POSITION STATEMENTS

As the national leader for occupational health in healthcare, the Executive Board of Directors for the Association of Occupational Health Professionals in Healthcare (AOHP) communicates the association's position when matters of importance emerge related to the health and safety of healthcare personnel in healthcare. Position statements are consistent with the vision and mission of the association. The formation of position statements may also offer the opportunity to collaborate with occupational health and safety professionals in related organizations.

Current Active Position Statements:

- Occupational Health Professional in Healthcare Settings
- Confidentiality of Employee Health Records
- Injury and Illness Prevention Programs
- Safe Patient Handling
- Influenza Vaccination of Healthcare Personnel
- Standards for Adult Immunization Practice
- Respiratory Protection for Healthcare Workers
- Workplace Violence
- Best Practices for Healthcare Worker Immunizations

Retired Position Statement

- Ergonomics (retired 4/2012; replaced by Injury and Illness Prevention Programs 4/2012)

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POSITION STATEMENT

Occupational Health Professional in Healthcare Settings

The Association of Occupational Health Professionals in Healthcare (AOHP) supports the utilization of a designated occupational health professional (HCP) in hospitals, clinics, home health agencies, long-term care facilities and other settings in which HCP are employed. Professionals specializing in occupational health in healthcare should be given responsibility for the development and implementation of a comprehensive program to address the complex workplace health issues of HCP. The presence of occupational health professionals promotes employee health and productivity, decreases direct and indirect costs of compensable work-related illness and injury, and reduces absenteeism.

Rationale

Occupational health services for HCP are provided in an increasingly complex technological and regulated environment. In this setting, it is the occupational health professional who:

- Assures that prevention programs for illness and injury are effective. This is accomplished through training on workplace hazards, preventive injury/illness techniques and immunization programs.

- Assures that the facility programs comply with federal, state and local regulations. There are now many occupational standards that have a major impact on HCP. A rapidly increasing body of occupational standards have a major impact on HCP health and safety programs.

- Develops a professional rapport with HCP, which enables addressing real and potential workplace problems and concerns.

- Interacts with the various professionals responsible for the care of injured HCP and, in an active case management style, assures the earliest possible return to work of injured personnel.

- Assures that HCP are placed in jobs that are compatible with their physical and emotional status, to enable each worker to perform his/her job safely, efficiently and effectively.

Recommendation

AOHP advocates the presence of a designated occupational health professional in each healthcare facility who is vested with the responsibility of managing the complex occupational issues of. These activities must be supported by management and take place in an environment committed to the principles of occupational health.

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POSITION STATEMENT

Confidentiality of Employee Health Records

The Association of Occupational Health Professionals in Healthcare (AOHP) believes an imperative exists with regard to the confidentiality of occupational/employee health records. The occupational health professionals in healthcare settings, including nurses, nurse practitioners, physicians, physician assistants, and all allied health professionals, are charged with the protection of the individual worker's right to privacy with regard to his or her employee health records. As a general rule, release of information beyond medical fitness for duty or that which is required by law cannot be undertaken without the specific written request of the employee.

Regulations and statutes that address privacy and confidentiality issues include federal regulations under the Occupational Safety and Health Administration (OSHA,) the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)* Federal law also restricts disclosure of drug and alcohol abuse treatment records. Workers' compensation is excluded by HIPAA, and pertinent information can be accessed according to the corresponding state's workers' compensation act for work-related injuries, illnesses or exposures. In addition, healthcare facilities may have health information requests made by other regulatory bodies such as The Joint Commission and state departments of public health. Each state has specific statutes for mandatory reporting of items, such as communicable disease diagnosis, which may include personally identifiable data. Release of information contained in the employee health record following receipt of a subpoena, warrant or summons that is issued or ordered by a court, grand jury or judicial officer must only be done based on the statutory requirements of the state where the records are maintained, and information released should only include that information specifically described in the subpoena, warrant or summons. Care must be taken to ensure that worker confidentiality is maintained when electronic communication methods are utilized. Specifically, institutional electronic security measures such as encryption may be needed to transmit this type of information.

Employee health records include the pre-placement medical history, results of physical examinations, medical surveillance and other screening data, vaccination records, information on assessments made at the request of the employer or the employee, exposure follow-up records, documentation of observations and counseling, and any other health records which come under the control of or are initiated by the occupational health professional, regardless of the source.

