EP 30: The structure(s) and process(es) used by the organization to improve workplace safety for nurses, based on recommendations such as the ANA’s Safety Patient Handling and Movement

Massachusetts General Hospital (MGH) has demonstrated a long-term, ongoing commitment to providing a safe working environment for all employees. MGH embraces the value that employees are the Hospital’s most valuable asset and the recruitment and retention of skilled employees is essential to achieving its mission. A workplace safety infrastructure that includes the Occupational Health Service (OHS), Infection Control Department, and the MGH Environmental Health and Safety Office (EH&S), along with a comprehensive network of oversight committees, sustains a safe working and practice environment and promotes a culture of workplace safety.

Workplace safety is supported at all levels of the organization. Key workplace safety indicators are viewed as an important measure of institutional quality and safety performance. In 2011, the employee influenza vaccination rate and the annual occupational injury and illness rate were selected as quality and safety measures significant enough to be added to the MGH Quality and Safety Dashboard (attachment EP 30.a).

The MGH approach to workplace safety is goal- and outcomes-oriented. Workplace safety is assessed on a continuous basis. Employee injury and illness data, as well as state and national occupational safety guidelines, are used to identify annual performance goals.

Occupational Health Service

The mission of the OHS is to provide occupational health services to the workforce to protect and promote the health, safety, and well-being of employees and their work environment. The OHS has a strong leadership foundation that includes two Physicians who are board certified in Occupational and Environmental Medicine and three Advanced Practice Nurses (APNs) who are certified as Occupational Health Nurse Specialists (COHN) by the American Association of Occupational Health Nurses; all have extensive work experience in occupational health. The OHS is staffed with a Program Manager for Ergonomics and a Staff Ergonomist who provide a specialized focus in safe patient handling. In addition to the program leadership, occupational health care is provided to the MGH employee population by a team of nine Nurse Practitioners, four of whom are certified as COHN, and four Staff Nurses. The OHS is available to employees on a twenty-four hour, seven day a week basis either through the occupational health clinic or by accessing an on-call Nurse Practitioner.

The OHS develops, utilizes, and regularly reviews clinical protocols specific to occupational health practice. There are eighty-three occupational health clinical protocols and standing orders detailing the evaluation and care of common occupational health presentations including environmental exposures, blood and body fluid exposures and other infectious disease exposures, occupational injuries and illnesses, and preventative care (attachment EP 30.b). These protocols establish evidence-based practice within the OHS and are developed utilizing guidelines and recommendations from the following:

- Advisory Committee on Immunization Practices (ACIP)
- Association for Professionals in Infection Control and Epidemiology (APIC),
- Boston Public Health Commission (BPHC), Centers for Disease Control (CDC)
- Department of Transportation (DOT)
- Massachusetts Department of Public Health (MDPH)
- National Guideline Clearinghouse (NGC)
National Institute of Occupational Health and Safety (NIOSH)
Occupational Health and Safety Administration (OSHA).

The Occupational Health Service works closely and collaboratively with many MGH departments to promote workplace safety. Most notably, the OHS coordinates activities and goals with the Infection Control Unit and the MGH Environmental Health and Safety Office, as there is frequent overlap in overseeing and executing elements of the workplace safety program.

The OHS also works with Human Resources to develop, review, and revise Human Resource Policies that support and promote workplace safety and organizational compliance with health and safety standards. These policies are reviewed at least every two years or more frequently when a health and safety standard is newly established or has been modified. Currently, the following policies are in place (attachment EP 30.c):

- Flu Vaccination of Employees (attachment EP 30.c.1)
- Health and Safety (attachment EP 30.c.2)
- Motor Vehicle Operator Safety (attachment EP 30.c.3)
- Substance Abuse (attachment EP 30.c.4)
- Work Health Clearance (attachment EP 30.c.5)

Infection Control Program

The MGH Infection Control Program is managed by the Infection Control Unit staff consisting of three Infectious Disease Physicians acting as Hospital Epidemiologists, a Nurse Director who is a Certified Infection Preventionist (IP), five nurses who are Certified Infection Preventionist (IP), a nurse Hand Hygiene Program Manager, a Data Manager and an Administrative Assistant. The Infection Control Program consists of organization-wide activities to identify risks for acquisition and transmission of infections in patients, visitors and employees; develop and implement policies and procedures to reduce or minimize risk in order to prevent infections; and detect and control transmission of identified infections. The components of the Infection Control Program are:

- Education
- Infection surveillance
- Outbreak/exposure investigations
- Process surveillance
- Policies related to infection prevention activities
  - Isolation precautions
  - Hand Hygiene
  - Sterilization and disinfection
  - Environment of care
- Reporting to public health authorities

The work of the Infection Control Unit is overseen by the MGH Infection Control Committee (ICC). The ICC is interdisciplinary, representing administrative and clinical areas of MGH and its satellite facilities, including representatives from the Medical Staff, including house staff, Administration, Patient Care Services, Compliance Office, Microbiology, support services (e.g. Sterile Supply, Materials Management, Pharmacy, Building and Grounds, and the Infection Control Unit staff). ICC minutes for February 12, 2012 are provided as attachment EP 30.d.

Environmental Health and Safety Department

The mission of the EH&S is to ensure the safety of patients, visitors, and staff in all MGH locations. This is accomplished by leading and supporting programs and activities described in the hospital’s Safety Management Plan that:

- Provide an environment free of recognized hazards
- Effectively manage behavior-based risks of workplace-related injury and illness
- Train personnel to interact safely with all aspects of their work environment
- Avoid property losses
- Mitigate adverse internal or external environmental impacts

The EH&S utilizes a number of data collection and operational monitoring activities to identify hazards across all sectors of the hospital, with a priority focus on patient care delivery areas and a specialized focus on support and research locations. This safety management strategy requires collaboration with several other hospital departments that include:

- Patient Care Services
- Infection Control Unit
- Occupational Health Services
- Center for Quality and Safety
- Biomedical Engineering
- Facilities Engineering
- Building and Grounds
- Emergency Department
- Human Resources
- Other support service departments

The EH&S program supports safety management at the both the unit level, where location-specific hazards are managed, and at the hospital level, where organizational trends and sentinel events are considered and reviewed by multidisciplinary committees. EH&S leadership and staff are members of the hospital’s Safety Committee and Environment of Care Committee. Safety Committee minutes for March 6, 2012, which include a report from the OHS are included as attachment EP 30.g.

