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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.

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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 professionals; 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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Include your full name, credentials, and hospital/business affiliation. Include your supervisor’s name and address so that a copy of your printed article may be forwarded.

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2007 September 26-29: Savannah, GA
2008 September 17-21: Denver, CO

All material written directly for the Journal of the Association of Occupational Health Professionals in Healthcare is peer reviewed.
President’s Message

Three Rs of Time Management
By Denise Knoblauch, RN, BSN, COHN-S/CM

To quote Will Rogers, “Half our life is spent trying to find something to do with the time we have rushed through life trying to save.” I am sure most of us can relate to Mr. Rogers’ insight on our lack of time.

A frequent comment by our members is that they can’t attend meetings because they don’t have the time. I know when I am asked how my new job is going, my response is “It’s busy.” I don’t have the time to answer e-mails, and I missed my first AOHP chapter meeting in years. Many members wear multiple hats in their jobs and juggle multiple responsibilities.

I share these tips to help you manage all your activities and reduce your stress. Hopefully, the end result will be the ability to participate in AOHP. As occupational health professionals, we have to learn to juggle our various roles while keeping our sanity!

Think about the principles used in other resource management projects: Recycle, Reuse, and Refuse.

Recycle your thoughts. Most of us know what tendencies prevent us from using our time wisely, such as procrastination, lack of confidence or striving for perfection.

I am writing this article two weeks past the deadline, fully aware that procrastination is my weakness. Sometimes we spend more time trying to avoid something than it actually takes to accomplish. Ask yourself, “What am I trying to avoid?” Then answer, “Stop fretting about it, and just get it done.” Set a goal to accomplish a small piece of the project today. Once you start the project, it is just easier to keep it going. In my case, I think I have to do it perfectly. Perfection can stand in your way of success. Think about “good enough.” Aim for 90 percent or 80 percent instead of 100 percent for certain tasks, but use discretion when applying this to healthcare.

You may need to readjust your goal if you feel anxious about a project. Ask for help. Asking others for help shows you appreciate their contributions. Recycle the thought that asking for help shows a lack of dedication into the concept that asking for help encourages other people to feel valued. One of the biggest time wasters is reinventing the wheel. Ask for advice. I see this method of recycling used continually on our list serv as members share policies, protocols, etc. Asking others for advice shows your respect for their wisdom.

Have confidence in yourself. Don’t waste your time justifying your priorities to others. Trying to change someone’s point of view or make them see your point of view often is nothing but a time waster. I used to spend a lot of time tracking statistics on the number of cases I case managed to prove that a case manager was needed. Since I have come back to this position, I am able to prove the assets of a case manager by simply doing my job: communicating, obtaining timely reports, etc., so I am not wasting my valuable work time with needless reports that no one read or asked for.

Learn from your mistakes. Give yourself permission to move on. Regretting something eats up valuable energy and time.

Reuse your time. We can’t rewind time, but we can use time twice by implementing timesavers like delegating and slowing down.

Delegation some work while performing other tasks or duties. I have learned that I don’t need to be the one to send the medical records requests to companies. The medical records department is very capable of doing that. I can use my time to do more complex case management issues. Use technology to your advantage. The board recently saved an hour on a conference call by simply e-mailing the issues and conducting a vote on pertinent issues.

Slow down and enjoy your time. Avoid confusing activity with action. Lack of organization often leads to lots of activity but not much in the way of meaningful results. Examine where you spend a lot of time but don’t achieve much in the way of results.
Refuse, and master your time.

Occupational health professionals believe they have to meet everyone’s expectations: the employees, the boss, Human Resources, management, etc. Focus on priorities in two dimensions – urgency and importance. Some tasks are important but not urgent, and they can be postponed. Other tasks are urgent but not important, and they can be let go. Focus on those tasks meeting both criteria. Resist the urge to act without planning.

Planning tips:
- Plan your day, and prioritize. Mark those AOHP meetings on your calendar!
- Set aside time in your day to answer e-mails and return phone calls.
- Plan for waiting. Use waiting time as an opportunity. Carry your AOHP Journal with you to read during down time.
- Carry paper and pen with you to jot down to-do items when you are at a red light.
- Learn to be unavailable. Protect your time by saying “No” to various interruptions, activities, etc. Turn off your phone. Close your door. Leave the scene by going to the library to work on that project (and don’t tell anyone where you are!) Use technology such as voice mail to take your calls.

By following these tips, you may find that you have more time to do things that make you happiest.

Denise Knoblauch, Executive President

“You’d diet, but you’re too hungry. You’d exercise, but you’re too tired. You’d like to feel better, but you don’t have the time. You need to get off your BUT!”
The Association of Occupational Health Professionals in Healthcare (AOHP) 2007 Public Policy Statement was released on January 10, 2007. This is the association’s second such statement. It will be utilized during the next two years to focus association activities, whether they are legislative, regulatory, research or policy making. The statement is based upon a survey taken of AOHP membership during the national elections in 2006. The top three issues for membership at that time were: bloodborne pathogen exposures, safe patient handling and respiratory protection.

**Bloodborne Pathogen Exposure**
The association is looking to focus activities around the Centers for Disease Control and Prevention’s (CDC) publication titled “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Setting,” released on September 22, 2006, in MMWR 55(RR14); 1-17. AOHP plans to work at the national and state levels to effect policy around HIV consenting for source patients to expedite the process when a healthcare worker sustains a blood or body fluid exposure in the workplace. AOHP is considering becoming a member of a work group(s) that has been organized by the CDC and the American Academy of HIV Medicine to work on ways to publicize these new guidelines and to help ensure their implementation. AOHP will also continue its work related to sharps safety as it has done in the past. Part of this will occur through AOHP’s Alliance with OSHA in updating the Hospital eTools that focus on this area.

**Safe Patient Handling**
AOHP continues to monitor any legislation at the national level regarding the issue of safe patient handling. At the national level, there was a bill introduced by Mr. Conyers on January 10, 2007, titled “Nurse and Patient Safety & Protection Act of 2007” (HR 378 IH.) Since the fiscal year 2008 budget has been released, it is expected that the budget and appropriations will take precedence over the next few months. AOHP is reviewing the bill at this time. The association is also attempting to monitor this issue at state levels via its Government Affairs Committee (GAC) members.

**Respiratory Protection**
AOHP is looking to work with NIOSH via its MOU to be involved in the research NIOSH will be doing on the N-95 particulate respirators. AOHP also has the goal of continuing to be involved with legislation and regulations at the national and state levels. As many AOHP members know, over the past two to three years at the federal level, a bill has limited money in appropriations to prevent OSHA from giving fines related to the particulate respirator in healthcare settings. It is unclear at this time how things will go in appropriations at the federal level as it relates to this topic. At the state level, some self-funded states, such as California and Washington, have chosen to enforce the annual fit testing for the particulate respirator since they are only partially funded by the federal government’s program. AOHP has been active in California on this topic and plans to continue to be so.

AOHP’s 2007 Public Policy Statement and 2006 survey can be viewed on AOHP’s web site at www.aohp.org. All information in this article is current as of February 27, 2007. It is subject to change after that time due to the nature of legislative and regulatory activities.

Please free to contact me if you are interested in active involvement with the GAC in any of these areas. It is your volunteerism that keeps AOHP in good health. I look forward to hearing from you.

Sincerely,

Sandra Domeracki Prickitt, RN, FNP, COHN-S

domeras@sutterhealth.org
In celebration of spring and National Employee Health and Fitness Day (May 17,) I am devoting this column to healthy living and eating!!! Please accept the gift of one of my own healthy recipes.

I hope you enjoy the healthy recipe and then get plenty of enjoyable exercise on these nice spring days. To quote Dr. Kenneth Cooper, a well-known fitness and wellness expert, “Fitness is a journey, not a destination. It must be continued for the rest of your life.”

**Italian Meat, Cheese & Veggie Pizzas**

2 1-lb. packages of Shady Brook Farms Low Fat Turkey Italian Sausage
1 package Hormel Turkey Pepperoni, chopped
1 large onion, chopped
2 14-oz. packages sliced mushrooms
1 each yellow, red and green pepper, chopped
2 cloves fresh garlic, crushed
1 large container skim milk ricotta cheese
1 package reduced fat Italian cheese
salt, pepper, Italian seasoning to taste
2 loaves French bread


Cut French bread into 6-inch sections, hollow out and fill with above meat mixture. Sprinkle with cheese, and bake at 400 degrees for 10 minutes or so (until crust is browned and cheese is bubbly.)
The first report provides a brief update, followed by an article from OSHA on its Voluntary Protection Programs (VPP) which OSHA wanted to share with Alliance members. The VPPs are health and safety programs that AOHP members should be aware of and may also want to consider implementing at the workplace.

**OSHA Alliance**

Representatives of a number of OSHA Alliances, as well as members of the AOHP OSHA Alliance Implementation Team, have been participating in the revision of the Hospital eTool. The revision process has been broken down into four priority modules. Each module will be reviewed and updated by a team comprised of OSHA staff and Alliance partner representatives with an interest and expertise in the module content. AOHP members are participating on three of the four teams, including bloodborne pathogens, ergonomics and sonography. Sonography will be a new module for the eTool and will be the first module on the priority list. The surgical suite module is the second module that will be updated during this process, and it will include updated information on laser safety. Revision of the bloodborne pathogens and ergonomics modules will follow. The targeted completion date is late 2007. To visit the eTool, go to www.osha.gov.

