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HHS draft: Hospitals must purchase antivirals for pandemic influenza

Draft recs would place new prophylaxis burden on hospitals

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Hospitals need to make a huge new investment in antiviral medications to protect their workers from pandemic influenza, according to new draft recommendations from the U.S. Department of Health and Human Services. Prophylaxis could cost an individual hospital more than \$125,000.

In a proposed major shift in strategy, federal public health authorities are recommending the use of antiviral medications for prophylaxis of workers “in the health care sector who have significant patient exposure and therefore increased risk of becoming ill and increased risk of transmitting illness to patients or, in long-term care settings, to residents,” says **Ben Schwartz**, MD, senior science adviser in the National Vaccine Program Office.

“If [hospitals] prophylax for the entire duration that pandemic influenza is in your community, it may take up to eight regimens, which would be 12 weeks,” he explains. A regimen is 10 doses.

Providing prophylaxis to the workers at highest risk — those in the ED and cohorted flu treatment units — may be essential to maintaining the work force, says **Eric Toner**, MD, senior associate with the Center for Biosecurity of the University of Pittsburgh Medical Center. “It’s likely you’re not going to get people to work in those units if you don’t provide them with prophylaxis,” he says.

Yet the logistics are daunting. Tamiflu has a shelf life of five years. “It’s a lot of money to invest if nothing happens,” concedes Toner. “Hospitals that have little money to spend are going to take a lot of convincing to spend it on this.”

Toner has estimated that it will cost a 164-bed hospital about \$1 million to prepare for a severe (1918-like) pandemic by drafting a pandemic plan, educating staff, and purchasing basic supplies and personal protective equipment.¹

The additional cost of providing prophylaxis to frontline workers for

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eight weeks would be about \$125,000 to \$250,000 “depending on the severity of the outbreak, the cost of the Tamiflu and the percentage of health care workers involved in the care of flu patients,” Toner estimates.

Currently, the federal government is stockpiling 50 million doses of antiviral medications and has asked states to stockpile another 31 million to treat patients during a pandemic. States have made variable progress in stockpiling their portion, says Schwartz.

Yet hospitals will be largely responsible for the antivirals needed for prophylaxis. Nationally,

providing prophylaxis for health care workers at risk of exposure would require a vaccine purchase as large as the target national stockpile — or another 81 million doses. HHS also is recommending post-exposure prophylaxis of household contacts of those who become ill — a tripling of the demand for antivirals, which would require yet another 80 million doses.

Based on federally negotiated prices for the antiviral medications of \$18.81 per treatment course for Tamiflu (oseltamivir), which may be lower than prices available to hospitals, the doses would cost the nation’s hospitals about \$1.5 billion.

Can hospitals afford that tab? “When you look at the cost of the antiviral drugs as a fraction of a hospital’s total pharmacy budget, it would be very small,” says Schwartz.

The proposed emphasis on antivirals for prophylaxis already has gained some traction. The Healthcare Infection Control Practices Advisory Committee, an expert panel that advises the Centers for Disease Control and Prevention in Atlanta, endorsed the recommendation in a November vote.

Four ‘partially effective’ strategies

This new strategy places a greater emphasis on the use of antivirals to prevent the spread of pandemic influenza. Protecting health care workers will require the use of four “partially effective” measures, says Schwartz.

“The concept of our pandemic response is layered protection,” he says. “It may include pre-pandemic vaccine, which we are stockpiling. Pre-pandemic vaccine is likely not to perfectly match the pandemic virus, and therefore will provide [only] partial protection.” **(For more information on pandemic influenza vaccine, see the related article on p. 3.)**

Personal protective equipment, including respirators, gowns, and gloves that would be stockpiled by hospitals, provides another layer of protection “but is not perfect,” Schwartz says. The experience of severe acute respiratory syndrome (SARS) in Toronto showed inconsistencies in the use of personal protective equipment, he notes. And some health care workers became ill despite the use of PPE.

Hospitals also may alter work practices to limit the number of workers who are exposed to infected patients.

Prophylaxis with antiviral drugs would be the fourth strategy. “I think antiviral drugs are

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particularly important because they have been shown to be 70%-90% effective [in prophylaxis] with seasonal influenza and they've been shown to be effective with H5N1 [the avian influenza strain that has infected several hundred people worldwide].

"In our planning, I think it's important that we plan to provide as many of these layers of protection as we can," Schwartz says.

Some hospitals have stockpiled antiviral medications as part of pandemic influenza preparedness. In fact, the HHS Hospital Preparedness Checklist for pandemic influenza advises hospitals to set priorities for vaccine and prophylactic antiviral medications.

