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The AOHP is dedicated to promoting the health and safety of workers in healthcare. This is accomplished through:
• Advocating for employee and patient 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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The occupational health professional in healthcare is in a key position to help insure the health and safety of both the employees and the patients. The focus of this journal is to provide current healthcare information pertinent to the hospital employee health professional; provide a means of networking and sharing for AOHP’s members; and thereby improve the quality of hospital employee health services.

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Upcoming AOHP Conferences
2005 October 12-15: San Antonio, TX
2006 October 4-7: Sacramento, CA
President’s Message

By Denise Strode, RN, BSN, COHN-S/CM

I hope you have been able to enjoy the summer and take some time for rest and relaxation. Now is the time to begin gearing up for fall flu shot campaigns as well as managing the day-to-day goings of your department.

I recently conducted a search of quotes using the word “Mission” to help me focus on writing this column. My goal was to use the word to place focus on our upcoming conference. I was able to find this quote to guide me. “When you discover your mission, you will feel its demand. It will fill you with enthusiasm and a burning desire to get to work on it.” I hope this quote by W. Clement Stone encourages you to think about two things: our upcoming conference in San Antonio and passion for our association. I hope you feel enthusiasm when you think about your AOHP chapter, our conference, and your job.

Our conference is just around the corner, and I hope you are registered. Many times I have heard members say how enthused they are after attending our conference. The conference can be so thought provoking you just can’t wait to get back to implement new programs or investigate new approaches for care at your facility! I hope your mission will be to experience this enthusiasm and desire. Remember to register before the early bird deadline and to book your hotel room early. Let’s fill up the Crowne Plaza in San Antonio!

Jan Frustaglia and her committee continue their mission of offering a great conference. Sandy Prickitt, 2006 conference chair, and her committee are already at work. The theme has been chosen. Joyce Safian, the founding member of AOHP, has agreed to be the keynote speaker and gave Sandy many historical documents regarding the formation of AOHP.

Our nearly full slate of candidates for open AOHP Executive Board positions evidences enthusiasm and desire for our association. Thank you to Dee Tyler, Barbara Burnett, and Kim Stanchfield who worked to develop the slate of candidates as well as to those members who agreed to run for office. I hope many members demonstrated their mission by participating in the election process.

Mary Ann Gruden continues her mission as Association Community Liaison by chairing the quarterly OSHA alliance conference calls. Refer to her column for more specific updates on this and other ACL activities.

By the time this column is published the individual and chapter winners of the ROC campaign will be announced. Thank you to all those who shared the AOHP mission by recruiting new members. We also need to focus on maintaining current AOHP membership. Please share your passion with fellow AOHP members so they see the value of maintaining AOHP membership in the years to follow.

I am pleased to announce the enthusiasm the Board is showing for the management abilities of Annie Wiest and Judy Lyle. The owner of Aspect Management decided to retire, and Annie and Judy were successful in starting their own management firm, Kamo Management Services LLC. Kāmó is a Mandarin word for “Excellent Services.” As of June 1, 2005, Judy and Annie began managing AOHP under the auspices of their company. No changes in services or address were noted by this transition. The Board is very pleased with services and is happy that Annie and Judy will continue to work with us. This change will give Annie and Judy the flexibility they need to provide the best services for AOHP. For example, this will allow Judy and Annie to seek other web site design services so we can continue to upgrade our website.

Do you have an enthusiasm for continuing education? If so, please contact AOHP headquarters or me with your interest or a name of someone who may consider this position. AOHP would really like to have someone have the opportunity to mentor with Kathleen VanDoren, the current continuing education chair.

I would like to thank all of the members who contacted me with such kind words regarding the letter AOHP sent to hospital CEOs during occupational health nursing week. It is my mission to have activities, which will focus specifically on our specialty next year. If you have some ideas for this celebration, please let me know. At my facility this year, I presented lunch and learn sessions on office ergonomics and held a health, safety, and wellness trivia quiz. What did you do at your facility to celebrate the week? Share your ideas. Perhaps we can publish some ideas in the Journal or e-newsletter.

Thank you for continuing your AOHP membership. I look forward to networking with you in San Antonio. Make it your MISSION to attend this year!

Denise Strode
Executive President
AOHP’s 2005 Public Policy Statement

The top two issues in occupational health in healthcare that most concern AOHP members according to the member survey completed in November 2004 are bloodborne pathogen exposures and safe patient handling. Based on member input AOHP has developed a policy statement dealing with both of these important issues.

In addition, the Association is further addressing these issues by working with the OSHA Alliance on safe patient handling in acute care to enhance the hospital employee health section of the OSHA website. Regarding the bloodborne pathogen issue, the New York chapter is involved with a bill regarding source patient HIV consenting. The bill was referred to committee on February 14, 2005, amended and sent back to committee on April 5, 2005. We very much applaud the New York chapter for monitoring this bill and it’s activity regarding it.

AOHP’s 2005 Public Policy Statement

At the time of this writing, the bills have passed the Housed Education and the Workforce Committee. H.R. 739 has been placed on the Union Calendar, number 26. H.R. 742 has been placed on Union Calendar number 46. They are also to be heard in the Senate subcommittee on employment and workplace safety in the near future.

Bills Related to Nurse Staffing Ratios

AOHP provided responses to H.R. 1372 (Quality of Nursing Care Act of 2005) and S. 71 (Registered Nurse Safe Staffing Act of 2005). Both bills are similar in nature and wording. AOHP opposes them as written. H.R. 1372 has been in the Ways and Means Committee since March 7, 2005. S. 71 is currently in the Finance Committee.

Bills Related to OSHA

In April, AOHP responded to two bills related to OSHA (H.R. 739 and H.R. 742). H.R. 739 is also called the Occupational Safety and Health Small Business Day in Court Act of 2005. AOHP stated its support of this bill with a suggestion for a language change related to extending the deadline for “additional time to respond.”

H.R. 742 is referred to as the Occupational Safety and Health Small Employer Access to Justice Act of 2005. AOHP also voiced its support of this bill.

Asbestos Litigation Bill

Bill S 852, related to asbestos litigation was introduced by Senator Arlen Specter of Pennsylvania with several other Senators co-sponsoring it. AOHP reviewed the bill and received several comments from members with various experiences with asbestos-related cases. AOHP responded to this bill in May 2005. AOHP opposed the bill unless there are substantial changes made to it. As of May 26, 2005 the bill was in the Committee on the Judiciary and ordered to be reported with amendments favorably.

AOHP Joins NIOSH and AHA Coalitions

AOHP has joined with the Friends of NIOSH coalition. This coalition of approximately fifteen organizations provides support for NIOSH. Key Coalition activities each budget cycle, include:

- Organizing a coalition meeting with the NIOSH Director
- Developing a professional budget recommendation for NIOSH funding
- Developing lobby materials to support the budget recommendation
- Conducting Capital Hill visits in support of the NIOSH budget

AOHP also joined with the American Hospital Association and several organizations to address the nursing shortage and the Nurse Reinvestment Act.

Thank-you to all members that have assisted provided feedback in the writing of these documents!

To view AOHP’s 2005 policy statement and for further information regarding activities since the last newsletter, please visit the website at www.aohp.org.

Member Comments

If you have comments regarding these activities or have thoughts or concerns pertaining to Government Affairs, please contact:

Sandy Prickitt
AOHP Executive Vice President
prickis@sutterhealth.org
I shared the same health problem as many of our employees in our facilities. I was morbidly obese. Morbid obesity has several medically accepted criteria for definition. One is considered morbidly obese if they are:

- more than 100 lbs. over their ideal body weight, or
- have a Body Mass Index (BMI) of over 40, or
- have a BMI of over 35 and are experiencing severe negative health effects such as high blood pressure or diabetes, related to being severely overweight
- unable to achieve a healthy body weight for a sustained period of time even through medically supervised dieting

Except for diabetes (which was knocking at my door), I had all of the above. Plus, I had hyper lipedemia, esophageal reflux, and joint pain. I just did not have any energy any more.

Obesity has long been my diagnosis. I was a chubby child, having been placed on amphetamine diet pills at 10 years of age by a well-meaning but misguided pediatrician. My teen years were a series of yo-yo diets as were most of my adult years. Actually, you name the diet and I tried it. This included a physician supervised 4-month liquid fast 18 years ago. I lost 70 lbs. that found their way back, plus more.

My life with obesity did not hold me back. I was always active and outgoing. I was a grade school and Junior High cheerleader. Granted a chubby one, but I had fun. I acted in plays, had many friends, and did well in school. I’ve had a great professional nursing career and a 22-year happy marriage. Still, I needed to lose a lot of weight. Many times I sat in my physician’s office and discussed my health. I voiced my frustration frequently that I was an intelligent medical professional, so why could I not take control of my weight and health. His answer was always “weight loss and health is not a matter of intelligence. It is much more about what lifestyle you choose and then dedicate to live.”

Three years ago when I was 47, my mother was diagnosed with Type II Diabetes. I knew that if I did not make some major changes in my health status, diabetes was certainly my future also. I had considered gastric bypass surgery for some time, but my mother’s diabetes was the final “kick” I needed to pursue weight loss surgery seriously.

And it has been an incredible 3-year journey. I used the first two years to research weight loss surgery. I talked to many people who had had the surgery. I talked to those that were successful and those that “screwed it up.” I researched physicians and facilities that performed the surgery. And I started the process with my insurance company for approval. I had my personal physician’s total support and encouragement as well as my husband’s.