When hazards in the workplace are identified, multidisciplinary teams are formed to conduct risk assessments, which, based on probability and severity considerations, lead to management decisions regarding implementation of preventive and/or corrective measures. The EH&S then provides oversight to assure continued efficacy of remedial efforts. EH&S staff provide operational and consulting support to technical program areas that require a focus on maintaining patient and employee safety, which include:
• Fire Management - emphasizes on prevention, preparedness and response
• Chemical Safety - focuses on chemical hazard communication at the departmental level, controlling individual exposures to hazardous materials, responding effectively to chemical spills and proper disposal of chemical materials
• Emergency Management - supports mitigation, preparedness, response and recovery activities, particularly with respect to hazardous materials incidents, fire and mass evacuation scenarios
• Construction Safety - assures work sites are properly separated from patient care activities and managed to exert no discernible impact of continuing clinical activities
• Environmental Safety - assures that safety and health parameters for indoor air quality are properly assessed and addressed and that the effects of other environmentally-related factors such as noise and vibrations are mitigated and minimized

In this structure, coordination and collaboration between departments is essential. The OHS and the Infection Control Unit work jointly to develop and review protocols utilized by the OHS to evaluate, treat and/or quarantine employees who have been exposed to an infectious disease. These two departments also work together to review and execute the MGH TB and Blood Borne Pathogen Exposure Control Plans. One OHS Nurse Practitioner is designated as the primary liaison between the OHS and Infection Control Unit to streamline communications and track information and outcomes related to infectious exposures.

A well-defined process with clear roles and expectations is utilized when an infectious exposure is identified. An Infection Control Practitioner (ICP) identifies the exposure, based on a patient’s clinical presentation and lab data. The ICP reviews patient documentation and contacts managers in the identified care areas so that a list of employees with contact to the source patient is developed. The list is shared with the OHS whose responsibility is to contact the employees to counsel them regarding the risk of exposure and recommend actions, which might include prophylactic treatment and/or quarantine. The OHS and Infection Control Unit maintain a shared report on each exposure that includes outcome data. The Infection Control Unit conducts a final review of the exposure to identify possible areas for improvement, for example precaution techniques, work practices, or the need for employee education regarding the clinical criteria to be used to recognize that a patient may be infectious. An exposure report for a rabies exposure that occurred in September 2011 is included to illustrate the exposure investigation process (attachment EP 30.h).

The OHS and Infection Control Unit provide quarterly reports to the Infection Control Committee on the following related employee activity and outcomes:
• Sharps exposure incidence
• Incidence by device type
• Incidence by employee jobs and work areas
• TB screening and conversion outcomes
• Employee infectious disease incidence and trends
• Occupational exposure incidence and trends
• Influenza vaccination rates (during influenza season)

The OHS works collaboratively with the MGH Safety Office to promote a safe practice and work environment for employees. The OHS and the Safety Office combine their knowledge and
expertise to manage air quality concerns, potential bio-safety issues, and exposures, including but not limited to noise, asbestos, and chemicals. An example of this shared responsibility is the medical clearance, fit testing, and provision of respirators that protect employees against tuberculosis, Severe Acute Respiratory Syndrome (SARS), and influenza. The OHS medically screens employees for respirator use while the Safety Office provides fit testing and training. This collaboration was essential during the summer and fall of 2009 when MGH experienced the H1N1 influenza and epidemic. During that time, the OHS and the Safety Office worked with the Infection Control Unit and the Department of Nursing to identify the practice areas likely to evaluate and treat patients infected with H1N1 influenza and identify, medically screen and fit test any employees in those areas that were not currently medically cleared and fit tested for a N95 or PAPR respirator. Leadership in the practice areas were notified of the employees needing clearance and fit testing. The OHS and the Safety Office then set up “respirator clinics” in various locations around the MGH to ensure employees had accessibility to health clearance and fit testing. As a result, 614 employees were cleared and fit tested and all employees in the identified practice area were able to use a respirator for protection if needed.

The OHS conducts routine and systematic surveillance of all occupational injuries, illnesses and exposures. Safety occurrence reports related to employee injuries, exposures, and/or possibly unsafe working conditions are flagged in the MGH Safety Reporting System and e-mail notification is sent to the OHS. A member of the OHS staff is assigned to review and, if appropriate, follow-up on each occurrence report. The OHS clinical staff members meet weekly to collectively examine all recent reports in an effort to identify short-term trends related to occupational injuries/exposures and to determine whether additional evaluation or intervention is needed. On a quarterly basis, OHS reports the incidence of employee slips, trips, and falls via the Environment of Care dashboard, the incidence and type of infectious exposures to the Infection Control Committee, and tracks the OSHA injury rate through the Workers’ Compensation Report Card. On an annual basis, a summary of occupational injuries/illnesses is compiled using annual OSHA data and is reported to the MGH Safety Committee. This annual report is also used to identify problem areas and develop interventions and goals for the next Calendar year.

The OHS participates in the several committees which help to form the health and safety infrastructure, including the Safety Committee, Infection Control Committee, Safe Patient Handling Committee, Hazardous Drug Task Force, Indoor Air Quality Committee, Needlestick Reduction Task Force, TB Task Force and the Council in Disability Awareness.

