Bullying in the Workplace
By Nancee Tardif, MSN RN

Nurses as Second Victims: Supporting Our Colleagues Following an Adverse Event
By Ron Hofeldt, MD and Patricia I. McCotter, RN, JD, CPHRM, CPC

Recognizing and Helping the Nurse “Second Victim”

Return to Work Getting Unstuck! A New Way of Thinking, Part 3
By Kenneth Mitchell, PhD

Alcohol Abuse in the Workplace and Patient Safety
By Camille A. Servodidio, RN MPH CRNO OCN® CCRP

Assisting the Drug Addicted Nurse: Information for the Legal Nurse Consultant
By Marilyn McHugh, MSN, JD, Karen Papastrat, MSN, and Kathleen C. Ashton, PhD, APRN, BC

Draft National Safe Patient Handling Standards Released for Comment. Standards to Establish Basis for Policies, Laws, Regulations to Protect Workers, Patients
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President’s Message

By Dee Tyler, RN COHN-S FAAOHN

AOHP Executive President’s Address

Editor’s Note: This report was delivered by Dee Tyler on October 5, 2012 to attendees of the 2012 Annual Business Luncheon at the AOHP Annual National Conference, held in Las Vegas, NV.

AOHP’s Executive Board continues to move the organization to be the defining resource and the leading advocate for occupational health and safety in healthcare. Here today, you have already heard ways that the Board is working hard on your behalf and representing the AOHP membership and occupational health professionals in healthcare.

As Ann Hook, AOHP’s Executive Treasurer, has indicated, the organization has remained fiscally sound, and a balanced budget has been accomplished for AOHP. This is the basis that the business of the Board hinges on, and we take our fiscal responsibility very seriously. You can be assured that the Board is constantly assessing how we are bringing value to our members.

Chapters are supported through chapter president quarterly calls, treasurer calls as needed, as well as assisting chapters to address challenges when necessary. AOHP regional directors work closely with chapter leadership to meet chapter needs. More and more chapters have incorporated conference call capabilities to their meetings to reach members not in the immediate meeting area or who are unable to get away from work.

MaryAnn Gruden, AOHP Association Community Liaison, has reported today regarding partnerships, conference calls, and collaborations with various groups. She has told you about AOHP writing NIOSH and offering public comment on the Collection & Use of Patient Work Information in the Clinical Setting: EMR. While I will not reiterate her report, I do want to highlight a few items, as this is important work for the association.

It is my privilege to also report that AOHP has begun a collaborative relationship with our ACOEM colleagues this year, including a reciprocal conference fee for AOHP Research Chair Linda Good to attend a portion of the ACOEM national conference while ACOEM representative Dr. William Buchta attends AOHP’s conference this week.

An exciting collaboration that will be occurring over the next year is with the Japan Infection Control Support Association (JICSA.) In 2011, AOHP began negotiations with the group, and an agreement was reached. AOHP is collaborating with the group to translate AOHP’s Getting Started Manual into Japanese, and the manual will be marketed to Japanese occupational health professionals.

OEM Press is the leading publisher of books related to the specialty of occupational and environmental health. AOHP is working with OEM Press to offer the Getting Started Manual as a publication through its publishing house.

Mary Bliss has represented AOHP on the Safe Patient Handling National Standards Work Group that has been developing national safe patient handling and movement standards. Late in 2012 the document will be available for public comment, with completion planned for the spring of 2013.

Biennially, the Getting Started Manual is reviewed and edited to reflect current information in the field of occupational health. During the summer of 2012, the manual update was completed by the AOHP Board.

Throughout the last year, AOHP has been working hard to formalize and increase AOHP’s research activity. Linda Good has informed you this day regarding the exciting work of the Research Committee.

I am pleased to report that the data has been analyzed,
and AOHP’s staffing survey results were published in the spring 2012 AOHP Journal by MaryAnn Gruden.

Support for the Consensus Statement for Sharps Injury Prevention with AORN and the OSHA Alliance was issued and a press release broadcast on August 13.

After a rigorous application process led by Mary Cox, the AOHP Continuing Education Chair, and her ANCC accreditation team, AOHP was awarded “Accreditation with Distinction,” the highest recognition awarded by ANCC as a provider of continuing nursing education. This provider-ship was awarded January 2012 through March 2014. Let us thank the Continuing Education ANCC Team, who worked diligently to accomplish this daunting task, with a round of applause for the hard work they did on our behalf! This was not an easy feat!

To increase AOHP visibility, collaboration, and to bring information back to the membership, AOHP has sent or will be sending representatives to conferences, including ACOEM’s Occupational Health Conference, the National Safety Conference, the International Society for Respiratory Protection and the 2012 Joint Commission Liaison Network Forum.

On October 1 and 2, the AOHP Board of Directors participated in a formal strategic planning process. A Request for Proposal was issued, and Impact Consulting was selected to lead AOHP through the strategic planning process. The Board wanted a professional strategic planner to help us strategize how to take AOHP to new heights. To prepare for the strategic planning process, both a Board and a membership survey were collected. Mary Partridge has worked with the Board to conduct an environment scan, analyze the information, strategize and develop a plan to move forward. An enhanced vision of “AOHP is the defining authority shaping healthcare worker health, safety and well being” was finalized. Five bold steps were also identified: 1) Increase marketing and membership by 30 percent. 2) Build technology capacity. 3) Communicate effectively with membership. 4) Increase research capacity. 5) Education and product development.

A Strategic Initiative Committee was identified, and the Marketing and Human Resources committees were moved into the Strategic Initiative Committee. The Board voted to invest in our members by taking $60,000 from our reserves and dedicating it toward strategic initiatives. Your AOHP Board will be working with Mary to finalize our blueprint for the future and identify specific allocations for the $60,000 earmarked for strategic initiatives.

In an effort to improve AOHP’s visibility as the defining resource and the leading advocate for occupational health and safety in healthcare, a conscious effort to spotlight AOHP through press releases has been continued. Several press releases were issued over the past year, including the 2011 election results, the Getting Started Manual translation and agreement with JICSA, AOHP Continuing Nursing Education Providership Accreditation from ANCC, AOHP Support of Sharps Safety Consensus Statement, and the Publishing of the 13th Edition of the Getting Started Manual.

In a world that has seen a technology explosion in recent years, it is important for AOHP to harness this tool to increase member value. The AOHP Technology Committee, led by Carla Stevens, has been assessing AOHP technology use and preparing for technology improvements, including establishing technology guidelines. Watch for significant and exciting changes to come in AOHP’s use of technology, including one that may not be so visible to begin with, the purchase and installation of a new Web platform for the AOHP Web site.

As Kim Stanchfield, AOHP Journal Editor, reported, PubMed indexing has been accomplished for the AOHP Journal, and the publication ISSN # has been updated after it was discovered that the previous association management company never accomplished this task when the Journal name changed.

Along with all that I have mentioned, since we have last met, the AOHP Board has been conducting customary board business with elections, bylaws review, award reviews and selections, as well as preparing for the 2012 AOHP National Conference, here in Las Vegas, NV.

It sounds as if I should even add that your AOHP Board “leaps tall buildings with a single bound.” So “What’s Next?”

In this next year, you can expect that your AOHP Board will be continuing to work on increasing membership and increasing AOHP brand recognition. One of the ways that AOHP can really bring value to members is by assisting them to be more visible within their places of business and by developing return on investment validation for the OHP position.

The Board has discussed the importance of using technology to increase the value of the association to its members, and there are plans to revise the AOHP Web site and to develop virtual education offerings via the Web site.

This past Monday and Tuesday, the AOHP Executive Board completed the strategic planning process and will be working to develop and implement the recommendations over the next two years.

I could go on and on. But, in the interest of time, those who would like more information can check the AOHP Journal and AOHP electronic publications, email info@aohp.org, or please feel free to talk to any AOHP Board member. The AOHP Board desires and encourages your input.

Please know the AOHP Board that you have elected is a hard working Board. All your elected officials are volunteer leaders, and they put much time and effort into supporting AOHP and its members. What a conscientious group I serve with. Thank you, AOHP Board!

Thank you to all our exhibitor and sponsor partners who help us to do so much for AOHP. Also, I would like to recognize our AOHP Head-
quarters staff members, Judy Lyle and Annie Wiest of Kamo, who support the Board so wonderfully. Let’s thank them for all they do for the association!

A big thank you also goes to the AOHP members for their passion and desire to support the organization, as well as for all your contributions and input. Thank you for your confidence in your association Board members.

I wish to challenge the AOHP membership to increase your active involvement in YOUR association. There are all sorts of ways to become involved, including at the chapter level, in chapter leadership and in meeting participation. There are also national committees that are looking to recruit new members and receive your input. Or, consider running for an Executive Board position. I got involved at the AOHP Board level because long-time member and then AOHP President Kathleen Van Doren said, “I think you would be good,” so let me say to all of you, “I think YOU would be good!”

I think you will find that your involvement with AOHP will be a rewarding experience. So, who takes care of you as you take care of others? WE DO! AOHP.

