits to determine how best to reduce the patient handling hazards and purchase equipment by 2011. The Minnesota legislature provided a \$500,000 fund for "hardship grants" to help facilities purchase equipment.

The Minnesota Nurses Association worked on the bill with the state's hospital association, and had an added advantage in the legislature, says **Carrie Mortrud**, RN, governmental affairs and public policy specialist and lobbyist for the nurses association in St. Paul. "It helps to have six nurse-legislators in the legislature to speak about how difficult it is for nurses to move patients with dignity and safely," she says.

Meanwhile, some states are trying to beef up weaker laws. The Texas law, for example, specifically addresses nurses; its backers touted the legislation as an important measure to preserve the nursing work force in the midst of a shortage. However, certified nursing assistants (CNAs) are still at risk of injury at nursing homes, which are not required to create safe patient handling programs.

"Everybody who does lifting should be included in a safety program," says **Sam Perlin**, a Houston retiree who has become a vocal and effective advocate for nursing home residents.

Nursing homes may have a lifting policy that requires CNAs to ask for assistance, but in reality, the aides often try to perform the lifts on their own — sometimes with dire consequences for themselves and for the frail residents.

"They're shorthanded. There's no supervision [to make sure the policy is followed]," says Perlin. "If the aide wants help, she can't find anyone."

Perlin and others are pushing for changes to the Texas safe patient handling law. The Texas legislature meets every two years, and the next session isn't until 2009. "It's not just in Houston that there's a problem, or in Texas," says Perlin. "It's all over the country." ■

NIOSH warns HCWs about anesthetic gases

Make sure 'scavenging' systems are working

Operating room and recovery room personnel may be exposed to waste anesthetic gases without realizing the danger, and employers should take steps to make sure their ventilation and gas "scavenging" systems are working prop-

erly, according to a new informational brochure from the National Institute of Occupational Safety and Health (NIOSH).

Health care workers can suffer from symptoms that include headache, fatigue and nausea from exposure to high concentrations, as well as possible long-term effects such as liver or kidney disease and reproductive problems, NIOSH said. Yet health care workers cannot detect the gases until they are many times higher than the recommended exposure limits, the agency said.

Workers may be exposed when they hook up or disconnect the scavenging and venting system or if there are leaks in the system, NIOSH said. The gases also may be exhaled by recovering patients or may seep from loose-fitting patient masks.

The information brochure on anesthetic gases is one of a series being published by NIOSH while the agency revises a larger health hazards book for health care. NIOSH also is seeking to take a closer look at waste anesthetic gases and has asked for information on the new anesthetic agents isoflurane, desflurane, and sevoflurane in a *Federal Register* notice, says **Charles L. Geraci**, PhD, CIH, chief of the document development branch in NIOSH's education and information division in Cincinnati.

"There are some new generation anesthetic agents on the market. They do require a higher volume to be delivered due to lower potency," says Geraci. "What we really need to do now is get a better handle on the new agents."

The Occupational Safety and Health Administration has voluntary guidelines but no regulatory exposure limit for anesthetic gases. (See www.osha.gov/dts/osta/anestheticgases/index.html.) NIOSH has not revised its recommended exposure limits since 1977, when it set a limit of 25 parts per million (ppm) for nitrous oxide if it was the sole agent used, measured as a time-weighted average during anesthetic administration. NIOSH also recommends a ceiling limit of 2 ppm for certain halogenated anesthetic gases (chloroform, trichloroethylene, halothane, methoxyflurane, fluroxene, and enflurane) in a sampling period of no more than an hour.

The American Conference of Governmental Industrial Hygienists set a threshold limit of 50 ppm as a time-weighted average over an eight-hour workday for nitrous oxide and halothane and 75 ppm for enflurane. There are no recommended limits for the commonly used anesthetics isoflurane, desflurane, or sevoflurane.

NIOSH recommends that employers take the

following measures to reduce exposures:

