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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.

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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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Publication deadlines for the Journal of AOHP—in Healthcare:

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Upcoming AOHP Conferences

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Spring greetings to all fellow AOHP members:

Author Ken Blanchard has said, “There’s a difference between interest and commitment. When you’re interested in doing something, you do it only when it’s convenient. When you’re committed to something, you accept no excuses—only results.”

I hope you as AOHP members are committed to our Association. Let me share with you some recent commitments.

• My local AOHP chapter held its regularly scheduled meeting at the end of February. I worked with the member hosting the meeting to investigate teleconferencing abilities. I committed to sending out notices to our membership regarding this opportunity. The host member committed to asking her IS department to assist us so we could offer networking abilities with our members who would have to travel 3 hours or more. We were able to have 9 members participate who rarely or never had the ability to attend a meeting before! It was so exciting to hear everyone say what a great opportunity they had by participating in this way.

• Our membership chair committed to mailing out over 100 invitations to hospitals in our state to inform them of our association and networking opportunities. The response rate was not what we hoped for but 3 people responded to the mailing, and 1 person committed to driving several hours to attend our meeting.

• We had members volunteer to serve as a nominations chair and to work on bylaws development.

Nationally, the Board continues its commitment to you, our members.

We are continuing our monthly conference calls to continue Board business and progress on our strategic plan. Strategic plans include:

• Membership Commitment - The ROC campaign is not off to a fast start yet this year. Please commit to personally contacting a hospital or health care facility in your area to invite the occupational health professional to a local networking opportunity. Remember an individual member and a chapter will receive recruitment awards this year. AOHP’s goal is to attain 1200 members by March 2005.

• Conference commitment – Jan Frustaglia and her hardworking committee have made lots of progress for our 2005 conference. Please commit to attend this excellent educational and networking opportunity October 13-15. Work has already begun for 2006! Please share any ideas for our special 25th anniversary celebration with co-chairs Sandy Prickitt and Dee Tyler.

• Leadership Commitment – Dee Tyler committed to serving as national nominations chair this year. Please consider a commitment to AOHP at the national level. Officers up for election are President, Secretary, Region 2 and Region 4 director.

In closing, remember commitment for yourself: I hope that you were able to celebrate National Occupational Health Nursing Week and National Nurses week. Enjoy the recognition you deserve!

Sincerely,

Denise Strode
AOHP Executive President
The Centers for Disease Control (CDC) released its long awaited draft Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, on December 6, 2004 in the Federal Register. Public comment was requested by February 4, 2005. AOHP sent in a response which can be viewed on the AOHP website, www.aohp.org.

The Guidelines is an approximately 300-page document covering an array of issues regarding the prevention of the transmission of tuberculosis (TB) in the health care setting. The areas that are most pertinent to hospital employee health services are as follows:

Risk assessment changes
Even though there is a general decline in TB rates in recent years, there is a marked variation in TB case rates that persists. Therefore, health-care workers (HCWs) in different geographic regions face different risks. The draft document now lists three risk classification groups versus five groups in the 1994 document:

1. Low-risk. For inpatient settings with >200 beds with a TB patient count of <6 for the past year. For inpatient settings with <200 beds with a TB patient count of <3 for the past year.
3. Potential ongoing transmission. This is a temporary classification only. It warrants immediate investigation and corrective steps. Testing for infection with M. TB would need to be performed every 8-10 weeks until lapses in infection control have been corrected and no further evidence of ongoing transmission is apparent. This setting should then be reclassified as medium risk and remain at this classification for at least one year.

It is advised that when in doubt to the classification, classify as medium-risk. Worksheets are provided in the document to assist with risk determination for your facility.

The Quantiferon-TB test
This is an in vitro cytokine assay that assesses the cell-mediated immune response to M. Tuberculosis in whole blood. It has been added in the draft as a mechanism to use for baseline and annual TB screening in facilities. The FDA for usage recently approved this test. It is called QuantiFERON-TB GOLD. The document discusses how to interpret results, details about the test, lab issues with the test, etc. For example, when using the QFT for baseline testing of HCWs, one negative QFT result is sufficient to demonstrate that the HCW is not infected with M. Tuberculosis. HCWs with conditionally positive and positive baseline QFT results should be evaluated for latent TB infection (LTBI) and TB disease. This evaluation should include a TST if no other risks of M. Tuberculosis infection are identified. The cost of the test is approximately $25 per person ($15 for the agent and $10 for lab time).

Conversions for the tuberculin skin test (TST) and for Quantiferon (QFT)
These conversions are described along with how to calculate the conversion rate. In this section it also describes how facilities that no longer perform serial testing should have ongoing communication with state or local health departments.

Training and education of HCWs
All HCWs, including physicians, must receive initial training and education relevant to their work setting and additional occupational specific education. Suggested components of the training program are listed in the document. The CDC and state or local health departments have sources available at no cost in hard copy, on videotape, on compact discs and on-line.

Privacy and Confidentiality
There is more information on protecting the privacy and maintenance of confidentiality of the HCW TB screening test results than in the 1994 document.

HCWs with LTBI
For those HCWs who decline or fail to complete a full course of treatment, they should receive a symptom screen annually and should be offered treatment for LTBI again unless medically contraindicated. HCWs who have a positive TST and leave employment should be coun-
seled about the risk for developing TB disease and instructed to seek prompt evaluation if symptoms of TB disease develop. This information should be recorded in the HCWs employee health record when they leave employment.

Respiratory Protection
The draft document essentially lists what OSHA published December 31, 2003 and July 1, 2004. The draft also states that respirator usage for TB is now regulated under the general industry standard for respiratory protection. The document lists annual fit testing per the OSHA regulation and then also states periodic fit testing. It recommends periodic fit testing based on the risk assessment. The CDC did have a workshop on fit testing and respiratory protection in Atlanta November 30 and December 1, 2004. The goal was to set a research agenda. No significant changes or comments have been made public yet.

TST
The document provides more in depth information on how to give, read and what to tell the employee at each step of the TST. Several tables are provided for interpretation of the reading as well.

TST Quality Control (QC) Program
This section of the document is quite lengthy and descriptive of what training, annual competency is needed for those who have been designated and trained for planting and reading the TST. It also lists what the trainer needs to do and what education is needed for them. The document states that “random variation in TST administration and reading TST results can cause poor quality TST results, including false-positive or false-negative TST results.” It states that this can be avoided with training and attention to details.” The training consists of:

• Initial training: to place the TST, three hours of lecture and demonstration, nine hours of supervised practical work using procedural checklists observed and coached by the expert TST trainer. to read the TST, six hours of introductory lecture and demonstration, four sessions of supervised practical work using procedural checklists, perform >80 readings, 50% of TST results need to be negative, at least 25% positive.

Per the Federal Register that announced the draft guideline, the CDC expects to publish the final Guidelines in 2005. As soon as we hear any additional information we will share it with you. In the meantime, the draft guidelines and comments made are available at www.cdc.gov/nchstp/tb/Federal_Register/default.htm

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Employees are the main focus of our work in Employee Health. We work hard to protect their safety, promote their health and provide them care and counseling. Granted, we also work diligently for our employers to make sure our companies comply with the many and varied regulatory agencies and provide cost saving programs to protect bottom lines. But, I firmly believe that one of our most important (and easily underestimated) functions is also to protect the safety of the patients our employees care for.