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Thank you, Hill-Rom
For sponsoring the AOHP Annual Business Luncheon during the AOHP 2012 Annual National Conference in Las Vegas.
Vice President’s Update

By Stephen Burt, BS MFA

Employer Incentive and Disincentive Programs May Be a “RED FLAG” to OSHA

It has long been a subject of debate among safety consultants – Do safety incentive programs reduce injuries, or do they encourage workers not to report when they get hurt so they can win the prize?

According to the March 12, 2012 Guidance Memorandum Employer Safety Incentive and Disincentive Policies and Practices issued by OSHA to its regional administrators and whistleblower program managers, employers who reward employees through certain kinds of safety incentive programs for the absence, or limited number, of workplace injuries might be violating OSHA’s anti-retaliation and recordkeeping rules. While the Obama Administration has been highly critical of employer safety bonus and incentive programs, OSHA now argues that these programs could themselves violate both anti-retaliation and recordkeeping laws.

In the memo, the agency challenges rules that impose discipline for injuries or safety rule violations if the employer learns of the unsafe behavior as a result of the employee’s report of an injury. The agency expresses concern with rules that impose discipline for the failure to report an injury within a specified time period without the employer first carefully considering potential justifications for the employee’s failure to timely report, such as the employee initially thinking the injury was not serious enough to report. OSHA contends these types of rules and programs effectively discourage employees from reporting injuries and could violate Section 11(c) of OSHA, which prohibits employers from discriminating against employees “in any manner” for exercising a protected right under the statute, including reporting an injury.

In the case of safety incentive programs, the memo specifically warns that “if the incentive involved is of sufficient magnitude that failure to receive it might have dissuaded reasonable workers from reporting injuries,” then the rule or program not only could violate OSHA whistleblower protections, but could also lead the employer to fail to record injuries as required by OSHA regulations.

There are several types of workplace policies and practices that could discourage reporting and constitute unlawful discrimination and a violation of Section 11(c) and other whistleblower protection statutes. Some of these policies and practices may also violate OSHA’s recordkeeping regulations, particularly the requirement to ensure that employees have a way to report work-related injuries and illnesses. 29 C.F.R. 1904.35(b)(1.) OSHA has also observed that the potential for unlawful discrimination under all of these policies may increase when management or supervisory bonuses are linked to lower reported injury rates.

OSHA states it appreciates employers using safety as a key management metric, but they also clearly enunciate that the agency cannot condone a program that encourages discrimination against workers who report injuries.

The following list, found in the memorandum, contains some of the most common policies which are potentially discriminatory to OSHA:

1. OSHA has received reports of employers who have a policy of taking disciplinary action against employees who are injured on the job, regardless of the circumstances surrounding the injury. Reporting an injury is always a protected activity. OSHA views discipline imposed under such a policy against an employee who reports an injury as a direct violation of Section 11(c) or the Federal Railroad Safety Act (FRSA.) In other words, an employer’s policy to discipline all employees who are injured, regardless of fault, is not a legitimate non-discriminatory reason that an employer may advance to justify adverse action against an employee who reports an injury. In addition,
such a policy is inconsistent with the employer’s obligation to establish a way for employees to report injuries under 29 CFR 1904.35(b) and where it is encountered, a referral for a recordkeeping investigation should be made. Where OSHA encounters such conduct by a railroad carrier, or a contractor or subcontractor of a railroad carrier, a referral to the Federal Railroad Administration (FRA), which may conduct a recordkeeping investigation, may also be appropriate.

2. Taking disciplinary action against an employee who reports an injury or illness, and the stated reason is that the employee has violated an employer rule about the time or manner for reporting injuries and illnesses. Such cases deserve careful scrutiny. Because the act of reporting the injury directly results in discipline, there is a clear potential for violating Section 11(c) or FRSA. OSHA recognizes that employers have a legitimate interest in establishing procedures for receiving and responding to reports of injuries. To be consistent with the statute, however, such procedures must be reasonable and may not unduly burden the employee’s right and ability to report. For example, the rules cannot penalize workers who do not realize immediately that their injuries are serious enough to report, or even that they are injured at all. Nor may enforcement of such rules be used as a pretext for unlawful discrimination.

Therefore, where such general rules are involved, the investigation must include an especially careful examination of whether and how the employer applies the rule in situations that do not involve an employee injury. Enforcing a rule more stringently against injured employees than non-injured employees may suggest that the rule is a pretext for discrimination against an injured employee in violation of Section 11(c) or FRSA.

3. Taking disciplinary action against an employee who reports an injury because the injury resulted from violation of a safety rule. OSHA encourages employers to maintain and enforce legitimate workplace safety rules to eliminate or reduce workplace hazards and prevent injuries from occurring. In some cases, however, an employer may attempt to use a work rule as a pretext for discrimination against a worker who reports an injury. A careful investigation is needed. Several circumstances are relevant. Does the employer monitor for compliance with the work rule in the absence of an injury? Does the employer consistently impose equivalent discipline against employees who violate the work rule in the absence of an injury? The nature of the rule cited by the employer should also be considered. Vague rules, such as a requirement that employees “maintain situational awareness” or “work carefully,” may be manipulated and used as a pretext for unlawful discrimination.

4. Maintenance of policies that intentionally or unintentionally provide employees with an incentive not to report an injury. For example, an employer might enter all employees who have not been injured in the previous year in a drawing to win a prize, or a team of employees might be awarded a bonus if no one from the team is injured over some period of time. Such programs might be well-intentioned efforts by employers to encourage their workers to use safe practices. However, there are better ways to encourage safe work practices, such as incentives that promote worker participation in safety-related activities like identifying hazards or participating in investigations of injuries, incidents or ‘near misses.’ OSHA’s VPP Guidance materials refer to a number of positive incentives, including: providing T-shirts to workers serving on safety and health committees; offering modest rewards for suggesting ways to strengthen safety and health; or throwing a recognition party at the successful completion of company-wide safety and health training. See Revised Policy Memo #5 - Further Improvements to VPP (June 29, 2011.)

The Guidance Memorandum issued by OSHA is intended to assist field compliance officers and whistleblower investigative staff. We can expect there will be a lawsuit filed over the memorandum. The lawsuit will address the content of the memorandum and OSHA’s attempt to impose enforcement through “memorandum” and “guidance” rather than rulemaking. Legislation introduced in the 112th Congress, the Regulatory Accountability Act of 2011, H.R. 3010, would require OSHA to treat “guidance” documents like rulemaking and follow a formal process including a notice and comment period. The proposed legislation states that agency guidance as currently created “may not be relied upon by an agency as legal grounds for agency action.”

Reporting a work-related injury or illness is a core employee right, and retaliating against a worker for reporting an injury or illness is illegal discrimination under Section 11(c). During a recent Department of Labor budget hearing, Labor Secretary Hilda Solis said she would review this memo, but assured House committee members that OSHA does not intend to issue citations for employer safety programs in general. Regardless of the Labor Secretary’s assurance that OSHA will not penalize employers for maintaining safety policies, the new memo is a reminder that workplace policies and incentive programs must be carefully reviewed and consistently enforced.
Employee Health is an interesting and challenging specialty in nursing. I have been in nursing for 37 years, the last 25 of them in Employee Health. During the past 25 years, I have observed much regarding human behavior. People fascinate me. People who work in healthcare fascinate me even more.

Please allow me to share with you in this column some of my observations of healthcare employees. My opinions are totally my own. To paraphrase a popular saying, “opinions are like noses…everyone has ‘em.”

Observation #1 Employees never come to your office so quickly as when they need a copy of something in their file for school or another job.

Observation #2 Physicians are very intelligent people, until they get a needle stick.

Observation #3 The single most anticipated event in a volunteer’s life is his or her annual flu shot.

Observation #4 It would never occur to most employees that you are working if you are at your desk on the phone.

Observation #5 If it is Friday at 5 pm, look in your doorway. There stands an employee with a blood exposure.

Observation #6 Employees can get their personal physicians to write a “note” for just about anything they desire.

Observation #7 If an employee sneezes at work (and never at home,) the reason has to be mold growing in the ceiling tiles.

Observation #8 You are grocery shopping at Super Wal-Mart. Sure, you will be happy to read an employee’s PPD.

Observation #9 No matter what manager messed up what, it is your job to fix it.

Observation #10 During any educational/informational presentation you conduct, someone’s going to come 15 minutes late…and ask questions about all the information you went over in the first 15 minutes.

Observation #11 Employees do not read…anything.

Observation #12 The Infection Control staff are on vacation…of course the ED is calling with a very sick patient suspected of having N. Meningitis.

Do you share any common observations? Healthcare employees, no matter what level, are some of the very best people I’ve ever known. Most of the time, I would do anything in the world for them, as you also would. Occasionally, we do need to share a collective “giggle” or two at their expense!