A number of representatives at the December meeting are also members of “Friends of NIOSH.” “Friends” held a meeting on February 23, 2007, and AOHP participated in the meeting by conference call. Dr. Howard also addressed this group. Budgetary issues were one of the primary topics due to reductions in funding. The goals for NIOSH at this time are the National Occupational Research Agenda (NORA) and the Work-Life Initiative, mentioned above. The issue of bio-aerosols as it relates to respirator use is an area of concern and research for NIOSH. “Prevention through design” is a term now being used at NIOSH and supported by the National Safety Council. Those of us in healthcare are already familiar with it when we talk about “engineering out the sharp.” Engineering out the occupational hazard is what is needed as new technologies develop. Nanotechnology is also a hot topic and among the priorities at NIOSH. AOHP members will be kept advised of the status of this group.

**VPP – A Proven Way to Reduce Injuries, Illnesses and Costs**

OSHA’s Voluntary Protection Programs (VPP) have proven over the years to be an effective means of reducing injuries, illnesses, fatalities and costs, all while fostering a more productive workforce and increasing employee morale.

OSHA’s Voluntary Protection Programs were developed and implemented in 1982 to encourage cooperative relationships among labor, management, unions and government in an effort to improve safety and health in the workplace. Approval into VPP is OSHA’s official recognition of the outstanding efforts of employers.
and employees who have achieved exemplary occupational safety and health. VPP sets performance-based criteria for a managed safety and health system, invites sites to apply, and then assesses applicants against these criteria. OSHA’s verification includes an application review and a rigorous on-site evaluation by a team of OSHA safety and health experts.

Beyond being a role model for safety and health, VPP companies generally experience many other positive benefits, such as: 60 percent to 80 percent fewer lost workday injuries; an injury and illness rate that is 52 percent below average (for industries that fall within the same classification) and reduced workers’ compensation costs. These sites typically do not start out with such low rates. Reductions in injuries and illnesses begin when the site commits to the VPP approach to safety and health management, and the challenging VPP application process. Bill Greehy, Chairman of Valero Energy Corporation, says of VPP, “It is our goal to have all of our refineries designated as Star Sites… It’s a great program with proven results, and we’re thankful to OSHA for their support because they truly treat you like a partner.”

VPP provides opportunities to a wide array of industries ranging from construction and agriculture to food manufacturing. Currently, companies from more than 270 industries participate in the program. Over the years, VPP has grown flexible enough to meet the demand of the workforce. Through several new initiatives – VPP Corporate, OSHA Challenge and Mobile Workforce Demonstration – VPP has expanded its presence and adapted programs to meet the needs of different industries and companies of varying sizes.

VPP Corporate Pilot Program
The VPP Corporate Pilot offers expedited application and approval procedures to encourage organizations to commit multiple sites to VPP standards of excellence. The U.S. Postal Service (USPS) is one of six corporate participants in this pilot. Before being accepted into the pilot in 2005, the USPS had just 17 sites in VPP. At the end of fiscal year 2006, the USPS had 62 approved sites, with 43 more applications expected to be approved soon.

The VPP Corporate Pilot is designed to test new VPP processes for “Corporate Applicants” who demonstrate a strong commitment to employee safety and health, and VPP. These applicants, typically large corporations or federal agencies, have adopted VPP on a large scale for protecting the safety and health of their employees. VPP Corporate Pilot applicants and participants must have established, standardized corporate-level safety and health management systems, effectively implemented organization-wide, as well as internal audit/screening processes that evaluate their facilities for safety and health performance.

Under the VPP Corporate Pilot, streamlined processes have been established to eliminate redundancies and expand VPP participation for “Corporate Applicants” in a more efficient manner. Upon acceptance of the participant into VPP Corporate, all eligible participant facilities will follow the streamlined application and on-site evaluation process when applying for VPP. General Electric and Dow Chemical Company are among a handful of charter participants in the pilot. Stephen Ramsey, Vice President of Corporate Environmental Programs for General Electric, remarked, “GE is honored to be accepted into the OSHA VPP Corporate Program and looks forward to continuing our cooperative and productive relationship with OSHA.”

OSHA Challenge
Over the years, many employers have asked for a program that caters specifically to organizations that are interested in VPP, but need some help in meeting program requirements. A new offering, the OSHA Challenge Pilot, aims to satisfy this need. Although Challenge is open to companies of all sizes, smaller companies find Challenge especially helpful in preparing for VPP. Fifty-eight percent of Challenge participants employ fewer than 200 people. OSHA Challenge recognizes that there are many employers at different stages in the process of working toward implementing a successful safety and health management system.

OSHA Challenge provides opportunities for employers not currently served by existing OSHA cooperative programs to work with the agency and receive recognition for their efforts. Challenge Participants link into either a General Industry or a Construction track. Within each track, participants follow a detailed three-stage roadmap that guides them to improve their safety and health management systems, and work toward VPP status. OSHA Challenge participants that have been in the program one year or more, on average, have reduced their TCIR and DART rates 37 percent and 31 percent respectively. OSHA Challenge has become a pipeline for participants to reach for the VPP Star.

Mobile Workforce Demonstration
OSHA’s newest component of its premiere cooperative program – the VPP Mobile Workforce Demonstration for Construction – was launched in October 2006. Edwin G. Foulke, Assistant Secretary, OSHA, said the program, “offers construction employers with mobile construction workforces and short-term projects the same opportunity for recognition that fixed-site employers receive.” And, it “recognizes those construction companies that should be held up as models of safety and health for the rest of the industry.”
This Demonstration is intended to create greater opportunity for employers and employees in the construction industry to participate in VPP and, in so doing, to strengthen worker protections significantly. It will also give OSHA more opportunities to explore and test appropriate modifications to VPP, alternative requirements that will help bring the benefits of this program to the construction industry. OSHA believes this new Demonstration will work both for companies that typically function as controlling general contractors and companies that perform specialty trade functions, regardless of size. While the core of the new program continues to be effective safety and health management systems, there are important differences (compared to site-based VPP participants) aimed to provide some flexibility for construction participants.

The Demonstration program involves a two-phased OSHA verification process: (1) a review of safety and health management system policies and procedures, plus management’s commitment to safety and health, and VPP; and (2) a visit to one or more worksites to determine the successful implementation of the corporate policies and procedures, and to verify employee involvement.

For more information on VPP, please contact OSHA’s Office of Partnerships and Recognition at (202) 693-2213, or visit www.osha.gov/vpp.
In this issue, we will discuss some of the safety concerns associated with the use of glutaraldehyde. Glutaraldehyde formulations have been used for many years as a high-level disinfectant or cold sterilizing agent, depending on contact time. Some formulations require the addition of an activator to achieve full potency. Glutaraldehyde used for disinfection purposes usually comes in a two percent solution. These solutions lose potency over time and especially with repeated use. Some examples of trade names include Cidex®, Sonicide® and Omnicide®. (NIOSH, 2001) Glutaraldehyde is also used in a much higher concentration (30 percent to 50 percent) as a hardening agent in x-ray film developing or as a tissue fixative in histology or pathology.

Glutaraldehyde is considered to be highly toxic to humans via inhalation, ingestion or skin contact, and allergic sensitization can occur. Skin sensitization has been documented in endoscopy nurses, x-ray technicians and others. (OSHA, 2006) The most serious health effect from exposure is occupational asthma. Because workers were becoming sensitized with low exposures, the American Conference of Governmental Industrial Hygienists (ACGIH) lowered the Threshold Limit Value (TLV) to 0.05 ppm as a ceiling level. To achieve this ceiling level, the best solution is to eliminate or minimize the use of the product.

The first step in reducing exposure is to make sure that the glutaraldehyde is used appropriately. For example, it should not be used as a cold sterilant for items that do not require sterilization or that can be steam sterilized. Glutaraldehyde usage may be eliminated by the substitution of glutaraldehyde-free x-ray film processing units, or digital radiography may be an option. Substituting equipment that can be steam sterilized for those pieces that require cold sterilization may also be feasible. Using glutaraldehyde as a surface disinfectant should be prohibited because it can generate exposures above the TLV level.

At a minimum, glutaraldehyde solutions must be tightly covered at all times or used in an area with good ventilation to capture any vapor release. (Rutala, 1996) In all cases, glutaraldehyde should only be used in locations with total exhaust, not re-circulated, ventilation. When glutaraldehyde is used as a tissue fixative, it is important that procedures be done inside a fume hood. The hood should be checked to be sure that the sash is at the proper height and that hood face velocities are between 80 and 100 feet per minute. (American Conference of Governmental Industrial Hygienists, 2001) The use of glutaraldehyde in automatic disinfecting units significantly reduces but does not eliminate exposures.

In terms of personal protective equipment, it is safer to use local exhaust ventilation than respirators. It is also important to avoid skin contact. Gloves should be made of nitrile or butyl rubber because glutaraldehyde has a tendency to penetrate latex. (NIOSH, 2001) Other forms of personal protection such as goggles, face shields and gowns may be necessary to protect the eyes and skin of workers.