Finally, I had a laproscopic RNY Gastric Bypass at the University of Virginia on September 13, 2004. Dr Bruce Schrimer performed the surgery. Dr Schirmer and his staff proved to be experienced, knowledgeable, and very caring. Since that date I have adapted and am devoted to a new lifestyle. I cook and eat low fat and healthy foods in moderation. I fast walk 30 minutes 6 days a week and I work out at Curves 4-5 days a week. I take the stairs everywhere.

I have lost over 100 pounds. My BMI went from 46.3% to 28%. And I’m still loosing weight. I have about 15 pounds to loose to get to my goal. Except for vitamins I am off all medications. And I feel terrific!!! Actually, I feel better than I ever remember feeling. It really has been quite an experience. My “best” moments so far:

- Crossing my legs comfortably. When you are very overweight you cannot do it. It is so comfortable to sit and easily cross your legs.
- Going to “The Gap” at a large mall and standing in line with all the teenagers to pay for a regular size sweater that I could wear. When you have purchased clothes for most of your life in “Plus” shops, no one knows what a real thrill this is.
- People that had not seen me since pre-surgery did not recognize me. That is sooo much fun!!
- Feeling healthy for the first time in my life. This is the absolute BEST of all. There is truly no greater goal than good health.

Would I recommend weight loss surgery to others? I am very careful about it. What I actually recommend is exactly what my personal physician advised me for many years. That is to “choose a healthy lifestyle and dedicate your life to living it.”
I, like you, have a very visible position in my facility. Employees with obesity and weight problems want to know what “magic” I have done to lose over 100 lbs. and look new and different. My first answer is “there is no magic.”

I caution others with obesity that surgery should never be a first option or viewed as an easy way to lose weight. I make sure that they understand that surgery has risks, potential for complications, and takes complete dedication to a whole new way of thinking, eating and living. Also included in my advice to those who want to pursue weight loss surgery:

- **Try other means of losing weight first.** A good program of healthy eating in moderation with exercise and stress modification.
- **Research. Research. Research.** Learn everything you can. Talk to many who have had the surgery. You learn valuable information from those that have been successful and what to avoid from those that have not.
- **Choose your surgeon and place of surgery carefully.** People who decide to have weight loss surgery then want it “tomorrow.” A good bariatric surgeon usually has a lengthy waiting list. Check out how many weight loss surgeries the physician has performed. What is his surgical mortality rate? Get the same information on the hospital. Does the hospital have a Bariatric Center? This is very important as these centers also have a team of dieticians, behavioral counselors, support groups and others that support your progress.
- **Consult a dietician early on.** Learn how weight loss surgery will change your way of eating for the rest of your life.
- **Find a good mental health counselor.** Weight loss will not be maintained long term if you do not discover why you were overweight in the first place. Psychological testing helps reveal clues to your past behavior and can help establish a plan for behavior modification.

I am happy to share my personal weight loss “story” with you. My hope is that you consider my experience and advice the next time an employee comes to your office seeking information on weight loss surgery or frustrated with their obesity. Tell them I never will consider myself “cured” of my morbid obesity, but through hard work and dedication I will make every attempt to keep it in “remission.”

P.S. I look forward to introducing myself to you in San Antiono in October as I bet you don’t recognize me.
USDA Unveils New Food Pyramid

Federal officials recently unveiled new dietary recommendations that update the widely known Food Guide Pyramid for the first time in 13 years. The updated pyramid adds a new emphasis on exercise and moderate eating, hoping to finally make a dent in the U.S. obesity epidemic.

Smoking: Good News & Bad

The September 2004 issue of ISHN summarized recent smoking related mortality findings from a 50-year study by British researchers Richard Doll and Bradford Hill. The bad news was that at least half and nearly two-thirds of people who smoke in their youth are eventually killed by their habit. On average, cigarette smokers die about ten years younger than non-smokers with the main causes of death being lung cancer; cancers of the mouth; pharynx; larynx; esophagus; emphysema; chronic bronchitis; and other respiratory diseases.

The good news – those who stopped at age 60 gained 3 years of life, those who quit at 50 gained 6 years, and those who stopped at 30 almost totally avoided the increased risk of death. The study followed approximately 35,000 smoking male physicians born between 1900 and 1930.

A Quote Worth Quoting

“Health is a blessing that money cannot buy.”

Izaak Walton (1595-1683 British writer)

AACN Supports Doctorate as Entry for NPs

The American Association of Colleges of Nursing (AACN) now advocates that a doctoral degree be the highest credential awarded for nursing practice. By 2015, new advanced practice nurses, including nurse practitioners, will be prepared at the doctoral rather than at the master’s level.

In the works since 2002, the AACN Position Statement on the Practice Doctorate in Nursing was ratified by the organization’s members at its annual business meeting in October 2004. The position statement and a list of frequently asked questions are available online at www.aacn.nche.edu.

Book Prepares Nurses for Disaster Management

A new book by two faculty members at the Saint Louis University School of Nursing in Missouri prepares nurses to do what the public expects-take the lead in caring for them when disaster strikes.

Preparing Nurses for Disaster Management is published by Prentice Hall.
OSHA Alliance Update

There have been two conference call implementation team meetings – one on March 28 and the other on May 24. During the March conference call, Dr. Bob Curtis from OSHA explained the differences between the Safety and Health Topic pages and eTools.

The Safety and Health Topic pages serve a resource for items of interest for a specific topic. An example would be Bloodborne Pathogens. Each Safety and Health Topic page has an editorial board that reviews the content usually twice a year to update it and add any new resources. AOHP members are invited to review the Health Care Facilities and Bloodborne Pathogens and Needlestick Prevention pages for any recommended changes.

ETools are developed to be training tools. For example the Hospital eTool is designed by departments. Some departments in the eTool include ICU, Emergency, Central Service. There is also a section on Health Care Wide Hazards. These hazards include industry-specific hazards such as Bloodborne Pathogens and more general safety hazards such as electrical and fire hazards.

To begin to address safe patient handling in the acute care setting, the AOHP team wanted to evaluate patient mobility assessment tools. The assessment tool used by Dr. Audrey Nelson was the tool that the team reviewed. Members felt that this was a tool that could be utilized in the acute care setting. During our call in May we learned of some other tools and want to review those before making a final decision. Member input was sought as to any ideas for the assessment tool.

This spring, Jan Frustaglia, Region 2 Director and Carolyn (Kirkpatrick) Amrich, AOHP member and supervisor of Employee Health at Children’s Medical Center, Dallas, Texas were invited to make a presentation on safe patient handling and bloodborne pathogens to approximately 50 Region VI OSHA consultants. The presentations were very well received. This was the first time that AOHP had the opportunity to be a part of training for OSHA. Jan has also agreed to have her power point presentation posted on the web as part of the OSHA Alliance. Once it is posted, our membership will be advised as to where it can be accessed on the web.

OSHA is also seeking examples of success stories in healthcare facilities. These can be related to patient handling or reduction in sharps injuries. Please forward these to MaryAnn Gruden.

As AOHP chapters plan meetings, keep in mind that OSHA will provide speakers. Contact the OSHA office closest to the chapter to secure speakers. Visit the OSHA website, www.osha.gov, for the OSHA office nearest the chapter.

AOHP has also been asked to review a guide that is being developed related to hospital-based first receivers. AOHP provided input into the draft guidelines last year. OSHA’s Occupational Health Nursing division will be working on this document. Once it is drafted AOHP will have the opportunity to review it.

OSHA will be at our national conference in San Antonio in October and we are looking forward to having them again be a part of our national meeting. Our next implementation conference call is scheduled for mid-September.

Please feel free to share any recommendations for Safety and Health Topic pages as well as any other thoughts regarding the OSHA Alliance with me by email at magaohp@yahoo.com or call 412/578-6792. I will look forward to hearing from you.

NORA Research Councils

Approximately 10 years ago the National Occupational Research Agenda (NORA) through the National Institute for Occupational Health and Safety (NIOSH) was developed to draft a common research vision for the nation. After nearly a decade of a general approach to workplace health and safety research, NORA is planning to move into the future using a sector-based approach.

NIOSH and its partners will form eight Sector Research Councils. In addition, there will also be a ninth Cross-sector Research Council that will address research needs affecting multiple sectors. The Sector Research Councils will have diverse membership from industry, labor, academia, government, and professional and trade associations. Each council will identify the highest priority safety and health concerns in their sectors or sub-sectors and, with stakeholder feedback, draft research goals, objectives, and action plans. With strong input the Research Councils will develop a set of strategic research agendas for the entire nation. The research councils will include agriculture, forestry and fishing; construction; healthcare and social assistance; manufacturing; mining; services; transportation; warehousing, and utilities; wholesale and retail trade; and cross-sector issues.

AOHP plans to be involved with this effort as it relates to healthcare. This will be a great opportunity to have input into the research that affects our practice and the health and safety of the healthcare workers we serve.

Have a great summer and see you in October!
I have been in Employee Health for 18 years. During that time I have made many observations on behavior...ours...and theirs. I bet you share some of that behavior, in which case, you might just be an Employee Health Nurse!!

If you give more injections that any other nurse in your entire hospital, then you might just be an Employee Health Nurse.

If you know the difference between PPE, PPD and PEP, then you might just be an Employee Health Nurse.

