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Hospitals making it harder for HCWs to 'just say no' to influenza vaccine

But will declinations really make a difference?

Just saying "no" to the flu shot isn't so simple anymore. Thanks to new state mandates and employer requirements, health care workers who don't want the vaccine are increasingly asked to acknowledge the risks for patients, themselves, and their family members.

Yet the debate persists about how effective those declination statements are — and how they should be used to improve influenza vaccination rates.

For some employee health professionals, a declination statement offers a golden opportunity for one-on-one education about influenza and the vaccine. Others view it as a heavy-handed effort to strong-arm health care workers into accepting a vaccine that is only partially effective.

One thing is clear: The impact of declination statements will vary widely depending on how they're used. There is a direct relationship between the burden and the benefit.

"The declination statement, at the end of the day, is no panacea and is undoubtedly a great encumbrance," acknowledges **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.

Schaffner is a strong proponent of declination statements as one strategy to improve influenza vaccination rates of health care workers. But he says the statements themselves are worthless if they simply involve health care workers checking a box electronically, or even on paper, without follow-up.

"You have to have a face-to-face meeting with every health care worker who says 'no.' That's the educational moment," he says. "Only after they listen to you, and then they say, 'No,' do you let them out."

For large or multi-campus facilities, tracking the declinations and providing the "educational moments" can be overwhelming. In fact, at Vanderbilt, employees must complete a mandatory flu training module, but they can signal their declination of the flu vaccine electronically. That

complies with new Tennessee Department of Health rule that requires health care facilities to provide flu education to all "direct care" employees and maintain a record of signed declination statements from those who refuse vaccination.

"We've already given 10,000 flu shots this season," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic. "There's just no way to lasso people and get them to sign a piece of paper."

Tennessee is just one state to adopt a regulation on declination statements. California and Rhode Island require health care facilities to collect declination statements. For example, the California Health and Safety Code requires employees of health care facilities who do not want the vaccine "to declare in writing that he or she has declined the vaccination." Minnesota has set a goal for 90% of all health care facilities to use an annual "declination" program by 2010.

Do declinations have a punitive tone?

The Joint Commission requirement to track health care worker influenza vaccination rates has clearly triggered a greater use of declination statements. **(See *Hospital Employee Health*, August 2006, p. 85.)** But while hospitals have struggled with the logistics, others ask a basic question: If you want to change behavior, is it better to use a carrot or a stick?

Nancy Rudner Lugo, DrPH, NP, health care consultant and associate professor at the University of Central Florida College of Nursing, analyzed studies related to influenza vaccination of health care workers, and concluded that there is "limited evidence of the effectiveness of declinations" and that education and immunization campaigns can make the vaccinations "as routine and accepted...as is wearing gloves."[1] Hospitals too often implement declination statements without first probing the reasons for low vaccination rates and ways to encourage and educate employees, she says.

For example, an employee survey can determine why some employees avoid the vaccine. While declination forms often ask employees why they are declining, they also often include a statement acknowledging "I am putting my patients and co-workers at risk."

"There's a punitive tone to a declination," says Lugo. "There's a sense of liability. If I sign that I'm refusing it, what's going to happen?"

Research needs to establish stronger scientific evidence that health care workers are the vectors of influenza to patients and that declination statements are the answer to better vaccination compliance, says Swift.

A greater risk may be posed by visitors who come to the hospital and give patients a hug or a kiss, notes Swift. And health care workers can effectively prevent transmission through hand hygiene and respiratory hygiene, including wearing a mask if they have a cough, she notes.

Meanwhile, Swift wonders, "If you vaccinate the health care workers, does that really help the patients?" Studies of flu vaccination programs often compare mortality rates from influenza in

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facilities with no flu vaccine program and those that have a voluntary program, she notes. There is little data on the impact of declination statements.

"I'm willing to take a strong stance and make things mandatory if I'm convinced it's good for the health of the worker," says Swift. "I don't think flu vaccine for healthy people rises to that level now. I don't think the evidence of the protection of the patients is strong enough to start mandatory or coercive programs."