Management's requests for information beyond medical fitness for duty, workplace safety or that required by law must be carefully reviewed, as management is not empowered to override the obligation of confidentiality imposed upon the employee health professional. Health related information contained in the record will be kept confidential, except that: supervisors and managers may be informed regarding restrictions on the duties of persons with certain injuries or illnesses and regarding necessary accommodation; medical, first-aid and safety personnel may be informed when emergency or special medical treatment may be required; and government officials investigating compliance with state and federal law may be informed. An employer also reserves the right to disclose information from an employee's health record to anyone other than the employee when failure to disclose such information might place others at risk. Consultation with company legal counsel may be indicated. Aggregate health information without any form of identifiers can be used for statistical purposes to justify the cost/benefit of safety and health program initiatives.

Accurate health information cannot be secured when the confidentiality of these records cannot be ensured. Failure to secure complete and accurate information from an employee in the

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healthcare setting may present a threat to the health of patients as well as other healthcare personnel.

**Note: HIPAA's authority does not address an employer's use of information contained in the employee health record. In addition, occupational health professionals should also be aware of and refer to any statutory laws governing their particular state.*

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POSITION STATEMENT

Injury and Illness Prevention Programs

The Association of Occupational Health Professionals in Healthcare (AOHP,) as the national leader for occupational health professionals (OHPs) in healthcare, strongly supports the creation and implementation of injury and illness prevention programs (also known as safety and health management systems) within all healthcare settings. These programs involve a proactive process to find and fix workplace hazards before healthcare personnel are injured. These programs have the ability to decrease injury and illnesses as well as to change the culture of the work environment, including increasing productivity and quality, reducing turnover, reducing costs and increasing employee satisfaction.

The basic elements of a program include:

- Management leadership.
- Employee participation.
- Hazard identification and assessment.
- Hazard prevention and control.
- Education and training.
- Program/system evaluation and improvement.

These elements are individually important and collectively are interrelated and interdependent.

Every healthcare setting is different. These elements can be developed in a manner that will meet the specific needs of each organization.

OHPs in healthcare are well-suited to initiate and lead these efforts in their organizations. If the OHP is not the leader of the program, he/she is definitely a stakeholder who needs to be a member of the Injury and Illness Prevention Team.

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POSITION STATEMENT

Safe Patient Handling

The Association of Occupational Health Professionals in Healthcare (AOHP) strongly supports the provision of a safe and healthy environment for the nurse/caregiver and patient. Back injuries and other musculoskeletal disorders related to patient handling are the leading cause of workplace disability for nurses and other direct patient care providers. The importance of developing reliable approaches for prevention of back injuries and other musculoskeletal disorders related to patient handling is critical. AOHP supports actions, policies and laws that will help to establish a safer environment of care for nurses, other direct patient care providers and patients as it relates to safer patient handling and prevention of injuries.

- Employer and management commitment is needed to adopt an institutional policy that encompasses the safest approach for the caregiver, as well as the patient, when handling, moving and transporting patients. The safest approach is the use of assistive equipment that discourages the use of manual handling. There needs to be initial and ongoing investment in adequate supply of appropriate devices, ensuring: availability of and adequate storage space for equipment; proper disinfection based on infection control principles; educating staff on usage; and designating resource personnel for ongoing assessment and evaluation.

- Employee participation is vital in the assessment and implementation process to encourage acceptance and success of the program. Staff have a wealth of essential information about specific hazards in their work environment associated with patient handling and can assist in guiding actions that will ensure program effectiveness and positive outcomes. Staff must also be involved and given authority in the evaluation and selection of patient handling devices and equipment. They should participate in initial and ongoing education/training activities related to patient handling and the use of assistive devices and equipment.

- Regulation and enforcement of a standard to control ergonomic hazards in the healthcare industry is necessary to prevent back injuries and musculoskeletal disorders. The regulation should include the use of engineering controls for patient handling activities. AOHP supports a continued call to OSHA and state legislators to develop such standards that are appropriate and reasonable to healthcare employers.

- Support of research and evidence-based practice is crucial to continue the ongoing development of interventions to prevent back injuries and musculoskeletal disorders related to patient handling. Further study is also recommended to redesign other high-risk tasks to promote safer work environments for nursing staff. Prompt communication of current study findings to the association and partnering organizations is critical in reducing these injuries and disorders.

In summary, AOHP believes that manual patient handling is unsafe for the caregiver and patient. Such handling is also directly responsible for disabling back injuries and musculoskeletal disorders in nurses and other direct patient care providers. Utilizing safe patient handling reduces stress for nurses to help them stay in the profession. Safe patient handling can occur with assistive devices, ensuring improved quality patient care and outcomes. The ultimate benefits are afforded to the nurse/caregiver, patient and employer. AOHP welcomes the opportunity to work collaboratively with regulatory agencies and professional associations to promote safe patient handling and reduced healthcare worker injuries.