If you spend a lot of time waiting for people to pee in a cup, you might just be an Employee Health Nurse.

If people wave their forearms at you and yell “mark me off,” you might just be an Employee Health Nurse.

If you forget what a lunch break feels like, then you might just be an Employee Health Nurse.

If people often walk into your office saying, “I hate needles,” then you might just be an Employee Health Nurse.

If you spend a lot of time fixing other people’s messes, then you might just be an Employee Health Nurse.

If people start asking you in July “when are we gonna get our flu shots?” you might just be an Employee Health Nurse.

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“The only diet shake I recommend is the shake your booty makes when you exercise.”
A OHP proudly spotlights another worthy member in this summer Journal, Betsy Holzworth, RN BSN, Employee Wellness Nurse at Culpepper Regional Hospital in Culpeper, Virginia.

Betsy is the current chapter president of the Virginia Chapter. Recently, we held our chapter Spring Educational Conference here at my facility. It became clear what a great leader and motivator Betsy is in her chapter president’s role. Through her hard work and leadership, (during some though times) the Virginia Chapter has remained a healthy chapter. The chapter has a dedicated membership that meets for 2 full day educational conferences a year plus at least 2 additional educational “mini-conferences”. Betsy also serves as the nurse administrator for the Virginia chapter CEU provider status.

Always willing to do more and support A OHP, Betsy actively participated on the 2004 and 2005 national A OHP Conference Committees. A member since 2001, she has served a term as Chapter Vice President and is preparing to serve a second term as Chapter President. During her presidency, Betsy initiated chapter board meetings via conference calls to facilitate participation and eliminate extra travel for busy board members. She obviously keeps a devoted chapter board active and motivated.

Betsy is a graduate of George Mason University and has been employed by Culpeper Regional Hospital for 10 years, the past 4 in Employee Wellness. Following employee illnesses and injuries, OSHA compliance, Workers’ Compensation are just a few of the ever increasing tasks added to Betsy busy work schedule. But the variety of all of it is what Betsy admits is the closest to her heart. Betsy tells us “I always make a plan of what I need to do the next day, but when I come in there’s always another fire that needs to be put out. My TO DO list is never ending, but I can honestly say my job is NEVER boring.”

In her spare time, Betsy enjoys reading, swimming in her pool, playing with her young son, and traveling nationally and internationally. Betsy also tries to work on the other units in her facility just to keep her skills up.

The busy mother of a young son, Betsy is the lone parent during the week; as her husband’s work allows him home only on weekends. Busy doesn’t seem to keep Betsy down, as she prepared and recently sat for the COHN exam (best of luck, Betsy!), while recovering from a recent surgery and successfully surviving a scheduled JACHO accreditation.

Betsy credits AOHP with assisting her in many ways. “The educational conferences are wonderful,” she shares. “I always leave with wanting or needing to change something in my daily practice. The networking is great. Someone is always doing something different. I am proud to be part of such a great organization. I have enjoyed meeting everyone and making new connections. Thanks to our executive board and management (Judy & Annie) for all they do to keep our organization strong.”

A OHP thanks you, Betsy, for your leadership and inspiration. Members like you are the reason we have such a wonderful organization. It is our pleasure to let your stardom shine for everyone to see.
Halogenated anesthetics, such as enflurane, halothane, isoflurane, desflurane, methoxyflurane, and sevoflurane are used in hospital operating suites. Nitrous oxide is also used in the operating theater for anesthesia, and in the dental clinic for conscious sedation. (McGlothlin, Crouch, & Mickelsen, 1994) It has also been used as a cryogenic agent. (This topic was discussed in the last issue.) Studies have shown an association between waste anesthetic gas exposure and the occurrence of cancer, reproductive effects such as spontaneous abortion and congenital anomalies, neurological effects, renal damage, and liver disease. (NIOSH, 1994) Anesthetic agents can cause irritation, confusion, drowsiness and decrease in audio-visual performance.

Reducing employee exposure to waste anesthetic gases involves utilizing scavenging equipment that removes the excess gases from the room environment and exhausts to the outside atmosphere. (NIOSH, 1994) A mask equipped with scavenging means that is connected to a local exhaust line, which is usually tied into the building vacuum system. Equipment leakage needs to be reduced or eliminated through an on-going proactive preventive maintenance program. Careless work practices can lead to waste anesthetic gas exposure through spillage during filling of the vaporizer, starting the flow of anesthetic before the delivery system is properly in place, use of poorly fitting face masks and endotracheal tube cuffs. Maintaining nitrous oxide levels to the lowest possible in the dental clinic requires properly maintained and utilized scavenging exhaust system and auxiliary room exhaust ventilation to pull any leaked nitrous oxide away from the staff members and out of the room air.

In addition to concerns about inhalation of waste anesthetic gases, there may also be some patient safety issues. While the risk of complications following anesthesia are low, halothane and other anesthetics are detoxified in the liver, and some patients may develop mild to severe hepatotoxicity after receiving the agent. Another concern is that these agents may potentiate the toxic effects of acetaminophen on the liver. It is therefore, critical that patients be warned to avoid taking acetaminophen after surgery.

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One of the continuing frustrations for organizations is why so many change initiatives either fail outright, or fail by withering away. The statistics relative to successful changes within organizations are disheartening. According to Michael Beer and Nitin Nohria of the Harvard Business School, about 70% of all change initiatives fail. Successful ergonomic change programs are no different.

Field discussions with organizations attest to the fact that beginning a new program can be hard enough. However, maintaining it, “cementing” the change, and achieving the long-term goals are very difficult. There is a large body of literature on change management though for most of us the study of change is not a core activity. Perhaps it should be; it is the constant within our organizations. This column is devoted to change management information, tips, and references that might be helpful as you begin, or try to sustain, an effective ergonomics program within your organization.

It is certainly possible that there are many “micro” changes that happen every day that are successful, however the bigger change initiatives clearly take a great deal of thoughtful, careful work. Our very nature, our societal norms, and stakeholder demands clamor for quick fixes to complex problems and are expressed in terms such as “If we just______, if we purchase______, if we just mandate____, if just reorganize, or if we just hold people accountable for ______” then change will occur. As Harrington puts it, “Change is not a simple process. It requires a lot of thought, a well-developed plan, a sophisticated approach, and unfaltering leadership.”

Tips for Change

1. Talk about the change initiative over and over and over. Duck expresses it well: “When you are so sick of talking about something that you can hardly stand it, your message is finally starting to get through. It takes time for people to hear, understand, and believe the message. And if they don’t particularly like what they hear, then it takes even more time for them to come to terms with the concept of change. Have they heard the message, do they believe it, do they know what it means, have they interpreted it for themselves and have they internalized it. Until managers have listened, watched, and talked enough to know that the answer to all these questions is yes, they haven’t communicated at all.”

2. Model the desired behavior. Modeling the behavior means that managers must not only say that they want a change, they must exhibit in actions that they want the change. That may mean actually modeling, such as using a new ergonomic piece of equipment, giving positive reinforcement when the equipment is used, including the desired performance in performance evaluations and even promoting those who exhibit the desired performance. When managers “walk the talk” they build predictability. Duck states that predictability leads to trust and both trust and competence are necessary to achieve change. Employees intuitively know that if an issue does not appear in their performance evaluations it is not very important. One thing is for certain, if managers ignore behavior that doesn’t reflect the desired change, they have sent a powerful message that the change really isn’t that important and employees don’t really have to change their actions.
Change is not sustainable if there is no change in the supporting management process, according to Harrington. In fact, he states, that managers must direct action quickly: “If people do not apply the information presented to them in the first week after they attend a class, there is only a 20% chance they will ever use the techniques or methods taught.” In short, behaviors change because of what managers do or do not do.

3. Reward the desired behavior. Behavior psychologists such as Aubrey Daniels are applying their theories and practical applications to the fields of safety, health, ergonomics and change management. He states that “when leaders initiate any change in the organization, they will do so in ways that will cause people to either increase or decrease their effort, their creativity, their cooperation, the quality of their work.”

Using behavior analysis techniques to examine the antecedent of the behavior (what comes before), the behavior, and the consequence (what happens after) is the cornerstone for behavioral change. According to Daniels, antecedents have limited control over behavior. Their function is to get a behavior to occur once, or at best a few times. Positive consequences, on the other hand, are the key to getting a behavior to occur again and again. Daniels summarizes by saying “If performance is not improving, reinforcement is not occurring.” Fray puts it a slightly different way, “In reality a continuous input of motivation is required to keep the change process moving.”

There are many who insist that “holding people accountable” means that disciplinary approaches are followed quickly, strictly and without exception when written policies are not followed. Experience has shown that there is an immediate change in behaviors, but it tends to come at the expense of morale and sometimes results compliance only when managers are watching. Change-weary employees sometimes find that not the same thing happens with all policies, or sometimes with all people with the same policies. These actions are problematic from a legal perspective and create distrust within the organization. Others feel just as strongly that softer approaches are more effective. They believe that winning an individual’s mind and heart result in sustainable desired long-term changes, though proponents will tell you that this approach does take more time. In fact, a combination of these approaches seems to be most effective.

Change is a very individual issue, requiring people to examine their current behavior, make a decision about their subsequent behavior and to act differently. Leaders must win their followers one by one, as Duck states. Combining plenty of communication, persistence in the message, unwavering modeling of the behavior, and rewards for the behavior are effective. However, after a reasonable period of “sinking in” there is a choice to be made. If the choice is not to adapt to the new behaviors/action, then disciplinary (punishing) measures may be appropriate.