I seem to have had a recent “run” on fitness for duty evaluations that were mainly psychiatric in nature. More than ever, I was reminded of the importance of working diligently to assure that the healthcare workers providing care to our facilities patients are physically and mentally healthy and capable of providing the needed care.

A very experienced operating room RN, who has had a long-standing diagnosis of bipolar disorder, came to my office in the middle of her shift requesting a medical leave. This was during the holiday season, and she expressed concerns about her ability to concentrate and feelings of sadness. She stated that during her shift that day she had to be excused, that she just could not continue to work. I offered our Employee Assistance Program counseling, provided necessary paperwork and the employee left my office. Immediately afterwards, I received a call from my director, the Director of Employment, regarding this employee. The nurse’s OR Nurse Director had just reported to my director that this nurse had just “abandoned” an anesthetized patient and left the OR. As we looked at the situation, it became clear to me the employee’s medical condition at the time caused her to leave the anesthetized patient in the care of an LPN (a clear violation of standard practice and safety rules).

The employee was given a final written warning for her behavior, but was not terminated. She was required to see our Occupational Health Physician for fitness for duty determination before returning. As I continued to work with the employee, I also provided much needed education to the manager and HR on mental health and illness. The nurse and I developed a trusting, productive working relationship. She understood that patient safety came first, but that I would advocate for her safe return and another opportunity for her in the OR. The nurse returned to the OR after treatment by a psychiatrist for one month and has continued to do well in her performance and managing her mental health.

Recently, I received a “Friday morning call” (those nightmares that only happen on Fridays, take all day to deal with, weird) from the assistant director of our Mental Health Center. She was concerned about the behavior of a staff RN in the Mental Health Center. The RN was described as exhibiting “paranoid behavior”, making medication errors, errors in judgment, intimidating other staff and having conflicts with staff. This staff nurse had returned to work 5 months earlier after surgery to remove a benign frontal lobe brain tumor. Actually, we had discovered the brain tumor in a fitness for duty evaluation we had performed a year earlier when the employee had exhibited what appeared to be focal seizures when working. My immediate action was to remove the nurse from duty this Friday and arrange for a fitness for duty evaluation by our Occupational Health physician. The nurse remained off work and a series of neuro-psych tests were performed. The concern was that the employee had had personality changes post surgery. These concerns were verified by co-workers in the Mental Health Center who reported that the nurse had returned to work from the surgery with some difficulty, but sympathy for her situation had prevented the staff from reporting the behavior, until now.

The staff realized that while “helping” the employee, they had created a climate of non-safety for the patients.

This nurse was found, during the neuro-psych testing, to have remarkable changes in her cognitive and judgement skills. She remained disabled, on a medical leave, with full medical benefits. Her claim for Long Term Disability benefits was accepted by our LTD insurance carrier. Consistent with our policy, this employee was terminated from employment when her LTD benefits commenced.

These two most recent cases remind me of how important our role is. We must make sure that our employees are “fit” and able to perform care. Our task may be to determine if an employee can safely lift and transfer patients, administer medications, counsel or whatever task is necessary. Our employees rely on us to be fair and accurate. And our hospital patients’ safety relies on that accuracy.
Steps to a Healthier US Workforce Symposium Web Page

This web site has recently been updated. Additions include proceedings from the October 2004 Symposium, a list of speakers and panelists, and a section featuring articles about the Symposium. The updated web site is http://www.cdc.gov/niosh/steps/2004/symposium.html.

NIOSH-Funded Study on Interns and Long Work Hours

First-year doctors in clinical training, or medical interns, who work shifts of longer than 24 hours are more than twice as likely to have a car crash leaving the hospital and five times as likely to have a “near miss” incident on the road as medical interns who work shorter shifts, according to a study co-funded by the National Institute for Occupational Safety and Health (NIOSH) that was reported in the January 13 issue on the New England Journal of Medicine.

The article, “Extended Work Shifts and the Risk of Motor Vehicle Crashes among Interns,” is the third in a series of studies on the impact of extended work hours and fatigue upon interns conducted by the Divisions of Sleep Medicine at the Brigham and Women’s Hospital and the Harvard Medical School in Boston. All three were co-funded by NIOSH and the Agency for Healthcare Research and Quality in the U.S. Department of Health and Human Services. The new article can be accessed at http://www2a.cdc.gov/NORA/newsletters/pdfs/nnewswin05.pdf.

A Quote Worth Quoting

“Learning is not attained by chance. It must be sought for with ardent and tended to with diligence.”
Abigail Adams
(1744-1818, American First Lady)

NIORA

The National Occupational Research Agenda (NORA) recently unveiled its newly redesigned newsletter, NORA News. NORA News informs readers of team activities, recent publications, and current trends in occupational health and safety. The revised newsletter responds to NORA’s partners’ and stakeholders’ requests for shorter, worker-focused materials that demonstrate impact in workplace safety and health. New features now include worker tips, summaries of NORA related documents, and inks to NIOSH resources. The latest edition can be accessed at http://www2a.cdc.gov/NORA/newsletters/pdfs/nnewswin05.pdf.

New OSHA Document


Great Immunization Website

The Immunization Action Coalition maintains an excellent website on immunizations for healthcare workers at http://www.immunize.org/hcw/ate/htm. CDC experts answer several questions including immunization concerns related to pregnancy and Hepatitis B vaccine boosters.

Practice “Pearls of Wisdom”

Liana Carty of Santa Barbara Cottage Hospital in California sends along this ‘pearl of practice tip’: “Besides the clinical, legal, regulatory, etc updates that help our practice, I can’t say enough good things about personal ‘enrichment’ classes, such as communication or priority planning as examples. I’ve benefited from taking classes on interpersonal communication and understanding people, and now my manager and staff understand each other better and my job satisfaction has increased. I just completed a priorities class and worked in small groups to understand how to prioritize our workloads and how to better understand why we procrastinate. The hands on approach is practical…and it makes the everyday tasks more ‘do-able,’ It helps to know we all face similar challenges.

Then there is the ‘boot camp’ class I’m taking at 6:00 am. Two ex-pro football players are coaching a group of us from the gym. We go to a football field, a track and the beach. We run sprints and the stadium steps and do calisthenics. This strengthens the body…and the mind! All this makes us ‘fit for duty’ and prepared for work!”
OSHA Alliance Update
The quarterly implementation team meeting was held by conference call February 9, 2005. The majority of the meeting was spent discussing the need for acute care ergonomic guidelines. The current process for developing guidelines was reviewed. The current OSHA website tools were also reviewed and there was discussion about how the Safety and Health Topic pages and the Hospital eTool could be utilized. Linda Haney prepared a power point presentation that outlined the differences between acute care and long term care. It was decided to add AOHP’s position statement on patient handling to the OSHA web page and to contact both Dr. Audrey Nelson and the American Nurses Association Handle with Care program to determine if this information could be added to the OSHA web page.

There will be a follow-up call on March 28 to complete other agenda items that will include OSHA’s participation in AOHP’s annual conference in San Antonio in October.