There have been recent efforts to replace glutaraldehyde with alternatives because of exposure concerns. Orthophthaldehyde (OPA) is a relatively new germicide that was cleared in 1999 by the FDA for use as an instrument disinfectant. (Rutala & Weber, 2001) It is similar in action to glutaraldehyde but has several advantages over glutaraldehyde. It requires no activation, and it is more stable than glutaraldehyde. It also has a lower vapor pressure, so it is less likely to be volatilized. One disadvantage is that it will stain unprotected skin a gray color. The most serious issue with OPA is that it is a potent skin sensitizer. For example, it should never be used for reprocessing of urological instruments to be used on patients with a history of bladder cancer because of reports of anaphylactic-like reactions. OPA also appears to be toxic to aquatic environments and may require neutralizing with glycine before it is discharged to the sewer. Some other alternatives include steam sterilization for heat stable...
instruments or hydrogen peroxide and ozone sterilizers for heat sensitive instruments.

Regardless of where glutaraldehyde is used, it should be included in the health care facility’s Hazard Communication training program. Topics to be included are an explanation of the material safety data sheets, possible health effects, locations where it is used, methods of minimizing exposure and steps to take in the event of a spill. For more information on glutaraldehyde safety, see NIOSH’s web site http://www.cdc.gov/niosh/topics/glutaraldehyde/ and OSHA’s Best Practices for the Safe Use of Glutaraldehyde in Health Care http://www.osha.gov/Publications/glutaraldehyde.pdf.

References

Call for Award Nominees
Nominees for the following awards are being sought.

Ann Stinson President’s Award for Association Excellence-recognizes a chapter that has demonstrated outstanding performance and enhanced the image of occupational health professionals in healthcare.

Joyce Safian Scholarship Award- recognizes a past or present association officer who best portrays an occupational health professional in healthcare role model.

Extraordinary Member Award-recognizes a current association member who demonstrates extraordinary leadership.

Honorary Membership Award- recognizes a person(s) who has made a significant contribution to the field of occupational health in healthcare.

NEW! Business Recognition Award- to recognize business(es) that support the occupational health professionals and membership and participation in AOHP.

Nominations need to be submitted to the national office by July 15th. You may contact your chapter president or regional representative for award criteria or at the AOHP website, http://www.aohp.org/Resources/Awards-and-Scholarships.asp
Florence Nightingale once said, “You ask me why I do not write something....I think one’s feelings waste themselves in words, they ought all to be distilled into actions and into actions which bring results.”

With funding by the National Institute for Occupational Safety and Health (NIOSH,) and support from the University of South Florida College of Nursing, the Tampa VA Patient Safety Research Center of Inquiry and the American Nurses Association’s Handle with Care Initiative, a pilot project was developed December 2005 to solicit the interest of academic institutions in a pilot-test of a safe patient handling curriculum module which included an evidence-based instructional module, lifting equipment and other supporting documents.

In this issue of Talking Points, we are pleased to present Part 1 of a two-part series which will highlight the perspective of a faculty member, Carol F. Durham, RN, EdD(c,) Director, Clinical Education & Resource Center, University of North Carolina at Chapel Hill (UNC-CH) School of Nursing, as she and her colleagues journeyed to incorporate the pilot project into their existing nursing school curriculum. In Part 2 of this series, we will feature the perspective of a nursing student who participated in the UNC-CH School of Nursing revised curriculum. The information is presented in question and answer format.

Laurette Wright, RN, MPH, COHN-S, Column Editor: How did you hear about the NIOSH project?

Carol Durham, RN, EdD(c), UNC-CH School of Nursing: When ANA released the call for proposals to nursing schools to be a pilot site for the Handle with Care: Effectiveness of an Evidence-Based Curriculum Module in Nursing Schools Targeting Safe Patient Handling and Movement (SPHM), I thought I should apply on behalf of the school. However, it was the end of the semester. I was very busy wrapping up the semester. I had been awarded a leave for the time of the implementation of the pilot and was concerned about that as well. Over the next couple of days, numerous colleagues forwarded the call for applications to me and encouraged me to apply. Sonda Oppewal, RN, PhD, Associate Dean for Community Partnerships and Practice, was willing to help pull together the materials and so, we decided to put our application forward. Lindsay A. Gainer, RN, MSN was slotted to cover my leave, so I discussed the project with her, and she and I collaborated on implementing the pilot project.

Laurette: What were the top three reasons UNC-CH School of Nursing decided to participate in the program?

Carol: We were very excited to be selected as part of the pilot since we value staying on the forefront of practice, and we felt this would be a way to make sure we remain current and evidence-based in regard to patient handling and movement. Secondly, we are committed to teaching our students best practices for patient safety, and this pilot was focused on that as well. Thirdly, we teach our students to be patient advocates, as well as advocates for better practice. When we learned that the focus would not only be on patient safety but also on nurse safety, that was an additional benefit.

Laurette: What was the initial reaction of your faculty when you introduced the SPHM curriculum? What is their reaction since the program was introduced?

Carol: When Ms. Gainer and I attended the mandatory faculty training in March 2005, we were amazed at how much...
we did not know about the evidence around body mechanics, patient transfer and positioning. As mentioned earlier, we value staying on the cutting edge of practice, but we were not aware of the content presented by Audrey L. Nelson, PhD, RN, FAAN and her colleagues. Dr. Nelson is masterful in her strategy to introduce the new material by dispelling myths. Her presentation was a very effective method of helping faculty shift from traditional teaching to evidence-based practice.

I realized when we returned to school that we would be bringing a new paradigm for teaching patient handling and movement. I informed faculty of the upcoming changes to be implemented in the fall courses. The faculty is committed to quality education and is willing to make changes as needed when supported with evidence. However, when we implemented the pilot content, there was more resistance than we expected. Faculty were concerned, and rightfully so, that students would be in clinical settings without mechanical lifting equipment. They were concerned if we did not teach the “old way” of transferring patients using manual lifting, then students would not be able to transfer and move patients in the clinical setting.

The majority of the faculty were committed to the new curriculum. However, one faculty member was adamant that she was going to teach her clinical group the “old way” of patient handling. She pulled her students into an empty patient care room and taught them manual lifting techniques. As faculty, we have to be aware not only what we intend to teach, but also of what we are teaching that is not intended. Allowing the faculty to circumvent the school’s decision to teach SPHM indirectly teaches students when they disagree with a policy change that it is appropriate to “ignore it” and continue doing it the “old way.” We do not want to set that precedent.

Bringing about culture change is always challenging. It was true with the implementation of universal precautions and the use of gloves or with needless systems. In light of the evidence, nursing faculty would be negligent if they asked a student to clean up a blood spill without gloves – you just would not do that! So, with the body of evidence about patient movement and its associated risk to the patient and the nurse, faculty should feel compelled to teach the SPHM program.

It is interesting to note that in the second year of the new SPHM curriculum, the same faculty member was surprised we were still not teaching the “old way.” Some things take time to bring about change (smile.)

**Laurette: What is the students’ reaction following introduction of the SPHM curriculum?**

**Carol:** Students in a program of study take at face value what is taught. They trust faculty to know what they need to know and how to help them to acquire the knowledge, skills and attitudes they need for the profession.

Students do not have the knowledge base to have a reaction. We explained to them that we were teaching them new evidence-based practice and that it is a culture change. As such, they would be encountering settings that would not have lifting equipment. If that was the case, they were to do their assessment of the patient, as well as the environmental assessment. If the assessment revealed they should use an assistive device and it was not available, they should let their faculty patient care nurse know what they had done and that they could not safely move the patient. Students seemed to be reassured that we were providing them with the best possible educational experience.

**Laurette: How many faculty have taught the curriculum and/or are qualified to teach SPHM curriculum?**

**Carol:** Initially, there were two faculty trained to teach SPHM, who in turn trained six teaching assistants (graduate students in our master’s program.) Currently, there are five faculty and seven teaching assistants who are qualified to teach portions, if not all, of the SPHM curriculum.

**Laurette: Do you think the students considered they are “at risk” when assigned to their clinical teaching facility?**

**Carol:** Students did not consider themselves “at risk” in clinical. At their clinical sites, the students would observe nurses manually moving patients without concern for risk. The manual movement of patients within healthcare has not been consistently highlighted as a risky behavior, contrasted with drawing blood on an HIV positive patient as an example. So, understandably, the students would accept the activity as a function of their role without concern about risk for themselves or for their patients.

**Laurette: What teaching methods did you use to introduce the SPHM program to your students?**

**Carol:** The pilot project partnered participating nursing schools with vendors of assistive equipment and patient-handling devices. UNC-CH had equipment on loan from ARJO, Inc., including gait belts with handles, a stand-assist lift, a mobile mechanical full-body lift, a floor-mounted over-bed lift, a lat-
eral transfer device and friction reducing devices for moving patients in bed. The ability to have the equipment to practice with was very important to the students. The educators were all trained on the equipment.

Specific patient assessment criteria and algorithms were developed by Dr. Audrey Nelson and researchers at the Tampa VA to assist with clinical decision-making based on the patient’s dependency level and other factors. The assessment criteria and algorithms are available from the VA National Center for Patient Safety and can be found at http://www.patientsafetycenter.com/Safe%20Pt%20Handling%20Div.htm.