Summary
Ergonomic change can be an opportunity for significant value and outcomes, or can be yet another initiative that comes and goes. Carefully following a process while understanding that the need for individualization is probable, obtaining unquestioning senior management support, communicating again and again, “walking the talk,” being doggedly persistent, and providing positive reinforcement are measures that have proven successful. All of the literature on change agrees on one dictum: change does not occur rapidly and the larger and more complex both the organization and the change are, the more time the change initiative will take. But it can, and often must, be done.

References
6 Ibid.

Please send any feedback, questions, and contributions to this column to LindaHaney@diligentservices.com.
AOHP continues to make significant financial gains. Over the last three years AOHP has gradually made progress back from a period when finances were extremely tight to a position where we are able to put monies in savings instruments. In 2004 we were able to save $50,000 and made $720 interest, which is a first in several years. For the last two years we have hired an independent auditor who has been working with the AOHP executive board to improve and tighten financial practices. Many of you have been involved with your chapters obtaining tax identification numbers and applying for tax exemption, an auditor recommendation. With the support of our association management company we have made significant increases in revenue especially in the areas of conference registrations and workshops, conference advertising, exhibitors, mailing lists, and sales of the “Getting Started Manual.” The Executive Board has also worked hard to improve the AOHP website over this past year, so we would encourage taking a look at it. The Association continues to grow as we work to attract new members by striving to provide our members with unsurpassed benefits and invaluable information. If you know someone who might benefit from membership in AOHP, call headquarters at 800 362-4347 or visit www.aohp.org for a membership application.

These graphs depict AOHP’s financial position for the year 2004. The Association has carefully reviewed expenses, and through monthly Board conference calls, has implemented measures to optimize the benefits of membership for all.

Please note that AOHP financials are available for membership review upon request. You may contact me by email at dtyler@mha.org if you are an active AOHP member who desires to review the actual financials, or if you have any questions.

Respectfully Submitted,

Dee Tyler, RN, COHN-S
Executive Treasurer
Colleague Connection

“A Combined Contribution to our OSHA/AOHP Alliance”

By Carolyn Amrich, RN, COHN

I am pleased to share with fellow AOHP members my experience regarding a recent presentation Jan Frustaglia, Aftab Ahmed and I had the honor of collaborating on for OSHA. Our presentation came at the request of OSHA Region VI Consultants who sought information from employee health professionals on prevention of blood/body fluid exposures and patient handling injuries at their Regional OSHA Consultation Conference in March of this year.

Jan, an occupational health professional from Austin, Texas presented patient handling information and I presented prevention of exposure to bloodborne pathogens and safe needle devices. Aftab, an occupational health nurse from Lubbock, TX arranged for Affinity Medical Systems to come with patient handling equipment for a hands-on demonstration.

During preparation for the presentation, Jeff Rucker, the Program Manager for Region VI asked that my presentation be given from the hospital aspect and to include some real life situations. Since all attendees were not necessarily from a medical background, giving them information from the hospital aspect was of great interest to them. Considering the presentation was to OSHA consultants, I must admit I was a little uneasy about including some of our real issues. However, Jeff assured me they were the OSHA “good guys” and were available to us for clarification and problem solving with any of the OSHA standards.

Prevention of blood/body fluid exposures is my passion, so presenting on bloodborne pathogens and sharps safety was a topic dear to my heart. I started with a brief discussion of the three main bloodborne pathogens, Hepatitis B, C and HIV. Hepatitis B virus is the most easily transmitted. For the unvaccinated who are exposed, the transmission rate is about 25%. Fortunately, a vaccine is available and since the institution of the vaccine program there has been a dramatic decrease in the transmission to healthcare workers.

Hepatitis C virus is not as easily transmitted and the risk after exposure is about 1.8%. There is no vaccine available for Hepatitis C and no post exposure prophylaxis (PEP). The recommendation, after exposure, is for early treatment if there is a seroconversion.

The HIV virus is often the most feared, however it is the least easily transmitted of the three. Risk after a percutaneous exposure is only about 0.3%. The risk, however, is increased with an exposure to a large quantity of infected blood and/or the source patient has a high viral load. PEP is available and should be started within 2-4 hours after a high risk exposure.

The Bloodborne Pathogen Standard, 29 CFR 1910.1030, was effective March 1992. It included universal precautions, hepatitis B vaccine requirement, engineering and work practice controls, personal protective equipment (PPE) and post exposure follow-up. The Enforcement Procedures Directive was effective November 1999. This directive brought the requirement for engineering controls and changes in work practices. It required the use of safe needle/medical devices unless it jeopardized the safety of the patient and/or procedure. Included are: needleless systems, safe needle devices, no hands passing of sharps, avoiding the use of needles where effective alternatives are available and prompt disposal of all sharps. Then, as of April 18, 2001, the Bloodborne Pathogen Final Rule was in effect. The Exposure Control Plan is now required to reflect how new safe needle devices and safe practices are implemented, to solicit input from employees responsible for direct patient care and a sharps injury log for recordkeeping.

I shared during my presentation that in 1999, the occupational health department at Children’s Medical Center Dallas, instituted a multidisciplinary task force to evaluate blood exposures and safety devices. The group included front line workers from our OR, ICU, ER, general medical and surgical units. Also included were members from infection control, Quality & Risk Management, materials management and two physicians.
Our task force at Children’s initially conducted weekly meetings and reviewed procedures involving sharps step by step. Representatives from several manufacturers presented their safe sharps products to the task force, which were then trialed by the front line healthcare workers. Safe sharps were selected by evaluation from the front line workers and the input of the task force. We also instituted safe practices such as no hand-to-hand passing of sharp instruments and needles, the use of goggles or eye shields to prevent exposure from blood splashes, and requiring assistance while immobilizing patients before starting procedures.

The consultants at the conference were very interested in problems encountered with instituting the mandatory requirement for use of safe sharps. I discussed the issue of resistance to change, which I am sure, was a problem for all and continues to be for some. Physician “buy-in” was a big hurdle to surpass, because many did not think this standard applied to them. Other issues included enforcing the use of proper PPE, removing the safety device before use (“it got in the way”), not activating the safety device before disposal, and using needles in needleless systems. I shared an incident involving a new graduate nurse who was handed a needle, instead of a needleless adaptor, to draw blood from an IV line. She was nervous and while removing the contaminated needle, stuck herself. The source patient of this exposure, a baby, was HIV positive. PEP was initiated and all follow up HIV testing on this new graduate nurse was negative, however, she suffered such severe mental trauma that she is no longer working as a nurse due to this very preventable needle stick.

OSHA Consultants were also advised that our task force at Children’s knew success also depended on continuing education for all staff using sharps. We produced a video of all the safety devices used in our institution detailing their proper use. Viewing this video is required for all new hires and recommended annually with other competencies. The occupational health nurses at Children’s do weekly safety audits of inpatient units and outpatient clinics. We look for any non-safety sharps that might still be there, full needle boxes, discuss knowledge of sharps safety with staff, and observe for proper PPE. We attend staff meeting in areas where we see an increase of blood exposures intending to address problems related to sharps safety. A monthly flyer called the Safety Net News was created giving direct education on actual incidents that occurred causing a needle stick or blood splash. The task force continues to meet every other month, sooner if needed, to evaluate recent blood exposures and explore ways they could have been prevented. The search continues for new and better safety devices and safe practices.

The OSHA consultants were appreciative of the information given and asked many questions throughout the presentation. What a wonderful opportunity this was for us to contribute to our OSHA/AOHP Alliance.

Carolyn Amrich, RN COHN is the Manager of Employee Health & Wellness at Children’s Medical Center in Dallas, Texas. She has enjoyed a professional nursing career for the past 30 years, the last 14 in Employee Health. Carolyn has been an AOHP member since 1991.
Incorporating Health Promotion into Daily Occupational Health Nurse Activities

By Margaret L. Radkowski, RN, BSN, COHN-S

As occupational health nurses we have the great opportunity to impact the businesses where we work by increasing productivity while helping our employees to make healthy choices and adopt healthy lifestyles. We currently care for injured and/or ill workers, perform health surveillance activities, and often assist with safety and ergonomic issues. As we perform all those duties and many others we also have another opportunity to provide for our workers- the very important opportunity to promote health living and disease prevention.

I am happy to share with fellow AOHP members a short history of health promotion and my recommendations for a successful approach to implementation in our occupational health practice.

History of Health Promotion in Occupational Health Services

The United States aggressively lead the early health promotion movement in the 1980’s and early 1990’s. Many U.S. industries and businesses enthusiastically supported health promotion activities as a benefit for their workers. Health Maintenance Organizations sought to guide care emphasizing general prevention activities to avoid development of chronic diseases. These efforts did not produce the expected results. Health promotion activities decreased by the mid to late 1990’s when downsizing and budgetary restrictions occurred. Time became a precious commodity for workers. Fast food and convenient pre-cooked, pre-packaged foods, high in fat, salt, carbohydrates, and calories first became popular at that time as well.. This coupled with a decline in physical activities, has contributed to an unprecedented rise in the rates of obesity, diabetes, hypertension, and other chronic diseases. The prevalence of diabetes has increased from 3.4% in 1976-1980 to 5.9% in 1999 to 2000. (Koopman, Mains,& Geese 2005)) Age at time of diagnosis of type 2 diabetes has decreased from 52 years old to 46 years old from 1988 to 2000. (Koopman,et al 2005) Eighteen million adults in the US in 2002 had diabetes, costing the US 132 billion dollars, 92 billion in direct costs and 40 billion in indirect costs such as disability, work loss, and premature mortality. (National Center for Chronic Disease Prevention and Health Promotion, Data & Trends 2005).