Reference

1. Toner E, Waldhorn R, Maldin B, et al. Hospital preparedness for pandemic influenza. *Biosecur Bioterror* 2006; 4:207-217. ■

'Highest-risk' HCWs to get first pandemic vaccine

CDC: Hospitals should decide on critical work force

Who will receive the first precious doses of vaccine to protect against an emerging pandemic influenza strain?

Hospital employees will be in the highest-priority tier to receive vaccine, according to draft guidance from the U.S. Department of Health and Human Services. Hospitals will receive enough to vaccinate about two-thirds of the employees working in inpatient care, reports **Ben Schwartz**, MD, senior science adviser in the National Vaccine Program Office.

If supply of vaccine is very limited, about a million critical emergency department employees, intensive care personnel and other "frontline" caregivers would be the first to receive vaccine. The guidelines cite their "critical role in providing care for the sickest persons" and "highest risk of exposure and occupational infection."

Other health care workers would be in "Tier 3," which would still place them in a higher priority for vaccine during a severe pandemic than high-risk adult patients, the elderly, or the general population. If the pandemic is less severe, those health care workers would receive vaccine with the general population based on their age and health status.

Hospitals have an abundance of vaccine

Anyone who wanted the flu vaccine could get it this year. About 132 million doses of vaccine were expected to be available this year — the largest supply ever, the Centers for Disease Control and Prevention in Atlanta reported.

The abundance resulted from a concerted effort by the U.S. Department of Health and Human Services to improve flu vaccine manufacturing capacity. There now are six manufacturers of injectable and nasal spray vaccines.

"This season's vaccine supply gives us the opportunity to protect more Americans than ever before," said **Jeanne Santoli**, MD, MPH, deputy director of the CDC's Immunization Services Division. "Vaccination is recommended for anyone who wants to decrease their risk of getting the flu."

CDC authorities urged the public — and especially health care workers — to become vaccinated this year. They acknowledged that a "drift" in the H3N2 strain may mean the vaccine contains a "sub-optimal match," but noted that the vaccine would still be about 52% effective against the drifted strain.

Meanwhile, **Joe Bresee**, MD, chief of the Epidemiology and Prevention Branch, noted, "Even if there's a strain mismatch against one of the types, you're protected very well against the other two types [contained in the vaccine]." ■

"Less severe pandemics pose less threat to delivery of health care, community support, and other essential services and products," the guideline states. "Historical analysis of the 1957 and 1968 pandemics in the United States indicates that health care and essential services were effectively maintained. Because of this, after Tier 1, occupational groups in the health care and community support services and critical infrastructure categories are not specifically prioritized."

Yet ultimately, the decision about whom to vaccinate first lies with individual hospitals, says Schwartz. "I think there are some clear decisions that can be made based on one's occupation and how that occupation contributes to maintaining good patient care, [as well as] the risk people in that occupation face due to their contact with ill persons," he says. "It's important that hospitals plan what they would need to do in order to maintain their critical functions and in order to maintain effective patient care."

For example, the hospital may need some

Preserving the Work Force in a Pandemic

Maintaining the work force during an influenza pandemic will be essential to a hospital's ability to handle the surge of patients. In the journal *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science*, **Eric Toner**, MD, and **Richard Waldhorn**, MD, offer this advice to hospitals:

- Minimize the duration of illness in staff by making rapid testing (if available and reliable) for influenza available to staff 24/7 and initiating antiviral treatment within six hours after onset of symptoms.
- Using screened volunteers, organize in-home child care for well children of health care workers if schools are closed.
- Provide medical day care for sick family members.
- Allay fear through open, honest, and transparent planning and careful training.
- Shift clinical staff to highest-need areas from areas that may be closed or quiet, employing "just in time" education (i.e., training staff "on the job" in new procedures) and "buddy teaming" (pairing staff new to an area with more experienced staff).
- Augment clinical staff with nontraditional personnel, employing "just-in-time" education and "buddy teaming." These groups could include medical professionals with prior clinical experience (e.g., administrators, researchers, retired clinicians), health professionals in related fields (e.g., dentists, veterinarians, emergency medical technicians), nonclinical hospital personnel, and nonclinical outside personnel. Specific training and operating procedures for each group must be created in advance.
- Coordinate with other hospitals in the region on plans to recruit and use volunteers.

Source: Toner E, Waldhorn R. What hospitals should do to prepare for an influenza pandemic. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 2006; 4:397-402.

maintenance workers, housekeepers, and registration clerks who would be in proximity to patients. Other work practices could be redesigned to limit the number of people who enter a patient's room, says Schwartz. For example, dietary staff may leave the trays on the floor for nurses to bring into the rooms.