AOHP Participates in Occupational Health and Safety Network Meeting
On February 3, 2005 AOHP was represented at the Occupational Health and Safety Network Meeting at the National Safety Council Office in Washington, D.C. The Occupational Health and Safety Network was formed approximately five years ago by Aaron Trippler of the American Industrial Hygiene Association. It is a networking group of occupational health and safety professionals. There were representatives from 12 organizations that are concerned with health and safety in the workplace. Some familiar organizations represented were AAOHN, ACOEM, AIHA, the National Safety Council, and the Federal Aviation Administration. Other organizations included the American Society of Safety Engineers, the Association of Occupational and Environmental Clinics, the Health Physics Society, the International Safety Equipment Association, the National Association of Environmental Management and the Voluntary Protection Participant’s Association. Each representative had the opportunity to provide a five-minute overview of their association and the top issues being addressed.

Hot issues included the upcoming budget and the recent changes in Congress and the Congressional committees. Areas of mutual concern include the issue of titling for safety professionals, as there are over 300 titles currently in use, demonstrating the value of health and safety, emergency preparedness and personal protective equipment. Representatives from Congressman Charlie Norwood (R-GA) provided a legislative update. Dr. John Howard, Director, NIOSH made a presentation to the group that was an update on the reorganization of NIOSH, programming issues, nanotechnology (research and technology development at the atomic, molecular or macromolecular levels, in the length scale of approximately 1 - 100 nanometer range); for more information go to www.nano.gov, emergency preparedness and applying research to practice.

The group agreed to continue its networking efforts through email and periodic meetings. It was a privilege to have the opportunity to represent AOHP and to network with so many colleagues who also have workforce health and safety as a priority.
Ergonomics certainly isn’t the only issue in health care, but it remains a very, very high priority because it is the “big” issue related to staff injuries within healthcare organizations as measured by human resource and cost losses. There is seems to be a sense of urgency and picking-up-the-pace as more and more healthcare organizations realize that they are far behind general industry on this issue. They are focusing in on the problem because it is impacting their profitability, their ability to attract and retain top-notch employees and equally important, the quality of care that they deliver to their clients. Concurrently there is a ground swell within healthcare staff that this is the right issue at the right time.

Subsequent columns will address the ergonomic issues of various departments within healthcare organizations, but this one will report on just a few of the very exciting things that are happening in the world, literally, of Safe Patient Handling. Currently, the only national conference in the United States that focuses 100% on this issue is held annually in Florida and sponsored by the the Patient Safety Research Center of Inquiry in cooperation with the University of Southern Florida, the American Nurses Association and the Department of Veterans’ Affairs. This conference began in 2000 with a meeting of the Veterans Administration, led by Dr. Audrey Nelson, regarding the problem of injuries to health care workers during the handling and movement of patients. In 2001 the conference was opened to the general public and the participant list as well as the influence of the conference has grown significantly each year. The 2005 meeting with over 400 participants concluded on March 4. Here are the highlights from this conference:

- Safe Patient Handling is an international issue with many other countries paving the way. Sue Hignett from the UK spoke about “evidence-based practice.” Sue’s book was highlighted for the “Ergonomic Bookshelf” in the previous column in this series. It is clear that healthcare organizations, as most organizations and systems, expend considerable activity and resources on programs and education that, in fact, are not effective and are perpetuated because “it is the way we’ve always done it.” It became crystal clear after listening to speaker after speaker that teaching “body mechanics” related to the manual handling of patients should no longer occur. It is a bold statement but one that is backed up by the evidence. Several participants, finding it difficult to let go of this approach, spoke on behalf of teaching body mechanics – they were told that there is no safe way to manually move patients. One physical therapist did win some support by saying that teaching body mechanics with equipment use remains important.

- Hanneke and Nico Knibbe from the Netherlands spoke several times with presentations including International Approaches to No Lift Policies, Safe Patient Handling in the Operating Room, and Ergonomic Challenges in Home Care. Holland is clearly leading the world in their approaches and in the tools that they have developed to address the issues of safe patient handling in a variety of healthcare settings. They include government-sponsored practical guidelines and various training materials for safe-patient-handling coaches including an annual conference, a magazine, and a web site. They have published [in English] in journals such as Ergonomics and Professional Safety. They are also the developers of tools for educators about dynamic lifting (DynaDisc) and about static postures associated with patient handling (StatMan)1

- Louise O’Shea, Australia – International Approach to No Lift Policies; Hilary Morton, UK – Risks and Solutions for Safe Transfers In and Out of Vehicles; Sue Hignett, UK – Ergonomic Evaluation of Ambulances in the UK; and Philippa Leggett, UK – Safe Ambulation of Patients – all provided helpful information developed from work in their countries.
More and more vendors are exhibiting at the conference with new and innovative approaches to safe patient handling. All were encouraged to let vendors know the needs.

In the space of just a couple of years, the American Nurses Association has taken this issue and run with it. Their respected “Handling With Care” campaign, supported by Johnson & Johnson, continues to increase awareness through a public campaign including mailings and “kits” to all healthcare facilities in the United States, on-the-road seminars and multiple presentations.

Rehabilitation professionals are being brought into the dialogue, through initiatives by Dr. Audrey Nelson, to enable multi-disciplinary healthcare professionals to speak with one voice on this topic. A white paper on safe patient handling is in the process of being finalized and published with the endorsement of the American Physical Therapy Association, the American Rehabilitation Nurses Association, and the Veterans Health Administration. The white paper puts forward six recommendations including: (1) implementing the OSHA Ergonomics for the Prevention of Musculoskeletal Disorders Guidelines for Nursing Homes, (2) building and supporting a culture of safety in rehabilitation settings that protects staff as well as patients, (3) improving communication channels between nurses and physical therapists to facilitate safe patient handling and movement tasks, (4) developing policies and procedures for the therapeutic use of patient handling equipment, (5) developing competency-based assessments that demonstrate proficiency for use of all patient handling equipment used on the respective patient care units, including return demonstrations, and (6) encouraging research that supports the improvement of patient and staff safety while maximizing patient rehabilitation potential.

One of the most exciting initiatives is the NIOSH grant that is involving a group of nursing educators and their institutions in developing and delivering curriculum that supports safe patient handling. Those institutions that applied for the grant and were accepted in the project will be receiving state-of-the-art equipment for loan or gratis supplied by a variety of vendors. The purpose is to teach students from the beginning, that their safety and health is critical to their ability to work as a nurse and to provide safe, high-quality care for their patients. We can now begin to envision a day, as Barbara Blakeney, President of the ANA, stated, when “nurses will no longer have to worry that their backs will take them out of the profession.” President Blakeney also was clear that new nurses would be told to ask the question about “no lift policies” when they apply for jobs and to reject employment by those who do not have them.

Equally exciting was the coalition building between high-profile leaders within the nursing community. The following nursing leaders spoke about their commitment and pledged their organizations support: Barbara Blakeney, President, American Nurses Association; Antoinette Bargagliotti, President-Elect, National League for Nursing; Jean Bartels, President, American Association of Colleges of Nursing; Marilyn Bowcutt, President, American Organization of Nurse Executives; Marilyn Fingerhut, Office of the Director, NIOSH; Christine Hancock, President, International Council of Nurses; and Cathy Rick, Chief Nursing Officer, Veterans Health Administration.