Asking for declination statements can be intimidating for employees, she says. "Employees are a vulnerable group," she says. "We need to advocate for the workers because they are susceptible to this power differential between them and their employer. Before we take any medical intervention and mandate or enforce it, we need to have some strong data behind it. We should not mandate that employees take any medication just because we have control over them and we can."

Will HCWs accept responsibility for shots?

Some hospitals that use declination statements have taken measures to take some of the negativity out of the process.

At Erickson Retirement Communities in Silver Spring, MD, national medical director **Craig D. Thorne**, MD, MPH, created a single flu vaccine consent form that emphasizes education, rather than usinga separate declination statement. The form stresses the importance of the flu vaccine to protect them, their family, co-workers and the patients or residents they care for.

Employees may then check a box either stating "I will accept the influenza vaccine, as it is my responsibility" or "whether for personal or medical reasons, I choose not to accept the vaccine at this time." They also may indicate that they received the flu vaccine elsewhere; those numbers are counted in the overall vaccination rate. **(See sample form, p. 17.)**

Thorne also implemented a program to bring flu vaccine to employees on the floors. "Just by introducing that influenza form and encouraging mobile vaccine campaigns, we're already seeing a 78% increase in rates compared to last year, and we're still vaccinating," he said in early December.

"In my experience, employee health programs that are positive in nature produce favorable results," says Thorne, a clinical assistant professor of medicine at the University of Maryland School of Medicine and adjunct assistant professor in the Department of Environmental Health Sciences at the Johns Hopkins University Bloomberg School of Public Health.

Erickson has 20 sites around the country with some 11,000 employees and many provide assisted living and nursing care as well as independent retirement living. Signing the declination form isn't mandatory, and Thorne isn't tracking which employees signed.

Individual sites may require employees to sign the forms. For example, at Riverwood Village in Silver Spring those directly providing healthcare services for residents must complete the form — but they also receive a $5 voucher to the cafeteria when they sign the form.

The bottom line, says Thorne: You have to balance the rights of the employee with the needs of the workplace, but education and convenience encourages workers to accept flu vaccines.

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Outbreak reveals stakes of HCW flu vaccine

Rehab unit shut during seasonal outbreak

The duty to protect patients from the flu has a very personal meaning at Central Maine Healthcare in Lewiston.

Two years ago, a flu outbreak forced Central Maine Medical Center to shut down an inpatient rehab unit to new admissions. Both patients and staff had been exposed and infected. The hospital used Tamiflu to treat ill patients and employees as well as for prophylaxis.

An outbreak has a way of sharpening the focus on prevention. "You don't think you're going to get sick or infect patients," says **Clark Phinney**, WSO-CST — employee health and workers' compensation coordinator — of employees who are reluctant to get the flu shot. "That absolutely drove home the quality and patient care piece to a lot of folks."

The three-hospital system now uses a consent form that includes education about the "myths" of the flu vaccine and a strongly worded declination statement: "I'm declining, but in doing so I know I'm putting myself, my co-workers and my patients at risk." Employees are asked why they are declining the vaccine.

With the help of a part-time volunteer who keys the consents and declinations into a database, Phinney tracks who has received the vaccine and who has declined. By the first week in December, each department manager receives a report so they can follow up with employees who have not gotten the vaccine or signed a declination.

Employee health also blitzes the hospitals with flu education, through interoffice email, articles and forms on the intranet, and newsletters that are included with employee paychecks. The health system's efforts were recognized by the American Nurses Association as one of the top five "best practices in seasonal influenza immunization." Phinney also was asked to present his program at the Institute for Healthcare Improvement conference in Orlando, FL, held in December.

In 2006, Central Maine Healthcare vaccinated about 65% of the 1,900 employees on the Lewiston campus. Phinney expects the final numbers to be even higher for this flu season.

The declination statements play an important role, says Phinney. They make employees think about their decision rather than just skipping the vaccine because they don't want to be bothered, he says. "They get their questions answered," he says. "[Some say], 'I was going to decline, but you know, I'm going to get it."