In addition to committee participation, the OHS formally reports occupational exposure, injury, and illness trends to the MGH Chiefs Council (attachment EP 30.i), Infection Control Committee (attachment EP 30.j), and the Safety Committee (attachment EP 30.k). Annually, the OHS reviews outcome measures of workplace safety to establish program needs and workplace safety goals. These outcome measures include:

- Rates of immunity and/or vaccination for Hepatitis B, Influenza, Measles, Mumps, Rubella, Pertussis, and Varicella
- Compliance rate of TB screening, number of TB exposures, and the TB conversion rate for routine and exposure screening
- Incidence and types of exposures to infectious diseases
- Incidence and types of exposures to chemicals
- Rate of direct care providers cleared and fitted for N95 respirators
- Prevalence, incidence, and rate of latex allergy and contact dermatitis
- Incidence and type of exposures to sharp devices and rate of exposure per 100 FTE
- Rate of occupational injury and illness and the incidence of lost and restricted workdays
- Incidence and type of injuries
- Incidence and type of events related to workplace violence

Based on outcome measures and identified areas for improvement, the OHS develops annual program goals to improve or further promote the safety of the practice environment. These goals and the identified outcome measure(s) to achieve these goals are reviewed quarterly by the OHS leadership. Workplace safety goals for 2010 and 2011 are listed in the tables that follow:

<table>
<thead>
<tr>
<th>2010 Occupational Health Program Goals</th>
<th>Rationale for Goal</th>
<th>Goal Measurement Methodology/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the rate of seasonal influenza vaccination among all hospital employees to 75% and direct care providers to 80%</td>
<td>The need to increase the vaccination rate is increasingly important due to H1N1 activity and newly promulgated state regulations related to mandatory vaccination or declination for all employees.</td>
<td>Vaccination rates obtained as determined by OHS database reports. 71% of all employees and 78% of direct care providers were vaccinated against seasonal influenza; vaccine outcomes were influenced by a vaccine shortage and by dual circulating vaccine strains.</td>
</tr>
<tr>
<td><strong>Goal #2</strong></td>
<td></td>
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<tr>
<td>Increase the rate of Tdap vaccination among ED physicians and nursing staff to 60% or higher</td>
<td>While there has been some gain in vaccination rates the increase has not been high enough to ensure the potential for pertussis transmission is reduced in the ED.</td>
<td>Vaccination rates obtained as determined by OHS database reports. 71% of ED physicians were vaccinated with Tdap but only 41% of nursing staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2011 Occupational Health Program Goals</th>
<th>Rationale for Goal</th>
<th>Goal Measurement Methodology/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve program management of surveillance programs to obtain 100% compliance for mandated surveillance programs for hearing conservation, day care clearance, asbestos exposure, and driver clearance.</td>
<td>Due to changes in program oversight compliance decreased below an acceptable rate. This surveillance is mandated by OSHA and/or other regulatory/accrediting agencies. Management of these programs must be revamped to obtain the necessary compliance to meet standards.</td>
<td>Assess and overhaul program management so as to demonstrate 100% compliance with required screening for these groups as determined by OHS database review. 100% compliance achieved.</td>
</tr>
<tr>
<td>Goal #2</td>
<td>Implement a plan established by OHS to meet changes in MMR standards set forth by the Massachusetts Department of Public Health.</td>
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<tr>
<td></td>
<td>There continue to be sporadic outbreaks of measles, mumps, and German measles which are of concern to public health, infection control, and OHS professionals. Recent DPH guidelines require 2 MMR for immunity and many of the long-term staff do not meet this new guideline and may be at risk of infection. While an outbreak is considered to be of low probability its impact on the hospital would be significant.</td>
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<tr>
<td></td>
<td>Obtain 100% compliance with the DPH guideline in all maternal and newborn areas, capture employees needing an additional MMR or screening during other OHS visits as well a new hires, and develop a plan based on final numbers of how to reach other employees.</td>
<td></td>
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<tr>
<td></td>
<td>100% compliance obtained in all maternal/newborn areas, all employees visiting OHS are being screened, and a plan was developed so that over a two year period remaining employees will be screened.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal #3</th>
<th>Improve OHS ability to identify individuals in Patient Care Services needing annual TB screening and attain improved compliance with screening.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not all employees in Patient Care Services have contact with patients and require an annual TB screening. It would be more effective to identify those employees who based on work area and job duties need annual screening so that efforts to attain a high rate of compliance with screening can be focused on them.</td>
</tr>
<tr>
<td></td>
<td>Implement a process to target all clinical employees in Patient Care Services department. This includes weekly email reminders to them when their annual TB screening is due in 4 weeks and then again in 2 weeks. Additionally, managers are sent a report each month that lists their employees who are overdue for screening.</td>
</tr>
<tr>
<td></td>
<td>Process fully implemented.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal #4</th>
<th>Refocus on Tdap vaccination for very high risk and high risk providers.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>While the MGH made progress with this goal in prior program years, last year the goal took a back seat to H1N1 influenza. While many very high risk and high risk providers have been vaccinated there remains opportunity to increase these rates as only about 50% of each group are vaccinated.</td>
</tr>
<tr>
<td></td>
<td>Improve the vaccination rate among these groups by at least 15% as demonstrated by OHTS report.</td>
</tr>
<tr>
<td></td>
<td>Achieved a gain of 5% despite outreach efforts and accessibility to vaccination. One limitation is that vaccination provided outside of the OHS is not being captured; will identify ways to capture outside</td>
</tr>
</tbody>
</table>
**Goal #5**  
Increase the rate of influenza vaccination among all hospital employees to 80% and direct care providers to 90%  

Influenza vaccination continues to be highly valued as the most effective means of protecting employees and patients during influenza season. Despite an increased rate of vaccination achieved during the prior season there is a need to further increase vaccination rates.  

Vaccination rates obtained as determined by OHS database reports  

83% of all employees and 91% of direct care providers were vaccinated.