- Establish a hazard communication program.
- Develop and implement a safety and health plan that includes information about exposure hazards and methods to control them.
- Label cylinders containing anesthetic agents.
- Make material safety data sheets (MSDS) available.
- Train workers as required by the Occupational Safety and Health Administration (OSHA) hazard communication standard [29 CFR 1910.1200].
- Install a scavenging system with the anesthesia delivery system to remove waste anesthetic gases from the operating room. Place the exhaust in an area where waste gases will not be reintroduced into intake air for the facility.
- Install a ventilation system that circulates and replenishes the air in operating rooms (at least 15 air changes per hour, with a minimum of three air changes of fresh air per hour).
- Install a ventilation system that circulates and replenishes the air in recovery rooms (at least six air changes per hour, with a minimum of two air changes of fresh air per hour) to prevent exposure to waste anesthetic gases exhaled by patients.
- Properly maintain anesthesia machines, breathing circuits, and waste-gas scavenging systems to minimize leaks of anesthetic gases into the operating rooms.
- Train all workers in hazard awareness, prevention, and control of exposures to waste anesthetic gases.
- Develop a monitoring program supervised by a knowledgeable person in every operating facility. Such a program should include quantitatively evaluating the effectiveness of a waste-gas control system and repeatedly measuring concentrations of anesthetic gas in the breathing zones of the most heavily exposed workers while they perform their usual procedures.
- Keep good records of all collected air sample results for at least 30 years.
- Keep medical records of a worker's exposure for 30 years after his or her employment has ended (see 29 CFR 1910.1020 Access to Employee Exposure and Medical Records).
- Obtain baseline liver and kidney data for operating room personnel and monitor their liver and kidney functions periodically.
- Record medical histories for workers and their families, including occupational histories and outcomes of all pregnancies of female workers and wives of male workers (if possible).

(Editor's note: The NIOSH document is available at

[www.cdc.gov/niosh/docs/2007-151/#d.\)](http://www.cdc.gov/niosh/docs/2007-151/#d.)

Reference

1. Centers for Disease Control and Prevention. Request for information on waste halogenated anesthetic agents: Isoflurane, desflurane, and sevoflurane. 71 Fed Reg 8,859-8,860 (Feb. 21, 2006). ■

Why health care employers should tackle depression

It causes more disability than back disorders

If you want to know the impact of depression on the workplace, just do the math.

A survey of 30,000 American workers found that 9.4% suffered from a depressive disorder. Depressive symptoms are about twice as common among women as among men — and women make up about 85% of the health care work force. Lost productivity due to depression cost employers \$44 billion per year — more than three times greater than any other illness, according to a study in the *Journal of the American Medical Association*.¹

The World Health Organization has designated depression as the leading cause of disability worldwide.

On a smaller scale, **T. Larry Myette**, MD, MPH, director, Strategic Workplace Health and Occupational Medicine Consultant at the Healthcare Benefit Trust in Vancouver, British Columbia, calculated the impact and realized that employers needed to address depression not only to improve productivity and cut medical costs, but to help their employees.

Depression was the single largest cause of long-term disability — larger even than back disorders.

"It really got our attention," says Myette. "Traditionally, we've been very focused on musculoskeletal disorders, such as back injuries from lifting and transferring patients."

The Healthcare Benefit Trust is a not-for-profit health and welfare trust that administers benefits for the province's health care and community social services employers. Coverage includes extended health benefits such as prescription drugs and psychology services not insured under the provincial health care system.

Myette began looking deeper into the issue of depression among the work force served by the trust. "We found that about 18.5% of all our

employees in health care and social services had at least one prescription for an antidepressant drug in a given year. When we looked at it over time, there was a steady upward progression," he says.

Myette created the Depression in the Workplace Collaborative with a team of occupational and mental health experts from British Columbia to study the problem. They summarized their findings in a report called *Depression & Work Function: Bridging the Gap Between Mental Health Care and the Workplace* (available at www.carmha.ca). He also authored a white paper on Managing Depression in the Workplace for hospital leaders and is co-editing a special supplement for the April 2008 issue of the *Journal of Occupational and Environmental Medicine*.

Getting the word out about depression is crucial, he says. Employers need to understand the cost of chronic diseases — including depression. "With the help of health and productivity measures now available, you can actually begin to calculate what the losses are for your organization, which helps create a business case for intervention," Myette says.

The business case for intervention recently was bolstered by a study published in the *Journal of the American Medical Association*. Researchers at the National Institute of Mental Health found that employees with clinically significant depression who received an intervention were 70% more likely to remain employed and worked an average of two hours more per week than employees who received "usual care."

The intervention group received phone calls from a trained case manager who encouraged them to receive psychotherapy and antidepressant medication and offered telephone psychotherapy to those who declined in-person psychotherapy. Those in the "usual care" group simply received feedback about the depression screening and were advised to seek help from a clinician.¹

The value of the extra hours worked amounted to about \$1,800 per employee per year, the researchers estimated. "Improving the treatment of depression is not just a cost. It actually is a way to get a return on investment and improve their bottom line," says Philip Wang, MD, DrPH, director of the Division of Services and Intervention Research at the National Institute of Mental Health in Rockville, MD. "Hopefully, this is evidence that interventions actually do work."