It's a no-brainer to vaccinate emergency department staff first, followed by intensive care. But hospitals need to have a healthy debate about which departments would be next on the list, says **William Schaffner**, MD, chairman of

the Department of Preventive Medicine and professor of infectious diseases at the Vanderbilt University School of Medicine in Nashville and vice president of the National Foundation for Infectious Diseases Board of Directors.

Will it be oncology? The neonatal unit? Bone marrow transplant? Many hospitals had an opportunity to ponder those questions in 2004 when manufacturing problems forced Chiron Corp. of Emeryville, CA, to halt production. It was then one of only two manufacturers of the influenza vaccine providing the vaccine to the United States.

Vanderbilt had ordered its vaccine from Chiron and suddenly faced the prospect of rationing whatever vaccine it had available. The shortage actually led to some curious decisions on individual units. At one point, Schaffner wanted to confirm that the vaccine had been used on the units, and he discovered that oncology had hoarded some of the vaccine. Health care workers there feared that even sicker patients would arrive the next week and that vaccine wouldn't be available for them.

"We instructed people they would be no more vaccine unless they used what they had," he recalls.

In a pandemic, the specific epidemiology of the strain will influence the prioritization, notes **Eric Toner**, MD, senior associate with the Center for Biosecurity of the University of Pittsburgh Medical Center.

"There are so many variables that can't be known until a pandemic starts," he says. "The best you can do is come up with an initial game plan that has to be modified."

Seasonal influenza campaigns provide a good training ground, says Schaffner. "If we gear up on an annual basis, it will be vastly easier to do this on a semi-crisis mode," he says. "There are even some data that suggest that repeated annual immunization offers some protection against pandemic influenza. That's another reason to get more people vaccinated on a regular basis."

Yet hospitals should place vaccines in context within their pandemic preparedness, cautions Toner. Personal protective equipment, including gowns, gloves and respirators, and antiviral medications will be essential, he says.

"Hospitals should not be planning on a vaccine having a big effect in protecting their staff," he says. "It is not likely to be available early on, and if it is, it is likely to be available in limited quantities."

Will the vaccine work and how soon will it be available? Those key questions will depend upon the nature of the pandemic.

Currently, the U.S. government has stockpiled

vaccine against the H5N1 virus, which has killed 206 people in 12 countries. The number of doses available depends on the amount of antigen that must be used to provide immunity. Adjuvants, which enhance the immune-response of the vaccine, may reduce the size of the effective dose from 90 micrograms to between 3.8 and 7.5 micrograms. "What that means is that we'll have 12-24 times as much vaccine as we thought we might," says Schwartz.

Toner notes that "the amount of vaccine you need varies a lot with the strain. It's hard to predict in advance what the dosage is going to be."

However, it will likely take two doses to provide protection, and those must be given three weeks apart. It takes two weeks after vaccination for sufficient immunity to build against influenza, says Schwartz. The stockpiled vaccine will be an imperfect one, since influenza viruses change. As soon as human-to-human transmission of a novel influenza strain is detected, manufacturers will begin developing a specific vaccine.

"With current technology, it will take at least 20 weeks from the time we start to develop the pandemic vaccine until it is available," Schwartz says.

The bottom line: Pandemic vaccine may not be available for about five months after a pandemic begins.

If the first cases occur in Asia during the summer, when influenza doesn't spread as readily in North America, there may be enough time to mobilize before the novel influenza strain triggers an outbreak in the United States. That was the case in the 1957 pandemic, which began in Asia in March. The first cases appeared in the United States in June, but the disease didn't spread significantly until children returned to school at the end of the summer. By then, public health authorities had already administered millions of doses of vaccine.

"There are lots of uncertainties regarding how quickly the pandemic might spread, where it might start, what the effectiveness of our control measures might be," he says. "We'll do everything as fast as we possibly can."

Meanwhile, federal public health authorities are updating the H5 vaccine and carefully looking at H7 and H9 influenza strains that could potentially affect humans and spark a pandemic.

Hospitals need to periodically review their pandemic plans as well. But Toner and others worry that hospitals have developed "disaster fatigue." After a flurry of concern about H5N1 and its pandemic potential, preparedness has been overshadowed by more immediate concerns.

"The pandemic threat hasn't gone away," he says. "Despite a lot of people turning their attention to other things, the threat is still there."

(Editor's note: The "Draft Guidance on Allocating and Targeting Pandemic Influenza Vaccine" is available at www.pandemicflu.gov/vaccine/prioritization.html.) ■

Are you in 'employee health' or 'occ health'?