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POSITION STATEMENT

Influenza Vaccination of Healthcare Personnel

Influenza vaccination of healthcare personnel (HCP) has been in place for many years to prevent the transmission of influenza. HCP compliance rates have been poor, and therefore patients and residents in at-risk populations (e.g. immunocompromised, the very young and older adults) are at risk for contracting influenza from staff who transmit it. Discussion has ensued about mandating influenza vaccination for HCP, which would improve vaccination rates and thereby reduce transmission of influenza to at-risk patients and residents. The Association of Occupational Health Professionals in Healthcare (AOHP) has examined this issue quite extensively, finding that there are many nuances to consider regarding mandating influenza vaccine in HCP. When developing AOHP's position statement on influenza vaccine, multiple publications were reviewed and membership input was obtained, reviewed and considered.

Historical/Background Data

Preventing Influenza Transmission

Infection prevention and control experts recognize that vaccination is an effective tool in preventing transmission of influenza and is important to patient safety and quality of care. The risk of HCP transmitting influenza to patients during the course of their duties is of significant concern. Vaccinating HCP will help reduce transmission of influenza to the patient population in general, as well as decrease the likelihood that HCP and/or patients will become ill. For many years, the Centers for Disease Control and Prevention (CDC,) along with many other organizations, has recommended influenza vaccination for HCP. Despite these recommendations, vaccination rates still hover at approximately 72% nationwide, well below the 90% goal recommended by Healthy People 2020.

The Association for Professionals in Infection Control and Epidemiology (APIC) Influenza Immunization of HCP 2011 Position Statement advises that "seasonal influenza vaccination of HCP offers an important method for preventing transmission of influenza to high-risk patients. Evidence supports the fact that influenza vaccine is effective, cost efficient and successful in reducing morbidity and mortality. Evidence also demonstrates that the current policy of voluntary vaccination has not been effective in achieving acceptable vaccination rates." APIC proposes that healthcare providers have an obligation to ensure that all HCP are vaccinated against influenza. They state "as healthcare providers, we have an obligation to ensure that all HCP are vaccinated against influenza. As a profession that relies on evidence to guide our decisions and actions, we can no longer afford to ignore the compelling evidence that supports requiring influenza vaccine for HCP. This is not only a patient safety imperative, but is a moral and ethical obligation to those who place their trust in our care." In the same document, they state "as a profession dedicated to the prevention of infection, we have an ethical responsibility to protect those individuals entrusted to our care. We must do a ***better job*** of immunizing HCP every year to ensure patient safety and to protect those individuals at high risk of developing complications of influenza."

According to the Clinical Infectious Disease publication, studies show that HCP who frequently have contact with high-risk patients can shed influenza virus before they are symptomatic, thereby putting their vulnerable patients at risk. It has been shown that HCP routinely report to work when ill with respiratory symptoms. The American College of Occupational and Environmental Medicine

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(ACOEM) states that “immunization against influenza should be strongly encouraged and employers should provide vaccine at no charge to the worker."

Vaccine Effectiveness

The variability of vaccine effectiveness is controversial when discussing mandating influenza vaccination. The CDC addresses the varying effectiveness of the influenza vaccine: “The effectiveness of inactivated influenza vaccine depends primarily on the age and immunocompetence of the vaccine recipient, and the degree of similarity between the viruses in the vaccine and those in circulation. In years when the vaccine strains are not well matched to circulating strains, vaccine effectiveness is generally lower. The vaccine may also be lower among persons with chronic medical conditions and among the elderly, as compared to healthy young adults and children. In addition, estimates of vaccine effectiveness vary, based on the specificity of the outcome that is being measured in the study.” Influenza vaccine is not as effective in some populations. Those most at risk for infection are young children, the elderly and the immune-suppressed. Vaccinating HCP helps to protect these vulnerable populations. The Infectious Diseases Society of America (IDSA) states, “influenza vaccine effectiveness varies by age, host immune status, and the match between circulating and vaccine virus strains."

According to the 2010 revised Society for Healthcare Epidemiology of America (SHEA) position paper, “a mismatch between the vaccine and the circulating wild-type strains is infrequent, but even in years with a substantial mismatch, the vaccine still may be partially effective. Vaccination of HCP serves several purposes: to prevent transmission to patients, including those with a lower likelihood of vaccination response themselves; to reduce the risk that HCP will become infected with influenza; to create “herd immunity” that protects both HCP and patients who are unable to receive vaccine or are unlikely to respond with a sufficient antibody response; to maintain a critical societal workforce during disease outbreaks, and to set an example concerning the importance of vaccination for every person.”

Mandating Vaccination

The support for mandating influenza vaccination varies, along with the use of the term. For the purpose of this position statement, AOHP has determined that the term “mandate” means a condition of employment.