Strongly consider attending this conference in 2006. For additional information visit www.patientsafetycenter.com.

We are truly on the cusp of a “new day” for direct-care healthcare workers.

Please send any feedback, questions, and contributions to this column to LindaHaney@diligentservices.com.

(Endnotes)

1 DynaDisc™ and StatMan™. Single copies are available, at no charge, from ARJO, Inc., Roselle, IL.

All product information is not endorsed by the author or AOHP but merely is a resource for individuals.
**Spotlight on an AOHP Star**

AOHP is very pleased to focus our spotlight on another worthy AOHP star, Betty Kuschel-Rapaski. Betty is an RN, BSN, COHN-S and currently the Assistant Director of Nursing and a Certified Occupational Health Specialist for the Martha T. Berry Medical Care Facility in Mt Clemens, Michigan.

Her Michigan Chapter colleague, Christine Pionk, nominated Betty for stardom. Christine shares with us that “Betty has been a member of the Michigan Chapter for many years and during that time she has participated extensively in chapter activities, making many recommendations to keep the chapter actively involved on both local and national levels. If something needs to be completed, Betty works industriously to make certain it happens. During her three terms as Treasurer, Betty was able to find the best banking arrangement for the Michigan Chapter while continuing to consider new resources. She presented as part of a Getting Started in Employee Health presentation at the national AOHP conference in Chicago. Betty is an excellent resource for new members and a steadying one for long-term members. She is a true ‘AOHP Star’.”

Betty has worked at Martha T Berry for 4 ½ years. She has been in the nursing profession 28 years, 12 of which were in Occupational Health. Her Occupational Health career began at St John Oakland Hospital in Madison Heights, Michigan in 1993.

Currently, in Betty’s dual position of Assistant Director and Occupational Health Professional, she coordinates the delivery of care to 217 residents of a Medicare/Medicaid certified long term care facility. Additionally, Betty manages the occupational health needs for the facility’s staff, including educating the staff on safe work habits, assuring proper patient lift/transfer equipment is utilized, reviewing needle safety devices, monitoring sharps injuries (they had no sharps injuries for 2004!), reviewing each employee incident and providing counseling on injury prevention. Betty serves as a member of her facility’s Safety Committee, Infection Control Committee, and Quality Council. Additionally, she certified the nursing staff in TB test administration and reading in December of 2004.

Betty describes her favorite part of her job is also her most challenging, handling the workers’ compensation cases. She states “I enjoy dealing with the medical specialist, therapies, and the attorneys that are handling the litigated cases. It makes me feel especially proud of my profession when I am able to work with an employee on a long and complicated case, assist them with the recovery process, return them to accommodated and then full original position. The Risk Manager at the acute care facility was a great mentor to me and thank him for taking me under his wing.” Betty also enjoys educating healthcare workers on safe working habits to prevent injuries when at work and teaching them how safe habits at work spill over into their personal lives at home and at play.

The mother of two sons, a Michigan State University Freshman and a high school sophomore, Betty also enjoys reading and running. Additionally, she loves presenting at educational conferences to fellow occupational health professionals. In addition to Getting Started in EH, Betty presented her evaluations of bariatric lifting equipment at the Accession Health Systems’ annual Workers’ Compensation Conference in Tucson, Arizona in 1999.

Betty has been an active AOHP member for 12 years and credits her Michigan Chapter with helping her learn the basics and details as a new occupational health professional. Very proud of her state chapter, Betty shares the Michigan Chapter “is a great professional organization to be a member of. We look to each other’s expert advice on handling Workers’ Comp claims, new products, policies and procedures for OH and current CDC and OSHA issues, or other current hot topics.” “I also appreciate the assistance that AOHP has nationally provided with lobbying concerns that affect our lives, our positions and ultimately our employees that we service. AOHP is an excellent source for providing education to the members.”

“I am very proud of my professional accomplishments and to be a member of such an elite group,” Betty advises. “I thank AOHP for being there for me and leading our profession.”

Betty, we thank you, for your many contributions to your profession and AOHP. You truly are a “star” in our midst!
Pink eye, or conjunctivitis, is a common problem among Employee Health Professionals. We often send employees home with it or advise parents of children who acquired it at school. Conjunctivitis happens when the conjunctiva (a thin, clear covering over the white part of the eye that also covers the eyelid) gets infected. The eye usually turns pink or red and often itches or hurts.

There are four types of pink eye common in the United States.

- **Viral conjunctivitis:** This is the leading cause of pink eye. It usually affects only one eye, but sometimes both eyes. Viral pink eye causes a lot of tearing and a light, watery, clear discharge. Sometimes, it causes eyelids to swell. Looking at bright lights can be painful. It can spread to other people very easily, especially in schools, workplaces and healthcare practitioner’s offices. It usually lasts 8-10 days.

- **Bacterial conjunctivitis:** This condition affects both eyes. It causes eye pain, swelling of eyelids, redness in and around the eye and a heavy discharge that can be yellow or green. When a person sleeps, this discharge may build up and can keep the eyelid from opening when they wake up. In most cases, it lasts 3-5 days.

- **Allergic conjunctivitis:** This condition usually affects both eyes and causes itching in the eyes and sometimes the nose. It also causes watery eyes and swollen eyelids. Like other allergies, this is more of a seasonal problem.

- **Giant papillary conjunctivitis (GPC):** This type of pink eye usually affects individuals who wear contact lenses. It can also result from prosthetics and stitches. Both eyes are usually irritated. GPC is not an infection, but a reaction from a foreign body (such as a contact lens) on the membrane covering the inner eyelids and the whites of the eyes. Symptoms include itching, a heavy discharge, watering of the eye and red bumps on the underside of the eyelids.

**Stopping The Spread of Pink Eye**

To avoid pink eye, keep your surroundings clean and stay away from a person who has pink eye. Pink eye is contagious and is spread by touching a person with pink eye, or items that person touched. An individual with pink eye also can spread it by coughing or sneezing. I often tell employees here at my facility that pink eye is something easily transmitted to a fresh post-op eye surgery patient. Then, a seemingly “harmless” irritation to the employee is a major post-op infection to that patient.

Here are some tips to avoid getting pink eye, or if the person has it, keep others from getting it.

- **WASH HANDS FREQUENTLY.** Use hand sanitizer between washings. Do not touch or rub your eyes.
- **Don’t share washcloths, towels or pillowcases with anyone else and wash after use.**
- **Don’t share eye drops or makeup.** If you have pink eye, discard eye drops and makeup and get new when your eye gets better. (You can get pink eye again if you don’t!).
- **If you or someone in your house has pink eye, clean surfaces such as doorknobs and counters with watered-down bleach to disinfect them.**
- **If you have pink eye, don’t swim (the bacteria can spread in the water), shake hands or use handkerchiefs (instead use tissues and throw away).**

**Treatment of Pink Eye**

Treatment of pink eye is determined by type of infection.