'Boot camp' raises training of HEH nurses

Q: *What's the difference between an employee health nurse and an occupational health nurse?*

A: *"Occupational health" is a specialty with certification that requires knowledge of workers' compensation, injury prevention, and wellness.*

It may sound like mere semantics. But the distinction between "employee health" and "occupational health" is an important one in a high-hazard field. As hospitals seek to contain workers' compensation costs and retain workers, there's a new push to elevate the training and professionalism of hospital employee health nurses.

Many hospitals offer occupational health services to local businesses and industrial plants. But internally, their program may be confined to regulatory compliance (vaccination, TB screening, bloodborne pathogen follow-up) rather than injury prevention, notes **Larry Gray**, AIC, executive vice president, Property and Casualty, for PHT Services, a risk management alliance and workers' compensation pool for hospitals and other health care employers in Columbia, SC.

Last fall, PHT Services encouraged its member hospitals to send employee health nurses to a "boot camp" organized by the American Association for Occupational Health Nurses (AAOHN) for a refresher on occupational health basics.

"When it comes to employee safety, health care tends to lag what they're doing in industry by 10 or 20 years," says Gray. "This is one of those prime examples. The typical employee health nurse is promoted into employee health usually from the floor in the hospital and doesn't really know anything about workers' compensation. We do our best to educate them. But they certainly don't have, in most cases, any occupational health background whatsoever."

The nurses themselves aren't the only ones who may take a narrow view of their role. The

Association of Occupational Health Professionals in Healthcare (AOHP) seeks to educate hospital CEOs, as well, by sending them letters each year during Occupational Health Nurses' Week." I focused on the challenges in health care, [asking them,] 'Do you have someone who takes care of your people and keeps them well and safe?'" says **Denise Knoblauch**, RN, BSN, COHN-S/CM, president emeritus of AOHP and clinical case manager at the Center for Occupational Health at the Saint Francis Medical Center in Peoria, IL.

In fact, when AOHP formed 26 years ago, it set out a mission to professionalize the hospital-based employee health nurse. Today, AOHP continues to educate nurses about such issues as making a business case for employee health. "We are not [just] the TB test nurses anymore," she says.

In many hospitals, employee health nurses also are responsible for workers' compensation programs. Even if they aren't, their activities influence accident prevention and return to work, says Gray. For example, they should conduct root-cause analysis of significant injuries to determine how to prevent future incidents, he says.

Hospital employee health nurses should look for trends in injuries and report them to the safety committee and risk manager, he says.

Employee health nurses also should identify themselves with the larger specialty field, says **Dean Burgess**, MSN, RN, COHN-S, director of professional affairs for AAOHN.

"Employee health nurses' and 'occupational health nurses' are synonymous [terms]," says Burgess. "Occupational health nurses take care of employees and workers populations. In the hospital environment, they're termed employee health, but they're still occupational health nurses."

Seeking certification is one way to demonstrate competence and knowledge in workers' compensation and other occupational health areas. The American Board for Occupational Health Nurses (ABOHN) in Hinsdale, IL, set a goal of certifying 500 new hospital employee health nurses over a two-year period.

To be a certified occupational health nurse (COHN), you must be a licensed registered nurse, have 4,000 hours of occupational health experience in the past five years, and at least 50 hours of continuing education in the past five years. Nurses with a bachelor's degree may receive the designation COHN-S.

Hospital employee health nurses often don't seek certification, but when they do, they typically score well on the certification exam, says

Ann Lachat, RN, BSN, COHN-S/CM, executive director of ABOHN. "There are a lot of hospitals that don't have certified employee health nurses on board," she says.

Certification requires an understanding of injury prevention, biological, chemical and physical hazards, disease management, and regulations. "They need to know the whole scope and practice of an occupational health nurse," she says. With a designation of COHN, the nurses also are qualified to work in occupational health in other industries, she notes.

(Editor's note: More information on COHN certification is available at www.abohn.org. More information about occupational health educational programs is available at www.aohp.org and www.aaoahn.org.) ■

Fit and Fat: Why not to promote weight loss

Thin isn't in at hospital wellness program

If you want to promote a healthy lifestyle for your employees, maybe you should start by throwing away the scale.

The cycle of dieting, the guilt about eating certain foods, the quest for the "ideal" weight — those result in lower self-esteem and poor body image but rarely in sustained weight loss, contend the wellness experts at Mercy Medical Center — North Iowa in Mason City. That's why the hospital doesn't offer to help employees lose weight.

