

Committing to SH&E in the Healthcare Industry

GEORGE BYRNS, PH.D., CIH, IS AN ASSOCIATE PROFESSOR OF ENVIRONMENTAL HEALTH AT ILLINOIS STATE UNIVERSITY.

In this interview with the Healthcare Practice Specialty, Byrns explains how SH&E practices can be improved in the healthcare industry.



HealthBeat: *What are the most effective management strategies to improve occupational safety and health in the healthcare industry?*

George Byrns: Unquestionably, the single most effective management strategy is to have the CEO

demonstrate his/her commitment to the safety and health program. This commitment must go beyond the establishment of written safety and health policies and procedures. To be effective, the manager must provide visible support for the program by participating in safety activities, such as environmental rounds, and by holding middle managers accountable for compliance with these policies.

HealthBeat: *Do you think attention to patient safety benefits or detracts from occupational safety programs?*

GB: This is a complex issue. Potentially, greater attention to patient safety could improve both patient safety and employee safety. For example, safer patient lifting techniques can help prevent injuries to both the patient and the caregiver. Unfortunately, much of the patient

safety effort appears to be directed at avoidance of malpractice suits from “medical misadventures.” This is the rather comical description given to a serious problem (e.g., giving the wrong medication, amputating the wrong limb). If the patient safety effort’s focus is to cover up serious errors, this demonstrates a poor safety culture. On the other hand, if the focus of patient safety is on identifying root causes and proactively solving them, then there is hope that both the patient safety and employee safety programs will improve.

HealthBeat: *Incidents of violence in the workplace are significantly higher in healthcare than in general industry. What are some strategies that hospitals/nursing homes have successfully used to minimize the risk of workplace violence?*

GB: Successful healthcare organizations enforce a zero-tolerance policy for workplace violence. An equally important strategy is to identify potential vulnerabilities. One way to accomplish this is to conduct an anonymous employee security survey. In this survey, employees are asked about their general sense of workplace security, about specific incidents when they felt threatened and any suggestions they may have to improve security.

Once the problems are identified, controls can be implemented that target specific concerns. Generally, the most effective controls are engineering modifications, such as improved light-

ing, bullet-proof glass in triage areas and mirrors. However, in some cases, administrative controls such as identification badges are needed. For hospitals, it is essential to have a competent security force. While most nursing homes are too small to have an in-house security team, they still need a plan to isolate and contain violent persons. This can be challenging because residents with Alzheimer’s disease are unpredictable and may strike out without warning. Persons with Alzheimer’s must be moved to facilities that are equipped to handle them.

HealthBeat: *What do you see as the biggest challenge for SH&E professionals working in healthcare?*

GB: In terms of the big picture, the greatest challenge is to get management to understand the importance of our program. Historically, SH&E professionals have not marketed the positive cost-benefit of having an effective safety program. Work-related musculoskeletal disability has significant direct and indirect costs. Direct costs, such as workers’ compensation and the need to hire temporary employees, are easily measured. Indirect costs, such as loss of productivity and poor morale, are much harder to measure but may be more costly to an organization. A safety program that effectively lowers these cost will more than pay for itself.

HealthBeat: *Can you comment on the proposed Nurse and Health Care Worker Protection Act of 2009? Specifically, do you think this*

type of legislation is necessary and do you believe it will significantly improve working conditions in healthcare?

GB: Legislation such as H.R. 2381 is long overdue. Requiring a 120-lb nurse to manually lift a 400-lb patient is asking for a serious back injury. Many surveys have shown that in the U.S., 30% to 50% of nurses and nursing aides suffer a serious back injury each year. I believe this adds to the severe nursing shortage in the U.S. My only concern is that having a no-lift policy is insufficient unless management provides sufficient resources to implement the program and makes it clear that compliance with the policy is not voluntary.