One in 10 diagnosed with depression

The first step toward addressing depression in

the workplace is to review your medical benefits and disability claims. Myette discovered that 22% of long-term disability claims were for mental health and 60% of those were for depression. A

CNE questions

21. According to an Institute of Medicine panel, there is an "urgent need" for research in what area of pandemic influenza preparedness?
 - A. Vaccines for children.
 - B. Susceptibility to antibiotics.
 - C. Impact on subpopulations, such as the elderly.
 - D. The science of influenza transmission.
22. According to the new manual lifting limit for health care from NIOSH, how many nurses would it take to safely lift a 180-pound partially dependent patient who could lift about half his own weight?
 - A. One
 - B. Two
 - C. Three
 - D. Four
23. What are the NIOSH recommended exposure limits for the commonly used anesthetics isoflurane, desflurane, or sevoflurane?
 - A. 2 ppm over a one-hour time period
 - B. 25 ppm over eight hours
 - C. 50 ppm over eight hours
 - D. There are no recommended exposure limits for those anesthetic gases.
24. How much money is saved due to increased work time when employees receive treatment for depression, according to a study by the National Institute for Mental Health?
 - A. \$500
 - B. \$1,200
 - C. \$1,800
 - D. \$2,500

Answer Key: 21. D; 22. C; 23. D; 24. C.

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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

similar pattern emerged for short-term disability.

Myette also initiated an employee health survey to gather additional information on personal and environmental health risks, depressive symptoms, chronic disease prevalence and associated productivity losses (absenteeism and presenteeism). The Trust also introduced a web-based screening and management tool for common mental disorders. "You have to have sufficient data to profile your organization" and understand their chronic health needs, including depression, he says.

About one in 10 (10.4%) of the employees reported that they had been diagnosed with depression and 7.1% had been diagnosed with anxiety disorders. "This is a significant issue," he says. "When we used the depression screening test at the usual cutoff for this instrument, 38% of respondents screened positive for depression."

Using a higher cutoff that indicated a greater likelihood of a current episode of depression, just over 12% of the employees who responded to the survey screened positive. "One of the major problems in the effective management of depression and other chronic disorders is detection," Myette says. "Less than half of people who actually have depression ever seek help for their depressive symptoms. Of those who seek help, many are not diagnosed or adequately treated."

Screening for depression should be incorporated into other regular health assessments of employees, he says." Screening can be as little as two questions or it can be as formal as using a tool such as the PHQ-9 [xx]. 'Have you been experiencing a depressed mood? Have you been noticing that you have decreased interest or experience less pleasure in normal activities that you used to enjoy?"'

Why it's work-related

To address the burden of depression, Myette and his colleagues created the Integrated Workplace Depression Management Program. He had discovered that the health care and social services employees did not have much access to cognitive behavioral therapy.

What is depression?

WHO offers definition

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities." ■

Employees with psychosocial needs often self-referred to their employee assistance programs (EAPs), but many EAPs did not screen for depression or were unable to offer a full course of evidence-based psychotherapy. EAPs are well positioned to support employees in distress and "one of our recommendations is that the type of services provided by EAP needs to be reassessed in light of this new evidence about depression," he says.

Need senior management buy-in

You need to get senior management buy-in to implement changes. For example, one health care employer created a steering committee to address depression. At educational sessions, they learned about the symptoms, treatments, and occupational impact of depression. "There was a transformation in the thinking of that group. By the end of the sequence they were highly motivated to take action," says Myette.

The onset of depression is usually multifactorial, including family history of depression, stress or interpersonal issues, and life events. But the workplace can contribute to depression if, for example, employees feel they have excessive demands on them but limited control or few rewards, or if their skill sets are a poor fit with the job requirements.

"On the other hand, if you have a very well-managed, very supportive, participatory workplace that

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■ The carrot or the stick: What works best on flu campaigns?

makes sure people are well trained and developed in their job, then that can serve to buffer the impact of depression," Myette says.

Addressing depression is just one step toward including chronic diseases in the spectrum of employee health, he says. "We're interested in not just looking at the impact of work on health, but also in the effects of health on work and productivity," he says.