Prior to lab, students had to do readings and watch a video on the CD-ROM, as prepared by Dr. Nancy N. Menzel, RN, PhD, of the University of South Florida College of Nursing. When they arrived at lab, they were given a packet containing four assessment forms and the algorithms. To prepare for clinical rotations, each student practiced selecting and using each device in simulated patient care scenarios following a two-step process. First, the students assessed the patient and the environment using these key assessment criteria:

- The ability of the patient to provide assistance.
- The ability of the patient to bear weight.
- The upper extremity strength of the patient.
- The ability of the patient to cooperate and follow instructions.
- Patient height and weight.
- Special circumstances likely to affect transfer or repositioning tasks such as abdominal wounds, contractures, presence of tubes, etc.
- Specific physician orders or physical therapy recommendations that relate to transferring or repositioning patients. For example, a patient with a knee or hip replacement may need a specific order or recommendation to maintain the correct angle of hip or knee flexion during transfer.
- Type of task to be completed, such as transferring, repositioning, ambulating or toileting.

Second, using the algorithms, the students selected the appropriate equipment or assistive device to use and the number of caregivers needed to complete the task safely. Under the supervision of faculty or teaching assistants, students actually practiced with the different types of lifting equipment. The students rotated through three rooms in groups of eight to 10 students. Each had different simulated patient scenarios and types of equipment, requiring students to use critical thinking to determine the correct algorithm to follow. The emphasis was on patient safety as well as nurse safety.

The access to the curriculum, patient assessment tools, algorithms and equipment made the process as easy as it could be. The vendor was very responsive to training needs and helped to make the access to equipment as convenient as possible. The challenging aspect was the culture change among faculty and affiliate agencies. This will take time and be an ongoing process.

Laurette: Were there situations where students did not have mechanical lifting devices available when they arrived to their assigned units? What did they do?

Carol: We taught students to use the assessment forms and algorithms found at the VA National Center for Patient Safety http://www.patientsafetycenter.com/Safe%20Pt%20Handling%20Div.htm. If their assessment determined they needed an assistive device and it was not available, they were not to transfer the patient. They would need to inform their faculty and the patient care nurse of the situation, including their assessment.

Laurette: Did students follow through with SPHM techniques/concepts during their clinical assignments?

Carol: As far as we know, they did.

Laurette: Did you develop an ongoing curriculum for SPHM?

Carol: We adapted the curriculum developed by Dr. Menzel. Additionally, Jean LeCluyse, RN, BSN, a medical illustrator, created drawings (non-vendor specific) to assist student conceptualization of the equipment used for various patient handling tasks. (See Figure 1 & Figure 2.) We duplicated the
materials on a CD and made packets for all 177 BSN students and faculty. Now, we post the materials on our course management system.

Faculty were given multiple times to come to hands-on labs to become familiar with the equipment. The Dean of the School of Nursing participated in one of these sessions, exemplifying her support.

Often, schools of nursing are asked to add more and more content to an already overloaded curriculum. It is important to realize that this curriculum replaces what schools are currently teaching and does not require more curricular time. We did not have a didactic lecture. We offered the content as a psychomotor lab that was three hours long. This was the same amount of time we had dedicated to this topic previously. We were able to teach 30 students at time and ran the labs across one week to accommodate all 177 students.

Laurette: What would you do differently if you were asked to re-introduce this program to a new class of nursing students?

Carol: As we continue to implement the SPHM curriculum, we plan to enhance our work with faculty adoption. Additionally, we will continue to empower students and faculty to know what to do when they do not have lift equipment at an agency.

Laurette: Have you highlighted your SPHM curriculum in your recruitment efforts for nursing students?

Carol: At this time, SPHM curriculum has not been highlighted in our recruitment of nursing students.

Laurette: Has your teaching hospital attained magnet certification? If not, would the teaching hospital incorporate SPHM in its magnet application process?

Carol: Our teaching hospital is preparing its magnet application and plans to highlight SPHM as part of the application.

Laurette: Do you think programs should be a mandatory part of magnet?

Carol: I do think that SPHM programs should be a mandatory part of the magnet application.

Laurette: What is your opinion about students who may refuse to work at a healthcare facility without an SPHM program?

Carol: We teach our students, when conducting their job interviews, to ask if the agency has a minimal lift policy. If yes, they are to explore what equipment is available and how accessible the equipment would be to them as they deliver patient care. If the agency does not have an SPHM program currently, or if there is not one on the horizon, we suggest they decline the job and go to the next interview.

Laurette: Do you see this as having any affect to change/motivate employers to develop safe patient handling programs?

Carol: This approach is having an affect locally among our affiliating agencies. Agencies are noting that our students are asking these questions in the interviews. The decision to adopt an SPHM program is multi-factorial, but I do think new graduates’ decisions to work for an agency or not is one of those factors.

Laurette: Are you willing for others to call you if they have questions?

Carol: Certainly. I can be contacted as follows: Carol F. Durham, RN, EdD(c) Director, Clinical Education & Resource Center Clinical Associate Professor The University of North Carolina at Chapel Hill Carol_Durham@unc.edu (Please enter SPHM in the subject line.) 919-966-1753

Laurette: Do you have any other thoughts you would like to share?

Carol: It is exciting to be on the forefront of a culture change in nursing. Once you become familiar with the evidence for
this new practice, you are compelled to teach the safer methods to your students.

Acknowledgements:
Carol Durham wishes to express sincere appreciation to the following individuals for their support and efforts in the implementation of the Safe Patient Handling and Movement curriculum at the University of North Carolina at Chapel Hill School of Nursing.

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The University of North Carolina at Chapel Hill School of Nursing

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Clinical Assistant Professor
The University of North Carolina at Chapel Hill School of Nursing

Jean LeCluyse, RN, BSN
Medical Illustrator and Clinical Education & Resource Center staff
The University of North Carolina at Chapel Hill School of Nursing

References


Spotlight on an AOHP Star

AOHP and this Journal are pleased to recognize another worthy member, Cynthia Harmer, from Los Gatos, California. Cynthia was nominated by fellow Northern California Chapter colleague Sandy Prickitt. “Cynthia is a fairly new member to the Employee Health profession and to AOHP, but she is doing an excellent job in a tough situation,” Sandy states. “She also willingly offered her assistance for the social events for the 2006 national conference, and ended up doing an absolutely splendid job! Cynthia rallied additional chapter members to step up and create a fun, elegant and delightful gala at the conference. She problem-solved issues with skill and a smile!”

Cindy has been the Manager of Employee Health at Community Hospital of Los Gatos for the past three years. Her major job responsibilities include EH standards, Workers’ Compensation coordination, Return to Work, managing the Safe Patient Handling Program, Bloodborne Pathogens and Employee Wellness. Currently serving as Treasurer of the Northern California Chapter of AOHP, Cindy has been an AOHP member for three years. She credits AOHP’s Getting Started with assisting her in learning her role, and she greatly relies on fellow AOHP members as valued mentors.

Cindy recently published a Colleague Connection article in the Journal on her successful wellness initiatives at her facility, and her current goal is to become COHN certified within the next year.

Congratulations, Cindy, on a well-deserved “spotlight;” you truly shine in this organization. We are lucky to have you as a member, colleague and friend!!
During the past year, we have had four guest authors for this column. They have written about a variety of topics that hopefully stimulated you, the membership, to venture into the world of the nurse researcher. Column topics have included information about journal clubs, how to critically read research articles, evidence-based practice, steps in the research process, the internal review board (IRB) and how to search the literature online. If you have conducted research, now is the time to think about publishing the research findings. First, you must prepare yourself; then, you must prepare the manuscript. To some, the former may be more daunting than the latter!

Preparing yourself

Why publish?
The purpose of research is to add to a specific body of professional knowledge and to share expertise. For healthcare, new research findings may lead to practice changes that will improve patient outcomes, whether those patients are inpatients or employees. To share this new knowledge or evidence, the researcher must be willing to communicate the research process and outcomes with professional colleagues. Research findings can be communicated in several ways. Podium presentations or poster sessions provide opportunities to present “live” at conferences. The third way is publishing research findings in a professional journal. Publishing findings offers many professionals the opportunity to keep abreast of the latest science in their respective professions. The importance of communicating research findings cannot be stressed enough.

Sometimes new writers are fearful of publishing in a professional journal. Writers should consider that they may have already published by writing for a newsletter in the workplace or the community. Consider teaming up with an experienced author for the first time. Working together will help build confidence. Even if the idea is not accepted by the first publisher, try others until you find one who will accept it. It is best to submit a manuscript to only one journal at a time.

Writing is one more thing to do
Research investigators have multiple responsibilities. However, they recognize the need to publish and work to accomplish this priority. Set a target date for completion of a draft of the manuscript. Identify the best time of the day to write. Start the manuscript draft. It does not have to be perfect. Manuscripts are usually rewritten three times before they are finalized. Find a mentor who will be willing to review the manuscript and provide feedback prior to its submission.