- **Viral:** Much like the common cold, there is no cure, but symptoms usually can be relieved without a prescription. Instead, cool compresses and artificial tears can help relieve the symptoms. For the worst cases, topical steroid drops may be prescribed to reduce discomfort.
- **Allergic:** Cool compresses and artificial tears sometimes help with...
itching and burning. If a more serious case, the healthcare practitioner may prescribe non-steroidal anti-inflammatory drugs and/or antihistamine pills or eye drops.

- **Bacterial**: Prescriptions for antibiotic eye drops or ointment and if additional symptoms such as a runny nose, cough or earache, an oral antibiotic. If discharge builds during sleep, a warm washcloth helps get rid of discharge.

- **GPC**: Stop wearing contacts for at least 3-4 weeks. Healthcare practitioner may also advise to switch to a different type of contact lens and cleaning solution to prevent pink eye from recurring. Eye drops may be prescribed to help relieve symptoms.

**Medication Administration**

**Drops**
- Wipe the eyes off with a tissue or cotton ball dipped in warm water. Clean off the mucus and pus.
- Vision should be directed upward when instilling the drops.
- Gently pull the lower lid down. Put one drop in the pouch of the lower eye. Do no touch the dropper to the eye.
- Wash hands immediately after administering the medication.

**Ointment**
- Gently pull the lower lid down. Put a line of ointment in the pink part of the lower lid (like making a line of glue). Do not touch the tube to the eye.
- Wash hands immediately after administering the medication.

Make sure that your Employee Health policies and Work Restrictions address employees with conjunctivitis.

**Resources**


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**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.

Nominations need to be submitted to the national office by July 15th. You may contact your chapter president or regional representative for award criteria.
On December 31, 2003, OSHA extended the requirement for mandatory annual fit testing to include health care settings. This ruling has been and continues to be challenged and is currently not being enforced. However, in January of 2004, as the only Employee Health professional in our 200+ bed hospital, I realized that responding to this ruling was on my shoulders. While waiting to see what the final outcome would be, I decided it was necessary to proceed with a plan to try to accomplish this seemingly insurmountable task. I am pleased to share with fellow AOHP members my experiences and our “final” implementation plan for our facility.

Realizing that I alone could not provide fit testing for over 500 employees, I began to consider decentralizing the process. I formulated a plan and presented it to our Division of Hospital Epidemiology/Environmental Health: Infection Control Committee. The key components of the plan included:

- Mandatory annual fit testing for yearly performance reviews.
- Individual department fit testers trained to provide fit testing for department employees.
- Management notification to employees of the fit testing process during the month prior to their annual performance review.
- Medical evaluation questionnaire available to all employees through the hospital intranet. Managers instruct employees to complete the medical evaluation questionnaire prior to fit testing.
- Employee Health Nurse reviews the medical screening questionnaire and clears the employee for fit testing or refers the employee for further evaluation.
- All communication for the process is done electronically.

The target date for implementation was set for April 1. All employees who had annual performance reviews during January, February, or March were to be scheduled during April, May and June – in addition to those employees who had performance reviews during those three months.

Following approval of this plan by the Division of Hospital Epidemiology, I met with the managers of designated departments and asked them to identify an employee(s) for their department to be trained in fit testing. A train-the-trainer session was scheduled and 21 employees were trained in fit testing. Each affected department was issued a Fit Test kit during the training session.

Our Information Systems Department provided tremendous support in planning and implementing this process. A copy of the Medical Evaluation Questionnaire was provided for them and it was placed on the hospital intranet in a yes/no format. The Medical Director for Employee Health Services established guidelines for clearance and/or referral for further evaluation based on the responses to the questionnaire. After review, the questionnaire was then electronically filed in a folder for that year. A hard copy could be printed for each individual employee health record. Electronic folders were set up for upcoming years so the process could continue in future years.

April 1st arrived and the process was up and going. There was an overwhelming initial response and the process seemed to be going well. As the months passed however, it became apparent the plan was not as streamlined as it could have been. Some of the problems we encountered were:

- Knowledge deficit for some employees who had limited exposure to computers.
- Difficulty recognizing compliant employees. Employee Health did not have access to anniversary dates and therefore could not effectively track the employees who failed to have the fit test done in a timely manner.
- Scheduling difficulties for those employees who worked only part time.

By the end of October, Employee Health prepared a list of all “at risk” employees who had not yet been fit tested. It was quite an extensive list of delinquent employees. This was presented to the Administrative Staff and Department Managers. The need for compliance received strong support from the Administrative Staff. Managers encouraged staff and fit testers to work to complete the process before the end of the year.

By the end of December 2004, we had obtained a 98% compliance rate. In further evaluation of the process, I
met with members of the Administrative Staff and Department Managers to try to identify ways to streamline the process for the upcoming year. We decided fit testing would remain a mandatory requirement but would not be connected to the employee’s anniversary date. Instead, each department would be assigned a designated month to complete fit testing of all employees within the department. The advantages of this change proved to easier tracking of noncompliance and a shorter period of time for each department to focus on fit testing.

Even though this has been a very challenging and somewhat difficult process to develop and implement, there are some advantages to following through with the process. One advantage is that after being fit tested again, some employees had a change in the size of respirator since their first fit test at the time of employment. This would mean they may have been wearing the wrong size in the work setting and therefore not protected as well as they should have been. Another advantage was in the re-education of the proper use of and need for this personal protective equipment. The increased awareness of the need for the respirators increases compliance.

In conclusion, mandatory annual fit testing continues to be a very controversial topic. It is very burdensome and costly for healthcare providers and may not be necessary to prohibit the transmission of TB in the healthcare setting. It is however possible to comply with the regulations and provide necessary protection for employees. After all, our employees are our greatest resource.

We are continuing the annual requirement even though enforcement has been put on hold for 2005. We feel it is easier to continue until a final ruling is made than it would be to stop the process and then reinstate it at a later date. Also, it does provide an extra level of confidence for our employees.

Ellen Glover, RN, COHN-S, MPH, is the Employee Health Nurse for Halifax Regional Medical Center in Roanoke Rapids, NC. Ellen has been an Employee Health Nurse and member of AOHP since 1993 and is the current Treasurer of the North Carolina Chapter of AOHP.

Visit the AOHP Web site to learn more about AOHP’s mission, goals, and professional standards. The site contains the most current information on chapter activities, membership, as well as helpful phone numbers. AOHP welcomes your comments or inquiries. E-mail us at info@aohp.org.
February 3, 2005

Centers for Disease Control and Prevention
Division of Tuberculosis Elimination
1600 Clifton Road, NE.
Mailstop E10
Atlanta, Georgia 30333.

RE: Public comment on Draft Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005

To Whom It May Concern:

On behalf of the Association of Occupational Health Professionals in Healthcare (AOHP), I am writing regarding Draft Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005.

AOHP’s public comments regarding this document are as follows:

II. B.3.4. TB screening risk classifications. Page 32
The determination of risk level for Tuberculosis (TB) hazard is defined as greater than or less than three cases of TB seen per 12 months. This fails to consider both the denominator and the potential for encounters with unrecognized patients with active TB disease.

AOHP strongly urges consideration of using the per capita rate of TB in a community as the indicator of risk to Emergency Medical Services (EMS), other first responders, and police personnel not included in B.3.6 as it is much simpler to determine and more reliable as an indicator of risk.