Reference

1. Wang PS, Simon GE, Avorn J, et al. Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized controlled trial. *JAMA* 2007; 298:1,401-1,411. ■

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. ■

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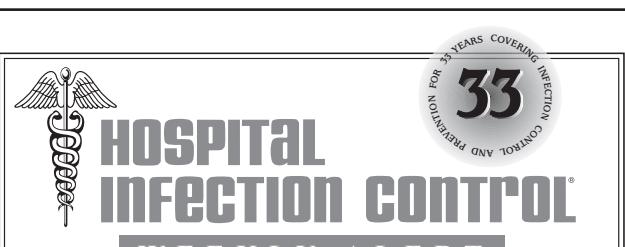
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The Joint Commission Update for Infection Control

News you can use to stay in compliance

As flu season hits, remember new Joint Commission immunization standard for health care workers

National groups decry abysmal record of laggard rates

As the 2007-2008 flu season strikes, infection control and employee health professionals are reminded that a new Joint Commission standard requiring accredited organizations to offer influenza vaccinations to staff now is in effect. The Joint Commission requires that all accredited hospitals and long-term care accreditation programs:

- establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- provide access to influenza vaccinations on site;
- educate staff and licensed independent practitioners about flu vaccination; nonvaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission, and potential impact of influenza;
- annually evaluate vaccination rates and reasons for nonparticipation in the organization's immunization program;
- implement enhancements to the program to increase participation.

The Joint Commission's new standard stops short of setting a required percentage of immunizations or requiring declination statements for those who decline the vaccine. However, surveyors will expect to see immunization rates to be rising as part of enforcement of the standard. The Joint Commission joins several other organizations in addressing the historic problem of laggard staff immunization rates in the health care population. The Association for Professionals in Infection Control and Epidemiology has come out in favor of mandatory seasonal flu vaccinations for patient caregivers; the Society for Healthcare Epidemiology of America is calling for workers to sign off on

declination statements if they turn down the shot; and the Centers for Disease Control and Prevention also puts declination statements on the table as an option.

There is no shortage of vaccine, as manufacturers are expected to increase last year's total by 12 million and distribute 132 million flu vaccine doses this season. Yet less than half of health care workers get the annual shot, citing a range of reasons and myths that have dogged the issue for decades. Some mistakenly think the vaccine can somehow give them the flu, while others do not understand they can transmit influenza before the onset of symptoms. There was little sympathy for this lingering mindset at a recent news conference at the National Foundation for Infectious Diseases in Bethesda, MD.

"We cannot be complacent [about] health care workers who fail to get the vaccination. It protects the personnel and their families," said Julie Gerberding, MD, MPH, director of the Centers for Disease Control and Prevention. "Also, it works in the opposite direction — the health care worker brings the virus to work, and puts patients at risk. It's unconscionable that they don't receive the influenza vaccine."

Consequently, unvaccinated health care workers not only risk contracting flu, but also can transmit the disease to patients and family members. "Many health care workers simply state, 'When I get sick, I'll stay home; I won't make others sick,'" said William Schaffner, MD, chairman of the department of preventive medicine at the Vanderbilt University School of Medicine in Nashville, TN. "However, the day before you feel sick, you are already covering your patients

with the influenza virus."

Jeanne M. Santoli, MD, MPH, deputy director of the immunization services division at the CDC, stated that only 40% of health care workers receive vaccinations in anticipation of the influenza season. (Likewise, only 20% of caregivers in general receive an influenza vaccine according to **Kerry Weems**, acting administrator of the Centers for Medicare & Medicaid Services.) Unfortunately, health care workers are also subject to the illness regardless of present health. "Some people think they are very healthy and are not aware of the risk of infection," said Santoli. "There is a knowledge gap."

'We don't need wounded healers'

In a separate interview, **Robert M. Jacobson**, MD, chairman of the department of pediatrics and adolescent medicine at the Mayo Clinic in Rochester, MN, emphasized that health care workers should not report to work if they have flu symptoms. "We don't need wounded healers," he said. "If you can't control your secretions, stay at home. It's not a badge of honor."

Jacobson has written editorials emphasizing his belief that all health care workers should be vaccinated. "It should be universal and required," he said. "Anyone working in a health care institution, whether on the phone, working with test tubes, or greeting patients should be vaccinated. We need to protect our patients and it is proper role modeling."

Unvaccinated health care workers not only risk contracting and experiencing influenza, but also can transmit the disease to patients and family members. A person with influenza is contagious for up to five days after infection, and children remain contagious for up to 10 days after infection with the virus.

This has particular impact upon the most vulnerable patients, including the elderly, patients with chronic health conditions such as asthma and diabetes, infants and children, and pregnant patients. Specifically, children have been known to be primary carriers of the disease in the general community. "Children are often in larger groups while the elderly rarely are," said Jacobson.

Influenza vaccination of health care workers also assists in supporting the immunity of patients who cannot receive vaccination due to egg allergy. The "halo effect" is provided to a susceptible patient by vaccination of family, friends, and those in contact with the unvaccinated person. The influenza vaccine available this year, in both injection and nasal spray forms, will cover

three strains: Influenza B, H1N1, and H3N2, which were the most common at the end of last season. Although identification of the exact strain to affect this season is an unknown, receiving an influenza vaccination will minimize the extent of illness once contracted regardless of strain. The vaccine nasal spray is contraindicated in pregnant women.