Yet Phinney and his colleagues also work hard to make the annual flu campaign fun and appealing. On Halloween, employee health urged health care workers to "say boo to the flu." Phinney wore a giant purple hat and his colleague, **Jen Messenger**, RN, BSN, COHN-S, CCM, clinical lead RN in employee health, dressed as a "flu fairy," with a pink wig, tiara and wand. Of course, they handed out candy along with flu shots.

On a different night, they promoted a late-night game show theme they called "Late and live," making rounds throughout the night shift. Phinney dressed as an '80s-era "preppy" and Messenger dressed as a "Valley girl." They held a Bop-It contest, allowing anyone who got the flu vaccine to play. The winning department received a trophy.

Just showing up in the wee hours of the night has an impact, says Messenger. "[It says,] 'We care enough about this that we're here,'" she says. In some units, nurses were lined up waiting for the flu vaccine, she says.

But beyond the fun and games, Central Maine Healthcare keeps a spotlight on the serious message. "If I remember correctly, when we all got into health care, we all promised to do no harm," says

(Continued on page 18)

Are flu shots a matter of employee health?

OSHA fact sheet warns of occupational risk

Here's a new spin on the campaign to convince health care workers to get the influenza vaccination: Do it for your own health.

The U.S. Occupational Safety and Health Administration has released a fact sheet on seasonal influenza vaccination that emphasizes the worker-safety aspect. OSHA states: "Employers have a duty to create a safe work environment. Encouraging influenza vaccination for their healthcare employees is one method of doing this. The current rate of influenza vaccination among healthcare workers is disappointing, and increasing this rate could significantly enhance health care worker safety and increase their productivity."

OSHA also notes that The Joint Commission, an Oakbrook Terrace, IL-based accrediting body, has made health care worker vaccination a priority, and that "employees increase their risk of contractingthe flu if they decide to decline vaccination."

"We consider it a form of personal protection for health care workers to receive the vaccine," says **Patricia Bray**, MD, MPH, acting director of OSHA's Office of Occupational Medicine. "Influenza is the most common cause of death from a vaccine preventable disease in the United States."

Although healthy adults are usually not at high risk of complications from influenza, she notes that the vaccine has been shown to reduce rates of illness and complications of illness in the 18- to 63-year-old age group.

Hospital-based outbreaks also affect health care workers, Bray notes, although there are no data showing that health care workers have a higher risk of contracting influenza than the general population. "It just makes sense that a group that has a high exposure rate has a higher likelihood of contracting the illness," she says.

OSHA did not mention the issue of declination statements. *(Editor's note: The OSHA influenza vaccination fact sheet is available at www.osha.gov/Publications/seasonal-flu-factsheet.pdf.)* ■

INFLUENZA VACCINATION CONSENT FORM
2007-2008

Occupational Health is recommending that I receive the influenza vaccination in order to PROTECT MYSELF, MY FAMILY, MY CO-WORKERS AND OUR PATIENTS. WHY?

- ✔ FLU STILL CAUSES MANY DEATHS — Influenza is a serious respiratory disease that kills an average of 36,000 people in the U.S. **every year**
- ✔ I CAN SPREAD FLU TO PATIENTS EVEN IF I DON'T HAVE SYMPTOMS — Patients most at risk are infants, older adults, pregnant women and those with chronic diseases. **Many of these people don't respond to the vaccine themselves and rely on others to be vaccinated**
- ✔ THE INJECTABLE VACCINE CANNOT MAKE ME SICK — **I cannot get the influenza disease from the influenza vaccine because the vaccine does not contain live virus**.

There are very few contraindications to the flu shot: 1) allergic reactions to the vaccine are rare but people with a severe egg allergy (as the vaccine is grown in eggs) should not get the vaccine; 2) a severe allergy to any vaccine component is also a reason to not get the vaccine; and 3) people with a history of Guillain-Barré Syndrome (a severe paralytic illness) should not get the vaccine. Also, people who are moderately or severely ill should usually wait until they recover before getting flu vaccine; people with a mild illness can usually get the vaccine.