The American Academy of Pediatrics (AAP) recommends mandatory Influenza vaccine for all HCP. AAP states, “healthcare associated influenza outbreaks are a common and serious public health problem that contribute significantly to patient morbidity and mortality and create a financial burden on healthcare systems. In its policy statement, AAP recommends that all HCP should be required to receive an annual influenza vaccine. The policy "Recommendation for Mandatory Influenza Immunization of All Health Care Personnel," published in the October 2010 print issue of *Pediatrics* (published online Sept. 13,) states that "despite the efforts of many organizations to improve influenza immunization rates with the use of voluntary campaigns, influenza coverage among HCP remains unacceptably low." Annual influenza epidemics account for 610,660 life-years lost, 3.1 million days of hospitalization and 31.4 million outpatient visits. Flu generates a cost burden of approximately $87 billion per year in the United States. Mandatory influenza immunization for all HCP is "ethically justified, necessary and long overdue to ensure patient safety," according to the statement. "The influenza vaccine is safe, effective and cost-effective, so healthcare organizations must work to assuage common fears and misconceptions about the influenza virus and the vaccine.”

Over the last eight to 10 years, many hospitals and healthcare systems have moved to mandatory vaccination programs. Implementation of mandates has improved vaccination rates in these facilities, typically into the 97th and 98th percentile range. Surveys of staff at the Mayo Clinic and

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the University of Pennsylvania Health System note that 59.3% to 84.6% of HCP in those respective clinics supported a policy that required influenza vaccination for HCP, with exemptions allowed for medical and religious purposes.

APIC recommends that "facilities that employ HCP require annual influenza vaccination as a condition of employment unless there are compelling medical contraindications. This requirement should be part of a comprehensive strategy which incorporates all of the recommendations for influenza vaccination of HCP of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the ACIP for influenza vaccination of HCP. An essential part of this comprehensive strategy includes strict attention to important infection prevention practices such as hand hygiene and respiratory etiquette." [2]

The American College of Occupational and Environmental Medicine (ACOEM) recognizes that "healthcare facilities must employ a comprehensive approach to reduce the risk of influenza transmission in the workplace, encompassing education, vaccination and infection control practices."

AOHP's Position

AOHP is a national association whose members represent thousands of HCP nationwide. AOHP promotes health, safety and well-being for HCP through: advocacy; occupational health education and networking opportunities; health and safety advancement through best practice and research; and partnering with other invested stakeholders.

- In an effort to promote the health, safety and well-being of HCP, AOHP advocates for a policy with the coordination of local, state, and national government that supports mandating influenza vaccination for HCP if the organization cannot reach a 90% compliance rate with a voluntary vaccination program.

- All HCP should be offered the influenza vaccine, at no charge, as long as it is not medically contraindicated.

- AOHP strongly supports that all HCP receive the influenza vaccine based upon an informed decision through education regarding influenza illness, vaccine efficacy and safety, and infection control practices, including CDC recommendations.

- AOHP supports local, state and national policies/recommendations that increase influenza vaccination rates.

- If an organization cannot reach a 90% compliance rate with a voluntary vaccination program, AOHP recommends that the facility evaluate the strategies that have been implemented to increase vaccination compliance rates. In cases where 90% compliance cannot be achieved through voluntary efforts, the organization may need to consider mandating the vaccine.

- AOHP supports that research and evidence-based practice is necessary related to influenza transmission in the healthcare environment and vaccination of HCP. Prompt communication of current study findings to the association and partnering organizations is critical in improving influenza prevention programs.

In summary, AOHP believes that influenza management through vaccination is vital to the protection of patients, and this approach is a cornerstone to minimize absenteeism related to

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influenza in HCP. Occupational health professionals should strongly encourage a comprehensive influenza prevention program within the facilities they serve.

For more information, please call AOHP Headquarters at (800) 362-4347 or e-mail info@aohp.org.

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POSITION STATEMENT

Standards for Adult Immunization Practice

The Association of Occupational Health Professionals in Healthcare (AOHP,) consisting of over 1,000 occupational health nurses, nurse practitioners, physicians and physician assistants, is dedicated to the health, safety, and well-being of healthcare workers. AOHP, through advocacy and education, strongly supports safe administration of immunizations to adults in the healthcare workplace as recommended by the Advisory Committee on Immunization Practices (ACIP) to help prevent serious illnesses, transmission of diseases and minimize absenteeism associated with vaccine-preventable diseases.

AOHP encourages its members and their organizations to adopt the Standards for Adult Immunization Practice and implement the following steps to ensure that adult patients are fully immunized: (1) assess immunization status of all patients in every clinical encounter, (2) share a strong recommendation for vaccines that patients need, (3) administer needed vaccines or refer to a provider who can vaccinate, and (4) document vaccines received by the patients in state vaccine registries. In addition, AOHP advocates for mandates that all healthcare workers be offered ACIP-recommended immunizations at no charge.

