HOSPITAL EMPLOYEE HEALTH

THE PRACTICAL GUIDE TO KEEPING HEALTHCARE WORKERS HEALTHY

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INSIDE

RELIAS MEDIA

Rhode Island Passes Landmark Law Protecting HCWs from Surgical Smoke

Small state takes big step; others may follow

Gary Evans, Medical Writer

In what may be a tipping point in the long struggle to end surgical smoke exposures in the operating room, Rhode Island has become the first state to mandate that healthcare facilities take measures to protect healthcare workers (HCWs) from the hazardous plume.

Testifying before passage of the bill recently was **Julie Greenhalgh**, RN, an operating room nurse with 42 years of experience in Cranston, RI.

"As a young nurse, we were at the beginning of cauterization," she said. "We knew that it smelled — a powerful, obnoxious odor — but we weren't aware of the side effects."

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She attributes her chronic lung disease to decades of occupational exposure to surgical smoke.

"I have a constant cough, bronchitis, and asthma," she said. "I have never smoked cigarettes and never had asthma as a child."

Testifying at a Feb. 14, 2018, hearing on the bill, Greenhalgh held up a plastic bag of medications she uses to treat her lung disease.

"I have three inhalers that I use every day as well as some oral medications," she said. "I have been trying to promote this for many years. Passing this bill will allow nurses to work to save patient lives without putting their own lives in danger."

Effective Jan. 1, 2019, the Rhode

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in 2017–18 was higher among physicians (96.1%), pharmacists (92.2%), nurses (90.5%), and nurse practitioners and physician assistants (87.8%), and lower among other clinical healthcare personnel (80.9%), assistants and aides (71.1%), and nonclinical health care personnel (72.8%)," the CDC concluded. ■

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1. CDC. Influenza Vaccination Coverage Among Health Care Personnel — United States, 2017–18 Influenza Season. *MMWR* 2018;67(38);1050–1054.
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New USP Hazardous Drug Rules Coming Soon

What employee health professionals need to know

The U.S. Pharmacopeia (USP) continues to revise its standards to protect workers exposed to hazardous drugs, including those involved in compounding medications.

Although employee health may not have oversight of a facility's hazardous drug policy, involvement and awareness is encouraged to protect workers. Hazardous drugs like those used in oncology include those that can cause cancer, genetic damage, and reproductive problems. While these effects necessitate following workers long-term, immediate effects of being exposed to the drugs include nausea, dizziness, and nasal damage.

The three general hazardous drug categories are antineoplastic, non-antineoplastic, and reproductive hazards. Design improvements may be needed to prevent exposures, but there also are compliance factors like insufficient stocks of personal protective equipment or failing to wear it if available. Occupational exposures also can occur if facilities are not using closed-system drug transfer devices. *(See* Hospital Employee Health*, March 2018.)*

HEH talked to **Ken Maxik**, director of patient safety for CompleteRx, a hospital pharmacy management company, about some of the changes.

HEH: Can you generally describe some of the actions the USP is taking?

Maxik: Over the last couple of years, the USP has been making some changes to their sterile and nonsterile compounding. They started by releasing USP 800, which deals with hazardous drug compounding. Then earlier this year they released USP 795, which deals with nonsterile compounding. Then more recently they released USP 797, which deals with sterile compounds.

What they essentially did in trying to match these three chapters is break off the section on hazardous drug compounding, which previously was a part of USP 797. They created it as a new chapter in USP 800, which I believe they did to place greater emphasis on safety related to compounding hazardous medications. In the [overview] of the USP 800 chapter, they point out that part of the purpose of the chapter is to describe worker safety.

HEH: Is this more a matter of emphasis, or are their new recommendations that employee health professionals should be aware of?

Maxik: There are changes. For example, they are now recommending that you conduct environmental wipe sampling of your hazardous drug surfaces for residue. They are also recommending that you have policy and procedures for safety data sheets to document effective training and proper garbing. They also outline that they now want you to use closed-system transfer devices. That must be used for administration. That is something that is new, and they are recommending that you use closed system devices for the compounding portions. They are trying to prevent aerosolization from occurring. They also aligned that with a recommendation to have a medical surveillance program in place [for employees]."