AOHP also urges the inclusion of more specific language for police personnel. “Correctional facilities” does not adequately describe the many police departments without any holding facilities. Exposure to TB in the field is a real hazard that appears overlooked when only correctional facilities are discussed.

Police and fire departments vary in size within the same geographic and demographic boundaries. By using the three patient standard you could have a small department designated very low risk in the same area as one designated higher risk merely due to the number of patients seen or transported. In reality, the personnel of both departments could be seeing the same number of patients/suspects per worker and individual workers have equal chances of seeing active cases of TB.
The description in B.3.6 clarifies correctional facilities with medical infirmaries with TB isolation cells but leaves all other correctional occupations with trying to determine the three patient encounter level. This means they have the same problem as in determining risk.

Police officers encounter TB hazards in the field, in six hour and seventy-two hour holding facilities as well as in local city jails without regular medical staff. In short-term correctional facilities police often rely on EMS should medical concerns arise. This does not always result in adequate evaluation of detainees with active TB.

In addition, contact investigation of identified cases of active TB does not always uncover prior contact with EMS or police. EMS and police personnel do not always follow up on potential cases to determine if TB was ruled in. While ideally they are supposed to, it just doesn’t happen consistently. Tuberculin Skin Tests are an important surveillance tool for these workers who don’t always have the same training, skills, or medical backup as in regular medical settings.

“B.3.4 For outpatient, outreach, and home-based health-care settings B.3.4a Classify those with a TB patient count of less than three for the past year as low risk. B.3.4b Classify those with a TB patient count of greater than three for the past year as medium risk.

B.3.6 For correctional facilities where inmates with TB disease are cared for or are housed Classify these settings as medium risk.”

II. B. 4.1-4.5. TB Risk Assessment. Page 45. The definitions and explanations in this section are quite complicated. It would be helpful if the information in this section were presented more clearly with some possible examples to further explain the points being made.

G5.3g Workplace restrictions. Page 93. AOHP feels it is unnecessary for employees who leave employment to be counseled upon termination of employment since they have already received annual tuberculosis screening and education in the hospital setting. It is quite difficult and unrealistic to capture these employees prior to leaving. Therefore, we feel this is placing an undue burden on such facilities.


The decision to withdraw the proposed Tuberculosis (TB) standard and require that respirators for occupational exposure to TB be covered by the General Industry Respirator Standard, 29 CFR 1910.134 presents significant concern to our members.

Our concern lies in two areas. They are outlined as follows:

- The General Industry Standard for Respiratory Protection was originally developed for airborne chemical hazards not biological hazards.
- Lack of proof that annual fit testing will in fact reduce transmission of TB when occupational exposure occurs.

Our position on these matters is that the health and safety requirements be based on current scientific outcomes. Annual fit testing has not been proven to be effective in decreasing the spread of TB when occupational exposure occurs.
First, the General Industry Standard for Respiratory Protection was originally developed for airborne chemical hazards not biological hazards.

The original General Industry Standard for Respiratory Protection when published in 1971 and later revised in 1998 was developed for airborne chemical hazards. Protecting healthcare workers from occupational exposure to airborne diseases is different from protecting workers against particulate and/or chemical hazards. Adequate protection for healthcare workers involves a variety of infection control measures that have been recommended by the Centers for Disease Control and Prevention (CDC). These measures have been effective in reducing the transmission of TB to healthcare workers and have not required annual fit testing in the past.

We concur with our colleagues from the Association for Professionals in Infection Control and Epidemiology (APIC) in their comments to OSHA that “health care facilities cannot measure or accurately determine the potential for exposure and/or the relevance when dealing with patients who may or may not have an infection; who may or may not have an infectious load capable of being transmitted; who may or may not have a way to disseminate their organisms; and who may or may not have an organism that is capable of being transmitted via airborne spread, etc.”

To clarify APIC’s comments when caring for patients there are many variables that must be considered, unlike chemical hazards. A patient who is coughing up blood does not necessarily have TB. There are other possible reasons for the cough, for example, lung cancer or a blood clot to the lungs. These are the everyday clinical decisions that healthcare practitioners make and that is why the general industry standard should not apply to healthcare.

Second, lack of proof that annual fit testing will in fact reduce transmission of TB when occupational exposure occurs.

Respiratory fit testing was addressed in the Institute of Medicine (IOM) report commissioned by Congress in 2000, “Tuberculosis in the Workplace.” The report states “in facilities that admit only the occasional individual with tuberculosis or that have a policy of transferring such individuals, workers are likely to see no or very marginal additional protection from an extensive respiratory protection program.” The report also discusses the costs of such a program. It reports that the direct costs estimated in the Federal Register are significantly lower than the actual cost of implementing a program.

We are especially concerned about small healthcare facilities in areas where there is a very low incidence of TB. Implementing a full respiratory protection program would be a significant burden in time and resources when the facility may never have a TB patient. Facilities should be able to determine the need for a TB respirator program based on the annual TB assessment recommended by the CDC.

In addition to the direct costs, the indirect cost of implementing such a program and its impact on the ability of healthcare workers to adequately provide patient care must also be considered. Such a program could 1) impact patient care services, 2) be labor intensive and 3) be a logistical challenge for the most seasoned manager. Given the current scientific evidence the cost/benefit of an annual fit testing program for TB cannot be supported.

We request continued research and updates of standards to reflect the research as it relates to fit testing and tuberculosis transmission. We also believe that the guidance in this draft document needs to be clearer regarding periodicity of fit testing.

Page 187 states that “data on protections against transmission of M. TB in health-care settings are not available,” and in C.1. Paragraph 2 “studies have found that a respirator’s fit characteristics can be more important than the accuracy of the fit test,” further define the problems with making a case for annual fit testing. We believe there are other ways to ensure the health and safety of healthcare workers with more periodic fit testing (i.e. every 2-5 years) with annual
education and user seal checking. Also request clarification on what the definition is of “periodic fit testing”. This document refers to both annual and periodic fit testing. It needs to be clearer what is being advised.

**Supplement 2: A.6. -A.6.2. Quality Control (QC) Program for techniques of TST administration and reading TST results, Pages 129-131.**

We find this area burdensome, costly and beyond what is needed to ensure that healthcare workers who administer and read the TST are competent. There is a large concern for who will train the TST trainers and how they are to remain competent on an annual basis.

There is also a concern for the support of hospitals to authorize healthcare workers to be trained due to the cost and the amount of nonproductive time for the employee to become and remain competent. Having healthcare workers trained in nursing departments and elsewhere in the hospital has been one of the main reasons that compliance has become consistently higher. The testing is more readily available, especially as Employee Health Services continue to be moved offsite. We believe that the number of hours for lecture, demonstration, practical work and coaching for both the placement and reading of the TST is far beyond that necessary to administer such testing. AOHP would recommend that for combined placing and reading that the lecture, demonstration be one hour with procedural work and coaching taking place concurrently.