Knowing this,

- ❑ **I will accept the influenza vaccine, as it is my responsibility. I HAVE READ THE VACCINE INFORMATION SHEET AND HAVE NO KNOWN CONTRAINDICATIONS (see section 5 of CDC's Vaccine Information Sheet) AND HAVE NO ADDITIONAL QUESTIONS**
- ❑ **I received the vaccine for the season, sometime between Sept. 2007–April 2008**
- ❑ **Whether for personal or medical reasons, I choose not to receive the vaccine at this time.**

I understand that I may change my mind and if the vaccine is still available, I can still get it later from my Occupational Health provider.
I have read and fully understand the information on this form.

Signature: _____ Date: _____
Printed Name: _____

Guardian Consent (THIS SHOULD BE REVIEWED BY YOUR LEGAL COUNSEL)

Note: this Consent must be signed by a parent or legal guardian of a minor (under 18 years of age) who wants to be vaccinated.
I am the parent/legal guardian of _____ who wants to be vaccinated against influenza (the 'flu'). By my signature below, I am indicating that **I HAVE READ THE CDC's VACCINE INFORMATION SHEET, THAT TO THE BEST OF MY KNOWLEDGE THE ABOVE NAMED INDIVIDUAL HAS NO KNOWN CONTRAINDICATIONS** (see section 5 of the CDC Vaccine Information Sheet), that I have no additional questions and that I am consenting to my Occupational Health provider to administer the inactivated influenza vaccine to him/her.

_____ _____
Parent or Guardian's Name (Printed) Signature of Parent or Guardian

Vaccine Administrator to complete:

Vaccine Manufacturer: _____
Vaccine Lot#: _____ **Site of Administration:** R L Deltoid
Date Vaccinated: _____ **Vaccine Information Sheet Given:** Y N

_____ _____
Name of Vaccine Administrator (Printed) Signature of Vaccine Administrator

Source: Craig Thorne, MD, MPH, National Medical Director, Erickson Retirement Communities, Clinical Assistant Professor of Medicine, University of Maryland School of Medicine.

Phinney. "Infecting a patient with flu because you didn't get a shot is doing harm." ■

Back-injured nurse tells her painful story

Job loss compounded physical pain

Being a nurse is all that **Rebecca Rhoads**, RN, BSN, CLNC, ever wanted to be. She loved working at the bedside. And that is where she'd be today — if she hadn't suffered a debilitating back injury.

"I look at young nurses, and I say 'Protect yourself. Be proactive to protect yourself. Use the lifts. Know that injuries happen and happen very frequently in nursing,'" says Rhoads. At 54, she lives on a 200-acre farm in Cedar, MI, takes pain medication every day, and has taken up painting as an avocation. She shared her story with *Hospital Employee Health* to provide the perspective of a back-injured nurse.

Her hospital, Munson Medical Center in Traverse City, MI, declined to comment on the specifics of her case because of privacy concerns. But Munson administrators discussed the hospital's program to prevent back injuries and help injured nurses return to work. **(See related article on p. 19.)** "We do value our people very much," says **Jan Lyon**, OTR, manager of the hospital's return-to-work program.

While hospitals around the country are in varying stages of implementing safe patient handling practices, each serious injury leaves an impact on a nurse's life. Some are able to return to work if the hospital has lift equipment and a minimal-lift policy. Others suffer from chronic pain and restrictions that force them to leave the field.

Injured nurses have found a forum in WING USA (Work Injured Nurses Group), where they post their stories online. They describe lifting, repositioning or transporting patients weighing as much as 500 pounds without mechanical devices. They tell of collapsed discs, multiple surgeries, paralysis and constant pain. **(See excerpts, below.)**

Anne Hudson, RN, a back-injured nurse from Coos Bay, OR, who lost her job because of her lift restrictions, founded WING USA to raise awareness and advocate for safe patient handling.