Health care workers need to be aware of the serious nature of influenza, which can lead to fever, cough, chills, fatigue, and muscle pain. Influenza should not be confused with stomach flu although children also may experience nausea and vomiting. An advanced state of influenza can lead to pneumonia, dehydration, bacteremia, meningitis, myocarditis, rhabdomyolysis, encephalopathy, and encephalitis, prolonged seizures, and renal failure. An estimated 36,000 people die of influenza annually.

The risk of health care worker exposure is great, since the majority of people still do not elect to receive an influenza vaccination. The highest rate of vaccination is in the senior population with 69% of those who are 65 years and older getting an influenza shot, according to Santoli. The statistics for other patient populations are worse: only 37% of those between the ages of 50 to 64 years and 31% of those at high risk in the 18- to 49-year-old age group reported receiving a flu shot. "In the pediatric population, only about one third of those aged 6 to 23 months received a flu shot in 2005-2006. Only two thirds received the full dose," said Santoli. "In all children less than 2 years old, only one fifth were fully protected."

The influenza vaccination rate in children is not surprising to Jacobson though, given that it is a relatively new indication in this patient population and the time-dependent nature of the vaccination. "The problem with the influenza vaccine, unlike all other vaccines, is that this one has to be given during flu season," said Jacobson.

To minimize exposure to patients with influenza, health care workers should consider triaging and providing masks and hand disinfectants to contagious patients. If suspected flu patients cannot be isolated from common areas, they can also be provided with tissues and asked to cover their coughs, under the general "respiratory etiquette" guidelines recommended by the CDC. Surfaces that are possible sources for respiratory secretions should be disinfected as soon as possible.

Vaccinations should be offered until supplies or March, whichever comes first. The continuance of vaccination is important because a disease can

Ten tips to stop flu spread

1. All health care workers, regardless of patient exposure, need to be vaccinated against influenza.
2. Wash hands frequently, specifically before and after patient contact.
3. Avoid contact with own eyes, nose, and mouth.
4. Provide immediate triage or isolate/segregate contagious patients.
5. Provide contagious patients with mask and disinfecting hand gel.
6. Give patients with respiratory symptoms tissues and ask them to cover coughs and practice respiratory etiquette.
7. Disinfect surfaces that are likely sources of respiratory secretions by infected patients.
8. Encourage "single-use" child toys, or disinfect available toys after every use.
9. Encourage patients and families to get influenza vaccine.
10. When you're sick, stay at home!

revisit a community, said Santoli. "The peak of disease is January or February or even later," she said. "Not to vaccinate in December is a missed opportunity."

At least one public health department (in Seattle and King County, WA) has specific rules on return to employment for those with influenza.

Workers who have had influenza are advised to wait to return to work for at least five days from onset of symptoms with resolution of fever and improvement of cough. Since mandating influenza vaccinations as a term of employment appears to be rarely required in institutions, action ultimately may come at the state level. Santoli said there has been some discussion about mandatory health care worker vaccination. The vaccination should extend beyond medical doctors and nurses to emergency department responders, technicians, and others who work in health care settings, she said.

According to Santoli, 15 states have regulations regarding vaccination of health care providers in long-term care facilities. Three states require health care facilities to offer flu vaccine to health care providers, and three states require that health care providers get the influenza vaccine unless they have a religious, medical or philosophical reason not to do so. "Some states have laws in long-term care facilities where every patient is a high-risk patient," said Santoli. "There has been a lot of discussion among provider groups as well." ■

Oncologists should offer flu shots to cancer patients

Pts risk lives by snubbing flu, pneumonia vaccines

Despite a Joint Commission recommendation that cancer patients ages 50 years and older get seasonal flu shots, many are putting their lives at risk by not doing so. A recent study found although flu and pneumonia can be lethal for cancer patients, more than one-quarter of patients undergoing radiation therapy are not complying with national guidelines to be vaccinated against these potentially life-threatening yet preventable illnesses. The study was presented Oct. 28 at the American Society for Therapeutic Radiology and Oncology's 49th Annual Meeting in Los Angeles.

While both the Joint Commission and the Centers for Disease Control and Prevention guidelines call for annual shots for cancer patients, 25% of patients 50 years or older reported never having received the flu vaccine. Similarly, the pneumococcus vaccine is recommended to all cancer patients 65 year or older; however, over one-third (36%) of cancer patients in that age range reported never having received the vaccine. Cancer patients are at a higher risk of acquiring and dying from these illnesses due to a weaker immune system, among other factors. According to the study, three reasons accounted for almost 80% of why patients didn't receive either vaccine: Patients either believed they didn't need the vaccines, they didn't know about the recommended vaccination guidelines or their physicians didn't recommend the vaccines. While 44% of patients who received either vaccine reported that they were asked or informed about these vaccines by their family physicians or internists, only 7% reported being asked or informed by their oncologists.