Thank you to Axion Health For sponsoring John Howard, MD MPH JD LLM as the AOHP 2012 Annual National Conference Keynote Speaker

Axion Health offers web-based routine health, assessment and clinical response software and services for workers and key personnel; including hazard and exposure prevention, emergency preparedness and response and medical surveillance programs. To learn more, visit www.axionhealth.com.
OSHA Alliance Update
On July 11, 2012 the Alliance held a regular conference call. A draft of the workplace violence (WPV) resource list was discussed. Additional suggestions were made and taken back to AOHP for consideration. The goal was to have the WPV resource list ready for publication for the AOHP National Conference. OSHA’s Heat Illness Prevention Campaign, Hazard Communication Webinar and AOHP’s participation with OSHA in the National Safety Council Conference in October were other topics that were discussed. An article highlighting AOHP’s revised safe patient handling guide was submitted for the Alliance Quarterly Report. AOHP remains in the queue for formal renewal of the Alliance. Until the Alliance is formally renewed, we will continue to work on projects of mutual interest.

OSHA and DOT Partner to Address Distracted Driving
Motor vehicle crashes are the leading cause of worker fatalities. Because many workers’ jobs require them to spend part or all of their work day driving, OSHA and DOT have joined together in a campaign to stop distracted driving and save lives. To learn more about OSHA’s efforts to protect workers on the road, visit OSHA’s Distracted Driving page: http://www.osha.gov/distracted-driving/index.html.

OSHA and NIOSH Inform Employers and Workers on Safe Work Practices When Using Cleaning Chemicals
Workers who clean buildings, schools, hospitals, hotels, restaurants and factories use a variety of cleaning chemicals that can pose health risks. Health effects from exposure to chemicals in cleaning products can range from skin rashes and burns to eye, nose and throat irritation, to cough and asthma. Many employers are switching to green cleaning products because they are thought to be less hazardous to workers and the environment. The new OSHA-NIOSH Infosheet “Protecting Workers Who Use Cleaning Chemicals” provides employers with guidance on choosing safer cleaning products, safe work practices, worker training and better cleaning methods. The accompanying poster, “Protect Yourself: Cleaning Chemicals and Your Health,” informs workers of the hazards of cleaning chemicals, symptoms and employer responsibilities. In addition to English, the poster is available in Spanish, Chinese and Tagalog. The Infosheet can be found at http://www.osha.gov/Publications/OSHA3512.pdf. Visit http://www.osha.gov/Publications/3511-CleanChemPoster.pdf for a copy of the poster.

OSHA eTool Helps Employers Prevent Shock and Electrocution Hazards
To provide assistance to employers in complying with OSHA’s Subpart S Electrical Standards for General Industry electrical installation standard, the agency has developed the new “Subpart S eTool” (eTools are “stand-alone,” interactive, Web-based training tools on occupational safety and health topics.) The standard, which became effective in 2007, is intended to reduce the risk of injury and death caused by unsafe electrical installations.

NIOSH Update
The Respiratory Protection Advisory Group has met on a regular basis since December 2011 to address two of seven recommendations from the Institute of Medicine’s (IOM) report Occupational Health Nurses and Respiratory Protection: Improving Education and Training: Letter Report. Team members include the American Association of Occupational Health Nurses, American Board of Occupational Health Nurses, American Nurses Association, AOHP and the IOM Committee on Personal Protective Equipment. A survey was developed, piloted and distributed to group’s association members and certified occupational health nurses, with more than 2,000 responses. AOHP has received a subset of data on healthcare workers and AOHP member responses for comparison. Barbara Burgel, PhD RN COHN-S/CM FAAN, analyzed the survey data. The preliminary data analysis appears in this issue of the Journal. A poster, Occupational Health Nurses and Respiratory Protection Competency, summarizing the work of the group and the survey results, was presented at the 2012 AOHP National Conference. Additional articles and posters will
be developed going forward, while the focus of the group will turn to developing educational products that will assist the occupational health nurse in developing and maintaining competency in this important area of practice.

On June 28, 2012 CDC/NIOSH and AOHP held a quarterly call. A variety of topics were discussed. Of significant interest was the revision of HIV post exposure prophylaxis. The revisions are projected for this fall. The next document that the CDC will be reviewing will be infection prevention guidelines for healthcare personnel.

AOHP submitted public comments on the NIOSH Request for Information on the Collection and Use of Patient Work Information in the Clinical Setting: Electronic Medical Record. The purpose of the public comments was to gather information to form its approach in recommending the inclusion of work information in the electronic health record (EHR.) An IOM committee, convened at the request of NIOSH in 2011, concluded that inclusion of occupational information in the EHR “could contribute to fully realizing the meaningful use for EHRs in improving individual and population health care.” The June 28, 2012 Federal Register notice included that NIOSH was “working to ensure the EHRs will contribute to improvements in individual and population health by meeting the need to support occupational considerations during clinical care and by enhancing public health professionals’ understanding of work-related conditions so they can identify effective treatment and prevention strategies.” There were three primary questions for which NIOSH sought input. First, for primary care providers, when do clinicians in a practice setting ask patients about their work? Second, for occupational health providers, how is the patient’s work information collected? Lastly, for developers and vendors of EHR/software, does their base/basic EHR product contain preordained fields for industry, occupation, employer or other information about the patient’s work, and if not, had they been asked to provide these fields? Comments were due August 27, 2012 and AOHP’s comments are available both on the AOHP Web site and the Federal eRulemaking Portal at http://www.regulations.gov.

Intimate Partner Violence and Working Women
Recent research conducted by NIOSH and West Virginia University’s Injury Control Research Center revealed intimate partner workplace violence among working women in the United States resulted in 142 homicides from 2003 to 2008. The study was published in the April 2012 issue of Annals of Epidemiology, and the results also indicated that women in healthcare, production and office/administration had the highest proportion of homicides in the workplace related to intimate partner violence. Read more at http://www.cdc.gov/NIOSH/updates/upd-05-03-12.html.

New Emergency Medical Services Resources
NIOSH has posted a Web page highlighting emergency medical service (EMS) worker safety and health. In addition to providing EMS safety and health resources and references, the Web page offers a data summary describing nonfatal injuries to EMS workers treated in emergency departments. This Web page evolved from a collaborative project between NIOSH and the National Highway Traffic Safety Administration, Office of Emergency Medical Services, focusing on occupational injuries to EMS workers. http://www.cdc.gov/niosh/topics/ems/.

NIOSH Study Finds Benefits of Paid Sick Leave
A NIOSH study published online on July 19 by the American Journal of Public Health found that workers with access to paid sick leave were almost 30 percent less likely to suffer nonfatal occupational injuries than workers without access to paid sick leave. The study results suggest that paid sick leave makes a greater difference in occupations and sectors with a high risk of injury, such as construction, manufacturing, agriculture, and healthcare and social assistance. Paid sick leave can also decrease other risks and costs related to sick workers, such as spread of contagious diseases to coworkers. Despite the potential benefits for employers offering paid sick leave, 43 percent of American private sector workers reported not having access to this benefit during the study period. http://www2a.cdc.gov/nioshsltic-2/BuildQyr.asp?s1=Asfaw&f1=%2A&Startyea r=&Adv=0&terms=1&EndYear =&Limit=10000&sort=D1 =10&BageNo=1&RecNo=1& View=f&.

ACOEM Collaboration
Linda Good, Southern California Chapter, attended the America College of Occupational and Environmental Medicine’s (ACOEM) Medical Center Occupational Health Special Interest Group meeting, held at the association’s national meeting in Los Angeles, on behalf of AOHP. Linda was also able to attend a portion of the ACOEM conference and reported on research findings from the conference in the summer issue of the AOHP Journal. On June 27, 2012 an AOHP/ACOEM conference call was held. The call included follow-up from the ACOEM meeting/conference and future opportunities for sharing educational expertise.

Technical Expert Panel on Respiratory Protection Update
The Technical Expert Panel on Respiratory Protection (TEP) led by The Joint Commission (TJC) and CDC/NIOSH/National Personal Protective Technology Laboratory, continues its work. This collaborative is led by TJC’s research division. The initiative is not intended to generate a new standard, but rather to gather information and develop a resource for healthcare facilities on respiratory protection. On May 21, a conference call was held with primary discussion focused on a survey that would gather information about effective practices of respiratory protection programs. AOHP had two members participate in the pilot, Carla Stevens, North Carolina Chapter, and Anna Hook, Illinois Chapter. The pilot results were analyzed and the survey disseminated in August to several organizations’ memberships, including AOHP. Thank you to all who participated in the survey. AOHP’s membership will be updated as the results are analyzed and the document prepared for distribution.

ANA Convenes Experts
on Safe Patient Handling

During the summer, the American Nurses Association (ANA) convened a panel of 26 experts in safe patient handling (SPH). AOHP is among the organizations represented on the multidisciplinary panel. The purpose of the Safe Patient Handling National Standards Working Group is to build consensus of evidence-based best practices in SPH that will apply to multiple healthcare professions and settings, and will develop a common language for use across the country. March 2013 is the target date for publication of the panel’s document. Mary Matz, National Program Manager for Patient Care Ergonomics at the Veterans Health Administration, is the chair of the panel. More information will be provided in the coming months about the panel’s work. Mary Bliss, Illinois Chapter, is the panel’s AOHP representative.