AOHP respects the individual healthcare worker's right to make an informed decision regarding vaccinations, and supports healthcare institutions in developing their own policies and practices to immunize their workforce that are consistent with the ACIP recommendations.
AOHP believes that immunization of healthcare workers is essential to their health and the health of their patients. AOHP is committed to promoting ACIP-recommended immunizations for healthcare workers and the Standards for Adult Immunization Practice in healthcare institutions represented by AOHP members.

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POSITION STATEMENT

Respiratory Protection for Healthcare Workers

The health and safety of healthcare personnel (HCP) is the primary function of the Occupational Health Professional (OHP) in healthcare. In order to advocate for worker safety, the OHP must be knowledgeable and competent in a variety of areas related to the health and safety of healthcare workers. One major area is respiratory protection (RP) which is governed by the Occupational Safety and Health Administration's (OSHA) Respiratory Protection Standard 1910.34.

OSHA's hierarchy of hazard prevention and control measures include engineering controls, safe work practices administrative controls and personal protection equipment (PPE). The use of PPE is the last line of protection in the hierarchy of safety controls. Respiratory protection is a form of PPE. In healthcare, the primary use of respiratory protection is for patients who are in isolation airborne precautions. The diseases that most often require respiratory protection include Mycobacterium tuberculosis, rubeola, varicella, disseminated herpes zoster and severe acute respiratory syndrome (SARS). In addition, there have been and will be future emerging infectious diseases, such as Ebola, that have demonstrated the importance of healthcare personnel (HCP) being prepared and competent in the use of personal protective equipment including respirator use.

On August 2, 2011, the Institute of Medicine (IOM) of the National Academies (IOM) published *Occupational Health Nurses and Respiratory Protection: Improving Education and Training - Letter Report.* The report was generated from the IOM Workshop on Respiratory Protection Curriculum for Occupational Health Nursing (OHN) Programs that was held on March 30, 2011 in Pittsburgh, PA. There were seven recommendations that included: 1) conduct a survey of OHNs; 2) achieve and maintain knowledge and skills in RP; 3) expand RP education across all levels of nursing education and training; 4) ensure essential respiratory protection content in OHN graduate curricula and adapt and apply it to continuing education programs and to the education and training of all nurses; 5) develop, expand and evaluate innovative teaching methods and resources to establish best practices; 6) expand online resources, particularly case studies and 7) explore the development of a set of core competencies in RP.

The IOM report led to the formation of an inter-professional advisory group whose task it was to achieve the first two recommendations of the report that was to conduct a survey of OHNs and develop educational materials to achieve and maintain RP knowledge and skills.

Representatives from the National Institute of Occupational Safety and Health's (NIOSH) National Personal Protective Technology Laboratory (NPPTL), the American Association of Occupational Health Nurses (AAOHN), the American Board for Occupational Health Nursing (ABOHN) and AOHP were members of the Respiratory Advisory Group. The Group's initial work was to develop, distribute and analyze an OHN Respiratory Protection survey.

Analysis of the survey led to the development of the Respiratory Protection Competencies for OHNs. To assist in achieving these competencies, an online educational product was developed and is available to OHPs at no cost through the Respiratory Protection Webkit. The Webkit includes a continuing education program and a variety of on-line resources to assist in the development of knowledge in this area of practice. AOHP encourages OHPs who have RP responsibilities to utilize these resources to build competence and comfort in RP.

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AOHP supports the additional work that is being done to develop tools to build the competence of front line HCP who use respiratory protection. Research has shown that HCP do not use personal protective equipment (PPE), including RP properly. The NIOSH NPPTL Respirator Evaluation for Acute Care Hospitals (REACH) Studies I and II revealed the following trends: 1) RP programs exist on paper; 2) HCP provide different responses to questions about RP than hospital/unit managers; 3) HCP are unclear about when to use RP including what type of protective devise should be used and how to properly don/doff the equipment and 4) the focus is on fit testing rather than training with training being less than 15 minutes per year. These results indicate the need for the ongoing development of strategies to educate frontline HCP and implement successful RP programs in healthcare settings. Ongoing NIOSH research is supported to analyze PPE use by HCP and the development of a respirator that will provide both protection and comfort for the HCW.

The Joint Commission has also recognized the importance RP in healthcare. AOHP supported their collaborative work with the Centers for Disease Control (CDC)/NIOSH/NPPTL and a Technical Expert Panel in developing a monograph, *Implementing Hospital Respiratory Protection Programs: Strategies from the Field,* to describe successful RP implementation strategies in the field. The free monograph, published in May 2015, is intended to stimulate greater awareness and knowledge of the importance of effective respiratory protection programs in hospitals as well as to assist in common implementation challenges. One of the most challenging aspects of an effective RP program is annual fit testing. The monograph offer case studies with strategies related to annual fit testing as well as comparisons of Joint Commission standards and OSHA's RP Standard. Lastly, this monograph serves as a companion document with the National Respiratory Protection Toolkit that is described below.