Select the journal
Select a journal that has the target audience you are trying to reach with the research findings. Many professional journals have internet sites that include “guidelines for authors.” Check to see that the journal is peer-reviewed; that the manuscript is subject to a double-blind review process. In this process, the reviewers do not know who the author is, and the author does not know who the reviewers are. A query letter can be sent to the journal editor to determine whether or not the journal is interested in the research topic. If the editor indicates interest, follow the journal’s guidelines for authors to prepare the manuscript. Once the manuscript is submitted, it will enter the peer review process and be accepted either without revision, accepted with request for revisions or rejected. The peer review process may take several weeks, even with electronic submission. Do not be discouraged if revisions are suggested. It is up to the author to decide whether or not to make the revisions. Moving through the process from submission to acceptance and then to final print may take a number of months or longer, depending on the backlog of articles for the journal.

Preparing the manuscript
As the manuscript is prepared, be sure to follow the author’s guidelines for submission. These will include the page setup, the number of copies that are to be submitted, the format for submission and other journal requirements. If electronic submission is acceptable, this will eliminate the need for multiple copies and mailing.
Write the abstract

The abstract summarizes the essential information about the research study and findings. There may be requirements that the abstract be less than a certain number of words. Writing the abstract causes the author to describe the research in a “nutshell.” Houser and Bokovoy identify five elements of an abstract. They are the:

- **Introduction** – This usually answers the question as to why the research was done and serves to grab the reader’s attention to read on.

- **Objective** – The purpose or aim of the research is stated in one or two sentences. If the objective of the research is the same as the research question in the introduction, do not repeat it.

- **Methods** – This part of the abstract describes the design of the study and the methods used to achieve the study’s purpose. Include sampling strategies, variables and statistical methods used. Do not overload this section with detail.

- **Results** – Summarize the results, including whether or not they were statistically significant. Limit the reporting of statistical results to the p values.

- **Conclusion** – Describe the most important implications of the research, including application issues.

Once created, the abstract may be used for multiple purposes. In addition to publication, abstracts – which should include the above elements – are required when submitting poster and podium presentation inquiries. Once the abstract is drafted, review and revise it yourself. Then have a peer review for comments and feedback. Revise it again as needed before it is submitted.

Writing about the research study should follow the steps of the research process. Since the researcher has already prepared a research proposal, portions of the proposal may be used, modified or condensed for the article. Oman et al, state that the average length of a research report is 15 to 20 double-spaced pages, exclusive of references and tables.

Check the journal’s author’s guidelines for acceptable length. Tables should not duplicate the content of the manuscript; rather, they should include unique information. No more than two to five tables should be included. Also, identify whether or not copyright permission will be needed for any part of the publication. If so, obtain the needed permission, and submit it with the manuscript.

Writing the manuscript

The abstract will introduce the research manuscript. The remainder of a research manuscript will usually follow a standard format. Nursing experts identify anywhere from five to eight sections for the remainder of the manuscript. Houser and Bokovoy’s sections include the introduction, methods and procedures, results, discussion and references.

- **Introduction** – Describe the research question and why it is important to conduct the research. Include a review of the most relevant sources of the literature review. Identify a theoretical framework and the specific purpose of the study, the research question or hypothesis.

- **Methods and procedures** – Take the reader through the process of the study. What was the sample size and why? Describe the data collection process. Include measures of reliability and validity. Procedures for treatments or the use of placebos should be included. Describe analysis procedures.

- **Results** – Only the results of the statistical analysis are included in this section. Describe the type of statistical analysis that was performed. Tables and figures can be included in this section if the information in them is unique and not stated in the content of the manuscript.

- **Discussion** – Interpretation of the results is stated in this section, including clinical relevance and implications for practice. Were the results expected or unexpected as compared to other studies? Identify the strengths and limitations of the study. What are the areas for future research?

- **References** – List all references for the manuscript. If listing a citation more than five years old, it should be included only if it is considered a “classic” in the field.

Publishing is a process that can be a great learning experience and opportunity. Working through the process successfully leads to seeing your name in print. It is a symbol of a job well done by contributing evidence-based knowledge to the profession. It is also a positive reflection on both you and your employer. Last, but not least, is the satisfaction and increased self-esteem when seeing your name in print to know that you have made a difference in the profession.

**References**


Are All “No-lift” Policies the Same?

By George Byrns, MPH, PhD, CIH, Denise Knoblauch, RN, BSN, COHN-S/CM
and Caroline Mallory, RN, PhD

Nursing home workers suffered more than 280,000 work-related injuries and illnesses in 2004. (Bureau of Labor Statistics, 2002) Because of the severity of this problem, in 2002 the Occupational Safety and Health Administration (OSHA) included nursing homes in its National Emphasis Program (NEP). NEP status means that OSHA gives the nursing home industry a higher priority in its attempts to reduce the number of occupational injuries and illnesses. (OSHA, 2002) Researchers have found that the under use of safety devices, such as mechanical patient lifts, contributes to the high prevalence of low back pain (LBP) in nursing personnel. (Engkvist, Hjelm, Hagberg, Menckel, & Ekenvall, 2000; Owen & Garg, 1999; Lynch & Freund, 2000) What is needed is a program that promotes the usage of mechanical lifts and discourages manual lifting of nursing home residents. In our study, this approach was referred to as a “no-lift” policy. However, simply having a policy that is not comprehensive and rigorously enforced may not be adequate. Our research question was “Are all no-lift policies the same in their abilities to reduce the frequency of manual lifting of residents?”

The purpose of this study was to assess lifting patterns at two nursing homes. At one site, there was a conventional program where mechanical lifting equipment was only required for transfers involving non-ambulatory (bed-ridden) residents. At the other site, there was an enforced, corporate-wide “no-lift” policy that applied to both non-ambulatory and partially ambulatory residents. Our hypotheses are that health care workers who routinely use mechanical lifts will have a lower prevalence of work-related back pain and that workers at facilities with a rigorously enforced “no-lift” policy will perform fewer manual lifts and transfers of residents than facilities with less enforcement.

Prior research demonstrated that approximately 36 percent of registered nurses (RNs) had LBP from occupational exposure so severe that it interfered with movement or routine performance of tasks. (Byrns, Reeder, Jin, & Pachis, 2004) In this earlier study, only about 10 percent to 11 percent of RNs reported using mechanical lifts on a daily basis. There are some differences between hospitals and nursing homes. Nursing homes typically employ a higher percentage of certified nursing assistants (CNAs) than RNs, and CNAs would be expected to do more manual lifting than RNs. Therefore, the 36 percent LBP prevalence measured in the prior study was expected to be an underestimate of the prevalence in nursing homes.

In the prior study, the frequency of lifting patients or heavy objects had the strongest association with LBP (b = 0.03, S.E. = 0.01, Wald = 8.9, p-value = 0.003.) Another significant finding was that individuals who worked more years as nurses reported more LBP (b = 0.06, S.E. = 0.03, Wald = 6.0, p-value = 0.014.) While age and years of experience are highly correlated, it is hypothesized that this effect is due to cumulative physical exposures.

In a follow-up study conducted approximately one year later, the highest incidence of new cases of LBP occurred in younger, less experienced RNs (3.9 years of nursing experience on average.) (Byrns, Jin, Mallory, Reeder, & Harris, 2005) It was also interesting to note that those individuals who became pain free at year two had the most experience (16.6 years on average.) These findings are consistent with a phenomenon known as “the healthy worker survivor effect” and with other research that has demonstrated that younger, less experienced workers have the highest incidence of injury. (Bigos et al., 1986) The healthy worker survivor effect has not been previously described among nursing home workers, but may have been an issue in our current research.

The above findings demonstrate some of the complexity in the study of LBP. While the lifetime prevalence of LBP increases with age, it is the younger and least experienced worker who is most at risk of becoming a new case. This higher incidence of LBP in the younger, less experienced worker is also a problem because prior history of LBP is the most important predictor of future LBP. (Feyer et al., 2000; van Poppel, Koes, Deville, Smid, & Bouter, 1998; Bigos et al., 1992) The initial onset of LBP must be prevented, as it is a debilitative cycle once started.

Our prior research also shed light on the relationship between frequency of exercise and LBP. In the initial survey, more frequent exercise appeared to prevent LBP. (Byrns et al., 2004) Using a longitudinal design, we were able to show that those in pain are less likely to exercise than those who are pain free. (Byrns et al., 2005) In contrast to the conclusions that emerged from the first cross-sectional study, these findings...
do not support a protective relationship between frequent exercise and prevention of LBP. This conclusion is consistent with research conducted by de Looze, et al., who found that having greater muscle strength was not protective against developing LBP. (de Looze, Zinzen, Caboor, Van Roy, & Claris, 1998) This is not surprising given that manual patient lifting exceeds safe manual lifting criteria established by the National Institute for Occupational Safety and Health. (Steinbrecher, 1994) These results lend credence to the importance of using mechanical devices to move patients or nursing home residents.

A final complication in the study of low back pain is that there is evidence that worker psychological stress contributes to musculoskeletal pain. (Bigos et al., 1991; Bongers, de Winter, Kompier, & Hildebrandt, 1993; Hoogendoorn et al., 2001; Houtman, Bongers, Smulders, & Kompier, 1994) Psychological stress may affect LBP due to increased muscle tension, guarded movements, or disuse syndrome. (Waddell & Main, 1998) Researchers have found that jobs high in physical and psychological demand, low in the control of job performance, and low in the availability of social support tend to be more stressful than jobs with the opposite characteristics. (Karasek et al., 1998) Karasek's Job Content Questionnaire is a useful way of measuring each of these potential job stressors. (Karasek, 1985)

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* The totals do not add to 108 because of non-response.