Conclusion

It is wonderful to see AOHP partnering with stakeholders to build a body of evidence-based knowledge that will continue to advance the specialty. On behalf of the Executive Board, I express special thanks to our members who have participated in AOHP’s partnerships. More information about our vision related to our partnerships will be presented in the coming months now that the Executive Board’s strategic planning process has been completed. Until then, I wish you and yours a safe and wonderful holiday season.

CALL FOR SPEAKERS

2013 AOHP NATIONAL CONFERENCE

September 11-14, 2013
Hilton Walt Disneyworld Resort, Orlando, FL

We are accepting presentation submissions for the AOHP 2013 National Conference. The speaker submission will be in two phases. The first submission will help the committee decide if your presentation meets the needs of the conference. Please complete this submission and provide as much detail as possible including a description of any relevant methods, techniques, tools, results, lessons learned, etc.

Deadline to submit: January 31, 2013  →  Successful applicants will be notified by March 29, 2013

Suggested topics:

- Healthcare reform
- Oncore clinic best practices
- How Employee/Occupational Health departments can assist companies to become Accountable Care Organizations
- Chronic pain management and the opiate epidemic
- Best practices to minimize splashes - selection of PPE and other engineering controls
- Physician employees as a part of the healthcare workforce
- Work restrictions best practices
- Medical surveillance in environmental services, endoscopy, EMS, labor & delivery
- Nurse or doctor sharing own addiction experience
- Surviving Mandatory Flu vaccination programs
- Safe patient handling
- Needle safety
- Latest advice of the PEP line for exposures
- TB screening and the CDC’s new treatment recommendation
- Effective hand hygiene compliance measures
- Workers comp, especially Orthopedic injury assessment, skin issues
- Effective Health Promotion programs
- New mandatory federal flu shot rate reporting
- “late breaking news” a hot topic so new it hasn't even happen yet!
- Tobacco Cessation Program
- Healthcare worker wellness
- Pharmacology in Occupational Health
- Diversion Substance Abuse and Nurses
- Advanced Practice in Occupational Health
- Wellness programs
- Talking with the C-suite, getting what you need
- Advanced TB review— where are we going with TB and MDR-TB
- The Joint Commission on high reliability organizations
- "late breaking news” a hot topic so new it hasn't even happen yet!
- Tobacco Cessation Program
- Healthcare worker wellness
- Pharmacology in Occupational Health
- Diversion Substance Abuse and Nurses
- Advanced Practice in Occupational Health
- Wellness programs
- Talking with the C-suite, getting what you need
- Advanced TB review— where are we going with TB and MDR-TB
- The Joint Commission on high reliability organizations

 “…or understand why your Smartphone doesn’t always act so smart.” Remember this phrase from the launch of the Tech Talk column? Security issues these days are wreaking such havoc that many users, of all kinds of technology, don’t even know they’ve been hacked – much less what to do next. This is the first article of a four-part series on how to improve your privacy, protect your identity and beef up security of various computing gadgets. Although the first topic is about Smartphones, plan on seeing themes overlap throughout.

Smartphones

What is a Smartphone?

When is: a blackberry not a fruit; an “i” referring to something other than you or me; an android not a sci-fi robot; an ice cream sandwich not eaten? When it’s a Smartphone – not a cell phone. Confused yet? You’re not alone. Remember early cell phones? Those “bricks” with antennas we held to our ears are now downsized to a deck of cards. Some of us also toted a PDA (personal digital assistant) to organize calendar events, contact info and to-do lists. Yet others carried a handheld PC which, in addition to PDA functions, had versions of Word and Excel, e-mail capabilities and games. The merging of all this technology resulted in a wireless collective known as a Smartphone, a mobile PC that can make calls and sync with your laptop or desktop PC.

How do Smartphones work?

Basic features include:

• Operating system, or OS – think PC, like Windows 7 or XP or Mac operating systems, just tweaked differently for a Smartphone in terms of how the computer operates. Does it have a touch screen only, a keyboard or both? Do you pinch the monitor to shrink screens or type the keyboard? Can you open “X” number of screens or only one at a time? Examples of an OS are the “ice cream sandwich” used by Android and of course, iOS for iPhones.

• Applications, or apps – think Word, Excel or Outlook; calculator, media player, Adobe, XYZ app that you downloaded – like a metronome, health tracker or QRC reader.

• Web access – unlike your cable modem, Smartphones have a wireless Web interface that connects to the Internet. The caveat is that you must match carrier service (AT&T, Verizon, T-Mobile, etc.) with the capability of the phone. If you have an older, slower, “chipped” phone, you will not get faster service just by signing up with a 4G carrier. Your connection speed will not exceed a speed faster than has been programmed (like the speed governors on some trucks not exceeding 55 mph even though you’ve floored the gas pedal.)

• Keyboard – whether typed, touched or penned, it’s the same layout as a typewriter. (Remember those?)

• Message center – manages e-mail account(s) through various vendors (AOL, Google, Yahoo, Hotmail,) incoming calls, contact list; basically your communication gateway.

It’s important to have a basic knowledge of these features, as this can help you decide on the next Smartphone (or cell phone) you buy. Just remember, Smartphones are mini PCs, so if you compare them to a laptop or desktop, you’ll find similar capabilities, as well as vulnerabilities.

Why would I want a Smartphone?

In my humble opinion, the biggest reason is peer pressure. “Everybody” has one. In the practical nutshell, though – efficiency and convenience are pretty compelling. Let’s face it. It’s much easier to pop a phone in your bag when going out than to lug a PC over your back. Standing in line can turn into productive time if you need to do research, check your bank balance or make notes for an upcoming project. Having apps that help to track your steps or calories, do song recognition and check traffic or weather can ease a few brain cells. The convenience
of having all your communication needs met with one device is certainly appealing.

**Why would I not want a Smartphone?**
A couple of reasons come to mind. Small screens are hard to see, and wireless connection fees add up. Sometimes, even with “cheaters” on, you may have difficulty seeing Web pages. This may not be the fault of the phone, but the way the page was initially set up. Web pages formatted to accommodate Smartphones have the most important information at the top of the page (because of the small screen.) Including menu tabs.

Getting and keeping the surfer’s attention can equate into possible sales, memberships or at least, revisits. Touch screens may not be user friendly for someone having a lifelong keyboard habit. Tip: Practice using demo phones in the store before you buy.

Also, consider that some phones must be charged every day vs. weekly; a cost wherever it is docked.

Phone fees are built on three categories: voice minutes available (cell phones and Smartphones,) text messaging (most cell phones; Smartphones) and data access (some cell phones; Smartphones.) The vendor’s goal is to create a combination of features that generate the most revenue. As consumers, our goal is to pay for what we’ll use without paying for unnecessary features. Wireless connection fees with some data plans cost anywhere from $300 to $1,200 per year, so it really pays to shop around for the right vendor. Not to worry. Many larger hospitals, corporations and credit unions have employee benefits that include discounts on monthly cell phone or Smartphone data plans, or even phones.

Are you mindful of your possessions, especially small items? You may not want to have a Smartphone if you are forgetful. Why? Theft! If you have personal or work files on your Smartphone, that’s one of the first things a thief will scour. In some businesses, loss of work data can get you fired. Tip:Smart people will have password protection and encryption capabilities for multiple folders.

Maybe you’re not forgetful, but do you have butter fingers? Those screens shatter, and the internals go wonky. This is a PC, so treat it as fragile as it is. Spend the extra bucks for a protective sheath or case. Better yet, buy one that is also waterproof. That could be lots of money literally circling the drain when your toddler is checking its floatability. You’ll find a variety of shapes, colors, sizes, prices and materials throughout the vending world.

**What are some Smartphone risks?**
Remember, you are holding a small PC that can crash like your desktop. Minimize this risk by backing it up, or by synchronizing (“syncing”) with your home PC or laptop. If you want to keep photos, videos, song or files safe – back ‘em up. Nice segue into obvious (or oblivious) privacy and security concerns, but where does one start?

First of all, recognize that your Smartphone (yes, even your cell phone) is a mobile monitoring device. If it’s equipped with a camera and/or microphone, your conversations or texts can be eavesdropped, and the camera becomes a roving “eye.” Phone turned off? It doesn’t matter, because monitoring can be accomplished remotely by spyware that can turn the phone back on. How can you tell if you’re a victim of spyware? Check your bill for changes, whether it’s increased fees or an increase in the number of messages or texts. Does the screen light up for no reason? Does your phone feel hot, or does the battery indicator show it’s drained? These are sure signs someone is hacking your phone.