On May 14, 2015, OSHA in conjunction with CDC/NIOSH released the national "*Hospital Respiratory Protection Program Toolkit Resources for Respiratory Protection Administrators*". This online tool is another free resource that provides information on why hospitals need RP programs, types of respirators and how to develop a RP program that meets OSHA requirements.

Building the RP competence of the OHP and front line HCP will better equip healthcare to be prepared for any airborne illness, whether it is an illness that is well known or whether it is an emerging airborne infectious disease. AOHP supports training strategies that will build the competence of the HCP in the use of PPE, specifically RP. AOHP will continue to support and participate in these national efforts to build a culture of safety in the healthcare setting.

Resources

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POSITION STATEMENT

Workplace Violence

Workplace violence (WPV) can range from offensive or threatening language to homicide. The National Institute for Occupational Safety and Health (NIOSH) defines WPV as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. The Association of Occupational Health Professionals in Healthcare (AOHP) is concerned about escalating WPV events, which are too often viewed as “part of the job”. Healthcare employers must adopt a zero tolerance approach to all types of WPV.

WPV Injury Data

In 2014, the Healthcare and Social Assistance sector sustained WPV injuries at an estimated injury rate of 8.2 per 10,000 full-time workers, a rate over four times higher than full-time employees in the private sector. Psychiatric hospitals had WPV injury rates 64 times higher than private industry, while nursing and residential care facilities had rates 11 times higher than private industry. Seventy-nine percent of the violent injuries were caused by interactions with patients. Although the vast majority of events are non-fatal, there were 14 fatal events due to homicide in the sector. Healthcare workers (HCWs) who provide direct care have a high risk for WPV due to the populations they serve, including those who may have altered mental status related to the influence of drugs and alcohol, psychiatric disorders, pain, multiple psychosocial stressors or grief.

Prevention - Comprehensive Approach

AOHP supports implementing comprehensive violence prevention programs to decrease WPV. These programs would be risk specific to the healthcare organization or facility. A comprehensive violence prevention program must include: a written program; management commitment; employee participation; hazard identification; safety and health training; and hazard prevention, control and reporting. Periodically, it is critical that the healthcare organization’s violence prevention program be evaluated and updated. These violence prevention programs need to address co-worker or lateral violence, as well.

Facility leadership support is key to the success of WPV prevention efforts. An individual should be identified to lead the WPV Prevention Team and be given the time and resources to develop and implement the program. This would include conducting the risk assessment and writing the formal program. The leader of the team must be able to work with a variety of professionals and disciplines to develop the program.

In some acute care settings, WPV prevention efforts may be delegated to the facility Safety/Environment of Care Committee or the Emergency Preparedness Committee. Depending on the size of the facility, a separate WPV Prevention Committee may be needed and should be staffed with an inter-professional team. Disciplines that should be represented, regardless of the WPV prevention structure, include Safety, Risk Management, Security, Emergency Department, Communication, Education, Occupational Health and Human Resources, at a minimum. Organizational mental health experts should also be part of the committee if their services are provided by the facility, or these experts could participate as consultants. In addition, collaboration with local law enforcement should be considered in developing the plan.

Employee participation and education is another key element in a successful program. All employees should be educated about the organization’s WPV policy at the time of hire, receive additional training if working in an identified high risk area and, at a minimum, have annual

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training or more frequent training as indicated. Initial training should include a review of the WPV policy (zero tolerance) emphasizing that these acts are not “part of the job”, to whom to report these events and how to take concerns through the chain of command if not satisfactorily managed by the immediate supervisor. A combination of online and face-to-face training should be utilized to ensure that the employee understands the department-specific risk and the importance of reporting WPV events. One example of employee participation is the designation of departmental safety champions. The champions are front-line staff trained to work with their managers to support the facility policy to report all WPV and to serve as a staff resource when WPV questions arise. In addition, safety champions can become staff trainers using the train-the-trainer model.

A centralized method of reporting WPV is critical for the facility to have a clear picture of the extent of WPV events. Online reporting programs can assist in the tracking and trending of events and injuries. WPV injuries should be reported following the facility’s reporting procedure. At a minimum, all injuries should be reviewed on a monthly basis. All Occupational Safety and Health Administration (OSHA) recordable injuries should have a root cause analysis completed within 48 hours. The findings of the root cause should be shared with staff to prevent further injuries and actions implemented to prevent further events. As the injury data is analyzed, trends need to be identified, and follow-up with managers needs to occur to develop action plans to prevent further injuries.