**TABLE I: Demographic characteristics of study participants**

**Methods**

**Design and Target Population**

In the summer of 2005, a cross-sectional study was conducted with 108 health care personnel (19 RNs, 19 Licensed Practical Nurses and 70 CNAs) currently employed by two nursing homes in central Illinois. Information was entered into a database using the software SPSS 13.0, and all data entry was double-checked for accuracy. The response rate for the survey was 81.1 percent (108 of 132 participants responded.) We originally expected a much higher number of potential participants; however, 17 worked only intermittently, 17 left employment before the start of the survey and 3 were on disability.

**Instrument Description and Measurements**

The questionnaire was similar to the one used in our initial survey of nurses. (Byrns et al., 2004) Prior results suggest that the questionnaire is valid and reliable for the study of LBP in nurses. Minor revisions were made to the questionnaire with the assistance of the nursing personnel at one of the two study sites to make the questionnaire applicable to nursing homes. Self-administered questionnaires were distributed by hand and collected by the research team or returned using pre-paid postage.

Information was gathered on work history, job tasks, description of work, basic health history, leisure time activities, current health, potential causes of back pain and basic personal information. Employees were asked to estimate the number of times they performed certain lifts each day, either manually or using a mechanical device. Site #1, with the limited “no-lift” policy, had three full-body lifts for totally dependent residents and three sit-to-stand lifts for partially dependent residents. Site #2, with the more rigorously enforced “no-lift” policy, had three full-body lifts and four sit-to-stand units. At both sites, a senior nurse had the responsibility to train and coach other personnel in the use of the mechanical lifts.

In our study, the primary outcome of interest was any self-reported pain, aching, stiffness or cramping in the lower back within the last 12 months that limited movement or interfered with work at home or on the job and that was not due to a sports injury or other non-occupational cause. This is the same defini-
tion used in the prior nursing study and in research on LBP in garment workers. See Byrns et al., for a complete description of the survey instrument. (Byrns, Agnew, & Curbow, 2002)

**Data Analysis**

Karasek’s job strain model was used to assess the effects of psychological stress on LBP. (Karasek et al., 1998) The survey results for these and other measures were dichotomized into high vs. low for a number of important variables. Bivariate analyses using chi-square and odds ratio were used to determine associations between the dependent variable and independent variables. Further analyses determined if associations existed between any two of the independent variables. If two independent variables were both associated with LBP, a stratified analysis was used to verify that none were confounding factors.

**Results**

The 108 health care providers in this study represented all shifts. Table I shows the demographic characteristics of study participants. They had a median age of 40 years old, and 97 percent were female. The median total number of years worked in health care was 13, and they had been working in their facility an average of 4.8 years (data not shown.) The majority (55.8 percent) had a high school education, and 41.3 percent had a college degree. They had a mean body mass index (BMI) of 26.6, and according to the new BMI criteria, 40.2 percent (37 of 92) were normal, 38.0 percent (35 of 92) were overweight, and 21.7 percent (20 of 92) were obese.

Table II shows the total prevalence of LBP and the prevalence by location. There were 34 of 73 (46.6 percent) participants who met the case definition of severe LBP. The prevalence of LBP was 50 percent (22 of 44) at site #1 and 41.4 percent (12 of 29) at site #2. Those individuals who reported having a prior sports or other non-occupational injury were excluded from the analysis.

Table III provides information on the risk of LBP due to manually lifting a fallen resident and the risk for those who did not use a mechanical lifting device when moving partially dependent residents. The odds of having LBP if you manually lifted a fallen resident were 3.5 (p = 0.016,) and the odds of LBP if you failed to use the mechanical lifts was 2.8 (p = 0.041.) Both results were significant. While there was a higher prevalence of LBP at site #1 than site #2, the results were not significant.

**Comparison of manual lifting patterns at site #1 vs. site #2**

Table IV explores differences in lifting patterns between the two study sites. The average number of manual lifts or transfers performed by an individual was 4.3 per day. At site #1, the average was 6.2 per day, and the average at site #2 was 2.2 per day. The average use of mechanical lifting devices by an individual was 1.1 per day. At site #1, the equipment was used on average 0.9 times each day, and at site #2, 1.7 times each day.

The odds of manually lifting a resident were 2.9 times greater at site #1 compared to site #2 (p = 0.017.) In addition, the odds were 10.3 times greater that a fallen ambulatory resident (one with some muscle function) would be manually lifted at site #1 (p < 0.001.) The other comparisons were manually lifting a fallen non-ambulatory resident,
and manually transferring a resident from the bed to a stretcher or to the toilet. If you were a health care worker at site #1, the odds were 4.7 that you would manually lift a fallen non-ambulatory resident \((p = 0.001)\). The odds were 2.9 and 2.4, respectively, that you would manually transfer residents to a stretcher or to the toilet \((p = 0.018\) and \(p = 0.035)\). All results were significant.

**Psychological stress measures**

Table V provides the results of psychological stress measures using Karasek’s Job Strain Model. Participants rated their workplaces high in both psychological and physical demand, but they also rated their ability to control their job tasks as high. Participants also rated both co-worker and supervisor social support high. Table VI displays differences between site #1 and site #2 in two of the job strain measures: physical demand and supervisor social support. Participants at site #1 perceived that their job demands were significantly higher than at site #2 \((OR = 3.2, p = 0.004)\). However, they also perceived that their supervisor support was higher \((OR = 2.7, p = 0.018)\). Perceived demand was highly correlated with self-reports of manual lifting and repositioning of residents \((Pearson\ correlation = 0.330, p = 0.001\) and Pearson correlation = 0.416, \(p < 0.001)\) respectively.

**Discussion**

In this study, we explored the relation between lifting policies and LBP in nursing home health care workers. Site #2 had a corporate-wide, rigorously enforced no-lift policy that included the provision of additional lifting equipment when the program was implemented. Site #1 had a no-lift policy, but it was limited to only non-ambulatory residents. While the prevalence of LBP was higher at site #1, due to small sample size, this difference between sites #1 and #2 was not significant.

In a prior study, we found that more frequent manual lifting was strongly associated with increased LBP. (Byrns et al., 2004) However, in that study, too few nurses used mechanical devices to assess their effectiveness. Our current results found that those who routinely used mechanical lifting devices reported significantly less LBP, especially when performing the most dangerous type of lift, a fallen resident. Our results also demonstrated that health care workers at site #1 were significantly more likely to manually lift fallen residents or transfer residents from the bed to a chair or a stretcher than those at site #2. Workers at site #2 also used mechanical equipment more frequently than site #1, but the difference was not significant. It is important to note that even at site #2, the ban on manually lifting was not totally effective.

The Karasek Psychological Strain model predicts that individuals who report high physical and psychological demand, low job control, and low social support are at risk for stress-related diseases, including low back pain. (Karasek & Theorell, 1990; Symonds, Burton, Tillotson, & Main, 1996) Psychological strain did not appear to be an important risk factor of LBP in our study because, while participants reported high levels of demand, they also reported high levels of control and social support. Personnel at site #1 reported significantly higher levels of perceived physical demand and supervisor social support than site #2. The reports of higher perceived demand at site #1 are consistent with higher levels of self-reported manual lifting since these were highly correlated. The reasons for the lower level of supervisor social support at site #2 are unknown, but one explanation might be employee irritation due to the more rigorous enforcement of no-lifting policies.

Since this was a pilot study, the sample size was small, and this limited the possibility of exploring all risk factors. Also, the cross-sectional design used in this study limits the ability to determine if risk factors such as manual lifting preceded the onset of LBP. A longitudinal design will be necessary to clarify this finding. Recall bias may be a problem when past information is collected using a questionnaire. However,
we believe that the use of functional limitations instead of duration of symptoms in the LBP case definition reduced the impact of recall bias.

Conclusion
This study provided support for both of our hypotheses. We found that workers who reported more frequent manual lifts and transfers reported significantly more LBP. Furthermore, there was evidence that a rigorously enforced, comprehensive “no-lift” policy was associated with a lower frequency of manual lifts and transfers of residents. Nursing home facilities may find that strict enforcement of comprehensive “no-lift” policies will reduce the prevalence of LBP. In addition, facilities should also provide an adequate supply of lift equipment. Reducing the risk for disabling LBP among nursing personnel could result in substantial cost savings and higher quality work settings, and LBP is one of the most costly occupational problems in the United States.

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George Byrns, MPH, PhD, CIH is an Associate Professor in the Department of Health Science at Illinois State University. Denise Knoblauch, RN, BSN, COHN-S/CM is a Case Manager for Saint Francis Medical Center in Peoria, Illinois and the current Executive President of the AOHP. Caroline Mallory, RN, PhD, is an Associate Professor in the Mennonite School of Nursing at Illinois State University.
AOHP’s Getting Started on the Road

Jan Frustaglia had a concern. Why offer the Getting Started program only one time a year, and only at the national AOHP conference site? Jan knew many more employee health professionals needed the valuable information and guidance Getting Started offered, but needed better access at different times.