What other privacy and security risks lurk? First of all, set up your phone to time out, and then make sure you have a password to log back on. Don’t use a 1-2-3-4 combo or the word “password,” these being the most common keystrokes used. Even though this may be annoying, it’s just one more stronghold for your Smartphone. Take a familiar word and use numbers or symbols to recreate it into something more secure. If your phone requires a finger trace over symbols or numbers, make sure there are two or more cross lines for the path. If not, the pressure from your finger will eventually make the invisible line, well, visible. Still stumped? Test out your revised password word on www.grc.com/haystack.htm. Better yet, install password protection and encryption capabilities for your phone.

Now, about that misplaced phone. As you read a few paragraphs earlier, if it’s truly lost or stolen, expect to have unprotected files breached, even if unintentional. That being said, you can – with the right software – remotely block access and/or wipe your phone clean of personal information, even if the SIM (subscriber identification module) card has been replaced. (This portable memory chip holds the user’s personal info, texts, addresses and other data.) Of course, you can also use software that will locate your phone using GPS (global positioning system.) Your phone may already have this feature. To locate this software, skim the owner’s manual, or do a Web search and you might find YouTube tutorials on these very features.

If you think your PC has lots of spam, guess what? So can your phone. Use anti-scam software to block calls and texts from known or unknown people. The program should also prevent spam and viruses from hitching a ride while you’re surfing. Combo software with anti-viral protection can perform real-time scanning and provide firewall protection. That, in turn, helps prevent the same trash from transferring to your PC or Mac when you sync.

Privacy software manages control of what others can see. Does your screen now show “You’ve got mail” or you have a message from “X”? Maybe you want to keep calls or texts hidden until ready to be viewed. Some programs are designed to set privacy mode manually, automatically or even remotely.

I can hear some people now… “Well, I’ll just keep my old Dumbphone and not worry about all this cyberjunk.” Fine. But, the aforementioned risks may not be
apparent to your family or friends. These same privacy and security issues make them just as vulnerable. As a parent, utilize controls on your child’s phone to block outgoing calls and texts to undesirable numbers. Child unit #2 hasn’t reported in by 10 pm curfew? You can use a GPS app to locate your child if the phone is with him or her.

If a user is shopping for protective software, I recommend purchasing it through a known carrier. You want it for free? This is one time I’ll pass. You get what you pay for and may end up downloading pirating, malware or spyware programs, which of course, you are trying to prevent. Whichever software program you choose must be compatible with your Smartphone. Do your homework, and run comparisons on mobile security software. You’ll be surprised at what is available. Sometimes what you run on your PC or Mac can be bundled to include your Smartphone, if compatible.

How about one last reason to get mobile security software? According to http://mobile-security-software-review.toptenreviews.com/, a mobile virus may not only drain the battery dry, but can delete personal and/or business information and render some features nonfunctional. Snoopware can also “take control of it, turning your mobile device into a walking tape recorder. It can even turn your camera on, take pictures and display them online.” Your Smartphone can also send infected files to your PC or Mac, infecting them, as well!

Bottom line: Smartphones are great technology. Like anything else in life, you get what you pay for, and you want to pay for what you’ll use. So, shop around for smart phones (one time cost,) smarter data plans (monthly cost) and the smartest mobile security software (annual cost) you can afford. BTW, happy surfing while you’re gridlocked in LA traffic.

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Executive Summary: Occupational Health Nursing Respiratory Protection Survey

This edition’s column not only provides a first look at new, original research findings, but is also an example of collaboration among representatives from several influential national occupational health organizations. The representatives that formed the working group that is discussed in the following article were:

**American Association of Occupational Health Nurses (AAOHN):** Barbara Burgel, PhD, RN, COHN-S, FAAN (co-chair); Candace Burns, PhD, ARNP; Annette Byrd, MPH, RN; Deborah Taormina, MS, RN, COHN-S

**American Board of Occupational Health Nursing (ABOHN):** Ann Lachat, BSN, RN, FAAOHN

**Association of Occupational Health Professionals in Healthcare (AOHP):** MaryAnn Gruden, MSN, CRNP, NP-C, COHN-S/CM

**American Nurses Association (ANA):** Holly Carpenter, BSN, RN

**Centers for Diseases Control and Prevention/National Institute for Occupational Safety and Health/National Personal Protective Technology Laboratory (CDC/NIOSH/NPPTL):** Debra Novak, DSN, RN (co-chair)

**Institute of Medicine (IOM) Standing Committee on Personal Protective Equipment for Workplace Safety and Health:** Patty Quinlan, MPH, CIH

Background and Project Aims
The Institute of Medicine (IOM) report Occupational Health Nurses (OHNs) and Respiratory Protection: Improving Education and Training (2011) outlined seven recommendations to improve the competency of OHNs in respiratory protection. An advisory board was convened in December 2011, with stakeholder representation from the CDC/NIOSH/NPPTL, the American Association of Occupational Health Nurses (AAOHN), the American Board for Occupational Health Nurses (ABOHN), the Association of Occupational Health Professionals in Healthcare (AOHP), the American Nurses Association (ANA) and the IOM Standing Committee on Personal Protective Equipment for Workplace Safety and Health. Two of the IOM recommendations guided the initial work of the advisory board with the goal to conduct a survey of a national sample of OHNs. Survey aims were to:

- Assess current OHN roles and responsibilities, and education and training needs in respiratory protection.
- Determine how OHNs achieve and maintain knowledge and skills in respiratory protection, and how OHNs motivate employees to use respirators appropriately.

Methods
A 30-item Web-based survey tool was developed and piloted tested in February 2012. To achieve a national sample of OHNs, announcements were posted and e-mailed to notify the memberships of AAOHN, ABOHN and AOHP of the upcoming survey. Individual e-mails were then sent to the memberships of AAOHN (n=5,183), ABOHN (n=4,928) and the ANA members who identified occupational health as a core interest area (n=249). Data were collected from May 2, 2012 through June 9, 2012. Each organization subgroup had a more than 30% response rate, with a total return of 2,263 surveys.

Findings
Respondents were members of AAOHN (73%), ABOHN (17%) and ANA (9%) with 15% non-members; 70% were board certified in occupational health. The highest level of education reflected 12% with diploma, 18% associate’s degree, 40% bachelor’s degree, 26% master’s degree and 2% with doctorate preparation. In addition, 9% were nurse practitioners. The top three industries represented were healthcare (35%),...
OHNs reported that 88% of their facilities had respiratory protection programs (RPP) with 50% of the OHNs responsible for the RPP program at their facility. For OHNs not responsible for the RPP, 43% reported that Safety was responsible for the program, 18% identified another OHN or OHN manager, and 16% identified that Industrial Hygiene (IH) was responsible. Also, 48% of OHNs identified that they currently evaluated job tasks at their worksite to determine the need for respiratory protection. For those OHNs who did not evaluate job tasks, 51% reported that Safety did this role function, followed by IH (30%) and Environmental Health (15%). Respirator types used at their facilities included N-95 (81%), PAPR (55%), half face (49%) and SCBA (38%). The majority (90%) offered fit testing for employees, with 50% of OHNs stating that the OHN performed the fit testing, followed by Safety (29%) and an outside vendor (17%). The majority (71%) of OHNs had performed fit testing in their careers, using both qualitative (86%) and quantitative methods (42%).

Education in respiratory protection education was gained from a variety of sources, including on-the-job training (67%), through a NIOSH spirometry course (55%), professional conferences (39%) and continuing education courses offered by manufacturers of respiratory protection equipment (29%). Online education in respiratory protection was the method used by 20% of the respondents, and 31% reported taking a NIOSH certified spirometry training course in the prior five years. Techniques used to motivate employees to use respiratory protection included tailoring of training according to culture (32%), incorporating the training with other health initiatives (e.g. smoking and lung health) (18%) and setting individual goals (13%), with more than 25% commenting specifically that respirator use was a job requirement and mandated by OSHA regulation. And, 91% of the sample perceived that their employer had created a culture of safety with regard to respirator use. Of the 9% who did not perceive a safety culture at their worksite, the comments ranged from budget constraints and trainers who were not experts in occupational health to conflicting messages re: need for respiratory protection, lack of accountability — managers “too busy,” lack of consequences for not wearing a required respirator, no respirator champion, healthcare workers downplaying the risks of airborne transmission and the observation that patient safety took priority over employee safety.

A 12-item scale evaluated comfort in the components of a respiratory protection program, ranging from not at all comfortable (1) to extremely comfortable (5). An overall comfort scale of these 12 items was calculated, with a mean of 3.3 (sd 0.91, median 3.4) on a 1 to 5 scale, with higher scores representing greater comfort (Cronbach’s Alpha =0.92). A high level of comfort (very to extremely comfortable) in explaining the difference between a surgical mask and an N-95 was reported by 50% of the respondents, whereas 21% reported moderate comfort and 28% reported slight to no comfort at all. Conducting medical evaluation of employees’ respiratory fitness had the highest comfort (m=3.87, sd 1.09) while lowest comfort levels were identified in writing a respiratory protection policy (m=2.96, sd 1.23) and inspection, cleaning and repair of respiratory equipment (m=3.09, sd 1.27). OHNs rated their level of overall competence in respiratory protection as novice (3%), beginner (14%), competent (40%), proficient (35%) and expert (8%). Years of OHN experience were significantly although modestly correlated with overall comfort in the components of a respiratory protection program (Pearson’s r= 0.15, p=0.000). Years of OHN experience were also significantly although modestly correlated with self-perceived competency in respiratory protection (Spearman’s rho= 0.109, p=0.000).