HealthBeat: *How is your book unique in providing guidance in the area of healthcare safety?*

GB: What I tried to do in the book (*Hazard Recognition and Control in Institutional Settings: A Guide for Hospitals Universities and Nursing Homes*) is provide a comprehensive framework for problem solving. It does not matter whether the problem is violence or bloodborne pathogen exposure, a consistent approach can be taken to anticipate, recognize, evaluate and control it. In controlling a problem, I recommend the use of Haddon's Matrix to focus on primary, secondary or tertiary prevention strategies that target the person, supplies or equipment or the environment.

HealthBeat: *In the book, you state that healthcare management has operated under the assumption that workers are responsible for their own protection. Can you elaborate on this point?*

GB: This issue goes back to my earlier statements about the poor culture of safety in healthcare organizations. There appears to have been an unfortunate misunderstanding on the part of healthcare managers that they need not be actively involved in the safety program because, after all, healthcare professionals should know how to protect themselves.

Complicating matters is that healthcare professionals to whom I

have spoken believe they must sacrifice their bodies for their patient. A case in point was a nursing home where the no-lift policy only applied to totally bedridden residents. When I asked the director of nursing why the policy did not apply to other residents with partial muscle function, her response was that using lift equipment would interfere with rehabilitation of these residents. What she failed to understand was that two kinds of mechanical lifts exist, one for bedridden individuals and another for partially ambulatory persons. These sit-to-stand lifts can actually aid in patient or resident rehabilitation. I believe this situation is gradually improving but it has a long way to go.

HealthBeat: *What is the best advice you can offer to SH&E professionals considering a career in healthcare safety?*

GB: The most important piece of advice I can offer is to keep communication lines open with all levels of the organization. Communication with top management is important to encourage support for your program, and communication with other levels is important to keep abreast of emerging issues. Also, it is important that your hazard surveillance team be multidisciplinary. Nurses should be part of the team, especially when evaluating patient care areas. Also work closely with occupational health and infection control nurses and network with your colleagues.

Join ASSE or AIHA to stay current on hot topics and to have someone to consult with when faced with new and unusual problems. ☺

From 1972 to 1997, George Byrns worked for the U.S. Public Health Service's Indian Health Service in environmental and occupational health. In his last assignment, he managed the agency's occupational safety and health program. Byrns holds a Ph.D. in Occupational and Environmental Health from The Johns Hopkins University, an M.P.H. in Environmental Health from the University of Minnesota and a B.S. in Environmental Health from Colorado State University.

Nominations Open Healthcare Practice Specialty Notice of Election

Nominations are open for election of the Healthcare Practice Specialty (HPS) administrator and assistant administrator for the 2010-12 term. To be considered for nomination to either office, an individual must be a professional member of ASSE prior to taking office, must be a member of the HPS and shall not concurrently hold any other Society office.

The deadline for submitting nominations is Dec. 15, 2009. Nominations should be sent via e-mail to:

Deborah Fell-Carlson, Chair
Healthcare Practice Specialty
Nominating Committee
debfel@saif.com

The nominating committee will consider all qualified HPS members who indicate an interest in running for each office and will nominate not more than two such members for each office by Jan. 15, 2010. HPS members who indicate an interest but are not nominated will be notified of their right to seek nomination by petition by Jan. 20, 2010. One percent, but not less than 25 HPS members may also, by written petition, submit qualified nominees by Feb. 15, 2010, for the open offices to the HPS nominating committee.

The nominating committee will obtain the approval of the current administrator of the slate of practice specialty officer candidates by Feb. 15, 2010. If there is a contested election, the approval of the Society Nominating and Elections committee will be necessary.

If uncontested, the nominated slate will be declared elected by acclamation, which will be announced in the next CPS technical publication published after Feb. 15, 2010. If either office is contested, ballots will be distributed, accompanied by biographies of the candidates involved, to all CPS members no later than April 30, 2010, with a deadline for return of the ballots not less than 30 days hence. A majority vote will be decisive. The nominee receiving a plurality of the votes cast for each office will be considered elected.