Her concern turned into a wonderful idea. Why not reach out to employee health professionals in various parts of the country throughout the year and take Getting Started on the road? Jan teamed up with other experienced employee health professionals and they have presented to 58 attendees in 4 different locations so far this year.

When AOHP requested attendees write about their experiences at Getting Started, we were thrilled that two “stepped up to the plate” and wrote the following thoughtful insights on their experiences “on the road.”

Many thanks to Katie Wald who writes about her experience at the St. Louis presentation, and Mary Sullivan who shares her experiences in Arizona. Special thanks and congratulations to Jan and the other presenters for making Getting Started on the Road a raving success!!!

AOHP Workshop—Getting Started On-the-Road 2007

By Kathryn Wald, RN, BSN

What is a perfect match to your job description, offers CEUs and is close enough to home to entice you to attend? That offering is Getting Started On-the-Road 2007! When I received an e-mail recently from Deb Rivera, RN addressing Kansas City Area Employee Health Nurses, I was impressed. She enthusiastically endorsed this workshop. It had been presented in multiple locations across the country and had received overwhelmingly positive feedback from attendees.

I had been in my position for less than a year, working PRN and knew this “wealth of information” would be very meaningful to me. I was impressed that it was presented by AOHP because I had been seeking an organization like this to use as my guide in this new job. My supervisor was equally enthusiastic and we agreed to split the cost of the workshop. The information I planned to share with my co-workers and supervisor was the AOHP Getting Started Manual on CD. I also planned to make a hard copy to keep in the Employee Health office as a convenient resource.

On the day of the workshop in St. Louis, I was excited to see a small group of eight Employee Health Nurses with varied backgrounds. Some attendees had never worked a day in employee health, while one was an experienced AOHP board member. Their positions were based at hospitals as well as at community free-standing facilities.

I discovered there are updates to this workshop approximately every two years which enables the nurse to keep current with new information. The instructors represented three different states who spoke in tag team fashion in a very organized manner outlining the manual and answering questions. I was very impressed that Jan Frustaglia had the insight and heart to

(Continued on page 26)
An Invaluable Resource …AOHP’s “Getting Started Class”  
By Mary Johnson, RN COHN-S/CM

I would like to share with fellow AOHP members what I found extremely helpful about attending “Getting Started on the Road.” Having worked as both Infection Control Director and Employee Health Nurse for a year and half, I found myself in the position of establishing a separate Employee Health Department that could evolve into an Occupational Health Department. Additionally, for the three and a half years I had been in this position, I tried to develop Employee Health policies and procedures that were consistent with Evidence Based Practice developed from an Employee Health and Occupational Health perspective.

Web research did not provide me with the information I needed. I even tried to locate books or sources to purchase policies and procedures for an Employee Health/Occupational Health program. I visited several different healthcare organizations to try to find the answers and information I needed. Some policies were discovered but the leaders in my organization wanted more in-depth policies and procedures that met our diverse needs. It was very frustrating trying to find what I needed to develop our Employee Health Program.

I am an ABOHN-certified Occupational Health Specialist and Case Manager. I have worked in Occupational Health since 1989 in Industry. There were some similarities to healthcare which helped, but the majority of the policies and procedures were totally different and needed different resources.

Through my resources and colleagues, I finally found the AHOP organization and learned about Getting Started on the Road. I was so excited when the flyer arrived about the Getting Started Program. Finally there were resources to help answer all of the questions I had about starting an evidenced-based Employee Health/Occupational Health program.

Jan Frustaglia was wonderful and patiently answered all of my questions about AOHP, how long it has been in existence, what resources it offers, what the benefits are and – most important to me - what’s involved in starting an Employee Health or Occupational Health program.

I attended Getting Started on the Road on January 26, 2007 in Phoenix, AZ, hoping to get answers and support about Employee Health and Occupational Health programs.

The class took us through what an Occupational Health program in healthcare involves and how to develop the program. We were provided many position papers including AOHP’s confidentiality and medical records. I found this an excellent tool to get “buy in” in adopting policies and procedures. “Getting Started” and AOHP also established credibility with my employer that there was an organization with the needed evidence-based practice information.

The eight-hour plus class detailed program development with an extensive table of contents. Power point lectures and question-and-answer sessions laid out pertinent program information step by step. At the conclusion of each session, our questions were answered with a lot of information given from other healthcare organizations based on their experience.

The class included a CD with sample policies and procedures. Topics also included writing your job descriptions and evaluations emphasizing the most important components. Sample questionnaires and physical assessments that address a post job offer screening were distributed and dis-

(Continued on page 26)
reach out to non-members of AOHP and develop this offering “On-the-Road.” It had previously only been offered at the annual conference.

The content of the presentations involved twelve different areas including History, Roles, Networking and Resources. Some topics were familiar to me while others were new and enlightening. Being PRN, it is great to have the manual at my fingertips as a resource. I was especially interested to learn more about FMLA and Workers’ Compensation. I found the Health and Safety section very interesting and pertinent. During each presentation the speaker shared real life examples gathered from their roles at different institutions. These shared examples provided us a sense of unity as well as perspective from different entities and situations.

I would highly recommend this workshop to anyone new to the role of Employee Health Nursing. I plan to join AOHP now that I have experienced this workshop because I realize the organization offers more than just educational opportunities. I know AOHP is a strong advocate for the Employee Health Nurse through its affiliation with OSHA, NIOSH, and the Joint Commission’s Nursing Advisory Council. The Journal, electronic newsletter, listserv and the national conference provide professional support in my role as Manager, Clinician, Case Manager, Educator, and Consultant.

Kathryn Wald, RN BSN, is currently an Employee Health Nurse at Saint Luke’s South Hospital in Overland Park, Kansas.

An Invaluable Resource …AOHP’s “Getting Started Class”

cussed. I learned that these are essential in determining the employees’ ability to perform essential functions of their job. The information I received in this program was invaluable and made it much easier to go back to my work site and develop policies and procedures and ultimately my goal of an excellent employee health program.

When I arrived back at work I immediately shared this information with management. I now had the tools and knowledge to finally develop the program we needed. Our end result would be a strong, evidence-based program. I was then able to use the information about the confidentiality and all of the position papers to take a stand on how these policies needed to be implemented.

Additionally, I utilized the information and position paper on patient lifting to start working on training and to look at what equipment is needed to develop a lift program for the unique needs of our organization. Some of those needs included the lifting of 300-500 pound patients, many of whom are in wheelchairs. At this time I have been able to design and use indicators to drive the lifting program and to look at a stretching program based on our workers’ compensation information. There are many more programs that need to be developed and evaluated by looking at the available indicators and data.

A big thank you goes to AHOP for the class, the wonderful resources, materials, and experienced employee contacts available to answer questions! Thanks so much for the data and research to support our questions and program needs.

I am currently the Director of Employee Health at Gila River Health Care Corporation. While I am in the process of changing jobs, I know we have made huge strides in developing our program and I am happy to be able to leave material that will train my replacement. Thank you again!!!

AOHP is already planning the 2007 National Conference which will be held September 26-29, in Savannah, GA. If you know a vendor who would be interested in “Experiencing AOHP Hospitality In Savannah” contact AOHP Headquarters at 800 362-4347 or info@aohp.org. You can also find details about this conference at the AOHP website, www.aohp.org.
Stress Management

Restructuring policies and workloads, along with providing training and support services, can help reduce employee stress.

By Kathryn Tyler
Leading a Multigenerational Nursing Workforce: Issues, Challenges and Strategies

By Rose O. Sherman, EdD, RN, CNAA

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Movers and Shakers Unite to Initiate a Minimal Lift Program

By Phillipa “Pip” Atkinson Maas, RN, MSc

I arrived as a Travel Nurse from London four and half years ago and braced myself for the cultural changes I would encounter. The technology that greeted me in my work environment was mind-blowing – computerized med carts, scanners to identify patients, touch screen dispensing of medicines, all decades ahead of what I had been used to. The cultural change that had the most impact on me, however, had nothing to do with “high tech” – it was not being able to find a MaxiSlide to help me reposition my patient in bed. No one I asked even knew what a MaxiSlide was! The nearest equivalent was pulling a patient around the bed using a geri-pad.

Government legislation in Britain makes it mandatory for hospitals to provide caregivers with suitable equipment to lift and reposition patients. No Lift policies exist in every hospital, and staff is expected to comply by attending training and by consistently using the equipment. Nursing in Britain, therefore, conditions nurses to expect to have equipment provided to them to help move and handle patients. I was surprised that my new colleagues did not have the same expectation.

I learned that Mary Washington Hospital (MWH) in Fredericksburg, Virginia, was not the only hospital in the United States without lift equipment or a policy to support its use. I feared for my personal safety against physical injury, so on one of my trips home to England, I made a couple of phone calls to find out the name of the company who supplied the London teaching hospitals with equipment. Coincidentally, the company’s local representative lived around the corner from where I was staying with my parents. So, 15 minutes after our introductory telephone call, the rep and I were sharing a cup of tea in my parents’ living room, enthusing about the joys of the MaxiSlide, with me proudly holding onto my complimentary MaxiSlide kit!