OHNs favored several methods to engage in continuing education learning activities, including face-to-face conferences and workshops (83%), self-paced educational/training modules (48%), live webinars (42%) recorded online education and training modules (41%), field observations and practice (34%), case studies (23%) and simulations (22%) as the preferred methods to engage in continuing education learning activities. OHNs had Internet access at work (99%), with 86% reporting that they had accessed online training/webinars at work.

**Conclusion**

In summary, the group who responded to the survey consisted of very experienced and professionally affiliated OHNs as reflected by an average of 17 years of experience, membership in AAOHN and/or AOHP and specialty board certification. The majority (88%) of OHNs worked in worksites with respiratory protection programs, with 50% of the OHNs reporting being primarily responsible for the RPP, and 50% currently performing respiratory fit testing at their facility, using both qualitative and quantitative methods. NIOSH spirometry certification was current for 31% of the sample. Many different professionals were involved in respiratory protection programs, including but not limited to the OHN, Safety, Environmental Health, Industrial Hygiene, physicians, managers, Infection Prevention and Control, Respiratory Therapy, Radiation Safety, Quality, Security, and a Train-the-Trainer model at the unit/department level used for fit testing. These survey results identified opportunities for RPP educational needs for OHNs. While most were comfortable explaining the difference between a surgical mask and an N-95, 28.5% reported none to slight comfort and 21% reported moderate comfort in explaining the distinction. For all aspects of an RPP, comfort scores averaged a moderate comfort score, with lowest comfort scores in the areas of writing a respiratory protection policy, and inspection and cleaning of respiratory equipment, and greatest comfort in performing the medical evaluation for respirator use. Preferred educational methods ranged from attendance at professional conferences to case studies and simulations, with 86% capable of accessing an online webinar from their worksites.

Future work of the advisory group will apply these survey results to develop innovative curricular materials to augment the education of OHNs regarding all aspects of an RPP. Future IOM goals include educating all levels of nurses in respiratory protection and developing interdisciplinary core competencies in respiratory protection for occupational health and safety professional education.
Colleague Connection

Brucella Exposure in Hospital Employees: A Case Study

By Catherine Kan, FNP-C COHN-S

In October 2011, a 77-year-old female was admitted on two separate occasions to a hospital in San Francisco, CA, for evaluation of chronic malaise, joint pains and fevers. Blood cultures obtained at each admission grew organisms identified only as gram positive cocci. At the end of October 2011, the patient was admitted to a different hospital in San Francisco for evaluation of continued thoracic back pain and occasional fevers. The treating physicians considered the possibility of tuberculosis, renal stones and malignancy. The patient had an extensive work-up to determine the underlying cause, including blood tests, blood cultures and radiography. Blood tests showed anemia, but were otherwise normal. X-rays of the chest and abdomen showed no pneumonia, free air or other concerning findings. An MRI of the spine revealed discitis and osteomyelitis at the level of T9 and T10, with a possible paraspinal abscess. This appeared to be the cause of her symptoms of malaise and fevers, but did not answer the question of the underlying pathology.

Laboratory workers processing the patient’s blood cultures identified an organism similar to the bacterium from her prior admissions, and a guided aspiration of the abscess also grew a similar organism. The blood cultures from the patient’s prior admission to the first hospital were still being evaluated for definitive identification of the organism, and no further detailed information was available at the time of her admission to the second hospital. Further investigation of this organism in the laboratory led to labeling the bacteria as a gram negative cocccobacillus, and more specific testing revealed that the organism in question was Brucella melitensis. The specimen was identified eight days after the sample arrived in the laboratory. Unfortunately, the laboratory workers had not been evaluating the specimen under a hood or with any personal protective equipment, with the exception of gloves. Some workers had performed catalase testing on the sample, which causes aerosolization of the bacteria as it reacts, and this led to the exposure of 10 hospital employees through the inhalation and mucus membrane routes of entry. Some exposed employees were laboratory workers, and others were not lab workers but were in the laboratory while the sample was being tested.

Brucellosis, also known as Malta fever and undulant fever, is the most common zoonotic infection worldwide (Skalsky et al., 2008). There are four different strains of Brucella: Brucella melitensis; Brucella abortus; Brucella suis; and Brucella canis (Bechtol, Carpenter, Mosites, Smalley & Dunn, 2011.) Brucellosis is rare in industrialized countries because it is usually acquired from consumption of unpasteurized and contaminated dairy products, although it remains a significant cause of morbidity in developing nations (Yagupsky & Baron, 2005.) In the United States, the incidence of the disease in humans occurs mainly in Hispanic populations in California and Texas, likely due to the illegal importation of unpasteurized dairy products from Mexico, where the disease is endemic in animals. This is possibly due to the frequent crossing of immigrants visiting family and friends, who may bring food products across the border (Pappas et al., 2005.)

In this case, the source patient was a recent Mexican immigrant who resided in the United States and had visited Mexico for about four months earlier in the year. During this visit, she had stayed in central Mexico with friends and relatives and recalled drinking milk (most likely cow’s milk) from a vat on a truck. It is likely that this milk was not pasteurized, which would represent the source of her exposure and subsequent acquisition of brucellosis. Osteoarticular disease, such as the osteomyelitis in this source patient, is unquestionably the most common complication of brucellosis, and it is more likely to occur with a delay in diagnosis and treatment (Pappas et al., 2005.) The four months that had elapsed between the date of her exposure and the definitive diagnosis of brucellosis were probably the reason that she developed this complication.

Due to the association of brucellosis with farm animals and dairy products, this disease remains an occupational hazard for shepherds, slaughterhouse workers, veterinarians and those in the dairy industry, even in industrialized countries (Pappas et al., 2005.) It is also a known risk for laboratory workers, accounting for up to two percent of laboratory-associated infections worldwide (Robichaud, Libman, Behr & Rubin, 2004.) Unfortunately, most laboratory workers in the United States are not familiar with this organism because of its rarity, making it more likely that the organism will not be handled with proper safety precautions, including using a venting hood and face shield to prevent mucous membrane exposure. It has a low infectious dose, and it easily aerosolizes with catalase testing, which can expose workers in close contact.
proximity to the sample. Additionally, the organism can take weeks to identify via positive blood cultures (Di Pierdomenico et al., 2011.) Other laboratory tests on the cultures, such as centrifuging, vortexing of bacterial suspensions and performing subcultures also have the potential to create aerosols or cause accidental spillage (Yagupsky & Baron, 2005.)

Because it is easy to aerosolize, highly infectious without the use of personal protective equipment and is difficult to identify, Biosafety Level Three precautions are recommended when handling Brucella species in the laboratory setting, even though brucellosis has a mortality rate of only two to five percent (Di Pierdomenico et al., 2011.) Research has demonstrated that the proper precautions are highly effective in preventing transmission of this disease to laboratory workers (Sayin-Kutlu et al., 2012.) In this particular case, the practitioners did not inform the laboratory workers of the details of this patient’s case, and the practitioners may not have been strongly considering the possibility of a diagnosis of brucellosis. The laboratory workers were therefore not aware of the potential risks of handling the sample and were not handling the sample with the appropriate protections in place.

Depending on the type of exposure, 30 percent to 100 percent of individuals exposed to Brucella in the laboratory setting will acquire the disease (Reddy et al., 2010.) Therefore, both the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) recommend prophylactic treatment of high risk exposures. Fortunately, person-to-person transmission of Brucella does not occur, so the workers pose no risk to others and may remain on their regular work duties (Yagupsky & Baron, 2005.) Different regimens are available, but the most commonly used regimen for prophylaxis is oral doxycycline 100 milligrams twice a day with rifampin 600 milligrams four times a day for three weeks, started as soon as possible after the exposure is confirmed (Di Pierdomenico et al., 2011.) The standard treatment for confirmed brucellosis without complications is this same regimen for a total of six weeks (CDC, 2008.)

For those who are allergic to the standard regimen, trimethoprim/sulfamethaxazole four times a day for three weeks with gentamicin for two weeks is an alternative regimen. For pregnant women, the recommended prophylactic course is treatment with trimethoprim/sulfamethaxazole and rifampin for three weeks (Robichaud et al., 2004.) Brucella infections have been associated with a high risk of spontaneous abortion and fetal intrauterine death, from 17 percent to 46 percent during the first and second trimesters. Therefore, prophylactic treatment of pregnant women is highly recommended (Robichaud et al., 2004.)