Instead, their motto is "Health for Every Body." The idea is to "help everyone be healthy regardless of weight," says **Laura McKibbin**, LISW, coordinator of Kailo for One, the hospital's employee counseling program. "This is not an approach that tells people to gain weight. This is not an approach that tells people to abandon health. This is not an approach that tells people to eat all they want and be sedentary. Do those things that are healthy for you, but don't attach it to weight loss."

It's tough to go against the prevailing dogma. Thin is in, not only as the ideal of beauty, but the image of health. Employees are naturally drawn to the goal of losing pounds as a way to boosting their esteem. **Kelly Putnam**, MA, who launched the Kailo wellness program and "Health for Every Body" program at Mercy Medical Center, understands that yearning. (Putnam recently was promoted to the hospital's parent organization,

Trinity Health, where she is working on a “Culture Transformation Initiative” that will focus on creating a culture of “quality, safety, and customer satisfaction.”)

A former dieter, Putnam once taught a weight loss program. But at Mercy Medical Center, she didn’t want to make hollow promises. When employees ventured into the Kailo office asking about weight management, Putnam would point out that the wellness program doesn’t even have a scale. “I almost feel like a dream killer,” she says. “They’re coming in with the dream of being thin.”

She notes that the vast majority of diets don’t work. The pounds may melt off initially, but some 95% of dieters will gain those back — and perhaps even more. “Would we be prescribing a pharmaceutical with a 95% failure rate?” Putnam wonders. “Weight loss is not a good place to put your precious budget dollars.”

Overweight people live longer

“Health for Every Body” begins with the premise that you can be “overweight” and still be healthy. In fact, there is scientific evidence to bolster that assertion.

Being overweight is actually associated with a lower death rate, according to a Center for Disease Control and Prevention study that correlated the cause of death and body mass index of 2.3 million Americans. However, being either underweight or obese was associated with increased mortality. Obesity, but not being overweight, was associated with cardiovascular disease.¹

However, CDC and others still lump together the problems of being overweight (a body mass index of 25 or higher) and obese (a body mass index of 30 or higher). The CDC web site lists the “health consequences” of obesity and overweight as increasing the risk of hypertension, stroke, Type 2 diabetes, coronary heart disease, and some cancers.

The Kailo message, however, is that someone can be fat and beautiful — and fat and fit. “Health for Every Body” provides seminars and services around six tenets: education, normal eating, movement for pleasure, self-acceptance, size tolerance, and social support.

It began in 2004 with a study group of 61 employees. They learned to stop thinking of certain foods as “bad” or taboo, and to eat in response to hunger rather than external cues. “When we promote weight loss, I also believe we’re promoting, at some level, eating disorders,” says Putnam.

They participated in “pleasurable movement,” not exercise to burn calories. Their goal weight was “the weight at which a person settles while moving toward a more fulfilling, meaningful lifestyle” — a definition coined by Jon Robison, PhD, an assistant professor at Michigan State University in East Lansing, who developed the “Health at Every Size” philosophy that the Kailo program uses.²

After 12 months, the Kailo study group improved in eating patterns, physical activity, body image, and emotional well-being. “It’s absolutely possible to improve our health without losing weight,” says Putnam.

Wouldn’t you naturally lose weight if you increased your physical activity and developed healthier eating habits? Not necessarily, says Putnam and McKibbin. While some may lose weight, others may find that their weight stabilizes. And those who have had chaotic eating or under-eating may actually gain weight.

Releasing the goal of losing weight can be liberating. “It’s a very hopeful message,” says McKibbin. “But if people care more about losing weight than they care about any of those [health benefits], then the message can come across as hopeless.”

Today, when employees come into the Kailo office, they may see a scale — but one without numbers. Step on it and it will deem you “smart and sassy” or “bright and beautiful.” That gives the message that body image is more important than any number.

McKibbin cautions hospital wellness programs against a focus on dieting and weight management. “When we promote weight loss . . . we’re risking an increase in overall weight because of yo-yo dieting [in which deprivation is followed by bingeing],” she says.

Instead, focus on healthy eating, physical activity, and a positive body image, she says. “It isn’t necessary to lose weight in order to achieve an improvement in health,” McKibbin says.

(Editor’s note: More information about “Health At Every Size” is available from the web site, www.healthatverysize.info or www.jonrobison.net/FDNH/INDEX.HTM.)

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Saving backs — hospital finds it's déjà vu again

L&M Hospital revives ergonomics

Ergonomics specialist **Catherine Gouvin**, EOTR/L, CHT, remembers how impressed she was when she heard of a Connecticut hospital that had reduced its patient handling injuries by almost 50% and cut its lost workdays by two-thirds by purchasing lifts and training its work force to use them.