<table>
<thead>
<tr>
<th>2012 Occupational Health Program Goals</th>
<th>Rationale for Goal</th>
<th>Goal Measurement Methodology/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #1</strong></td>
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</tbody>
</table>
| Increase the rate of seasonal influenza vaccination among all hospital employees to 90% and direct care providers to 95% | While vaccination rates have steadily increased over the past few years in response to increased organizational efforts, there is continued need to reach higher vaccination rates to reach herd immunity and gain the most protection for employees and patients. | Vaccination rates obtained as determined by OHS database reports  
91% of all employees and 95% of direct care providers were vaccinated against seasonal influenza |
| **Goal #2**                           |                   |                                     |
| Refocus on Tdap vaccination for direct care providers in maternal/infant areas | Despite prior efforts and a continued occupational health program goal, the Tdap vaccination goal has not yet been achieved in this provider group. More efforts to increase vaccination are required given that the neonatal population is most at risk of morbidity and mortality if infected with pertussis. | Vaccination rates obtained as determined by OHS database reports  
Vaccination rates for direct care providers in maternal/infant areas ranged from 46% - 100% with a mean rate of 65%. The vaccination rate for this group of providers increased by 10% from 2011 |
<p>| <strong>Goal #3</strong>                           |                   |                                     |
| Further reduce the potential for exposure to sharp devices by decreasing the availability and use of non-safety sharp devices through inventory | While in 2011 significant gains were made in reducing and securing the use of non-safety sharps, there is a continued need to build on | Trial conducted of safety scalpels in at least two clinical areas, review of all waivers on file, and introduction of a new 16 gauge safety needle. |</p>
<table>
<thead>
<tr>
<th>2012 Occupational Health Program Goals</th>
<th>Rationale for Goal</th>
<th>Goal Measurement Methodology/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>control and expanding the inventory of safety devices</td>
<td>these efforts to further reduce the incidence of exposures via ongoing waiver management and user testing of safety scalpels and other sharps associated with continued exposures.</td>
<td>Safety scalpel trialed in Pathology which has now fully implemented use of the device. Dermatology and Dental Services are scheduled to trial the safety scalpel later this year. Sixteen gauge safety sharp introduced after positive user trial results, and 100% of waivers on file reviewed and 15 newly reviewed waivers filed.</td>
</tr>
</tbody>
</table>

In addition to the OHS goals listed above, a number of workplace safety initiatives have been the focus of attention over the past two years, including: 1) Safe Patient Handling and Nursing Ergonomic Initiatives, 2) the Be Well Work Well Program, 3) the Employee Influenza Vaccination Program, and 4) the Sharps Exposure Reduction Program. Detailed descriptions of this work and the associated outcomes are included in EP 30 EO.
Keeping Employees Safe

Healthcare employees encounter a range of potential hazards in the hospital environment, including exposure to infectious diseases and musculoskeletal injuries from lifting. As a healthcare employer, Massachusetts General Hospital (MGH) values its employees and is committed to providing a safe environment for them. There is growing evidence that providing a safe work environment for employees corresponds with a safer patient environment.

One important measure of a safe work environment is the employee injury rate. The Occupational Health and Safety Administration (OSHA) requires that annually employers report the rate of employee injuries and illnesses per 100 full-time employees (FTEs).

Influenza is also of concern in the healthcare environment and the vaccination rate of hospital employees is another important measure of a safe work environment. Achieving high rates of vaccination among hospital employees has been demonstrated to reduce employee absenteeism, protect patients, and reduce overall healthcare costs. Since 2009, the Massachusetts Department of Public Health (MDPH) requires that all hospital employees be offered flu vaccination and either be vaccinated or decline the vaccine. Additionally, hospitals are required to report their rate of employee influenza vaccination to the MDPH each year.

Click on any of the measure names below to see a detailed description of the measure, our performance over time and what we are doing to improve. On the chart below, hover your mouse over the data columns or icons to see more information.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Our Current Performance</th>
<th>Comparison Group</th>
<th>How We Compare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (Flu) Vaccination Rate</td>
<td>81.1%</td>
<td>61.4%</td>
<td></td>
</tr>
<tr>
<td>Employee Influenza Vaccination Rate</td>
<td>81.1%</td>
<td>61.4%</td>
<td></td>
</tr>
<tr>
<td>OSHA Illness/Injury Rate</td>
<td>4.1</td>
<td>7.0</td>
<td></td>
</tr>
</tbody>
</table>
**MGH OCCUPATIONAL HEALTH SERVICE CLINICAL GUIDELINE LISTING**

**VACCINATION PROTOCOLS/STANDING ORDERS**
- Hepatitis A vaccination
- Hepatitis B vaccination
- Hepatitis B vaccination standing order
- Influenza vaccination
- Influenza vaccination standing order
- Meningococcal vaccination
- MMR vaccination
- MMR vaccination standing order
- Rabies vaccination
- Tetanus containing vaccination
- Tetanus Containing vaccine standing order
- Vaccination general guidelines
- Varicella vaccination
- Varicella vaccination standing order

**OCCUPATIONAL INJURY/ILLNESS PROTOCOLS**
- Anaphylaxis
- Anaphylaxis standing order
- Animal bite
- Ankle pain
- Burns
- Dermatitis
- Elbow pain
- Electrical shock
- Hand and wrist pain
- Head injury
- Knee pain
- Latex allergy
- Lacerations
- Low back pain initial
- Low back pain follow-up
- Neck pain
- Rescue inhaler
- Shoulder pain
- Subungual hematoma
OCCUPATIONAL SURVEILLANCE PROTOCOLS
- Asbestos exposure
- Cadmium exposure
- Color vision screening for point-of-care testing
- Daycare worker screening and clearance
- Driver screening and clearance
- Ethylene Oxide exposure
- Fitness for duty assessment
- Family medical leave act certification review
- Formaldehyde exposure
- Hearing conservation screening
- Laser surveillance
- Lead exposure
- Pre-placement screening
- Respirator clearance
- TB screening
- Work clearance

INFECTIOUS EXPOSURES/DISEASE PROTOCOLS/STANDING ORDERS
- Bacterial exposure
- Conjunctivitis
- Contact with research animals
- Dengue fever
- Diphtheria exposure assessment and treatment
- Exposure to blood borne pathogens
- Exposure to Herpes B Simian virus
- Group A Strep carrier assessment and treatment
- Group A Strep carrier treatment standing order
- Hepatitis A exposure assessment and prophylaxis
- Hepatitis A prophylaxis standing order
- Herpes simplex
- HIV Testing
- HIV post-exposure prophylaxis standing order
- Influenza exposure assessment and prophylaxis
- Influenza exposure prophylaxis standing order
- Latent TB Infection Assessment and Treatment
- Lice exposure
- Lice treatment standing order
- Measles exposure
- Meningococcal exposure
- Meningococcal standing order
Attachment EP 30.b continued

- MRSA carrier assessment and treatment
- Mumps exposure
- Norovirus exposure
- Parvovirus B19 exposure
- Pertussis exposure assessment and prophylaxis
- Pertussis exposure prophylaxis standing order
- RSV exposure
- Salmonella exposure
- Scabies exposure and treatment
- Scabies treatment standing order
- Tularemia exposure
- Varicella exposure
MASSACHUSETTS GENERAL HOSPITAL
Flu Vaccination of Employees

APPLIES TO: All employees

1. **POLICY**
   1.1. Massachusetts Department of Public Health regulations require that all hospital employees (including medical staff, certain contractors and volunteers) are vaccinated against seasonal influenza virus.