For this exposure, 10 employees were identified as being at risk of exposure to this organism while it was being studied in the laboratory, including the attending infectious disease physician for the source patient and the manager of the laboratory. This group comprised four males and six females. When the organism was positively identified as Brucella melitensis, the infection control practitioner of the hospital was notified immediately, and the manager of the laboratory informed the Employee Health Department. Ten hospital employees were considered to be at risk of acquiring the disease. On the day that the exposure was recognized, all 10 were interviewed to determine their level of exposure to the organism, and prophylaxis was ultimately recommended for eight of the employees. The level of risk was determined by the degree of exposure, with workers who had worked directly with the sample and those who were in close proximity while the sample was being tested considered to be at higher risk. All 10 of the at-risk workers agreed to the recommended surveillance and blood testing.

It was decided that the workers who did not work directly with the organism would be considered low risk and would start treatment only if any developed signs or symptoms of disease. This approach is a well recognized and accepted practice to prevent unnecessary administration of antibiotics which can have unpleasant side effects, and possibly, serious adverse effects (Robichaud et al., 2004.) Of these eight employees, six chose to take the recommended regimen of doxycycline and rifampin for three weeks, and none had any contraindications or conditions that would have warranted a different medication, such as pregnancy or allergy. Due to some difficulty in contacting some of the exposed employees as soon as the exposure was recognized, there was a difference in the amount of time that elapsed from the date of the exposure to the date that the six employees began to take prophylaxis. Three employees began to take the medication five days post exposure, one began six days post exposure, one began eight days post exposure, and one began 11 days post exposure. The employees were not all exposed on the same date because of differences in their work schedules.

Brucella is a reportable disease in the United States, and therefore, the public health department was notified on the date that the bacterium was identified. Each of the 10 employees was interviewed on a weekly basis to monitor for signs and symptoms of brucellosis. For employees who elected to take prophylaxis, interviews included questions to monitor the side effects and quickly detect any adverse reactions from the antibiotics. These interviews continued for six months, the duration of surveillance recommended by the CDC (CDC, 2008.) This extended period of surveillance is warranted because the onset of disease of laboratory-acquired brucellosis can range from a few days to five months post exposure, although the average incubation period for laboratory-acquired brucellosis is two to 10 weeks (Reddy et al., 2010.) The workers were encouraged to report any concerning signs or symptoms of disease, such as headaches, fatigue, fevers, arthralgias, unintentional weight loss and night sweats (Di Pierdomenico et al., 2011.) As the symptoms of brucellosis are typically those of a non-specific febrile illness, similar in some ways to influenza, the workers were encouraged to report any unusual symptoms (Bechtol et al., 2011.) The results
of these weekly surveillance interviews were reported to the public health department, as recommended by the CDC (CDC, 2008.) Research has demonstrated that in most cases of laboratory associated brucellosis, seroconversion occurs prior to the development of symptomatic illness (Reddy et al., 2010.) Six of the 10 exposed employees had a blood sample taken for Brucella microagglutination on the day that the exposure was recognized to serve as a baseline for subsequent surveillance. A seventh employee had a blood sample taken four days after the other employees. While three of the employees did not have their blood samples taken initially, all 10 completed the other post exposure blood work at two, four, six and 24 weeks (six months) after the date of the exposure, as recommended by the CDC (CDC, 2008.) These blood samples were sent to the public health laboratory for analysis and then subsequently reported to the employees when the results were available, approximately two weeks after the blood samples were drawn.

During the six month surveillance period, five employees reported occasional myalgias, fatigue and headaches but were able to attribute these symptoms to another logical cause, such as over exertion or migraines. While all of the employees taking prophylaxis reported occasional feelings of nausea, all were able to complete the full three weeks of the medication. All 10 of the employees completed the full six months of surveillance, and all had negative blood tests for Brucella microagglutination each time that their blood was tested. This case is considered a success in that every employee who was at risk did not develop disease or adverse effects from the prophylactic antibiotics. The organism was also identified quickly after its arrival in the laboratory, allowing the employees to start surveillance and treatment before the end of the minimal incubation period, which is two weeks in length (Bechtol et al., 2011.)

During her stay in the hospital, the source patient was treated with ciprofloxacin and doxycycline. After her symptoms were correctly diagnosed as brucellosis, she was treated successfully with doxycycline and gentamicin for several more weeks. She also had a T9-T10 vertebrectomy and spinal fusion, necessary due to the osteomyelitis and spinal abscess. During her stay in the hospital, the source patient was treated with ciprofloxacin and doxycycline. After her symptoms were correctly diagnosed as brucellosis, she was treated successfully with doxycycline and gentamicin for several more weeks. She also had a T9-T10 vertebrectomy and spinal fusion, necessary due to the osteomyelitis and spinal abscess. After she was discharged from inpatient care, she was treated with doxycycline and rifampin for six more weeks, bringing her total course of antibiotics to six months in length. She made a full recovery and had resumed her usual routine at her last follow-up.

References
Catherine Kan, MSN COHN-S, is an Occupational Health Nurse Practitioner at California Pacific Medical Center in San Francisco, CA. She is a member of the AOHP Northern California Chapter
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This award is to encourage, promote and strengthen the knowledge base and expertise of the occupational health professional in healthcare.

* * *

**Sandra Bobbitt Scholarship**

*Angela Avvento, RN MPH COHN/CM*

*John Furman, PhD MSN COHN-S*

*Julie Nicholas, BSN RN COHN-S*

*Russell Walker, MSN RN*

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Mandatory Flu Vaccination Program: To Be or Not To Be?

Our Speakers

Dee Tyler, RN COHN-S FAAOHN
AOHP Executive President

2012 Annual National Conference
“Entertain Your Professionals Needs”
Annual Membership Luncheon
Meeting & Awards Presentation

Extraordinary Member Award
Christine Pionk, MS, RN, COHN-S (Peggy Anderson accepted award on behalf of Chris Pionk)

2012 Conference Chair Award
Lydia F. Crutchfield, BSN

AOHP Business Award
MAP-ERC

Journal Contributor Awards

Joyce Safian Scholarship Award
Nancy Pike, RN

Elvis joined us at the Opening Reception

Mickey and Minnie invite you to join our 2013 National Conference Sept 11 -14, Orlando, FL

2012 Annual National Conference, Las Vegas, NV
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Improve cost-effectiveness compared with TST
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**ROC A COLLEAGUE’S WORLD**

By Betsy Holzworth, BSN RN COHN-S/CM, Human Resources Committee Chair

**Recruit a Colleague (ROC) Campaign 11 years running...**

Our past ROC campaigns have been successful, and the AOHP board has decided to continue this program which runs October 1, 2012 through June 30, 2013.

In the past 3 years, you have recruited a total of 170 new members. However, there are 7000 hospitals in the U.S. so there are many who are not enjoying AOHP benefits.

**What can you do?**

Go out and recruit new members! When a new member joins, have them write your name on the membership application. HQ will keep track of the number of new members you recruit; at the end of the campaign the two individual members and chapter who recruited the most new members can win....

**Grand Prize:** “Whole Shebang” for the member who recruits 10 or more new members. This prize includes: 2013 national conference registration and 4 nights hotel. In the event that no member recruits 10 or more members, the member who recruits at least 4 new members will receive a 2013 National Conference Registration.

**Chapter Award:** The Chapter that recruits the most new members will receive a check for $250.00 to be used at their discretion.

We are 1061 members strong but there are many Occupational Health Professionals who may not know about the benefit of AOHP membership. Reach out and share the benefits of AOHP membership and you too can “ROC” someone’s world!!!!

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**Ergo-Express Drive Systems**

As seen at The 2012 AOHP NATIONAL CONFERENCE Las Vegas, NV

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Pantone solid coated - Light Blue 292 C
Tuberculosis Testing 2012
A free Online Tutorial Using IGRA

Faculty

Dana C Drew-Nord, PhD, RN, ANP-BC
Assistant Clinical Professor
University of California, San Francisco School of Nursing
San Francisco, California
Nurse Practitioner/Administrator
Premier COMP Medical Group, Inc
Pleasanton, California

Target Audience

This activity is intended for nurses, phlebotomists and clinical laboratory staff involved in the collection and processing of tuberculosis screening tests.

About the Program

Two types of tuberculosis (TB) screening tests are available in the United States: tuberculin skin tests (TSTs) and interferon gamma release assays (IGRAs). IGRAs are faster, more accurate, and less prone to misinterpretation than TSTs, but require careful technique when collecting and preparing patient samples for testing. This online tutorial will provide practical information that will help nurses and technicians obtain and process IGRA specimens properly.

Learning Objectives

At the conclusion of this activity, participants should be able to:
- Differentiate between latent and active TB infection
- Discuss the differences between TSTs and IGRAs in TB surveillance and diagnosis
- Explain the possible consequences of false-positive and false-negative TB tests and what they would mean for misdiagnosed individuals and public health
- Describe the steps involved in preparing a patient sample for IGRA testing
- Identify and correct common sources of error in IGRA sample processing

Accreditation and Credit Designation Statements

Nurses
The Institute for Medical and Nursing Education, Inc (IMNE) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s (ANCC’s) Committee on Accreditation.
IMNE designates this educational activity for 0.75 contact hours (0.75 CEUs). Accreditation by the ANCC’s Committee on Accreditation refers to recognition of educational activities and does not imply approval or endorsement of any product.