People with diabetes lost eight days of work per year, accounting for fourteen million disability days. (National Center for Chronic Disease Prevention and Health Promotion, Data, Trends 2005). Heart disease and stroke are the first and third leading causes of death in the US. Cardiovascular disease costs the US more than $300 billion each year. (CDC 2005)

Benefits of a Health Promotion Program

In today’s business world the provision of health promotion activities and resources can clearly be seen as an employee benefit, influencing retention rates, increasing job loyalty, lower health care costs, decreased absenteeism, and improved quality of life for workers. (Sexner, Anderson, & Gold, 2004) Management support has been demonstrated to be essential to the success of the programs and is indeed worth this expense. (Chapman 2004)

Incorporating Health Promotion into Our Daily Practice

Most American adults spend one third of their day in the workplace. While many employed Americans require some level of occupational monitoring; the workplace is an ideal location to encourage and counsel or coach employees to adopt healthier lifestyles.

While taking personal history information in preparation for pulmonary function studies, audiometric tests, electrocardiograms, and other surveillance activities, the nurse could ask if the worker has a primary healthcare provider. If the answer is no, occupational health nurses are capable of assisting the worker in the search for a physician. If the answer is yes, the nurse may be able to inquire about medications and assisting the worker in understanding their disease conditions. Referral to other community resources, as needed can also be done. The worker can also be instructed on how to get important information about their condition from their treating healthcare
provider. Knowing the right questions, can unlock information, improve understanding, and improve the worker’s encounters with their treating physician. It is also an opportunity to encourage healthy workers to participate in preventive care to maintain their good health.

While you are drawing personal laboratory tests, you can also inquire about diet and exercise. This affords the opportunity to discuss any programs or opportunities in the community as well as in the workplace that might be of interest to the worker or their family.

During employee injury evaluation and treatment, questions regarding activity, diet, fitness, and exercise flow very naturally and provide opportunities to share information on these health topics. Each re-check visit or call provides another opportunity to talk, develop a rapport, as well as monitor the worker’s health status. Always be familiar with your state and federal laws regarding what is permissible with such history taking.

**Provision of Health Promotion Activities**

There are various ways that we can promote healthy living and disease prevention in the workplace. Some of these include health fairs, brown bag or lunch time sessions, inviting local groups or vendors, such as Weight Watchers, yoga instructors, aerobics instructors, into your business or facility.

For health fairs the OHN can consider inviting one of the many groups listed in the accompanying list.

You will want to be aware of health plan coverage of these types of services. The OHN can also consider massage therapists, Chinese medicine doctors who perform acupuncture, cupping, and herbal medicine, yoga, meditation, Reiki practitioners, integrative medicine practitioners (8), in their selection. A wide variety of topics and activities tends to draw more workers to the health fair and can get them to consider ideas for more healthy lifestyles. Door prizes can increase attendance and motivation.

Partnering with the disability nurse (if your company has one) or vendor can help you identify the most common illness in your worker population that cause employee absences. Be sure to use these in determining which groups to invite to your health fair. This information can also assist in determining a theme.

Selecting a theme will help with advertising and further planning for successful attendance. Current areas that the OHN may wish to consider focusing on are the new food pyramid, stress management, and fitness programs and centers.

Your health plan can be a source of interactive components for your health fair as well. Health Risk Appraisals (HRA’s), are another health promotion tool. They provide the participating employees with specific identification of areas that they may need to target. They often provide suggestions as well. HRA’s generate aggregate reports and provide another method to determine topics the OHN may elect to focus on. They are good indicators of the needs of the worker population. In addition, HRA findings provide an opportunity for the OHN to coach or counsel the worker. Individual attention has proven to be a valuable and effective resource.

Health coaching, as defined by Stephen Palmer in the International Journal of Health Promotion And Education, volume 41, number 3, page 91, “is the art of helping someone by educating them on specific health-related topics and subsequently support them in achieving their health-related goals.”

Lunch and learn programs are another option to consider. They need to be brief and targeted. Look into your own group for experts as well experts in your community and professional network.

An on-site health library with books, tapes, CDs, pamphlets, and posters is another type of health promotion delivery method. Depending on your company or facility’s resources,
e-mail flyers can also be included in your health promotion activities. Via e-mail whole articles or links to articles and web sites can be distributed. Be sure your workers have printer access and knowledge to use this system.

Many options are available for providing health information in routine surveillance visit activities, injury and illness care, disability management, occupational training sessions, and other direct contacts with workers.

All of these take a minimum of time and effort on the part of the occupational health nurse and can have a big impact on the health and wellbeing of the workers as well as benefit the company.

The most important aspect of health promotion activities, in my opinion, is having VISIBLE management support. And, have FUN!!

*Margaret L. Radkowski, RN, BSN, COHN-S, is an Employee Health Nurse for GlaxoSmithKline in King of Prussia, PA. A professional nurse since 1973, Margaret’s career has included service in the US Navy Nurse Corps and the last 18 years in occupational health settings. Margaret is a current member of the Pennsylvania Chapter of AOHP.*

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**Additional Resources**

- Alzheimer’s Association
- American Arthritis Foundation
- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- American Meditation Institute
- American Red Cross
- American Stroke Association
- Asthma and Allergy Foundation of America
- breast cancer.org
- Center for Science in the Public Interest
- National Alliance for the Mentally Ill
- National Association for Health and Fitness
- National Breast Cancer Foundation, Inc.
- National Chronic Fatigue Syndrome and Fibromyalgia Association
- National Coalition for Adult Immunization
- National Coalition on Health Care
- National Eating Disorders Association
- National Foundation for Infectious Diseases
- National Organization for Rare Disorders, Inc.
A Wealth of Great Information at the Safe Patient Handling & Movement Conference

By Jan Frustaglia, BS, RN, CCM, COHN-S

Attending the 2004 Safe Patient Handling & Movement Conference in Tampa, Florida proved to be such a great learning experience that I paid my way this year to the 2005 conference. I am pleased to share with fellow AOHP members a small part of the excellent information I left the conference with. I share this information in question and answer format.

Question: Where can I find complete information - including equipment - for implementing a patient lift, transfer, and repositioning program for my hospital system?


Q. If I attend will I get scientific, research-based information?

A. Yes. Cutting edge research and evidence-based practices have been the content since the 1st Conference was held February 2001. To review the evolution of the VISN 8 Patient Safety Center’s research behind safe patient handling go to www.patientsafetycenter.com

Q. What was presented at the 5th Annual Conference?

A. The 5th Annual Safe Patient Handling & Movement Conference held February 2005 in St. Pete Beach, Florida offered ‘Best Practices’ and ‘Lessons Learned’ type topics. There were general sessions, several outstanding panel discussions, and breakout sessions. There were a variety of poster displays most of which were a department’s patient handling success stories. Almost every manufacturer of patient handling equipment and devices were present, giving demonstrations and plenty of information. The attendee can get extensive knowledge of the variety and unique features of patient handling equipment from this conference.

Q. From the previous year, how was it different?

A. The 2005 conference seemed to add two distinct dimensions – the academic pathway and (non-US) implementation outcomes. Let me explain the academic first. ANA - Handle With Care Initiative - received NIOSH funding. Designated nursing school faculty, charged with developing and implementing safe patient handling concepts into academic curriculum, were in attendance. The 2005 conference was their training ground. The VAMC research team will align with this curriculum development group. Together the research and faculty group chose the Theory of Planned Behavior as the theoretical framework for the evaluation phase. ANA’s Handle With Care initiative will campaign to establish a nationwide “no lift” policy similar to policies that are already in place in other Western industrialized nations; objective is to call national attention to the hazards within the nursing workforce. ANA will support states interested in introducing state-based legislation.

Attendees heard implementation of ‘lessons learned’ from the UK, The Netherlands, England, Switzerland, Australia, and BC. For most of Europe, public healthcare governance compensates the interventions. Regulations around manual patient handling operations were instituted early 1990’s. The presenting conference faculty gave enormous data points demonstrating the human factor challenges of implementation. One interesting fact that was given by the international presenters was that they were able to view all of the US research/studies over the internet, but in the US research/studies cannot be viewed – no one knew why, but that clearly is a disadvantage for the US, as these countries have and are willing to share their research.
Q. Who are the co-sponsors of this 2005 conference?

A. USF (University of South Florida) Health Sciences Center and the College of Nursing, the James A. Haley Veterans’ Hospital, and the American Nurses Association were the co-sponsors for 2005.

Q. Who were some of the speakers from the United States?

A. Of course Audrey Nelson, the Director of the Safe Patient Handling VAMC Project. Also William Marras from Ohio State University’s Institute for Ergonomics, Guy Fragala from Environmental Health & Engineering, Inc, Newton, MA, Donna Haiduven, Nurse Researcher from USF College of Public Health, Butch de Castro from ANA’s Handle With Care Initiative, Arun Garg from University of Wisconsin-Milwaukee’s Industrial & Manufacturing Engineering Department, Tamara James from Duke University Medical Center, and Thomas R. Waters from Human Factors and Ergonomics, NIOSH, Cincinnati, OH., just to name a few.