2. **DEFINITIONS AND REGULATIONS**
   2.1. Flu vaccination clinics will be offered at no cost to Mass General employees at various locations.
   2.2. An employee can decline to be vaccinated for the following reasons:
       - The vaccine is medically contraindicated for that employee
       - Vaccination is against the employee’s religious beliefs or
       - The employee refuses the vaccine
   2.3. The hospital will notify employees of the seasonal influenza requirement and provide information about the risks and benefits of the vaccination.
   2.4. Employees will be required to record their flu vaccination status in PeopleSoft Employee Self Service. All employees will be given instructions which detail how to log onto PeopleSoft to record their vaccination status. When logging onto PeopleSoft, employees can choose one of the following options:
       - Vaccinated
       - Declined vaccination

Last Revision: 2009
Last Review: 2009
1. **POLICY**

1.1. It is vital to the health and safety of all employees, patients, and visitors that Health and Safety Guidelines be followed as established by Hospital Policy and Procedure in accordance with standards and guidelines from various legal and accrediting agencies.

1.2. As part of a comprehensive health and safety program, employees are required to utilize appropriate precautions when exposed, or potentially exposed, to agents with a potential to harm themselves or others. These agents may be physical, biological, or chemical in nature. Precautions may be in the form of work practices and/or personal protective equipment. Work practices are to be followed in accordance with established department and Hospital procedure and policy.

1.3. Employees are required to participate in appropriate initial and annual safety training for their position and job duties. Training is important to understanding risks of exposure and Hospital practices regarding reducing risk.

1.4. All employees are required to attend annual fire safety training. In order to process the annual performance appraisal, a supervisor should document the date of the employee's fire training and record it in PeopleSoft. Training sessions are held regularly by the office of Environmental Health and Safety.

1.5. Health screenings and vaccinations are an essential component to protecting Hospital employees from injuries and infectious diseases. Employees are required to participate in specific required health screening and vaccination programs.

1.6. Any potentially unsafe condition in the working environment should be reported promptly so as to avoid injury and to allow for correction of the condition.

1.6.1. Per the Work Clearance Policy, all persons who accept a job offer must be screened by Occupational Health Services prior to beginning work. Employees must be capable of performing the essential functions of the job.

1.6.2. All persons who accept a job offer must receive a general health screening and will receive, if appropriate, screening specific to workplace exposures and in accordance with all applicable mandated regulations and standards.

1.6.3. All persons who accept a job offer must either present documentation to MGH Occupational Health Services of Measles, Mumps and Rubella (MMR) (vaccines or antibody tests are acceptable), consent to lab testing to verify immunization status, or receive MMR vaccinations as deemed appropriate.
by Occupational Health Services in accordance with Massachusetts
Department of Public Health and CDC Guidelines.

1.6.4. All persons who accept a job offer must receive a two step Tuberculosis
(TB) testing or, if they have a history of a positive reaction to TB testing,
must submit proof of a negative chest X-ray (taken within 1 year) and
complete a symptom analysis documenting that they do not have any
symptoms suggestive of active TB.

1.7. Employees with exposure to -- or potential exposure to -- blood and/or body
fluids must either present proof of Hepatitis B vaccinations, consent to
vaccination, or sign a statement declining vaccination.

1.8. Employees should receive a complete general MGH orientation and be oriented
to their work area upon hire by their department regarding safe and established
work practices and use of personal protective equipment, if appropriate.

1.9. Employees who have a change in job duties which results in a change in
physical, biological, or chemical exposures or potential for exposure, should be
referred to Occupational Health Services for an updated health screening and
should receive updated safety training specific to their change in exposures or
potential exposures.

1.10. The MGH Manual of Safety Practices should be available in all work
areas. For clinical work areas, the MGH Manual of Precaution Techniques
should also be available in the work area.

1.11. Appropriate personal protective equipment should be used in accordance
with established Hospital policy and practice.

1.12. Employees, who are operating vehicles or are passengers in vehicles
performing hospital business are required to wear seat belts, except as
referenced by MGL chapter 90 section 13A.

1.13. Employees, who are not appropriately performing work practices in regard
to health and safety concerns and/or not utilizing personal protective equipment
appropriately, should be counseled by their supervisor and, if necessary, receive
retraining. An employee’s personal electronic devices should not be used if they
pose a health and/or safety concern. If retraining has occurred and the
employee continues to not appropriately perform work practices and utilization of
personal protective equipment, the employee should be counseled per the
Corrective Action Policy.

1.14. Employees must receive TB testing as required by the Centers for
Disease Control (CDC) and regulated by Occupational Safety and Health
Administration (OSHA) as appropriate for their level of occupational exposure to
TB.

1.15. Per the Work Clearance Policy, employees must report all exposures to
Infectious Diseases and blood or body fluids to the Occupational Health
Services for a determination as to appropriate to prophylactic treatment and
whether the employee needs to be restricted from work while potentially incubating an infectious disease.

1.16. Per the Workers’ Compensation Policy, employees must report all work related injuries and illnesses to their supervisor and Occupational Health Services, and file an incident report within 24 hours of the occurrence.

1.16.1. Any potentially unsafe conditions resulting in a work related injury should be corrected immediately so as to avoid injury to others.

1.17. Employees, who are not able to perform the essential functions of their job due to a possible change in mental and/or physical health, or potential substance abuse, and who may pose a health and safety risk to others, should be referred to Occupational Health Services for an updated health screening after the supervisor consults with Human Resources.