"People undergoing cancer treatment and their loved ones should ask their oncologists about these vaccines. They are a very simple, yet very effective, way for people living with cancer to extend their lives," says Neha Vapiwala, MD, study researcher and a radiation oncologist at the Hospital of the University of Pennsylvania in Philadelphia. "Oncologists have the opportunity to talk to patients about recommended vaccines during their frequent interactions with patients, whether it is before, during, or after cancer therapy. This discussion could result in better cancer

care and ultimately save lives."

This was the first study done to find out whether cancer patients receiving radiation therapy complied with national vaccination guidelines. The anonymous study asked 207 patients from August 2006 to January 2007 about whether they received the flu and pneumococcus vaccines. Those who reported receiving neither vaccine were asked further questions about the reasons they didn't receive them. ■

Joint Commission, CDC to study rapid flu test use

Study targets outpatient settings, EDs, doc offices

The Joint Commission recently announced that its Division of Quality Research and Measurement will study how rapid tests for influenza are implemented in outpatient medical settings including solo and group practice physician offices, community health centers, and acute care hospital emergency departments throughout the United States.

The study is funded by a cooperative agreement from the Centers for Disease Control and Prevention (CDC), with Nancy Kupka, DNSc, MPH, RN, designated as the principal investigator. Influenza kills approximately 36,000 people in the United States each year. Rapid diagnostic tests have been developed to test for influenza outside of the clinical laboratory. However, the current extent and quality of testing for influenza outside the clinical laboratory is unknown, especially in places such as physicians' offices, emergency departments, and community health centers. "Surveillance is the most important tool for identifying new or reemerging infectious diseases or pandemics and establishes the scientific foundation for a public health response," says **Jerod M. Loeb**, PhD, executive vice president, Division of Quality Research and Measurement.

The project will examine outpatient settings that have adopted the use of rapid tests for influenza, including the types of rapid tests in use and how they are selected; the training and competency of individuals performing testing; the extent to which good laboratory practices and testing guidelines are being followed; the impact of use of the rapid tests on antiviral and antibiotic prescribing practices; and the perceived advantages and disadvantages of using rapid influenza testing. The first

phase of the three-year project began in October 2007 plans to survey 5,000 outpatient medical settings to determine how rapid tests for influenza are being implemented. Later in the study, 300 survey participants will be interviewed to identify the factors that influence the adoption of rapid testing for influenza, barriers to implementation and strategies to overcome the barriers in outpatient settings. This study is completely independent from The Joint Commission accreditation process.

"Many rapid influenza tests are available for widespread use in outpatient settings such as physician's offices, clinics and emergency rooms, but the reliability of results from these tests is influenced by a number of variables that deserve examination," says **Devery Howerton**, PhD, chief of laboratory practice evaluation in the CDC's National Center for Preparedness, Detection and Control of Infectious Diseases. "We are also interested in evaluating the extent to which these testing sites are linked to their local public health system," he adds.

The Joint Commission requires accredited organizations to meet both federal Clinical Laboratory Improvement Amendment of 1988 (CLIA) requirements and Joint Commission standards regarding the use of waived tests such as rapid influenza tests. Accreditation surveys conducted by The Joint Commission in hospitals and ambulatory facilities, including physician offices and community health centers, in 2005, 2006, and the first quarter of 2007 found that test controls are not always used as directed by the manufacturer; test kits are improperly stored and sometimes used past their expiration date; individuals conducting the tests are not always trained to use the test or evaluated and deemed to be competent to conduct or interpret the test; staff within organizations are confused about the use of confirmatory tests and whether the waived test is done for screening purposes or for definitive diagnosis; and there were insufficient policies and procedures in place to support conducting the tests.

The Joint Commission will convene a technical advisory panel to assist with the study, composed of public health officials and representatives from the following professional associations: The American Public Health Association, American Medical Association, National Association of Community Health Centers, American College of Physicians, American College of Emergency Physicians, American Academy of Pediatrics, American Academy of Family Physicians and the Association of Public Health Laboratories. ■

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Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your certificate.** Thank you.