Feeling their pain: Back-injured RNs tell their stories

On an online "Read Other Stories" page at www.wingusa.org, back-injured nurses tell their stories of enduring pain, surgeries, and job loss. Here are some excerpts:

"I would have never dreamed that one day I would go to work and face the possibility of never walking or feeling the ground below my feet again. To this day, I cannot feel my hands or the lower one-half of my body and I catheterize myself six to eight times a day. My career is over since I cannot lift more than 10 pounds."

"At the time of my injury, I had been a critical care nurse for 17 years. About every three years there would be the 'minor' back strain event, with the necessary paperwork filed, and a day off to recuperate. But on that fateful night came the straw that broke the camel's back. That night, I transported an elderly patient for a chest x-ray who was about 4'10", around 250 lbs., and, unknown to me, had a collapsible hip (replacement in the past). When the radiology tech and I helped the patient to stand for the x-ray, the leg collapsed and the patient dropped like a rock. She grabbed my shoulder on the way down and the rest is history."

"My brain is fine; it's my back that's not. And, at 52, I feel like I'm just too young to give up on life because I can't walk or stand."

"No wonder there's a nursing shortage. If we're not injured, we don't want to [become injured] and so leave the field."

"I broke seven discs in my back and five in my neck. Four surgeries and four years later I am permanently disabled... It is a shame that when you are really given a calling to this field of nursing, and you give so much, you never realize that you can lose so much, too. I used proper body mechanics, but a body is only capable of doing so much before it gives up. Today, I spend my time watching nursing programs instead of being able to do what I loved the best." ■

Hudson suffered cumulative trauma disc injury to her back from years of lifting patients. "I've talked with nurses that still are unaware of the equipment that's available, nurses who still have not heard of the phrase 'safe patient handling,'" she says.

One pull on the draw sheet

Rhoads' back problems actually began when she was still a student nurse. She developed a herniated disc after moving a patient and needed back surgery to decompress the disc. The surgery was successful, and she was cleared to work with no restrictions. But she knew she would always need to be protective of her back. She thought good body mechanics would protect her.

Rhoads remembers using a scale with a sling as a makeshift lift. When she and her fellow nurses would place bedridden patients in the sling to weigh, they would quickly make the bed and reposition the patient.

But one day, she was working in radiology when she reached across the exam table to transfer an elderly woman using a draw sheet. "She kind of pulled her body up toward her right side. I was on the left side. It set me a little off balance," says Rhoads. "Immediately, I could feel it down my leg and back."

She felt a surge of pain in her back and down her right leg to her ankle, and her foot went numb. Each time she put on a lead apron, she felt pain. "I still didn't want to report the injury, until two days later my co-worker said, 'You have to report this injury.'"

Repeated heavy lifting had placed stress on Rhoads' spine, and but she wasn't aware of the cumulative trauma until that acute injury.

"There was nothing remarkable about the patient transfer that ultimately led to the end of my career, but only that the disc was ready to give way," she says. "I spent the next six months telling myself it was going to go away and I didn't need any help. Finally, my personal physician told me I needed to see the occupational health physician because I was still having problems."

That began a years-long saga of pain and medical interventions. She says the hospital's occupational health physician sent her to physical therapy and back school, then back to work with restrictions. She couldn't wear the heavy lead aprons of radiology. When she went off restrictions, and put the lead aprons back on, the pain began to increase again.

She used ice and over-the-counter anti-inflammatories and tried to keep working. Although Jan Lyons at Munson stresses that "immediately we start to look at what work possibilities are out there for [injured nurses]," Rhoads says she knew of injured nurses who "disappeared" and never returned to the hospital. Rhoads feared that her injury would cause her to be forced out of her job. "I was scared to death," she says. "I wanted to protect my job. I didn't want to lose my job."

Finally, Rhoads needed back surgery. She found herself in a battle with the hospital over workers' compensation coverage and whether the back injury was work-related. The surgery wasn't successful and she needed another surgery. She went through physical therapy and was cleared to return with restrictions.

Just when Rhoads was preparing to return to work, she says she learned that her job had been posted. She applied for at least six other jobs, trying to find an appropriate spot, but she was unsuccessful. "I did everything I possibly could," she said.