HEH: Are these recommendation or requirements?

Maxik: USP by itself does not enforce its own recommendations. They do not have an enforcement division. The way that USP recommendations get enforced is through state boards of pharmacy and accreditation organizations, which adopt the USP recommendations. They either put it into their accreditation standards or their state board rules and regulations.

HEH: Generally, when you look at these changes, would you say that healthcare facilities that adopt these measures will better protect their workers?

Maxik: Absolutely. We are already

finding in facilities that we are working with that the pharmacies have placed the recommended changes into their capital budgets. That way, they can redesign their clean rooms and split out the separate clean rooms for hazardous compounding. Also, many of the organizations have begun to conduct risk assessments, which are called for in the USP 800 chapter. They are now identifying and assessing the risks to employees. I'm certainly not saying everybody didn't have something previously, but they are developing what their organization's mitigation strategies will be for those potential risks. ■

How to Deal With the Disruptive, Difficult Physician

Employee health professionals assessing their work culture can point to difficult and disruptive staff, sometimes entire units.

Dealing with such a physician or group always is a tough proposition. That is especially so when, for example, a physician is a high-revenue generator, a leader in a specialty, or otherwise powerful and important to the organization. And how do you get staff to comply with directives without singling out individuals for discipline?

Accountability is key, even though there has been a movement away from holding individuals accountable in favor of redesigning systems to encourage the desired behavior, says **Gerald B. Hickson**, MD, senior vice president for quality, safety, and risk prevention at Vanderbilt University Medical Center in Nashville.

Rude or abusive physicians must be managed affirmatively no matter how much cachet or power they have within the hospital, Hickson says. Vanderbilt uses a program that addresses disruptive physician behavior in an escalating fashion, and he says it must be employed without regard to the doctor's position in the hierarchy.

Dealing with dysfunctional systems requires returning the right amount of professional accountability to the healthcare environment, but without returning to the unproductive approach of past decades, Hickson says. No one wants to go back to the old way of shaming and blaming individuals for every error, he says, but there must be accountability for disruptive and abusive behavior.

"If you focus only on intentionally designed systems without pairing it with professional accountability, you get a lot of discussions that don't go anywhere," he says. "We can all agree that washing hands is a good thing, but just saying that doesn't make people wash their hands. At some point, you have to hold people accountable."

Hickson recalls how a unit at Vanderbilt was not compliant with handwashing expectations, and when called to task, staff said conditions on the unit were not conducive to good hand hygiene. He agreed that they could not be held responsible if the hospital did not provide adequate conditions for good hygiene, so the hospital improved the work area in the way the staff asked.

"After we made all of those improvements, to their specifications, their performance didn't improve a bit," he says. "We can spend a lot of time as quality and safety officers fixing things that need to be fixed, but it must be coupled with a clear, unambiguous declaration that we expect our members to do every time. Unless you have people, process, and technology aligned to help you with professional accountability, your safety program cannot move forward because of the influence of a very small number of people who decide these things don't apply to them."

That reasoning can be applied to a number of quality and safety efforts — everything from handwashing and timeout compliance to physician interactions with staff and patients, he says.

"If you don't have a plan for dealing with the subset of people who don't comply with expectations, it is hard for everyone else to maintain high reliability," he says.

Whether the unacceptable behavior is poor hand hygiene or a physician who is verbally abusive to staff, hospital leadership must engage the problem head-on and make clear that such behavior is not acceptable, Hickson says. Once the organization makes the proper behavior possible by providing the necessary resources and processes, it is reasonable to expect compliance with your expectations, he says.

"Some of the best interventions come from people who are manning a desk somewhere but realize they are part of the safety team. If they see someone engaged in behavior that is not appropriate, they interact in a socially appropriate way," Hickson says. "That means you never embarrass, never humiliate, but you

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