Related Policies:
Corrective Action
Leaves of Absence
Motor Vehicle Operator Safety
Recruitment, New Hire and Termination Process
Substance Abuse
Work Health Clearance
Workers’ Compensation

Last Review: 2009
Last Revision: 2009
MASSACHUSETTS GENERAL HOSPITAL
Motor Vehicle Operator Safety

APPLIES TO: Weekly paid employees

1. **Policy**
   
   1.1. The Massachusetts General Hospital is committed to providing safe and efficient motor vehicle services in support of our Hospital mission.
   
   1.2. In addition, the Hospital will implement the Commonwealth of Massachusetts' Motor Carrier Safety regulations, which impose certain obligations on employers and their employees who operate or supervise the operation of commercial vehicles covered by these regulations.
   
   1.3. These regulations include the obligation to institute and to provide education concerning the effects of drugs and to maintain a program to detect the use of controlled substances by applicable employees. This program must include medical clearance and controlled substance testing.
   
   1.4. In order to meet this goal, the Hospital expects employees to arrive for work in a condition free of the influence of controlled substances, and to remain so while they are on the job, and to refrain from their use (except as noted below), possession, sale, or unlawful distribution on Hospital property.

2. **Definitions and Regulations**
   
   2.1. Vehicles which weigh more than five (5) tons and which operate on public roads are covered by the regulations.
   
   2.2. The following are applicable employees:
   
   2.2.1. Current and future drivers of vehicles covered by the regulations;
   
   2.2.2. Those employees who might be required to drive a vehicle covered by state regulations;
   
   2.2.3. Current and future supervisors of employees covered by the state regulations;
   
   2.2.4. Drivers due for an annual examination.
   
   2.3. Applicable employees will be subject to:
   
   2.3.1. Baseline examinations;
   
   2.3.2. Annual physical examinations;
   
   2.3.3. Random, periodic testing for controlled substances which may include a urine and/or a blood test;
   
   2.3.4. Post-incident testing for controlled substances, which may include a urine and/or a blood test.
2.4. Applicable employees may use a controlled substance (as described by federal law, Schedule I-5) if it has been prescribed by an appropriate licensed medical practitioner who has advised the employee that use of the controlled substance should not affect the employee's ability to safely operate vehicles covered by this policy.

2.5. It is the employee's responsibility to notify his/her supervisor that these substances have been prescribed.

It is the employee's responsibility to notify his/her supervisor any time s/he is involved in a vehicular accident involving a vehicle owned or operated by the Hospital. As soon as possible (but no later than 32 hours following the accident), the supervisor will immediately refer the employee to Occupational Health Services for:

2.5.1. A medical assessment is necessary if there is reasonable cause to believe that the operator or the Hospital vehicle may have been at fault and drug use may have been a factor, or, that the employee was operating under the influence of a controlled substance covered by this policy;

2.5.2. Post-incident testing is necessary if:

2.5.2.1. The driver or the Hospital vehicle receives a citation for a moving violation arising from the accident; or

2.5.2.2. A fatality occurs as a result of the accident; or

2.5.2.3. An individual injured in the accident receives immediate medical treatment away from the accident scene; or

2.5.2.4. There is reason to believe that total property damage will exceed $4,400.

2.6. It is the employer's responsibility to require an employee to be tested if there is reasonable cause to believe that the employee's conduct indicates that s/he may be under the influence of a controlled substance. The conduct should be witnessed by at least two supervisors, if feasible. However, if only one supervisor is available s/he can request that the employee submit to testing.

2.7. Employees and their supervisors will be required to attend a training program that includes a review of the effects of drugs.

2.8. Supervisors will be required to attend a training program on how to recognize and manage situations involving employees who appear to be under the influence of a controlled substance.

2.9. Offers of employment or transfer in job classifications covered by this policy will be conditional pending the results of the baseline physical and testing.

2.10. Physical examinations and controlled substance testing required by the policy and by Center for Disease Control (CDC) regulations will be performed by Occupational Health Services.

2.11. If an examination or test is failed, the following, in most cases, will occur:
2.11.1. New hires - conditional offer will be revoked.

2.11.2. Transfers - conditional offer will be revoked; will remain in current position, and referral to the employee assistance program will be provided.

2.11.3. Current drivers - action taken will be in accordance with the MGH substance abuse policy, a program of corrective action, rehabilitation and conditional reinstatement. However, due to the automatic loss of the commercial driver's license (per Federal regulations), a position as driver will not be held. Additionally, if the employee meets the terms of his/her conditional reinstatement, the Hospital will make every effort to place the employee in another position. Employees who do not follow the specified preventive maintenance treatment and/or engage in drug abuse within three years of discovery of problem will be subject to immediate discharge.

2.11.3.1. Per the MGH Substance Abuse Policy, the Hospital reserves the right to not offer this program of corrective action, rehabilitation and conditional reinstatement.

2.12. If a covered employee refuses to participate in testing following a vehicular accident involving a vehicle owned or operated by the Hospital in which a fatality occurs, s/he should be placed on investigatory absence and informed of the following:

2.12.1. Due to automatic disqualification from operating a vehicle for a period of one year (per federal regulations) the employee's position will not be held. If the employee agrees to the test and follows the terms of any subsequent conditional reinstatement, the Hospital will make reasonable attempts to place the employee in another position.

2.13. In accordance with the MGH substance abuse policy, refusal to take a test may result in further investigation, from which appropriate corrective action may be taken, up to and including discharge.

Related Policies:
Corrective Action
Health and Safety
Substance Abuse
Work Health Clearance

Last Revision: 2009
Last Review: 2009
1. **POLICY**

1.1. Employees are Massachusetts General Hospital’s most valuable resource and, for that reason, their health and safety are of paramount concern.

1.2. Massachusetts General Hospital is committed to maintaining a safe, healthy and efficient environment that enhances the welfare of its employees, patients and visitors. It is the policy of the Hospital to maintain an environment that is free from impairment related to substance abuse by any of its employees.

1.3. Our patients and the Hospital expect employees to arrive for work in a condition free from the influence of alcohol and drugs, and to remain so while they are on the job and to refrain, except as noted below, from their use, possession, sale or unlawful distribution on Hospital property. All new employees must sign the MGH Drug-free Workplace Statement upon hire.