Rhoads won her workers' compensation case in 2003, and the hospital dropped its appeal and signed a voluntary agreement in 2007. She also sued for wrongful termination and disability discrimination. The hospital settled this fall, and did not acknowledge any wrongdoing. As a condition, Rhoads is not allowed to reapply for any jobs there in the future.

Rhoads joined WING USA and tells her story in the hope of making the workplace safer for nurses so they can stay by the patient's bedside, where they belong. ■

Hospital eases work for 'seasoned nurses'

Goal is workplace with less reaching, minimal lift

As nurses age, keeping them safe as they lift and transfer patients becomes a greater challenge. Munson Medical Center in Traverse City, MI, has responded to that by creating a Seasoned Nurse Initiative.

It started with a task force and a focus group to find out about the workplace concerns of nurses over 45. An ergonomist then visited the floors to evaluate hazards and tailor a plan to adapt the workplace. "She spent time on every single unit

with nurses looking at how they do their work, what they do, where things are stored," says **Jim Fischer,** RN, MS, MBA, vice president for patient care and chief nursing officer.

For example, changes in storing supplies could make them more convenient for nurses. The hospital moved electrical outlets so the nurses don't have to bend. Other equipment, such as chairs, was adjusted to the appropriate height. Gait belts were added to each patient room.

As new patient care areas are being designed or renovated, the hospital is considering putting in ceiling lifts. Meanwhile, the hospital purchased new lift equipment as well as Hill-Rom beds that fold into a chair.

"[There are] a litany of things to make the work environment better for the older nurse," says Fischer.

The task force also looked at the issue of fatigue and the older nurse, offering eight-hour shifts as well as 12-hour shifts.

Meanwhile, the hospital monitors back strains and looks for trends, says Fischer. Despite a growing patient census and workforce, the number of strains has remained stable. There were 117 in 2006, he says.

The goal is to have a minimal lift environment that leads to a reduction in strains and enables back-injured nurses to return to work, says Jan Lyon, OTR, manager of the hospital's return-to-work program. "If we have everything in place for minimal lift, nurses with restrictions will still be able to provide nursing care," she says. ■

Does working at night cause breast cancer?

'Graveyard shift' may actually be true

Warning: Working the night shift may cause cancer.

The International Agency for Research on Cancer (IARC), a World Health Organization agency based in Lyon, France, has designated working the night shift as a "probable" carcinogen. The finding is based on human and animal studies.

About 15 studies show a link between breast cancer and night shift work, indicating that women working the night shift may have a 30% to 80% increase in relative risk. That makes night shift work a potentially greater risk of cancer than second-hand smoke, which increases lung cancer risk by 25%, says **Kurt Straif,** MD, MPH, PhD, scientist, cancer epidemiologist for the monograph series.

The IARC has brought together working groups of scientific experts to evaluate evidence on the carcinogenicity of 900 agents. About 400 have been designated as carcinogenic or potentially carcinogenic.

Yet scientists want to see more research before classifying night shift work as a definite carcinogen. "The evidence in experimental animals was sufficient and in humans it was limited. There's some clear signal that there's an increased risk of breast cancer, but we could not rule out other explanations," says Straif.

A prospective study that followed 115,000 women for 12 years found an elevated breast cancer risk among women who worked more than 20 years of rotating night shifts.[1] Another prospective study of women in the Nurses' Health Study found that working a night shift for at least three nights per month for 15 or more years was linked to an increased risk of colorectal cancer.[2]

Not every night shift worker seems to be at risk. "It seems to apply perhaps only to people who work long durations of shift work for extended periods of their lives," says lead author **Eva S. Schernhammer**, MD, DrPH, assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School in Boston.

Why would night work cause cancer? That's not entirely clear, but Schernhammer and her colleagues believe that it may have something to do with melatonin production, light exposure, and circadian rhythm.

"Many hormones are secreted throughout the day, but melatonin is secreted almost exclusively when it's dark. That's usually when we sleep," says Schernhammer. Light exposure at night suppressed the production of melatonin, she says.