Prevention Strategies

Case reports of prevention strategies that have reduced WPV in the healthcare setting include installing metal detectors at Emergency Department entrances, establishing a violent patient database, hiring department-based security officers and limiting visitor access to specific floors or areas via a GPS tracking badge. Personal staff alarm devices have also increased security for staff. AOHP supports and encourages healthcare organizations to endeavor to protect their patients, employees and visitors from acts of violence, as well as to advocate for further research on prevention strategies for WPV.

Home health staff are in unique and often uncertain environments when they visit patients in their homes. Home health agencies should have established policies and procedures for staff to follow if the staff would feel that their safety is at risk. These types of interventions may not be feasible, especially for small organizations. Interventions must be tailored to the environment and the identified risks.

AOHP looks to national organizations such as NIOSH to identify evidence-based best practice strategies for the variety of healthcare settings that may experience WPV. OSHA has included some of these strategies in the Federal Register notice for a possible WPV standard.

Working with Partners

AOHP will continue to advocate for violence-free workplaces, participate in the regulatory process and seek collaborative opportunities with organizations such as The Joint Commission (TJC) that are focused on decreasing WPV events. Although it does not have a specific WPV prevention standard, TJC has recognized the significance of this issue for all individuals involved in healthcare and has taken action to increase the safety of patients, staff and visitors.

In July 2008, TJC’s Sentinel Event Alert #40, *Behaviors That Undermine a Culture of Safety,* first addressed this critical issue. TJC issued Sentinel Event Alert #45 in June 2010 on *Preventing Violence in the Healthcare Setting*. In the alert, TJC sited the Environment of Care standard that requires a safe environment for patients, staff and visitors. Lastly, TJC published a free WPV

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resource portal on its website in February 2017, *Teaming Up Against Workplace Violence*. The purpose of the portal is to support healthcare organizations in preventing, preparing for and mitigating the impact of WPV.

Through AOHP's Memorandum of Understanding with NIOSH, AOHP was a participant in the development of the NIOSH online educational program *Workplace Violence Prevention for Nurses*. Identifying research opportunities through the major sites within the NIOSH National Occupational Health Research Agenda Healthcare and Social Assistance sector may be a strategy to identify additional WPV prevention strategies.

AOHP responded to OSHA's request for information regarding a possible WPV standard in April 2017. The association supports the attention of TJC, OSHA, and other accrediting and federal agencies to this serious problem and will continue efforts to decrease WPV risks for all healthcare workers.

AOHP will support opportunities to identify evidence-based prevention strategies by participating in ongoing research efforts and contributing to education and training projects for healthcare workers to decrease WPV events.

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POSTITON STATEMENT

Best Practices for Healthcare Worker Immunizations

The Association of Occupational Health Professionals in Healthcare (AOHP), consisting of over 1,000 occupational health professionals, encourages its members and their organizations to adopt practices to ensure that healthcare workers be assessed for immunization status and properly immunized against vaccine preventable communicable diseases. These vaccines should be offered at no charge and must comply with state and federal regulations.

To assist members with questions regarding vaccines, AOHP reviewed the current Advisory Committee on Immunization Practices (ACIP) recommendations and current practices to develop this position statement documenting immunization best practices for healthcare workers. Note that the use of trade names for vaccines in this document is for identification purposes only and does not imply endorsement by AOHP.
A healthcare worker is defined as any paid or unpaid person working in any healthcare setting, including home health.

Hepatitis B

Healthcare workers should complete the hepatitis B vaccination series with two or three doses of hepatitis B vaccine (HepB), depending on the vaccine*, and have serologic evidence of immunity to hepatitis B (HBsAB).

A healthcare worker who does not have immunity to hepatitis B should complete the HepB series and have serology done one to two months after completing the series. If the serology is negative or indeterminate (<10 mIU/mL, refer to package insert), administer another dose of HepB and test for serology one to two months later. If the negative or indeterminate serology persists, complete a second HepB series and recheck the serology. Alternatively, one can complete a second HepB series and check the serology one to two months after the last dose. If the serology remains negative or indeterminate, the healthcare worker is considered susceptible to hepatitis B virus infection and should be counseled about precautions to prevent hepatitis B virus infection and the need for hepatitis B immunoglobulin post-exposure prophylaxis for known or likely exposure to hepatitis B virus. An HBsAg should also be drawn on the individual to determine the current status of hepatitis B.

No more HepB vaccines shall be administered.