A panel presentation, “STEPS TOWARD A NATIONAL NO MANUAL LIFT POLICY” was moderated by the President of the ANA. Panelists included the President-Elect from the NLN, the President of the AACN, the President of the AONE, the spokesperson from the Director’s office of NIOSH, the President of the International Council of Nurses, and the Chief Nursing Officer from the Veterans Health Administration. Listening to the lively discussion gave the audience a sample of how immense and persuasive this group of stakeholders will need to be to accomplish the GOAL of reducing the incidence and severity of job-related injuries related to patient handling and movement tasks.

Q. What are some of your “take aways” from the 2005 Conference

- It will take 10-15 years to translate research to practice. (EX: Fragala research 1992; the VAMC research started 2000)
- ROI for implementing a program is approx 3.75 years.
- Safe Patient Handling is Ergonomics.
- Training is “knowledge transfer”
- Facilities need an Ergonomics “leader” and an Ergonomics Committee (keep small #; approx. 10). Vendor should train the Committee; Committee then trains employees.
- Once department is trained on interventions, then department is held accountable to maintain the interventions.
- When assessing patient capabilities, apply the 5 second rule (ie can patient bear weight for 5 seconds).
- Worker won’t report an injury if his unit is understaffed.
- Popular names for the “key” safety leader of the Safe Patient Handling Program: Ergo Coordinator, Ergo Ranger, BIRN (Back Injury Resource Nurse).
- Right intervention, right use, used right-ly

Jan Frustaglia, RN, BS, CCM, COHN-S is the Program Coordinator for the Health Professions Institute at Austin Community College in Austin, Texas. Jan has 14 years of Employee Health experience and currently serves as the Region 2 Director of AOHP.
Employee Health professionals continually seek ways in which to inform and communicate with our employees. One such communication tool we successfully utilize here at Inova Loudoun Hospital is our employee newsletter “The Pulse.” The Pulse is distributed throughout the hospital and other off-site campuses every other Friday. It contains various employee and hospital news.

Our Employee Health staff contributes regular articles on various health and wellness subjects of interest to employees. Past articles have shared information on diabetes, the benefits of drinking water, breast and colon cancer, and fast food. We aim to keep our information relevant and seasonal, such as “Starting the New Year Off Right”. We are always looking for a variety of health and wellness related issues. Articles are written at the 4th grade level in order to be meaningful to employees with all levels of education and literacy. I am pleased to share two recent articles with fellow AOHP members. One addresses latex allergies and the other shares some very eye-opening information on fast food.

“Latex Allergy & Sensitivity”
Latex gloves have proved effective in preventing transmission of many infectious diseases to health care workers. Most people have no health problems from the use of these and other latex products. Latex allergy in health care workers can result from repeated exposures to the proteins in natural rubber latex through skin contact or inhalation. The rate of latex allergy in the health care industry is higher than the general population.

In some instances, latex-sensitive persons have also experienced allergies to certain foods such as avocados, potatoes, bananas, tomatoes, chestnuts, kiwi fruit and papaya. Sensitivity may occur outside the workplace as well, with reaction to a variety of common household products such as balloons, rubber bands, adhesive tape, foam pillows, pacifiers, carpeting, clothing features such as waistbands & belts, footwear, condoms and toys such as teething rings and rubber balls. Many household objects and hospital supplies are now available in latex-free forms.

For some workers, exposures to latex may result in various symptoms such as skin rashes, hives, flushing, itching, nasal/eye/sinus symptoms, asthma and (rarely) shock. Reactions usually begin within minutes of exposure to latex, but they can occur hours later.

There are three types of reactions that can occur in persons using latex products:

- **Irritant contact dermatitis:** the most common reaction—the development of dry, itchy irritated areas on the skin, usually hands. This is caused by skin irritation from using gloves and can also result from repeated hand washing and drying, incomplete hand drying, use of sanitizers and exposure to powdered gloves. Not a true allergy.

- **Allergic contact dermatitis:** results from exposure to chemicals added to latex during harvesting, processing or manufacturing. Can cause skin reactions similar to those found with contact with poison ivy. The rash usually begins 24 to 48 hours after contact and may progress to oozing skin blisters or spread to other areas.

- **Latex allergy:** a more serious reaction than irritant contact or allergic contact dermatitis. Although the amount of exposure needed to cause sensitization is not known, exposures at even very low levels can trigger allergic reactions in some persons. Positive blood or skin test will document sensitization.

According to the National Institute for Occupational Safety and Health, workers should take the following steps to protect themselves from latex exposure and allergy in the workplace and in their private life: Use non-latex gloves for activities that are not likely to involve contact with infectious material. Do not use oil-based hand creams or lotions with the use of latex gloves. Select powder-free gloves. Learn to recognize the symptoms of latex allergy: skin rash, hives, flushing, itching, nasal/eye/sinus symptoms, asthma or shock. If symptoms of latex allergy develop, avoid direct contact with latex gloves and household products containing latex until you see a physician.

If you think you have latex allergy or contact dermatitis, talk to your health care provider. An evaluation may include a
physical exam, a medical history and blood or skin testing.

Inova Loudoun Hospital (ILH) used approximately $110,000 worth of sterile surgeon’s gloves last year, excluding The Birthing Inn (obstetrics). About that much was spent on non-sterile gloves, excluding Lab and Food Handling. ILH is nearly a latex-free facility and is committed to providing the safest environment possible for workers, patients and visitors. All non-sterile gloves are powder-free. A very limited number of supplies are stocked without non-latex substitution. Materials Management requests that any latex items in pre-packaged medical or surgical trays be brought to their attention. The Standards Committee will be looking at eliminating these few latex options entirely. Be alert-report and remove any latex products that patients and visitors bring into the facility: balloon bouquets are an example.

Keep informed on the subject of latex allergy; healthcare workers are among the highest industry groups at risk of developing latex allergy, followed by housekeepers, law enforcement personnel, fire/rescue workers, food service employees, painters and funeral home employees. Make your own health and wellness a priority. For further information on latex, visit www.cdc.gov/niosh/latex or email pubstaff@cdc.gov.

“Fast Food vs. Health Eating in Moderation”
There is no secret to healthy eating. Healthy eating involves a variety of foods, balanced diet and moderation. Good nutrition should be part of an overall healthy lifestyle that also includes regular physical activity, no smoking, and stress management. Healthy ranges of daily fat intake are 30-60 grams for women and 40-80 grams for men. Sodium should be limited to below 2400 mg daily for healthy people with normal blood pressure.

Eating at fast food restaurants can sabotage your healthful eating plan. These meals and snacks can be high in fat, sodium, calories and carbohydrates. If you know the nutritional content of the menu items you order, you can make educated choices toward lower sodium, calorie and fat content. Consider the hidden pitfalls of these options:

- ¼ of a Domino’s Medium Thin Crust Cheese Pizza has 273 calories, 12 grams fat, 835 mg sodium
- ¼ of a Domino’s Medium Ultimate Deep Dish Pepperoni pizza has 556 calories, 28 grams fat, 1397 mg sodium
- Dunkin Donuts Blueberry Muffin has 490 calories, 17 gms fat, 610 mg sodium
- Dunkin Donuts Reduced Fat Muffin, 450 calories, 12 gms fat, 590 mg sodium
- Nestea Unsweetened Iced Tea 16 oz. has 0 calories, 0 gms fat, 28 mg sodium
- Mocha Smoothie 16 oz. has 470 calories, 5 gms fat, 170 mg sodium
- McDonald’s Cheddar Bacon Suasage McMuffin has 560 calories, 39 gms fat, 1430 mg sodium
- McDonald’s Egg McMuffin has 290 calories, 12 gms fat, 790 mg sodium
- McDonald’s Scrambled Eggs (2) has 160 calories, 11 gms fat, 170 mg sodium
- McDonald’s French Fries (small serving) has 210 calories, 10 gms fat, 135 mg sodium
- McDonald’s French Fries SUPERSIZE serving has 610 calories, 29 gms fat 390 mg sodium

You can work fast food into your diet once in awhile and still maintain good health. Look for lower sodium, calories and fat content & decaffeinated choices. Remember that some ‘lite,’ ‘low-cal’ or ‘reduced fat’ foods contain just what you are trying to avoid.

Make your own health and wellness a priority! For further information on Nutritional Variety, Balance and Moderation, we search on ‘health eating.’ There are hundreds of websites sponsored by the CDC, American Dietetic Association, USDA Center for Nutrition, the National Cancer Institute and other reliable and non-biased sources.

Victoria Raabe, RN, BSN has been a professional nurse since 1974 with over 20 years of Emergency Department experience. She is currently an Employee Health Nurse for Inova Loudon Hospital in Leesburg, Virginia. Victoria has been a member of the Virginia Chapter of AOHP for 3 years and is currently preparing for the COHN exam. Colleagues Elizabeth Troha and Elaine Dawson are other regular contributors to “The Pulse” employee newsletter.