Animal studies found that constant light or disruptions in circadian rhythm or the circadian period gene led to tumor formation.[3]

Role of melatonin explored

It's not clear whether melatonin itself is has a cancer-protective effect or whether it is a marker for the circadian rhythm, which may be an important factor, she says. Because that relationship isn't well-understood, Schernhammer and her colleagues do not recommend taking melatonin supplements.

Schernhammer noted that cancer isn't the only health risk associated with night shifts. "Night work has also been linked to a higher cardiovascular risk, higher rates of obesity, and other health outcomes that are not directly in the cancer pathway. It's fair to assume that this type of circadian disruption may actually cause a number of different [problems]," she says.

Health care workers and employers should be aware that night shift work may have health effects, says Straif. "Clearly, it sends a very strong signal that we should be concerned and as a precautionary principle we should not have unnecessary night shift work. We need more research to understand it," he says.

But Schernhammer puts it into perspective as just one more environmental exposure that can influence cancer risk. "There are many ways you can try to reduce your breast cancer risk," she says. "People can take other measures like losing weight or exercising more."

Meanwhile, researchers hope to gather more information about the cancer link. "My sense is that in five years from now, if we reconvene (as an IARC working group), we will have a much firmer answer to whether this moves up to being a definite carcinogen, or moves down to a potential carcinogen," she says.

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Keeping sticks low is an endless challenge

Evaluate new devices, monitor work practice

No more needlesticks. That is the ambitious goal set by the Centers for Disease Control and Prevention (CDC) as one of its "healthcare safety challenges." But for many hospitals, dramatic reductions in sharps injuries have given way to a stabilizing level or even increases in needlesticks.

The work of continuing to decrease needlesticks is indeed a challenge.

"Once you've made a big push to get the devices in place, it's easy to think, 'We've taken care of that,'" says **Jane Perry**, MA, director of communications for the International Healthcare Worker Safety Center at the University of Virginia in Charlottesville. "This is not something you can just do once and it's done."

Of course, the U.S. Occupational Safety and Health Administration's bloodborne pathogens standard requires hospitals to update their exposure control plan every year and to evaluate new technology.

To keep needlestick rates low, a simple annual review isn't enough, sharps safety experts say. Many employee health professionals monitor their

sharps exposures monthly or quarterly. That can lead to quality improvement projects to address the cause of injuries, says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN.

"You need a good system to electronically track how your injuries are happening," she says. "It's just a continual process."

More acceptance of blunt suture needles

Syringes remain the major source of injury (39%), either because they were not safety-engineered, the safety feature was not activated, or for some other reason a stick occurred during or after use, according to the recently released 2004 EPINet data. EPINet is a network of 41 hospitals coordinated by the International Healthcare Workers Safety Center at the University of Virginia in Charlottesville.

The operating room remains a primary location for sharps injuries (30.4%) and one in five sharps injuries involves a suture needle.

Blunt suture needles may finally be gaining acceptance. As *Hospital Employee Health* previously reported, the American College of Surgeons, OSHA and the National Institute for Occupational Safety and Health have issued statements encouraging the use of blunt suture needles. **(See *HEH*, June 2007, p. 65.)**

Vanderbilt has begun using blunt suture needles routinely for muscle or fascia, says Swift. The hospital first conducted a trial with the blunt suture needles, then made the change hospital-wide.

"In the past, there was a lot of resistance from surgeons and others who used them. But this time around, our surgeons have been very receptive," she says.

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. ■

CNE *questions*

5. According to William Schaffner, MD, chairman of the Department of Preventive Medicine and professor of infectious diseases at the Vanderbilt University School of Medicine in Nashville, what is the most important aspect of a declination statement used to improve flu vaccination of health care workers?
A. The wording of the statement
B. Mandatory signing of the declination
C. Timing of the declination
D. Face-to-face meetings with employees

6. According to Eva S. Schernhammer, MD, DrPH, assistant professor of medicine at Brigham and Women's Hospital and Harvard Medical School in Boston, who is at risk of cancer due to night shift work?
A. All women
B. All night shift workers
C. Those who work night shifts for many years
D. Night shift work doesn't lead to cancer