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1. If you are claiming nursing contact hours, please indicate your highest credential: RN NP Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees.	<input type="radio"/>					
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5. The test questions were clear and appropriate.	<input type="radio"/>					
6. I am satisfied with customer service for the CNE program.	<input type="radio"/>					
7. I detected no commercial bias in this activity.	<input type="radio"/>					
8. This activity reaffirmed my clinical practice.	<input type="radio"/>					
9. This activity has changed my clinical practice.	<input type="radio"/>					
If so, how? _____						
10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.						
11. Do you have any general comments about the effectiveness of this CNE program?						

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2007 Index

Absenteeism

Brace for norovirus outbreaks with new strains, NOV:121
Outbreak leads to 40% absenteeism, OCT:114

Avian influenza

OSHA: Use airborne precautions with H5N1, FEB:17
Which HCWs will be first to get vaccine? FEB:17

Bloodborne exposures (see HBV, HCV, HIV, Needlesticks, Safer needle devices)

Centers for Disease Control and Prevention (CDC)

CDC isolation guideline sparks debate on respiratory protection, SEP:97
CDC issues new checklist for pandemic planning, AUG:87
CDC: Use declination statements on flu vaccine, SEP:102
CDC: Vaccinate all health care workers, SEP:102

Chemical hazards

NIOSH: Monitor HCWs with chemo exposure, JUL:79
NIOSH to study safety of orthophthalaldehyde, OCT:115
NIOSH updates hazardous drug list, SEP:107
NIOSH warns HCWs about anesthetic gases, DEC:140

Depression

Hospital battles depression in the workplace, AUG:94
Why HC employers should tackle depression, DEC:141

Drug tests

Do random tests create a drug-free workplace? JUN:67

Employee health services (EHS)

Do random tests create a drug-free workplace? JUN:67
How to make the most of rural resources, OCT:117
SARS lesson: Err on side of precautions, APR:37
Strategies to get the salary you deserve, NOV:SUP1
Twenty-fifth anniversary of HEH, JAN:1

Want to prove your value? Audit it, SEP:105

Ergonomics (see Safe patient handling)

Fatigue

Are sleepy HCWs a danger? MAY:49
Proposed National Patient Safety Goal on fatigue, MAY:49
Residency programs open eyes to sleep deprivation, MAY:52
Why naps boost job safety, NOV:124

Forms

Annual medical survey for hazardous drug handlers, JUL:SUP
Gluteraldehyde use survey, OCT:116
Hand hygiene monitoring tool, APR:SUP3
Medical conditions affect sling selection, NOV:128
OR patient handling algorithm, DEC:138

Hand hygiene

Joint Commission studies hand hygiene compliance, MAY:57
Will HCWs swear to have clean hands? MAR:31
WHO hand hygiene guidance added to safety goals, SEP:SUP3
WHO hand hygiene guidance added to safety goals, SEP:SUP3

HBV infection

Gaps persist in HBV immunization, FEB:21

HIV infection

OSHA may cite for failing to use rapid HIV test, MAY:56
Rapid response lowers HIV risk, JAN:6

Immunizations (for Flu vaccine, see

Influenza)

Boosting flu vaccination one worker at a time, NOV:131
CDC: Extend flu shots through Jan., JAN:10
CDC: Use declination statements on flu vaccine, SEP:102
CDC: Vaccinate all health care workers, SEP:102
Convenience, persistence raise flu vaccine rates, OCT:112
Coping with cost of pertussis vaccine, APR:42

Expect delays in flu vaccine delivery, MAY:59

Flu campaign goes beyond mandate, FEB:22

Flu shot declinations irk HCWs, JUN:66

Flu shot standard stirs response, SEP:SUP2

Gaps persist in HBV immunization, FEB:21

Myth-buster: Flu vaccine doesn't cause flu, MAR:32

Infection control

Hospitals not offering pneumonia shot to at-risk patients, JUN:SUP1
Patients with MRSA put HCWs at risk, JUN:61

Plain language protects patients, APR:SUP2

SHEA protests Joint Commission IC standards, SEP:SUP1

What's new in isolation precautions? SEP:99

Influenza (see also Avian influenza)