Then, in a kind of lost-in-the-future moment, she discovered *that was actually her own hospital*. It had once had a successful ergonomics effort, but the program lost its champion, its focus, and its effectiveness.

The story of ergonomics at Lawrence & Memorial (L&M) Hospital of New London, CT, is a cautionary tale. Without continued support, a safe patient handling program won't remain viable, Gouvin says. "We had devalued the safety culture," she says. "There was a lack of ownership of the program. There was no monitoring."

Safe lifting simply wasn't a priority. "When staffing got tight, the nurses stopped going to the quarterly training," recalls occupational health director **Ruth Moreau**, RN, MS, COHN-S, who struggled to revive interest in the program. "They didn't have enough equipment. "If you don't have enough [and it's not convenient], they'll stop using it."

Gouvin and Moreau became committed to bringing back a strong safe patient handling program — and protecting the hospital's employees. "Every day that went by that we didn't have a program was a risk to someone I worked with," Gouvin says.

In 2007, those efforts came to fruition as the hospital's workers' compensation costs related to new patient handling claims were a mere \$3,000 as of November. The number of claims deemed preventable dropped from 26 in FY 2005 to four in 2007. In FY 2005, the hospital paid \$247,000 in preventable claims; in 2007, it had incurred no costs for preventable claims and no days away from work.

Who needs safety?

The demise of the earlier program began when a management consultant recommended saving money by cutting the safety director to part time. After all, the workers' compensation costs already

had declined. Administration had been assured back injuries would remain at their low level.

The safety director left, and Moreau did what she could with an occupational therapist who spent 12 hours a week on ergonomic issues.

By 2001, almost 10 years after the inception of the first program, the hospital had few floor lifts. Slings were hard to find. Some 58 health care workers suffered from patient-handling injuries in a single year. There was no lift equipment that could be used on patients weighing more than 350 pounds — and obese patients were becoming more common.

Moreau understood the risks in a very personal way. She was a nurse in the cardiac care unit when two patients went into cardiac arrest. Moreau and her fellow nurse each had to work on their own, as quickly as possible. As she positioned a backboard beneath the heavy patient, she could feel a jolt in her back. Within days, Moreau learned she had ruptured a disc and needed back surgery. She was out of work for three months and, although she returned to the unit, she ultimately realized she could no longer handle the physical demands of bedside nursing.

"I definitely have an interest in making sure the cycle [of injury] gets stopped somehow," she says.

Gouvin, a certified hand therapist who occasionally treated employees with wrist and hand pain, became committed to the cause when she studied the hospital's injury trends and learned how they could be prevented with safe patient handling. She began by helping rearrange work stations to reduce upper extremity injuries.

Then she discovered that the hospital was planning to replace 164 mattresses — and she was determined to lobby for new beds that would take into account the nurses' needs. When a hospital benefactor died and left \$17 million to the hospital, the plan for better beds became a reality.

The new beds could convert into chairs. They had an adjustable foot so patients could push against it to reposition themselves. They had in-bed scales and a "max inflate" air mattress that eased repositioning and lateral transfers.

Gouvin was emboldened by that success, but moving forward still presented challenges. She gathered some key stakeholders, such as the employee health manager, inpatient occupational therapy/physical therapist, patient transport and risk management, to write a safe patient handling policy. It established safe work practices and set lifting limits. Yet she notes, "It was really unenforceable because we had inadequate equipment

and employees hadn't been trained."

The program struggled even when the vice president of nursing wrangled \$40,000 for Gouvin to buy lift equipment. There weren't enough lifts for the entire hospital. The education department didn't embrace safe patient handling as a top priority. The slings were being stored in central services and weren't making it back onto the floors.

She focused her first efforts on the med-surg/oncology unit and recalls coming to the hospital at 2 in the morning to talk to the night shift about safe lifts. The staff said they were too busy. "You just have to say, 'OK, I'll come back another time,'" Gouvin recalls.

"You have to be persistent. You just need them to know that you're not going away because their health really matters that much to you," she says.

The turning point came in 2005 when Bruce Cummings, the new CEO of Lawrence & Memorial Hospital, read an article about safe patient handling in *The Wall Street Journal*. He was ready to become the champion of safe patient handling. He e-mailed Gouvin and asked, "What would it take to make L&M a no-lift facility?"

That was the support she needed. "I knew what we needed to make it right," Gouvin says. "We didn't have enough awareness of the effort. I needed everybody on board and they needed to know it was important from the top down."