2. **DEFINITIONS**

2.1. Unfit for Duty means, for the purposes of this Policy, that the employee is affected by a drug or alcohol, or the combination of a drug and alcohol, in any detectable manner wherein such use or influence may affect the safety of the employee, co-workers, patients, members of the public, the employee's job performance or the safe or efficient operation of the Hospital. The symptoms may be exhibited in the employee’s behavior and/or job performance.

2.2. Legal Drug includes prescribed drugs and over-the-counter drugs which have been legally obtained and are being used for the purpose for which they were prescribed or manufactured.

2.3. Illegal Drug means: Any drug (a) which is not legally obtainable; or (b) which is legally obtainable but has not been legally obtained. The term includes prescribed drugs not legally obtained and prescribed drugs not being used for the prescribed purposes.

3. **PROCEDURE**

3.1. On-The-Job Use or Possession of Drugs or Alcohol

3.1.1. Legal Drugs

3.1.1.1. Employees are permitted to take legally prescribed and/or over the counter medications consistent with appropriate medical treatment plans while performing their jobs. However, when such prescribed or over the counter drug therapies affect the employee's job performance, safety or the efficient operation of the Hospital, the Senior Vice President of Human Resources, or his/her designee, or in the case of a member of the professional staff, the chief of service or department
head or his/her designee, should be consulted to determine if the employee is capable of continuing to perform his/her job or if action, including corrective action or a leave from the work site, may be required.

3.1.2. Illegal Drugs

3.1.2.1. The use, sale, purchase, distribution, transfer or possession of an illegal drug by any employee while performing Hospital business or while on Hospital property is prohibited.

3.1.3. Alcohol

3.1.3.1. The consumption of alcohol, or being unfit for duty due to consumption of alcohol, by any employee while performing Hospital business or while on Hospital property is prohibited. The moderate consumption of alcohol on Hospital property when it is served during Hospital sponsored or approved events is permitted, provided that the employee will not be subsequently performing any patient care activities, and provided further that this does not relieve an employee from meeting reasonable and acceptable standards of conduct.

3.2. Corrective Action

3.2.1. Violation of this Policy may result in corrective action up to and including discharge, even for a first offense. With respect to a member of the professional staff, corrective action will be taken in accordance with the bylaws of the professional staff (bylaws) and any other governing documents. To the extent that an employee is handicapped by virtue of his or her addiction to drugs or alcohol, this factor will be taken into account in any corrective action decisions.

3.3. Reports of Incompetence

3.3.1. The Patient Care Assessment Plan of the Hospital sets forth certain requirements for reporting conduct of a licensed health care provider that includes incompetence or conduct which might be inconsistent with, or harmful to, good patient care and safety. This includes such conduct that may be the result of substance abuse.

3.3.2. If the provider is a member of the professional staff, the report should be directed to the chief of service. If the provider is not a member of the professional staff, the report should be directed to the head of the clinical department in which the provider works, and the Senior Vice President of Human Resources, if the provider is believed unfit for duty.

3.4. Alcohol and Drug Screening

3.4.1. The Hospital may require a medical assessment, blood test, urinalysis, or other alcohol/drug screening of those employees suspected of using or being unfit for duty by drug or alcohol use. For members of the professional staff, any such examination shall be required in accordance with Section
3.05 of the bylaws. This screening, based on reasonable suspicion, will be conducted in the following manner:

3.4.1.1. The Hospital must have reasonable suspicion based on specific, objective facts and/or observed behaviors that the employee is unfit for duty on the job because of the consumption of alcohol or drugs. (See 3.5 below.)

3.4.1.2. The employee must be given the opportunity to have the test sample evaluated at an independent laboratory if sufficient specimen remains; and

3.4.1.3. The employee is to be informed of the results and given an opportunity to justify or to explain the test results.

3.5. Procedures to be Followed Before Request of Alcohol and Drug Screening

3.5.1. The supervisor (or, in the case of a member of the professional staff, the Chief of Service or Department, or his/her designee) who observes or to whom it is reported that an employee appears unfit for duty must confirm the observations or report, by establishing that reasonable suspicion of being unfit for duty by drugs or alcohol is manifested in the employee's job performance using the visual observation checklist (Attachment B).

3.5.2. Except in the case of a member of the Professional staff prior to initiating questioning relative to use or possession, the supervisor is to first consult with a Human Resources generalist, if one is available. The supervisor is to have another Hospital supervisor present (in the case of a member of the professional staff, this is optional in the discretion of the supervisor) and limit questioning to that which will determine the appropriateness of the employee's condition for work.

3.5.3. The supervisor is to follow the procedures outlined in Attachment A and the "Opinion based on observations and questioning by supervisor" (Attachment C). They (A and C) must be fully completed and signed by both the supervisor and witness prior to initiating medical assessment and any obtaining of specimen.

3.5.4. If the employee refuses to be assessed after the supervisor has determined the need by the process outlined in 3.5.3 above, the employee should be placed on Investigatory Absence and told that, after further investigation, appropriate corrective action may be taken, up to and including discharge. With respect to a member of the professional staff, the professional staff (or, in his/her absence, the chief of service or department head) shall place the individual on immediate Medical Leave of Absence or Summary Suspension, and other appropriate corrective action shall be taken in accordance with the bylaws.

3.5.5. Pending return of any test results, the employee should be placed on Investigatory Absence and told that appropriate corrective action may be taken once the test results are available. This corrective action could be up to and including discharge. With respect to a member of the professional
staff, the professional staff (or, in his/her absence, the chief of service or department head) shall place the individual on immediate Medical Leave of Absence or Summary Suspension, and, once the test results are available, other appropriate corrective action may be taken in accordance with the bylaws.

3.5.6. At the point that the employee has been placed on Investigatory Absence to await the results of the tests or because the employee has refused testing, the Senior Vice President of Human Resources (or, for a member of the professional staff, the chief of service or department head) will assume responsibility for the further direction of the incident.