Boosting flu vaccination one worker at a time, NOV:131

CDC: Extend flu shots through Jan., JAN:10

CDC: Use declination statements on flu vaccine, SEP:102

CDC: Vaccinate all health care workers, SEP:102

Expect delays in flu vaccine delivery, MAY:59

Flu campaign goes beyond mandate, FEB:22

Flu shot declinations irk HCWs, JUN:66

Flu shot standard stirs response, SEP:SUP2

Myth-buster: Flu vaccine doesn't cause flu, MAR:32

Convenience, persistence raise flu vaccine rates, OCT:112

Joint Commission

Flu shot standard stirs response, SEP:SUP2

Joint Commission adds occ health to council, MAR:35

Joint Commission Q&A on safe tissue handling, JUN:SUP3

Joint Commission studies hand

hygiene compliance, MAY:57	SEP:97	Guidelines bring relief from heavy lifting in the OR, DEC:xx
Hospitals not offering pneumonia shot to at-risk patients, JUN:SUP1	OSHA may cite for failing to use rapid HIV test, MAY:56	Hospitals lag in patient handling, JAN:8
Monitoring HCW hand hygiene compliance, APR:SUP1	OSHA: Take steps now on pandemic protection, JUL:76	Linen lift teams lighten the load, JUN:68
Proposed National Patient Safety Goal on fatigue, MAY:49	OSHA: Use airborne precautions with H5N1, FEB:17	Mandating safe lifts state-by-state, DEC:139
SHEA protests Joint Commission IC standards, SEP:SUP1	OSHA warns high-hazard hospitals, MAY:59	Medical conditions affect sling selection, NOV:128
WHO hand hygiene guidance added to safety goals, SEP:SUP3		NIOSH: 35 lbs is the max for safe lifts, DEC:136
Latex	Pandemic influenza	NIOSH offers solutions for sonographers, MAR:28
Latex allergy has almost disappeared, JAN:9	Can you manage employee absences during a pandemic, AUG:87	Solve common ergo problems, MAR:29
Methicillin-resistant <i>S. aureus</i> (MRSA)	CDC issues new checklist for pandemic planning, AUG:87	Twisting, bending add to ergo risk, MAR:33
Patients with MRSA put HCWs at risk, JUN:61	Complacency could be deadly in pandemic, FEB:15	Why one sling doesn't fit all, NOV:127
PA law calls for MRSA testing of HCWs, OCT:118	IOM: HCW safety is weak link in pandemic preparedness, DEC:133	
Pittsburgh VA vows to stamp out MRSA, SEP:103	OSHA: Take steps now on pandemic protection, JUL:76	
National Institute for Occupational Safety and Health (NIOSH)	OSHA: Use airborne precautions with H5N1, FEB:17	
Call for GAO study of NIOSH, AUG:91	Pandemic mask guidance frees N95s for HCWs, JUL:78	
NIOSH: 35 lbs is the max for safe lifts, DEC:136	Pandemic warnings could trigger closings, APR:47	
NIOSH: Monitor HCWs with chemo exposure, JUL:79	Stockpiling causes N95 shortages, FEB:13	
NIOSH offers solutions for sonographers, MAR:28	Which HCWs will be first to get vaccine? FEB:17	
NIOSH to mandate better-fitting respirators, AUG:85		
NIOSH to study safety of orthophthalaldehyde, OCT:115	Personal protective equipment	
NIOSH updates hazardous drug list, SEP:107	Lesson of SARS: HCWs don't always use precautions, JUL:77	
NIOSH warns HCWs about anesthetic gases, DEC:140		
Needlesticks (see also Safer needle devices)	Pertussis	
Must needlesticks be a rite of passage in OR? OCT:112	Coping with cost of pertussis vaccine, APR:42	
Needlesticks remain a EH challenge, JAN:3	Lessons from 'pertussis epidemic that wasn't,' APR:40	
OSHA may cite for failing to use rapid HIV test, MAY:56		
Rapid response lowers HIV risk, JAN:6	Post-exposure prophylaxis	
Norovirus	OSHA may cite for failing to use rapid HIV test, MAY:56	
Brace for norovirus outbreaks with new strains, NOV:121	Rapid response lowers HIV risk, JAN:6	
Outbreak leads to 40% absenteeism, OCT:114		
Preventing spread of norovirus, NOV:123	Respiratory protection	
Occupational Safety and Health Administration (OSHA)	CA proposes biannual fit-testing, MAY:57	
Computer-based training doesn't meet OSHA reg, MAR:25	CDC isolation guideline sparks debate on respiratory protection, SEP:97	
Congress calls for hospital-specific OSHA regs, JUL:73	Evaluate risk before choosing respirators, SEP:100	
OSHA, AAOHN renew alliance, AUG:96	IOM panel considers PPE certification, MAR:35	
OSHA and NIOSH: Use blunt suture needles, JUN:65	Lesson of SARS: HCWs don't always use precautions, JUL:77	
OSHA can enforce annual fit-testing,	NIOSH to mandate better-fitting respirators, AUG:85	
	OSHA can enforce annual fit-testing, SEP:97	
	OSHA: Use airborne precautions with H5N1, FEB:17	
	Pandemic mask guidance frees N95s for HCWs, JUL:78	
	Stockpiling causes N95 shortages, FEB:13	
	Safe patient handling (see Ergonomics)	
	ADA may require lifts for injured RNs, MAY:54	