'Get a lift!' monitors progress

The hospital found a successful framework for implementing changes with Prevent Inc. consultants, a Hickory, NC-based firm that specializes in implementing safe patient handling programs with its "Get a Lift!" program. L&M developed a task force that included representatives from central service, laundry, education, and human resources. They analyzed patient handling needs by department. They considered the logistics of laundry and storage. They drafted a streamlined policy that guided employees to assess the patients' mobility.

The result: The white board in each patient's room includes a notation for patient handling. Color-coded carts on the floors contain the slings. The hospital purchased 21 total lifts, seven sit-to-stand devices, one ceiling lift, Hover Mats, repositioning sheets and gait belts. Through a rental agreement, the hospital gained access to lifts that could handle patients up to 1,100 pounds.

In a massive training blitz, the hospital trained 747 nurses in six days. "Super Users" received special training — and ongoing training — to

help fellow nurses with the equipment.

For two years, "Get a Lift!" consultants will visit the hospital every other month to coach "Super Users," train new employees and reinforce training. Then the hospital will carry on those functions in-house, reports Moreau. "You have to have somebody assigned to keeping it going," she says.

Moreau reports to the chief operating officer, and she makes sure information on the cost savings is relayed to the hospital's board. Her advice for those struggling to establish a safe patient handling program at other hospitals: "Don't give up. Find new champions. Use every opportunity you have to get your information out there [to hospital leaders]. Sooner or later, someone will listen and you'll have your program."

(Editor's note: More information about the "Get A Lift!" Program is available at www.getalift.com.) ■

Sharps injury risk higher in home health

Focus groups reveal hazards in homes

Home health nurses face a substantial risk of sharps injuries but often do not get prompt follow-up, according to a study by researchers at the University of Massachusetts Lowell.¹

In focus groups and interviews, nurses also told of exposed sharps in their patients' homes, a lack of safety-engineered devices, and sharps containers that overturn and spill in their cars. The study highlights the need to tailor sharps injury prevention to home health care needs, says study co-author **Stephanie M. Chalupka**, EdD, APRN, BC, CNS, FAAOHN, professor in the Department of Nursing in the School of Health and Environment at the university.

"In the hospitals, it's very rare, and people frown on people leaving improperly disposed of sharps around. In the home care setting, insulin-dependent diabetics are going to leave their equipment around in places that nurses may not expect to encounter it," says Chalupka. "There are frequently used devices left unsheathed until the next use. When you're on a fixed income, in an effort to be economical, you may say, 'I can use this until the needle gets dull.'"

Meanwhile, patients being treated in the home have an increasingly high acuity. "More and more demanding medical procedures are moving into the

home setting,” says co-author **Pia Markkanen, ScD**, research assistant professor at the Department of Work Environment and Lowell Center for Sustainable Production at the University of Massachusetts Lowell.

In all, 17 nurses and seven home health aides participated in five 90-minute focus groups. They were recruited from participating home health agencies and worker unions. The researchers also conducted 10 in-depth interviews with managers and union representatives.

Many of the nurses, aides, and managers had experience in the hospital setting, and they noted that hospitals provided a more supportive environment for reporting and follow-up of blood-borne pathogen exposures.

Home health nurses ‘working in isolation’

The home health nurses lack backup, notes Chalupka. “[Home health] nurses are working in isolation. They are the only person caring for that patient,” she says. They are reluctant to seek care for their needlestick if there is no other nurse or aide who can take over for them, she says. Meanwhile, the closest health care facility may be many miles away, Chalupka adds.

In fact, the isolation of home health workers also makes their workplace hazards less visible, the authors conclude. Meanwhile, the home health workers are dedicated to patient care — and report that they enjoy the independence of the job. “In some ways, people we have spoken to take it just as part of the job [if they suffer a needlestick],” says Chalupka. “I find that to be one of the most unfortunate aspects of work in home care with sharps injuries.”

Researchers have used the focus group results to craft a survey of 1,225 home health workers. The surveys will provide more information about sharps safety in home health care and may lead to recommendations for improvements, says Markkanen.