A healthcare worker who does not have immunity to hepatitis B and refuses vaccination must be counseled as above for hepatitis B susceptibility and provide a declination statement.
*Three doses of aluminum-adjuvanted HepB (HepB-alum [Engerix-B, Recombivax HB]) or hepatitis A and hepatitis B combination vaccine (HepA-HepB [Twinrix]) at zero, one, and six months, or two doses of Cytosine-phosphate-Guanine-adjuvanted HepB (HepB-CpG [Heplisav-B]) one month apart.

MMR

Healthcare workers should have immunity to measles, mumps, and rubella. Evidence of immunity for healthcare workers is documentation of receipt of measles, mumps, and rubella vaccine (MMR [M-M-R II]) or serologic evidence of immunity or disease.

For a healthcare worker born in 1957 or later who does not have immunity: to measles, administer two doses of MMR at least four weeks apart; to mumps, administer two doses of MMR at least

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four weeks apart; to rubella, administer one dose of MMR. For a healthcare worker born before 1957 who does not have serologic evidence of immunity, consider administering MMR as above.

In the rare instance when the serology to measles, mumps, or rubella is negative but the healthcare worker has documentation of vaccination, whether to vaccinate or not will be based on individual clinical decision. There is no recommendation or general policy for a case like this.

A healthcare worker who does not have immunity to measles, mumps, or rubella and refuses vaccination should provide a declination statement and not be engaged in direct or indirect patient care.

Varicella

Healthcare workers should have immunity to varicella. Evidence of immunity for healthcare workers is documentation of receipt of two doses of varicella vaccine (VAR [Varivax]) or varicella-containing vaccine (childhood combination vaccines), diagnosis or verification of history of varicella or herpes zoster by a qualified healthcare provider, or laboratory evidence of immunity or disease.

For a healthcare worker who does not have immunity to varicella, administer two doses of VAR four to eight weeks apart. If the healthcare worker previously received one dose of VAR, administer one dose of VAR.

A healthcare worker who does not have immunity to varicella and refuses vaccination should provide a declination statement and not be engaged in direct or indirect patient care.

Tdap and Td

Healthcare workers should be current on tetanus, diphtheria, and pertussis vaccination. For a healthcare worker who did not receive tetanus, diphtheria, and acelluar pertussis vaccine (Tdap [Adacel, Boostrix]) as an adult or child (Tdap is routinely recommended at age 11–12 years, and catch-up vaccination is recommended for adults who did not receive Tdap as a child), administer a dose of Tdap (to boost immunity to pertussis) regardless of when the last dose of Td was administered. Resume Td booster every 10 years after Tdap.

Pregnant women should receive one dose of Tdap during each pregnancy, preferably in the early part of gestational weeks 27–36 weeks.

A healthcare worker who refuses Tdap should be counseled on pertussis susceptibility and its transmission, not be engaged in direct or indirect patient care, and provide a declination statement. A healthcare worker who refuses Td should provide a declination statement and be counseled for post-exposure prophylaxis and wound management for tetanus.

Influenza

Healthcare workers should be vaccinated against influenza annually. Healthcare administrators may consider a policy that makes annual influenza vaccination mandatory (with medical exemptions) or offer alternatives to vaccination such as requiring the use of surgical masks for patient care by healthcare workers who refuse the vaccine.

Any age-appropriate inactivated influenza vaccine (IIV [several brands]), recombinant influenza vaccine (RIV [Flublok]), or live attenuated influenza vaccine (LAIV [FluMist]) may be used*. Healthcare workers who care for severely immunocompromised patients should not receive LAIV. If LAIV is received, the healthcare worker should avoid contact with severely immunocompromised patients for seven days after receiving LAIV.

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*A list of current influenza vaccines is available at www.cdc.gov/flu/protect/vaccine/vaccines.htm.

Meningococcal

Healthcare workers, i.e., microbiologists, who are routinely exposed to isolates of *Neisseria meningitides* should be vaccinated with one dose of serogroups A, C, W, and Y meningococcal vaccine (MenACWY [Menactra, Menveo]) and revaccinate every five years if the risk remains, and two or three doses of serogroup B meningococcal vaccine (MenB [Bexsero, Trumenba]), depending on the vaccine*.

*Two doses MenB-4C (Bexsero) at least one month apart or three doses MenB-FHbp (Trumenba) at zero, one to two, and six months.

Other vaccines routinely recommended for adults based on age, medical conditions, or other indications which may not be available through Employee/Occupational Health include zoster (RZV or ZVL), human papillomavirus, pneumococcal (PCV13 and PPSV23), hepatitis A, and *Haemophilus influenzae* type b vaccines. Remind employees to consult with their own healthcare providers if these vaccinations are not offered through Employee/Occupational Health.

AOHP is committed to promoting recommended immunizations for healthcare workers and the Standards for Adult Immunization Practice in healthcare organizations represented by AOHP members.

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