7. The U.S. Occupational Safety and Health Administration released a fact sheet on seasonal influenza vaccination that emphasizes:
A. patient safety.
B. the use of live nasal spray vaccine.
C. worker safety.
D. All of the above

8. According to EPINet data from the International Healthcare Workers Safety Center at the University of Virginia in Charlottesville, what device is most likely to be the source of sharps injuries?
A. Suture needles
B. Syringes
C. IV catheter stylets
D. Butterfly needles

Answer Key: 5. D; 6 C; 7 C; 8. B

Younger surgeons, in particular, are more open to the change, she says. "They're a little less inclined to hold nonevidence based opinions about their preferences," she says.

When an employee has multiple sticks

At Upper Chesapeake Health in Bel Air, MD, **Vickie Bands**, MSA, RN, director of community outreach and occupational health, keeps a close eye on sharps injuries. She reports needlesticks every month to the Infectious Disease Committee and employee health nurses investigate the causes. They also educate employees about needle safety. The hospital's OR manager also tells employees about OR exposures in a quarterly newsletter.

Bands and her colleagues recently noticed that several employees were injured while activating a safety device. The hospital is now evaluating a retractable needle to see if it would reduce the risk of injury and be acceptable to employees.

After a stick, the employee health nurses ask the injured employees for their opinion: "Were you not trained? Were you not comfortable with it? Do you feel it's not a good safety device?"

"We feel we need to do everything we possibly can [to reduce sharps injuries]," says Bands.

Yet the device is not always the problem. Addressing the issue of work practice can be especially challenging, she says.

Recently, a scrub tech had three sharps injuries in the past six months — and failed to follow hospital policy on prompt reporting. The tech had not complied with the no-pass zone — which provides a neutral place to pass sharps — and hadn't told a charge nurse about the injury until after the surgical case was over, Bands says.

On a case-by-case basis, situations like that will be referred to human resources, says Bands. For example, the scrub tech met with the OR director and human resources and received a written warning. If she has another exposure and fails to follow policy, she could face disciplinary action. The message is not a punitive one for those have multiple sticks, says Bands; it's an emphasis on safety.

"You need to be as worried about you as we are," she says. ■

CDC looking into deaths after treatment for TB

No HCWs reported, but CDC beefing up tracking

Alarmed by continuing deaths and severe adverse reactions after treatment for latent tuberculosis, the Centers for Disease Control and Prevention (CDC) is seeking funding approval for a national surveillance system to track the events.

Between October 2000 and October 2007, 79 patients receiving treatment for latent TB infection (LTBI) were reported to the CDC for severe adverse events related to medications. "None of them were health care workers, which is a good thing," says **Lilia Mangan**, RN, MPH, epidemiologist in the CDC division of TB elimination.

However, the findings have implications for health care workers, who may receive treatment after a TB skin test conversion resulting from an occupational exposure. "We do not think that being a health care worker poses a greater risk of developing severe adverse events related to [treatment] than other patients being treated for LTBI," she says. "There is no change in the recommendation for treatment of health care workers exposed to TB. Isoniziad right now is the preferred treatment."

A severe adverse event is defined as a drug-related reaction resulting in hospitalization or death of a person receiving treatment for LTBI. Deaths reported among people treated for LTBI included two of 50 people who were on the then recommended two-month regimen of rifampin and pyrazinamide (RZ). "As a result of those investigations, we don't recommend RZ anymore for treatment for latent TB infection," Mangan says. "The preferred treatment right now is nine months of isoniziad [alone]."

However, adverse events continue to be reported, including nine deaths in 22 severe adverse reactions in people treated with isoniziad. The purpose of the surveillance system is to determine the annual number of the events, reveal trends, and identify any common characteristics of the patients affected. ■

COMING IN FUTURE MONTHS

- Why aging baby boomers will increase workers' comp claims
- Reducing noise for food service workers
- Will incentives give workers healthier habits?
- Strategies to improve hand hygiene
- Teaming with risk management to reduce back injuries

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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