**Supplement 4: Respiratory Protection. II. Implementing a Respiratory Protection Program. C. Screening, Page 190**

Recommend language change to reflect OSHA language of who can perform the medical screening prior to fit testing. The CDC draft document states that the screen needs to be done by a medical doctor. The OSHA document states a “physician or licensed health care professional (LHCP)” can perform. AOHP recommends that the CDC document read as follows: a “physician or licensed health care professional can perform”. This would provide consistency between the two organizations.

We thank you for this opportunity to communicate our comments and look forward to an opportunity to collaborate in the development of a standard that would be appropriate for healthcare. Please contact Sandra Prickitt at 415/492-4790 or prickis@sutterhealth.org for additional information.

AOHP, a national association of approximately 1000 members, is dedicated to promoting the health and safety of workers in healthcare. This is accomplished through:

- Advocating for employee health 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.

Sincerely,

Denise Strode, BSN, COHN-S/CM
Executive President
2005 Call for Nominations

Executive President - Executive Secretary  
Regional Directors for Regions 2 and 4

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 the above Executive Board of Directors’ positions for a two-year term (October 2005- October 2007).

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.

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.

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.

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:

AOHP Nominations Chairperson  
Dee Tyler  
E-Mail: dtyler@mha.org  
Phone: (248) 304-4214  
Fax: (248) 304-4226

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 17, 2005.

Elections shall be held in August 2005. Elected officers shall be installed at the annual membership meeting held during the national conference in October.
Industrial Hygiene in Healthcare

Safety Issues Regarding Liquid and Compressed Gas Cryogenics

By George Byrns, MPH, Ph.D, CIH and Lee Shands, MPH, CIH

Editor’s Note: With this Journal we are inaugurating a regular Industrial Hygiene Column in each issue of the AOHP Journal. We know it will be useful to you. Please send your feedback, questions and contributions to gebyrns@ilstu.edu. This first issue will discuss the use of liquid and compressed gas cryogenics in healthcare and the safety concerns it requires.

Mss Shands and Dr Byrns are in the process of co-authoring a book, Controlling the Institutional Environment: A Guide for Health and Safety Managers in Hospitals and University Settings.

Cryogenic liquids have a boiling point below –238°F (–150°C). In controlled situations, cryogens can be used to remove skin lesions or growths. Cryogenics are used in both the liquid and compressed gas forms in health care. The ability to produce extremely low temperatures is the reason for their use in health care; however, this property poses occupational hazards as well. Inadvertent contact with the skin can cause severe burns.

Safe handling of liquid cryogenics (usually liquid nitrogen) requires that the staff be familiar with the nature and hazard of the material. Appropriate safety precautions during handling include using appropriate personal protective equipment (face shield, plastic apron, insulated gloves with gauntlet cuff and pants worn outside shoe tops) and long-handled dip-pers when transferring the liquid to smaller containers.

Compressed gases such as nitrous oxide (N₂O) and carbon dioxide (CO₂) are used as cryogenic agents. (NIOSH) The compressed gases when allowed to expand reach very low temperatures. In a cryosurgical unit, the gases expand in the tip of a probe, causing the tip to freeze at a low temperature. The frozen tip is placed upon the lesion or growth that is to be removed.

Cryosurgical units, if not vented to the outside atmosphere, can result in room concentrations of the cryogenic gas of several thousand parts per million. Nitrous oxide levels from cryosurgical units can be controlled through proper preventive maintenance of the unit to control leakage and venting of the discharge gas from the unit. Substitution of CO₂ for N₂O as a cryogenic agent is not always advised. The freezing temperature of CO₂ (-79°C) is higher than N₂O (-89°C) and can result in inadequate depth of freeze during lesion removal. Cryosurgical units are often used by gynecologists, to remove cervical lesions, by general practitioners or dermatologists to remove skin lesions and by ophthalmologists for eye surgery. The health hazards associated with N₂O exposure are discussed in the waste anesthetic gases section of our book.

George Byrns, MPH, Ph.D., CIH is the Assistant Professor of Environmental Health at Illinois State University. Dr. Byrns completed his MPH in Environmental Health from the University of Minnesota and his Doctor of Philosophy in Environmental & Occupational Health from John Hopkins. Dr. Byrns has extensive experience in Industrial Hygiene including work as an Institutional Environmental Control Officer and a private consultant. We are pleased to have Dr. Byrns’ column as a regular feature of our AOHP Journal.

All product information is not endorsed by the author or AOHP but merely is a resource for individuals.
A Review of the Effect of an Accommodation Program to Support Nurses with Functional Limitations

By Pamela Koviack

Copyrighted content. Please contact AOHP Headquarters at 800-362-4347 or info@aohp.org to purchase a copy of this Journal issue.
Partners at the Bedside: The Importance of Nurse-Physician Relationships

By Alison P. Smith
Congratulations to the Michigan Chapter of AOHP!

They were awarded the 2004 Ann Stinson President’s Award for Association Excellence at annual AOHP Business Meeting October 8, 2004. The Michigan chapter was recognized for demonstrating outstanding performance and enhancing the image of occupational health professionals in healthcare.

*The Journal incorrectly identified another chapter as the award recipient in the Winter issue. We apologize for our error and send congratulations to the Michigan chapter for their well deserved award.*
Symposium Gets
‘Steps to a Healthier US Workforce’ Initiative Moving

President Bush announced the effort last July, with a focus on preventing work-related illness and living healthier lifestyles.

By Fred Drennan

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Health Care System Changes and Reported Musculoskeletal Disorders Among Registered Nurses

By Jane Lipscomb, PhD, RN; Alison Trinkoff, ScD, RN; Barbara Brady, RN, MS, Jeanne Geiger-Brown, PhD, RN

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An Occupational Sentinel Health Event (SHE(O)) is a disease, disability, or untimely death, which is occupationally related and whose occurrence may:
1. provide the impetus for epidemiologic or industrial hygiene studies; or
2. serve as a warning signal that materials substitution, engineering control, personal protection, or medical care may be required. 1

The genesis of the SHEO arises from a table of disease events that was developed by David D. Rutstein based on the concept of the Sentinel Health Event (SHE). According to Rutstein, an SHE is a preventable disease, disability, or untimely death whose occurrence serves as a warning signal that the quality of preventive and/or therapeutic medical care may need to be improved. 2 Thus, these events serve as negative indices of the quality of medical care. For example, a case of polio is an SHE. The occurrence of this disease signals a breakdown in the immunization aspect of health care.

This approach of identifying and counting the number of preventable tragedies in the health care field was also used in the 1930s in New York State in preventing maternal mortality and in the 1960s for preventing infant deaths in the State of Massachusetts.

Based on the experience with maternal and infant mortality, Rutstein collaborated with NIOSH and successfully applied the SHE concept to the field of occupational disease. Thus the SHEO concept evolved with appropriate modification of the SHE table.

Following survey of the scientific literature, a list of 50 disease conditions linked to the workplace was published in 1983; these were codable within the framework of WHO’s International Classification of Diseases system (ICD-9). 1

An updated list of 64 disease conditions was published in 1991. 3 Criteria used for inclusion in the original list presented in 1983 were: documentation of associated agent(s), of involved industries, and of involved occupations. For the 1991 update, the following additional criteria were considered:
1. Sound epidemiologic study with appropriate controls, endpoint, and specifics concerning occupation, industry, and agent; and
2. For case reports or case series reports, more than one case or case series identifying similar industry and occupation characteristics;
3. In the case of lung cancer, the study must have been controlled for smoking history; and
4. For death certificate studies, there must have been confirmatory studies using more rigorous methodologies.