Clinical Laboratory Staff
The Institute for Medical and Nursing Education, Inc has applied for approval as a provider of continuing education programs in the clinical laboratory sciences by the ASCLS P.A.C.E.® Program. This program is P.A.C.E.® approved for 0.5 contact hours.

Visit www.webbasedcme.com/TBTesting to complete this activity
Bullying in the Workplace

By Nancee Tardif, MSN RN

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Nurses as Second Victims:
Supporting Our Colleagues
Following an Adverse Event

By Ron Hofeldt, MD and Patricia I. McCotter, RN, JD, CPHRM, CPC

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NEW! Blood Collection Set

Automated In-Vein Retraction Effectively Reduces The Risk of Needlestick Injuries

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Watch the video:
Recognizing and Helping the Nurse “Second Victim”


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Return to Work
Getting Unstuck! A New Way of Thinking,
Part 3

By Kenneth Mitchell, PhD

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2012 Election Results

Executive Vice President
Dana Jennings, BSN RN CCM

Executive Treasurer
Elaine Dawson, RN COHN

Region 1 Director
Beverly Hagar, BSN RN COHN-S (re-elected)

Region 3 Director
Mary Bliss, RN COHN (re-elected)

Region 5 Director
Carla Stevens, RN (re-elected)

Is Your Contact Info CORRECT?

When you receive your membership renewal, check to make sure that all content is correct. AOHP Headquarters relies on this data to deliver print and electronic information to you.
Alcohol Abuse in the Workplace and Patient Safety

By Camille A. Servodidio, RN MPH CRNO OCN® CCRP
Assisting the Drug Addicted Nurse: Information for the Legal Nurse Consultant

By Marilyn McHugh, MSN, JD, Karen Papastrat, MSN, and Kathleen C. Ashton, PhD, APRN, BC

Copyrighted content. Please contact AOHP Headquarters at 800-362-4347 or info@aohp.org to purchase a copy of this Journal issue.
Check out our new tag line on cover:

AOHP is… committed to the health, safety and well-being of healthcare workers.
Editors’ Note: The following press release from the American Nurses Association announces the work to date by this multidisciplinary group on Safe Patient Handling. Mary Bliss, AOHP Region 3 Director, has provided her great expertise on this subject since the group assembled, and represents AOHP in this important venture.

The Safe Patient Handling National Standards Working Group includes representatives from the following organizations:

- American Association for Long Term Care Nursing
- American Association of Occupational Health Nurses
- American Association for Safe Patient Handling and Movement
- American Nurses Association
- American Occupational Therapy Association
- American Physical Therapy Association
- American Society for Healthcare Risk Management
- Ascension Health
- Association of Occupational Health Professionals in Healthcare
- Association of periOperative Registered Nurses
- Association of Safe Patient Handling Professionals
- Coalition for Health Care Worker and Patient Safety
- DELHEC, LLC
- Diligent Services
- Hill-Rom
- Human Fit
- Liberty Mutual Insurance Company
- Lockton Companies, LLC
- National Association for Home Care & Hospice
- National Institute for Occupational Safety and Health
- National Network of Nursing Assistants
- Park Nicollet Health Services
- Stanford University Medical Center
- U.S. Army Public Health Command
- Veterans Health Administration
- Veterans Health Administration, Patient Safety Center of Inquiry
- Washington State Department of Labor and Industries

SILVER SPRING, MD – The American Nurses Association (ANA) has released draft Safe Patient Handling and Mobility National Standards to a broad array of professions and individuals for public comment, a critical step toward establishing a uniform, national foundation for programs to improve safety for patients and health care workers. The public comment period is open through Nov. 30.

The standards outline eight broad areas considered essential to implementing an effective program to safely lift, move, and transfer patients. The standards apply to multiple health care disciplines and settings and to different intensity levels of patient care. Main principles include: creating a culture of safety; implementing and sustaining a program; incorporating prevention through design; managing technological resources; educating and training staff; and evaluating the program.

“To create a true universal culture of safety that promotes consistent, high-quality care, we want to get input from professionals working in all disciplines and health care settings where patient handling and mobility is a major safety concern,” said Suzy Harrington, DNP, RN, MCHES, director of ANA’s Center for Health, Safety, and Wellness, which convened an expert panel to draft the standards.

Once finalized in mid-2013, the standards are intended to be used to create policy, laws, and regulations to protect health care workers and patients from injury and encourage best practices in patient handling and mobility. They also could serve as the basis for resource toolkits and certifications.

The 26-member Safe Patient Handling National Standards Working Group brought together experts from nursing, occupational and physical therapy, ergonomics, architecture, health care systems, risk management, and other disciplines to devise standards rooted in evidence-based best practices. Currently, there are no broadly recognized national standards for safe patient handling. Health care facility programs lack consistency, as do regulations in 10 states that have enacted safe patient handling laws.

Since the launch of the ANA Handle with Care® Campaign in 2003, ANA has advocated for policies and legislation that would result in the elimination of manual patient handling. Using mechanical devices to lift, transfer, and reposition patients reduces the risk that patients will be dropped or suffer skin tears and helps preserve their dignity.

ANA conducted a Health and Safety Survey of nurses in 2011, in which 62 percent of the more than 4,600 respondents indicated that suffering a disabling musculoskeletal injury was one of their top three safety concerns.

To comment by Nov. 30, visit: www.nursingworld.org/public-comment-safe-patient-handling-standards

ANA is the only full-service professional organization representing the interests of the nation’s 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.
Journal of the Association of Occupational Health Professionals in Healthcare

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Mission
The AOHP is dedicated to promoting the health and safety of workers in healthcare. This is accomplished through:
• Advocating for employee and safety
• Occupational health education and networking opportunities.
• Health and safety advancement through best practice and research.
• Partnering with employers, regulatory agencies and related associations.

Statement of Editorial Purpose
The occupational health professional in healthcare is in a key position to help insure the health and safety of both the employees and the patients. The focus of this Journal is to provide current healthcare information pertinent to the hospital employee health professional; provide a means of networking and sharing for AOHP’s members; and thereby improve the quality of hospital employee health services.

The Association of Occupational Health Professionals in Healthcare and its directors and editor are not responsible for the views expressed in its publications or any inaccuracies that may be contained therein. Materials in the articles are the sole responsibility of the authors.

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AOHP Journal actively solicits material to be considered for publication. Complete Editorial Guidelines can be found at http://aohp.org/pages/member_services/journal.html.

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<table>
<thead>
<tr>
<th>Issue</th>
<th>Closing Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>November 30</td>
</tr>
<tr>
<td>Winter</td>
<td>May 31</td>
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Upcoming AOHP Conferences
2013 – Sept. 11-14
Hilton Walt Disney World – Orlando

All material written directly for the Journal of the Association of Occupational Health Professionals in Healthcare is peer reviewed.
CDC has notified hospitals that healthcare workers should wear a fit tested N95 rated mask or PAPR when dealing with any patient with flu symptoms.

Over 1,000 healthcare facilities in the US already rely on TSI for compliance as required by OSHA, JAHCO and the CDC.

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Are you a hospital occupational/employee health nurse? If you answered, "Yes," you should give strong consideration to becoming certified! Why? Read on for the Top 10 reasons to become a certified occupational health nurse.

1. Certification is a mark of prestige.
2. Certification is a significant personal and professional accomplishment.
3. Certification can advance your career. Certification is required for Magnet Status.
4. Certified OHNs earn significantly more.
5. Employers regard certification as a mark of quality and rely on certification when making employment decisions.
6. The certified OHN provides knowledgeable management of occupational injuries and illnesses and facilitates early return to work processes.
7. The certified OHN can reduce the employer’s legal exposure through management of regulatory requirements such as OSHA, FMLA, ADA, DOT, HIPAA, etc.
8. Certification enhances your disease management and health promotion skills.
9. Certified OHNs make a positive impact on the employer’s financial bottom line.
10. Certification augments competence and on-the-job productivity.

Be sure to stop by the ABOHN booth at the AOHP Conference and attend the reception for Certified Occupational Health Nurses on Friday, September 17th at 6 P.M.

For further information please contact www.abohn.org or call the ABOHN office at 888-842-2646 or 630-789-5799.

ABOHN’S CORE CREDENTIALS  
Which one is right for YOU?

COHN - Certified Occupational Health Nurse  
COHN/S - Certified Occupational Health Nurse - Specialist

Which credential should you apply for? Does your practice involve consulting, educating and managing or do you work more as an advisor and coordinator? Check out the chart below to find your niche!

Credentials matter.  
For eligibility requirements and additional information on our credentials, please go to our website; www.abohn.org or feel free to give us a call at 630-789-5799 or 888-842-2646.