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5. www.diabetes.org
6. www.health.gov/dietaryguidelines
Effectiveness of a Ceiling Mounted Patient Lift System

By Esther Carlson, MSN, ARNP, BC, FNP, CCRN, Barbara Herman, RN, BSN, COHN-S, and Patricia Brown, MS, MN, PhD, RN

Conventional methods of preventing injuries such as training and education have not been effective among members of the increasingly aging nursing workforce. This two-year retrospective study compares the rate of injuries to healthcare workers related to patient handling before and after the installation of a hospital-wide ceiling-mounted lift system. The study also compares the difference in cost to the healthcare institution in medical and indemnity costs and lost and restricted workdays of injured healthcare workers resulting from patient-handling injuries. Mann Whitney testing was completed to evaluate these variables to show individual significance and Chi-square to evaluate the institutional significance.

Facility size is 240 licensed beds with an average daily patient census of 130. Nursing staff has approximately 600 employees. Lost workdays significantly decreased from 24 per 100,000 worked hours to zero, X² = 508, p < .0001. Also, medical and indemnity cost of injuries were significantly decreased from $213,744 to $5,266, U = 183, p < .0001. A thirty-percent reduction in staff injury was also noted but was not found to be statistically significantly.

While patient handling injuries are not the only reason nurses are being injured, estimates show that ten percent of all nurses will suffer from serious work-related back injuries and about twelve percent of nurses will leave the profession because of back injuries. This research supports the use of ceiling mounted lift systems to decrease injuries and as a cost affective means for the institution.

**Keywords**: Ceiling mounted, lift system, injuries, prevention

Effectiveness of a Ceiling Mounted Patient Lift System

Work-related back injuries in nursing personnel are a severe problem affecting quality of care, personal suffering and financial cost (Tiesman, Nelson, Charney, Siddharthan, & Fragal, 2003). The 1998, the Bureau of Labor Statistics reported that nearly 12 out of 100 nurses who work in the hospital setting and 17.3 out of 100 nurses working in nursing homes report having experienced work-related musculoskeletal injuries. Nurses are not alone in being at risk for occupational injuries resulting from handling of patients; daily in the United States approximately 9,000 healthcare workers of all kinds sustain disabling injuries on the job. Work related back injuries among hospital personnel, in combination with associated lost and restricted days, account for high volume, high cost workers’ compensation claims (Charney, 1999). The American Nurses Association (2003) has issued a position statement which supports the elimination of manual patient handling to prevent work-related musculoskeletal disorders. It is essential for acute care hospitals to establish a safe environment of care for nurses and patients, which eliminates manual patient lifting.

The purpose of this two-year retrospective study was to evaluate the impact of introducing a hospital-wide ceiling-mounted patient lift system on the prevalence of injuries to workers, the number of lost and restricted work days, and the amount of medical and indemnity paid annually for patient handling lift injuries to workers.

There are very few published studies on the effectiveness of a ceiling-mounted lift system in reducing injuries of healthcare personnel related to moving and handling patients. Three types of lift-assistance systems have been reported in the literature: 1) lift teams 2) lift teams using mechanical lift devices, and 3) ceiling-mounted lift systems. Donaldson (2000) studied the effect of using a lift team on the incidence of patient-handling injuries in acute, subacute, and extended care areas of a 296-bed medical hospital. A pilot team was started that performed lifting and transferring per request. The team was expected to use proper technique and were available Monday through Friday, for an eight hour period. He reported a 62 percent reduction in the frequency of claims related to injuries incurred while moving patients. Only descriptive statistics were presented for this study.

Charney (2000) used a case study approach to study the use of both mechanical lift equipment and a hospital lift team to reduce back injuries among nurses. A transport team was cross-trained as a lift team and supplied with mechanical equipment to assist in patient handling. Manual lifting was forbidden. Only one nurse reported an injury during the one-year-long study but did not require any time off as a result of the injury. He reported a cost savings of greater than $62,000 and a 91% decrease in the incidence of injuries compared to the years prior to the initiation of the lift team with mechanical lift equipment.
Tiesman, et al. (2003) studied the use of ceiling-mounted patient lift systems in a long-term care setting. This study was done in a sixty-bed long-term care unit, where all nursing staff performing direct patient care on the unit were invited to participate. A track-mounted patient lift system was installed in each patient room and training was provided to staff. All staff who sustained injuries were required to report injuries and data was entered in the Automated Safety Incident Surveillance Tracking System (ASIST) program. Nurse satisfaction surveys were given to the sample group. The surveys revealed a high level of satisfaction among the nursing staff for the ASIST program. They reported a decrease in the rate of injury from 20.99 injuries per 100,000 worked hours before the installation of the ceiling-mounted lift system to 13.25 injuries per 100,000 worked hours after the installation of the lift system.

**Research hypotheses**
The present study sought to examine the effect of the installation of a hospital-wide ceiling-mounted lift system on the incidence of injuries resulting from handling patients reported by hospital personnel. The hypotheses which were tested were as follows:

1. Health care workers will experience fewer injuries related to the handling of patients after a ceiling-mounted lift system is installed than prior to the installation of the lift system.
2. The health care institution will incur less cost related to medical and indemnity charges resulting from patient-handling injuries after a ceiling-mounted lift system is installed.
3. The number of restricted and lost work-days incurred by nurses because of patient-handling injuries will decrease after the installation of a ceiling-mounted lift system.

It was assumed that hospital staff had been trained on using the ceiling-mounted lift system and were following the hospital policy and protocols.

**Operational definitions**

**Patient-handling injuries:** Any reported injury suffered by a health care worker while moving or handling a patient.

**Lost work days:** The number of days when a health care worker is unable to work because of a patient handling injury.

**Restricted days:** The number of days when a health care worker is able to work but cannot perform 100% of job duties following a patient-handling injury.

**Medical and indemnity paid:** The direct and indirect cost of medical care and lost productivity which includes medical expenses, workman’s compensation payments, and paid time-off because of patient-handling injuries.

**Research design**
This was a retrospective study which compared the number of patient handling injuries, the amount of medical and indemnity costs, and the number of restricted and lost workdays of healthcare workers during the 12-month period eleven months prior installation of a ceiling-mounted lift system (January 1, 2001-December 31, 2001) and those incurred during the 12-month period after the installation of the lift system (January 1, 2003-December 31, 2003). Data was obtained from the records of the employee health nurse on work-related incidents, medical and indemnity costs, and restricted and lost workdays.

**Sample**
The sample consisted of the records of all hospital personnel who reported an injury which was judged to be related to patient handling injuries during this study period. All hospital healthcare workers were included in the study with the exception of units where the lift system was not installed. These areas included staff who worked in the emergency department, behavioral health, radiology, and pediatrics.

**Procedure for Data Collection**
A healthcare worker who incurred a patient-handling injury was required to complete a standardized hospital incident report. The Employee Health nurse and/or house supervisor verified that the injury was caused by patient handling. After verification, the data were entered into an Excel program. The data were retrieved and made into a report format which included the following: injury date, day of the week that the injury occurred, time of injury, years of employment, body part affected, type of injury, location in the hospital where the injury occurred, the amount of medical and indemnity paid, and the number of restricted and lost work days.

**Results**
Thirty health care workers reported injuries related to lifting patients in the one-year period prior to installation of the ceiling-mounted lift system; however, twenty-one workers reported such injuries during the twelve month period following the installation of the lift system (Table 1). This represents a 30% decrease in patient-handling injuries after the installation of the ceiling-mounted lift system. Chi Square Goodness of Fit analyses were applied to evaluate statistical analysis for the hospital; a Mann Whitney U Test was applied to evaluate the statistical analysis to individual healthcare worker. A Chi Square Goodness of Fit Test applied to this data revealed a non-significant change in the number of injuries after the installation of the lift system. ($X^2=1.26, p > .26$), degrees of freedom = 1, but a significant decrease in total medical and indemnity costs (Figure 1) to the hospital ($X^2= 198,454.29$, ...
A Mann Whitney Test applied to medical costs also revealed a significant decrease in costs related to patient-handling injuries (U= 183, p< .001). The number of lost workdays resulting from patient-handling injuries dropped from an average of 17 to zero, a 100% decrease, while the number of restricted workdays decreased from an average of 22.3 to 7.8, representing a 21.5% decrease in restricted workdays resulting from patient-handling injuries after the installation of a lift system. A Mann Whitney analysis of lost days showed a significant reduction (U= 0, p<.05), although the decrease in restricted days was not significant (U=204, p= .16) due the small sample size.

A total reduction of restricted days after the insertion of the ceiling mounted lift system was 538 days and this figure does not include staff that experienced lost work days. The data fail to support the first hypothesis regarding the number of injuries incurred by hospital personnel. The data does support the second hypothesis that the hospital will incur less cost related to medical and indemnity charges resulting from patient-handling injuries after a ceiling-mounted lift system is installed. This is true for both total costs and for average cost per event. The data supports the hypothesis that the number of lost workdays will be reduced (both total and per event), and that the total lost days will be significantly reduced, but there is not a significant reduction in the restricted days/event after the installation of the lift system.

In the sample of those who were injured prior to the installation of the lift system 13% were male and 87% were female; they had an average age of 30 years with a range between 21 and 56 years. In the group of workers injured after the installation of the lift system, 19% were male and 81% were female; they had a mean age of 30 years with a range between 25 and 61 years.