Studies that were equivocal were not included in the updated list. Reports that needed confirmation by more supportive studies were also not included in the updated list. These included the following:
1. studies in which results were only suggestive or preliminary;
2. a single death certificate study;
3. a single case report or a single report of cases in one workplace (i.e., a case series report);
4. a questionnaire study; or
5. studies using collapsed ICD codes for disease conditions.

In the updated list, two broad categories of SHE(O) were represented. The first group included those diseases or conditions that, by their inherent nature, are occupationally related, e.g., the pneumoconioses. It is unlikely that these diseases would occur in the absence of the inciting agent. The second set of conditions included diseases such as lung cancer, leukemia, peripheral neuropathy, and ornithosis, which may or may not be occupationally related; further information on the industry and occupation is required to establish a possible link between disease condition and occupation.

References

Reprinted from NIOSH Website: http://www.cdc.gov/niosh/topics/SHEO.
How do you achieve career contentment?

The likelihood of being in a situation that does not enable contentment is very real, unless you know what to do and where to get assistance.

By Jeff Garton

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October 12-15, 2005 at the Crowne Plaza Hotel in beautiful San Antonio, Texas is where AOHP will be “ON A MISSION.”

The Crowne Plaza sits directly on the famous Riverwalk – a few steps away from shopping and restaurants – if you can tear yourself from our exciting venue this year!!

Pre-conference workshops on Wednesday, October 12th give a wonderful variety of choice:
1) Getting Started in Employee Health presented by AOHP “seasoned” members.
2) The Economics of Workplace Safety by Equitable Safety Group (formerly ErgoLogix).
3) Workshop for RESPOND (software) Users by ICPA, Inc. The attendee will be transported to a computer lab for this workshop.
4) Emotional Intelligence: The Next Competency in Leadership by Dennis Ondrejka, PhD, RN, COHN-S/CM from Colorado.
6) Case Management Adherence Guidelines by Sherry Aliotta, RN.
7) Indoor and Environmental Air Quality Issues by Robert Booth, MPH, CIH, LHRM from Oncore, Inc.

Dr. Kathleen Quinn, EdD, MSN will present her Spirited Mission Keynote on Thursday October 13th, followed by Dr. Steve Bierman, MD, founder of NAPPSI. The conference will continue until 5:30 with nine Breakout Sessions – topics include Measuring Wcomp Outcomes, Lessons Learned from Safe Patient Handling programs, Recordkeeping, Inspiring Health & Safety in Orientation, Preparation for Disaster Preparedness, Laser Safety, Drug Testing in Workplace, Flu Vaccines, Prevention of MSDs. On Thursday you will have plenty of time to visit our 30+ vendors during breaks and at noon, as we have invited Dr. David Ashkin, MD back to present an update on TB.

We have switched the reception with our Exhibitors from Wednesday to Thursday, October 13 6-8:30pm. Come dressed in those western duds’ ‘cause ya know ya ‘re in Texas! Munchies, networking and the annual Scavenger Hunt with the vendors will keep ya kick’in!

Friday, October 14th will keep us cruising with seven more Breakout Sessions from 8-12. Topics include Expert Witness Sagas, Maximizing Employee’s Safety Habits, Results Using Hypnotherapy, Risk Reduction Assessments for Patient Handling, For-Cause Testing, Overweight/Obesity Puzzle, Maximum Participation from Minimal Lift Program and Effective Return to Work-the Healthcare Providers Prospective, from Pat Crawford of Texas Workers’ Compensation Commission. Our AOHP Annual Business Meeting and Luncheon will be held 12-2, followed by Dr. Michael Hodgson, MD, MPH and Jane Derebery, MD speaking on occupational topics for the healthcare worker population. Friday evening will be your night to stroll around the Riverwalk!
2005 Conference

Saturday, October 15th from 8-2pm we will have all General Session speakers. On the agenda: 1) Dr. Gregory Schears, MD from Mayo Clinic, NY  2) Dr. Thomas Connor, PhD from NIOSH 3) Guy Fragala, PhD, PE, CSP  4) Ron Stoker, Executive Director-ISIPS and…..we are very pleased to have Beverly DaCosta Tobias, MBA, RN, COHN-S, CCM energize our closing of the ’05 Conference with “Selling Your Skills to Management.”

New in 2005: The Conference Committee is proud to announce that the Poster Session will be open for viewing from October 13, 10:45 am to October 14, 10:00 am. Stop by to see how the presenter has successfully implemented a program or learn about their success story.

Come join us at the annual business meeting and award luncheon on Friday, October 14, from 12:05 pm to 2:00 pm. This luncheon meeting is included in your main conference registration. This special event recognizes our winners of AOHP individual and chapter awards. Celebrate with the awards winners and learn the news from the AOHP Board members & Regional Directors.

Enjoy the lunch and socialize with friends and peers. Get the chance to win one of the door prizes. Prizes included 1 free main conference registration for 2006 conference and exciting prizes donated by Liko, Inc. Thank you to Liko, Inc. for their generous donation.

The reception will be held on Thursday, October 13, 2005 at the Exhibit Hall in the Crowne Plaza Hotel. The event will start at 6:00 pm and will end at 8:30 pm. Great food and beverages are provided. Discover new products, mingle with exhibitors and learn about new companies.

As usual we will have the scavenger hunt and lucky draw. The winner of the scavenger hunt will receive a free main conference registration for the 2006 conference. Thanks to Diligent/ARJO, Inc for donating the prizes for AOHP’s lucky draw.

AOHP will again welcome the nurses who will be sitting for ABOHN exam 8-12 noon on Saturday.

AOHP is so honored to have so many vendors and organizations not only attending and bringing vital information for the attendees, but also sponsoring our conference! Come join us on October 12th in San Antonio – home of the Alamo! It’s a fantastic chance for learning and growth, the opportunity to bond with friends and associates. You’ll return recharged and rewarded with fresh ideas, insights and memories to last a lifetime.

The conference brochure should now be in your hands. If you know someone who is not an AOHP member and you would like to invite he/she to the 2005 conference, please contact Annie Wiest at AOHP Headquarters. She can be reached at 800-362-4347 or email info@aohp.org.
Because we know there are still many other occupational health professionals who could benefit by becoming members of AOHP, the Board voted to extend our Recruit Our Colleagues—ROC campaign through June 30, 2005. To acknowledge members’ recruitment efforts, the Board voted to once again offer a free AOHP conference registration to the member who recruits the most members from October 1, 2004 through June 30, 2005. The member who recruits the second highest number of new members will be awarded a free one-year membership to AOHP. AND…. just to sweeten the efforts…. the CHAPTER that recruits the most members will also be awarded $500.00 to be used at their discretion to support their members.

Keep in mind, the cost for membership to AOHP is less than $0.35 a day. What a sweet deal! So, keep on “ROC” ’n for AOHP. Recruit your colleagues and increase your changes to receive even more valuable rewards! For more information, call AOHP Headquarters 1-800-362-4347.