“Home health care can be made safer,” she says. “These interventions should preserve the wonderful aspects that home health care can provide and as much as possible to minimize the hazards

Here are some issues raised by the focus group study:

- **Do the home health nurses have access to safety-engineered devices?** The focus groups revealed significant differences in the availability of sharps safety devices. At one agency, for example, focus group participants reported that more than

CNE questions

1. According to Ben Schwartz, MD, how many regimens of the anti-viral medication Tamiflu would be required for prophylaxis of at-risk health care workers during a 12-week pandemic?
A. Two
B. Four
C. Eight
D. 10
2. Based on current technology for vaccine development, how long will it take to develop a vaccine once a pandemic strain is identified?
A. Two weeks.
B. Two months.
C. Five months.
D. Development would be continuous as the strain mutates.
3. According to a CDC study that correlated the cause of death and body mass index, which of the following is linked to lower mortality?
A. Being underweight.
B. Being overweight.
C. Maintaining a stable weight regardless of the level.
D. Weight is not related to disease or mortality.
4. What did Lawrence & Memorial Hospital of New London, CT, discover is the key to maintaining reductions in patient handling injuries?
A. Prompt laundering of slings.
B. Disciplinary action against nurses who don't use equipment.
C. Updating lift technology.
D. Monitoring of the program and leadership support.

Answer Key: 1. C; 2. C; 3. B; 4. D.

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. ■

90% of the devices they used had safety features. Yet at another agency, participants said safety devices weren't available to them in some categories, such as lancets used by diabetics. Hospitals also need to encourage insurance companies to reimburse patients for safety-engineered devices, says Chalupka. Home health nurses often educate patients in how to use their own devices — and often those do not have safety features, she says.

• **Are home health workers included in sharps safety device evaluations?** The U.S. Occupational Safety and Health Administration requires employers to include frontline health care workers in the evaluation of sharps safety devices. Home health nurses need to be part of that dialogue because they have some unique issues, the study authors say. For example, a sharps container that works well on the wall of patient's room in the hospital may overturn in their trunk, spilling contaminated needles and creating a risk for exposure.

• **Is worker safety a part of the home health assessment?** Bloodborne pathogen exposure is just one workplace hazard that confronts the home health nurse. The focus group nurses raised concerns about lifting patients and violence in the home or neighborhood. The risk of injury also may be greater because of cramped workspace or clutter in the home. "Home health care nurses have very little control over their work environment," notes Chalupka.

• **Are home health nurses receiving adequate training?** OSHA requires employers to provide training as a part of the bloodborne pathogen standard. For home health nurses, that training must be focused on their particular needs but also broad enough to encompass the wide variety of devices that their patients may be using. Home health nurses should know how to get immediate follow-up care if they have a needlestick and there should be a method to provide backup care for the nurse's other patients, says **Evie Bain**, MEd, RN, COHN-S, FAOHN, associate director and coordinator of the Division of Health and Safety with the Massachusetts Nurses Association in Canton, who helped coordinate focus groups. "A lot of nurses don't know that the best outcomes for bloodborne pathogen exposure are to get treatment in the first

hour [after exposure]," she says.

• **Can a patient's home be made safer?** To enhance safety, home health should incorporate needless devices whenever possible. For example, some medications may be available in transdermal patches or inhalers. Of course, when home health nurses go to a new patient's home, there always will be an element of unpredictability. Chalupka recalls when she worked as a home health nurse and was bitten by a German shepherd while starting an IV line. "Very seldom do you have a German shepherd jump up on the bed in the hospital," she says. "One of the first things you'll learn [in home health] is to lock pets in the bathroom." ■

Safety primer targets frontline nurse staff

What nurses need to know about safety

Don't you wish nurses knew how to care for themselves as well as they do their patients?

Deborah Fell-Carlson, RN, MSPH, COHN-S, HEM, a long-time occupational health nurse who works for a workers' compensation insurer in Lebanon, OR, has compiled a primer to educate staff nurses about the basics, from job hazard analysis to hazardous chemicals, needle safety to safe patient handling.

Working Safety in Health Care: A Practical Guide (Delmar Cengage Learning, \$44.95) tells frontline caregivers what they need to know to stay safe. Written by experts in occupational health, the book has a companion quick-reference guide and training manual.

Fell-Carlson recalls when she became an employee health nurse at an Oregon hospital after a stint as an occupational health nurse for the National Guard. She was surprised to find few safety resources and little awareness of safety issues at the hospital.

Fell-Carlson wrote a chapter for a nursing text on employee health and, when it was published, it was illustrated with a photo of a nurse wearing

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a respirator improperly. Then caption called it a surgical mask.

She realized that nursing students need better health and safety resources — and so do frontline nurses.

“You are never going to achieve the goal of patient safety if the caregiver doesn’t first know how to make their own work environment safe,” Fell-Carson says. “That environment of patient care is inside the environment of work. If the environment of work is not safe, the care environment is not going to be safe.”

The book covers a wide range of issues, including wellness and stress management, workplace violence, infection control, respiratory protection, and emergency management. ■

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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