Discussion
There was a 30 percent decrease of patient handling injuries and a statistically significant reduction in costs to the institution, both in medical costs and in terms of lost workdays from employees following the installation of the ceiling-mounted lift system. It should be noted that although 30 healthcare workers reported injuries resulting from moving patients prior to the installation of the lift system, seven of the staff incurred no medical or indemnity costs and had no restriction on workdays (Table 2). Of those who reported such injuries after the installation of the lift system, ten of them incurred no medical or indemnity costs and had no reduction in workdays. This suggests, perhaps that these injuries were less severe. Out of 510 lost workdays incurred prior to the installation of the lift system, 501 of these were lost by a single worker. This institution had documented four consecutive years of at least one employee having extensive lost work days as noted in 2001. The remaining 9 days were lost by four other workers. A larger sample might reveal a significant reduction in the number of injuries after the installation of a lift system. However, the significant reduction in costs and lost or restricted workdays suggests that the injuries which were incurred after the lift system was installed were less severe than those incurred prior to the installation of the lift system. A reduction or even elimination of a severe injury such as the one which resulted in the loss of 501 workdays would be a significant savings to a healthcare institution. The cost of the installation of the ceiling-mounted patient lift system was $446,000; the direct cost savings after one year was greater than $200,000. If the savings continues at this rate, the lift system would pay for itself within three years.

Limitations of the study include the small sample size and the self-reporting of hospital personnel. Areas in the hospital where the lift system was not installed were excluded from the study. These areas included the emergency department, pediatrics, behavioral health, hospice, and radiology. The lift system was installed in November of 2002. Since there was not a complete year of data, 2002 data were omitted from the study.

This research should be duplicated in other acute care settings and over a longer period of time. Studies should also be conducted to determine whether there is a decrease in injuries suffered by patients and/or increase in patient comfort and satisfaction when they are moved with a ceiling-mounted lift system in place.

Esther A. Carlson, MSN, ARNP, BC, FNP, CCRN is an Advance Practice Nurse at Salina Regional Health Center in Salina Kansas. Barbara J. Herman, RN, BSN, COHN-S is an Employee Health Nurse at Salina Regional Health Center. Patricia Brown, MS, MN, PhD, RN is Interim Chair of the Kansa Wesleyan University Division of Nursing.
OSHA Issues “Best Practices” Guidance for Hospital Workers Exposed to Hazardous Substances During Mass Casualty Incidents

By Kimberly W. Daniel and Stephanie Lindsey Hiss

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Does Walking 15 Minutes per Day Keep the Obesity Epidemic Away? Simulation of the Efficacy of a Populationwide Campaign

By Alfredo Morabia, MD, PhD; Michael C. Costanza, PhD

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Office ergonomics
Can split keyboards solve your ergo woes?

By Linda Tapp, ALCM, CSP

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Call for Speakers

for 2006 AOHP Conference

Sacramento, CA October 4 –7, 2006

This is the official “call-for-speakers” for the 2006 National Conference.

- Deadline to submit: November 18, 2005
- Successful applicants will be notified by January 27, 2006

AOHP invites those interested in presenting at the AOHP National Conference to submit a proposal to present. The Conference Planning Committee will review and notify applicants (see above timelines.). All presentations – pre-conference, general session, break-out session, success stories – need to be submitted by the above deadline.

Include in Your Submission:

- Title of your presentation.
- Three (3) behavioral objectives (i.e., what will attendee be able to do after completing your session.)
- Topic overview – a paragraph to be inserted in Conference Brochure, giving overview of your topic.
- Outline of your presentation.
- Your resume.
- Your bio - to be inserted into the Conference Brochure.
- Electronic picture.

Length of Presentation-Format

Each general session and breakout session lasts 1 or 1 ½ hours, which includes 10 minutes for questions. Pre-conference workshops should be 4 hours or 8 hours.

Submit your application by Email/fax/mail: prickis@sutterhealth.org
Sandra Prickitt, RN, FNP, COHN-S
AOHP 2006 Conference Chair
639 Larkspur Plaza Drive Phone: 415-492-4790
Larkspur, CA 94939 Fax: 415-492-4791

Topics may include any of the following:

- Flu Vaccine Campaign
- TB Screening
- Physician/Nurse Relationships
- EHS and IC Roles-The Challenges, The Rewards
- Successful Joint Commission Survey
- Successful Wellness Programs
- New Employee Orientation To Employee Health
- Workers’ Compensation
- Return To Work Programs
- No Lift Programs Safety Programs
- Accident Investigation
- Back Safety Programs
- Injury Management
- Safe Sharp Devices Management
- Surviving An OSHA Inspection
- Surviving A Department Of Health Survey
- Successful Post Offer Health Screening Program
- Respirator Fit Testing-Headache Or Help
- ADA-What You Need To Know
- HIPPA-Where Are We?

Contact Conference Chair Sandra Prickitt (415) 492-4790 if you have conference questions.
2006 AOHP National Conference
Sacramento, CA

SPEAKER APPLICATION FORM

PRESENTER(S)______________________________________________________________

ADDRESS______________________________________________________________

PHONE_________________________ FAX__________________________

EMAIL______________________________________________________________

CURRENT POSITION & EMPLOYER___________________________________________

☐ Title of your presentation.

☐ Three (3) behavioral objectives (i.e., what will attendee be able to do after completing your session.)
1. ______________________________________________________________________
2. ______________________________________________________________________
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☐ Topic overview – a paragraph to be inserted in Conference Brochure, giving overview of your topic.

☐ Your resume.
☐ Your bio
☐ Electronic picture.

Length of Presentation-Format (pick one):
Each general session and break-out session lasts 1 or 1 ½ hours, which includes 10 minutes for questions. Pre-conference workshops should be 4 hours or 8 hours.

___Pre-Conference 4-hour ___Pre-Conf 8-hour ___General Session ___Break-Out

Level (check all that apply):
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AOHP ON A MISSION

Have you registered yet? By now you should have received your copy of the AOHP 2005 Conference brochure. If you did not receive one, contact AOHP Headquarters at 800-362-4347 or download from our website www.aohp.org.

This year’s conference will be held on Oct 12-15 in San Antonio, TX. Don’t miss this incredible opportunity to meet with your friends, exhibitors, network & have fun.

Also, don’t forget to sign up for our Annual Business meeting and Award Luncheon on Friday. Enjoy the lunch, get the latest information on AOHP and socialize with friends and peers. And get the chance to win one of the door prizes donated by Liko, Inc.

The vendor reception will be held on Thursday, at the Exhibit Hall. The event will start at 6:00 pm. Great food and beverages are provided. We will also have the scavenger hunt and lucky draw. Prizes for the “lucky draw” are donated by Diligent/ARJO, Inc. After the reception, we will have country/western music, so you can kick off your cowboy boots and dance. We invite you to wear your cowboy attire and have fun!

ABOHN will again offer the certification exam on Saturday October 15 at the Crowne Plaza Riverwalk Hotel. If you missed the deadline for ‘05 exam, contact ABOHN toll free 888-842-2646 or email info@ABOHN.org or visit their website www.abohn.org for the next test session. The ABOHN Reception will be held on Friday, October 14, 2005, at 6:00 pm at the Crowne Plaza Riverwalk Hotel to celebrate Certified Occupational Nurses’ outstanding achievements. Certified and Non-Certified OHNs are invited.

Prevent, Inc. & Liko, Inc. Platinum Sponsor

“Caring for the Caregiver”

AOHP again welcomes Prevent, Inc. and Liko Inc. as a Platinum Sponsor for the second year - for their generosity in underwriting AOHP’s Annual Business Luncheon October 14, 12:05 – 2:05 pm. Prevent, Inc. professional nurses develop, implement and promote comprehensive safety programs, including a “no manual lift” component, which dramatically reduce health care workplace injuries. Liko, Inc. develops, manufactures and markets patient lifts and the most complete range of lifting accessories. Visit their booths at the conference and URL www.getalift.com and www.liko.com.
Many thanks are extended to our twenty-one (21) AOHP members who participated in the extension of our “Recruit Our Colleagues” campaign from October 1, 2004 through June 30, 2005. Thirty-one (31) new members were recruited as a direct result of your efforts!

Congratulations to Cheryl Martin from Virginia who recruited 4 new members! Because of her efforts, Cheryl wins a free registration to “On A Mission”—the 2005 AOHP conference! Way to go, Cheryl!

In addition, Kerry Owens from Illinois recruited 3 new members and is entitled to a free one-year membership to AOHP. Good job, Kerry!

AND…. Congratulations to the VIRGINIA CHAPTER. These members recruited the most members—8 new members—and will be awarded $500.00 to be used at their discretion to support their members!

All in all, we’ve all had a “ROC” ’N good time! Our current membership totals 857 active members. We know there are still other occupational health professionals who could benefit from being members of our outstanding Association. Your continued effort to recruit additional new members is still needed. So continue to spread the word regarding the great benefits of membership to AOHP—THE Resource for Occupational Health Professionals in Healthcare!

AOHP “ROC” Campaign Participants
October 2004–June 2005

Lynn Arndt
Mary Bliss
Mary Jane Brown
Albert Carbuto
Kim Casey
Tisha DeNiro
Diane Dickerson
Rhonda Ellis
Connie Grady
Nancy Hughes
Juana Ituarte

Pam Kemp
Cheryl Martin
Debbie McGuire
Kerry Owens
Pat Price
Kim Stanchfield
Kala Stevens
Cindy Swigart
Dee Tyler
Rose Wetzel

Many thanks to All!

Diane Dickerson, RN, MS, COHN-CM, SPHR
Membership Chair