In 2004, I proceeded to carry out a small survey on my unit to investigate existing patient moving and handling practices, but this time, without promoting the MaxiSlides. I wanted to get a clearer perspective of how staff had coped with handling patients’ mobility. I was saddened to read in many of the responses how experienced CNAs and nurses had improvised over the years, using blankets and sheets to lift patients from the floor who had fallen. Many commented about injuries they had sustained and how they struggled to ensure the patient was safe at the cost of their own wellbeing. Respondents appeared to believe that “good body mechanics” would protect them, but this was plainly impossible for those involved with lifting anyone more than 100 pounds on a daily basis. How did caregivers ever come to believe that 100 pounds is light? Some described the “dead lift,” which involved recruiting as many staff as possible to grab every limb of a patient in their efforts to lift him or her. My heart sank, and my resolve to see change was heightened.

In early 2005, I wrote to the chief executive officer at MWH, protesting at the injustice of nurses having to lift a dead weight using physical strength alone. I received a quick response. The CEO was ready to address the matter, and within two weeks he had initiated support to help address the problem. This led to the formation of the Lift Team and the creation of a Minimal Lift policy.

In 2007, I proceeded to do a pilot study on the unit where I was working using my solitary MaxiSlide kit. The aim of the study was to gauge reaction to the slide sheets from both staff and patients. Around that time, my Travel Nurse status changed, and I was relocated to a new unit. I continued promoting the MaxiSlides, but I had become a PRN nurse and opted to take on an additional role as a consultant for a company that assisted hospitals to establish Minimal Lift Programs, as well as train staff in the use of patient handling equipment. Over a three-year period, I traveled America with this company, specializing in training caregivers. All the while, I held on to my vision that I might one day see MaxiSlides and mechanical lifts on the units of MWH.

A term I picked up when I first moved to America was how a person can be a “mover and shaker.” While I could see that,
in the process of becoming socialized to the American way of life, I had become a mover and shaker, I also recognized that I had become part of a culture of movers and shakers at MWH. I encountered this at every level in this journey of change. The nucleus of the Lift Team is comprised of movers and shakers who are directors of varying Nursing Departments, including MHS Health & Wellness. Other important movers and shakers have been managers responsible for Materials Management, Environmental Services, Engineering, Biomed and the Nursing Units throughout the hospital. Together, these individuals have teamed together to lay the foundation for a viable Minimal Lift Program at MWH.

The opportunity for other movers and shakers at MWH to make themselves known is now possible, as we are in the process of creating a Mobility Resource Team. “Safety First” is our motto! In this instance, the priority is to promote safety first for the caregiver and then for the patient. We want to replace the dead lift and the use of blankets and geri-pads with mechanical lifts and Maxislides, as they are designed to handle weights that our backs and limbs cannot!

Participation in this project requires ingenuity and some courage, because “moving” and “shaking” old practices that have been established forever will not necessarily come easily! The invitation to rise to the challenge, however, is open to everyone. This is because every caregiver has experience with moving and handling patients. Sharing skills and experiences will open up innovative ways of integrating the lifts and Maxislides so they become a part of every-day practice, much the same as using disposable gloves and hand washing.

Changes in patient moving and handling practices have been slow to occur in America. But, by all accounts, the “safety first” mentality is gathering momentum. The Lift Team and the new Mobility Resource Team hope that you will capture the same vision that we have and actively participate in the change process. You may even feel inspired to initiate your own pilot study using a Maxislide kit!

Pip Atkinson Maas, RN, MSc, is a staff RN and Mobility Resource Team Coordinator with Mary Washington Hospital in Fredericksburg, Virginia. Ms. Mass recognizes the essential support and valuable work of fellow MWH associates, including:

- Mr. Fred Rankin, Chief Executive Officer, MediCorp Health System
- Lisa Lucas, RN, BSN, Director, Cardiac Services
- Rosemary Burke, RN, MSN, Director of Associate Wellness
- April Wills, RN, MWH, Health & Wellness
- Linda Koch, RN, BSN, Director, Medical Care Services
- Sydney Stone, Med-Surg Supply Chain Manager
- Drema Hopson, Operations Supervisor, Environmental Services
- Ken Patton, Director, Engineering
- Steve Lee & Charles Hicks, Biomed Technicians

**AOHP ROC Campaign Continues**

**It’s not too late!** Our “Recruit Our Colleagues—ROC” campaign is still going strong and will do so through June 2007...providing you with the opportunity to be eligible to win some great prizes!

**One Grand Prize** – 2007 Conference Registration plus 4 nights hotel accommodations will be awarded to the one member who recruits the highest number of new members >/=15 members through June 30, 2007. If no member recruits 15 new members, the member who recruits the greatest number under 15 will receive a 2007 conference registration!

**One 2nd Place Prize** – The member who recruits the second highest number of new members will be awarded a FREE one-year membership to AOHP.

**AND...** The Chapter that recruits the most members will be awarded $500 to be used at their discretion to support their members!

In the event of a tie, a drawing will be held to select the prize winners.

To date, we have 210 new members of which 56 were recruited through our ROC campaign. Please join in and recruit your colleagues so that they can also enjoy the many great benefits of membership in AOHP...and you could be a winner too! You can download a membership application from the AOHP website (www.aohp.org) and start recruiting! Contact AOHP Headquarters at 800 362-4347 or info@aohp.org with any questions you may have.

**AOHP...Dedicated to the health and safety of healthcare workers!**
2007 Call
for Nominations

Would you like a great opportunity to use your experience and commitment to AOHP in a leadership role? Now is an excellent time to accept the challenge and take advantage of this opportunity for professional growth and networking!

AOHP is seeking leaders to fill these Executive Board of Directors’ positions for a two-year term (October 2007- October 2009).

Executive President
Position Summary: Provides leadership to the Executive Board of Directors and the general membership-at-large by collaborative development, promotion, coordination, planning, and evaluation of the association’s philosophy, bylaws, and short and long term goals and objectives.

Executive Secretary
Position Summary: Maintains current historical written records of the association, chairs the Membership Committee, and coordinates continuing education records. This individual must have been a member of the association for at least four years, be employed in the field of occupational health in healthcare, have an interest and/or experience in continuing education, have access to clerical and/or computer support, and be an employee health role model for the association.

Regional Director
Position Summary: Provides leadership through effective communication to the designated chapters and chapter presidents by supporting the development, planning, coordination, and evaluation of regional activities; promotes the association’s philosophy, objectives and goals; and serves on the Executive Board of Directors.

Additional information may be obtained from your chapter president or the business office. If you are a qualified candidate, wish to nominate a qualified member, or would like to explore being nominated please contact:

Kim Stanchfield, Nominations Chair
540-433-4180
kstanchf@rhcc.com

Lydia Crutchfield
704-444-3175
lydia.crutchfield@carolinas.org

Christine Pionk
734-936-9242
cpionk@med.umich.edu

Nominations will be accepted until Friday, June 15, 2007.

All nominees shall be verified by telephone. Nominees who agree to run for office:
- Will be provided with a complete job description
- Shall submit a brief (2 paragraph ) philosophy and platform statement, and
- Shall submit a curriculum vitae to the nomination chairperson by June 15, 2007.

Elections shall be held in August 2007. Elected officers shall be installed at the annual membership meeting held during the national conference in October.
The AOHP 2007 Annual Conference in Savannah, GA from September 26-29, 2007 promises to be very exciting. Our Conference Committee has nearly finalized the agenda. This year we are featuring “Learning Tracts” to help participants to better identify topics and their content. “Learning Tracts” include general learning areas of the Aging Worker, Business Side of OH, Clinical, Construction, Emotional Health, Ergonomics, Injury Prevention, Legislative, Program Development/Management, Wellness, and Workers’ Compensation. Some of the sessions you can expect to be offered are:

- 2007 Spirometry Update
- Developing and Implementing a Respiratory Protection Program
- Emotional Intelligence: The Next Competency
- Accident and Cost Reduction Through Safe Patient Handling
- Can Management Really Control Musculoskeletal Costs in Workers’ Compensation
- Business of Health and Safety: Metrics that Work
- Auricular Acupuncture: A New Needle in Employee Health Services
- Understanding the Maze of Non-Rational Thinking
- Getting to Zero: An Open Forum On Reducing Needlesticks and Sharps Exposures
- Workers’ Compensation: Challenges and Opportunities in Orthopedics
- Construction and Hard Hats
- MRSA & VISA/VRSA
- Research: HBV & HCV Transmission and Prevention
- Promoting Safe Needle Devices
- Target HCV - HBV
- How Many Ill? Estimating the Impact of the Next Influenza Pandemic on the Workforce
- Stress & Depression in the Workplace

Not only does the AOHP 2007 Annual conference promise great learning opportunities, we also are planning to offer a variety of outstanding leisure experiences for attendees, including a “High Tea” Party, River Cruise, Ghost Walk, and a post conference Mini-Vacation/Retreat option for those who want to relax before returning home and putting their noses back to “the old grindstone.” It promises to be a wonderful time in a very quaint and charming city which is abundant in “Southern Hospitality!” SO PLAN NOW!!!! Come and join us as so that you can see firsthand that AOHP’s hospitality and charm is as notable as that of the city we will be visiting.

—Dee Tyler, RN, COHN-S  AOHP 2007 Conference Chair