3.5.7. In order to maintain strict confidentiality, management and supervisors are to restrict communications concerning possible violations of this Policy to those who are participating in any questioning, evaluation, investigation or corrective action, and to those who have a need to know about the details of the alcohol/drug investigation. As with any other circumstance involving an employee issue, every good faith effort should be made to protect the employee's privacy. Nothing in this policy shall prohibit the making of a report to the Patient Care Assessment Committee, Patient Care Assessment Coordinator, Quality Assurance Committee for a Service or Department, or other appropriate body as required by the Patient Care Assessment Plan.

3.5.8. The Hospital recognizes that substance abuse may occur outside the workplace. If the suspected substance abuse is not affecting the job performance or behavior, (i.e. the employee appears fit for duty), the supervisor may not request a medical assessment nor can corrective action be utilized at any time. However, the supervisor may inform the employee of the availability of the Employee Assistance Program. With respect to a member of the professional staff, substance abuse outside the workplace may be the basis for a request for medical assessment or corrective action as appropriate and consistent with the bylaws and any other governing rules or procedures.

3.6. Relationship to Employee Assistance Program

3.6.1. The Hospital maintains an Employee Assistance Program (EAP) that provides confidential help to employees who abuse alcohol or drugs and/or have other personal or emotional problems.

3.6.2. However, it is the responsibility of each employee to seek assistance from the Employee Assistance Program before alcohol and drug problems lead to corrective action, which can include discharge for a first offense. Once a violation of the Policy occurs, subsequent use of the EAP on a voluntary basis will not necessarily lessen corrective action and may, in fact, have no bearing on the determination of appropriate corrective action.

3.6.3. Should an employee choose to make it known, his/her decision to seek prior assistance from the Employee Assistance Program will not in itself be used as a basis for corrective action and will not be used against the
employee in any disciplinary proceeding. On the other hand, using the EAP will not necessarily be a defense to the imposition of corrective action.

3.7. Rehabilitation

3.7.1. Employees who are under treatment at approved rehabilitation programs acceptable to the Massachusetts General Hospital may protect their employment status at the Hospital as follows:

3.7.1.1. The Hospital has paid time off benefits and a leave of absence policy whereby, among other things, an employee, by his/her own volition, may request a leave from the work site to confidentially correct an alcohol or drug abuse problem before overall performance is affected. Employees must notify their supervisor as required by the Earned Time or Leave of Absence policy or other applicable policy. Employees may keep their substance abuse problem and treatment confidential from the Hospital if they wish to pursue this option. Because of the confidential nature of the EAP, the employee may still use the EAP.

3.7.1.2. Employees who have been determined by the Hospital to have a substance abuse problem and who agree to go through an approved alcohol and/or drug rehabilitation program for the first time will be conditionally reinstated to a job provided they:

3.7.1.2.1. Immediately enroll, and

3.7.1.2.2. Successfully complete an approved substance abuse rehabilitation program and maintain the preventive course of conduct prescribed by the employee's drug or alcohol program; and

3.7.1.2.3. Supply on-going documentation that indicates they are remaining free of impairment.

3.7.1.2.4. The period of eligibility for conditional reinstatement shall not exceed six months from the last day of work.

3.7.1.3. Employees returning from a rehabilitation absence will be required to sign the Conditional Reinstatement Agreement (Attachment E) or other appropriate documents or agreements as determined by the Senior Vice President of Human Resources (or, for a member of the professional staff, by the chief of service or department head) on a case-by-case basis.

3.7.1.4. Employees who do not follow preventative maintenance treatment recommended by their drug or alcohol programs and/or engage in drug or alcohol abuse within three years of discovery of the problem will be subject to immediate discharge. For a member of the professional staff, corrective action shall be taken in accordance with the bylaws.

3.7.1.5. An employee whose lack of fitness for duty status was discovered under conditions potentially endangering his/her own, patients' or other
employees' safety, or involving theft or other major malfeasance will not be permitted to use the above options.

3.8. Involvement of Law Enforcement Agencies/Licensing Agencies/Granting Agencies

3.8.1. The use, sale, purchase, transfer, theft, possession or distribution of an illegal drug is a violation of the law, which will be reported by the Hospital to law enforcement agencies as appropriate. All such referrals will be done only after appropriate senior management and the Senior Vice President of Human Resources (or, for a member of the professional staff, the chief of service or department head) are informed. Furthermore, the Hospital will comply with legal requirements for making reports to various licensing and credentialing authorities regarding certain incidents, disciplinary actions, or licensed professionals who practice while impaired.

3.8.2. Those employees whose work involves federal grants or contracts must notify the Senior Vice President of Human Resources or his/her designee, of any conviction of a drug offense occurring in the workplace within five days of such conviction. The Hospital will notify the granting agency within ten days of such conviction as required by law.

3.8.3. As part of the Omnibus drug legislation enacted in November of 1955, Congress passed the Drug-Free Workplace Act of 1988. This statute requires federal grant and contract awardees to certify that they will provide drug-free workplaces for their employees. This policy meets the Hospital's obligation under the law as requested by the U.S. Public Health Service.

4. PRE-PLACEMENT SCREENING

4.1. The Hospital does not conduct pre-placement drug screening except for those employees for which this is required by regulation. Pre-placement drug screening is provided specifically to those employees hired as drivers for certain Hospital vehicles per the MGH Motor Carrier Safety Policy. In the event of a positive screening, the driver would be considered ineligible for placement.

4.2. If Occupational Health Services (OHS) finds evidence of substance abuse during a screening, the employee may be denied clearance to work until the employee is evaluated and cleared by the OHS physician.

5. RESPONSIBILITY

5.1. The administration of this policy is the responsibility of each department head and supervisor working in conjunction with the Senior Vice President of Human Resources, or, for a member of the professional staff working in conjunction with the chief of service or department head.

Related Policies:
Confidential Information
Corrective Action
Health and Safety
Motor Vehicle Operator Safety
Standards of Behavior
Work Health Clearance

Last Review: 2009
Last Revision: 2009
Attachments Index

A. Procedures To Be Followed By Supervisor Who Suspects An Employee Is Unfit For Duty.

B. Visual Observation Checklist

C. Opinion Based On Observation And Questioning By Supervisor

D. Agreement To Submit To Medical Assessment And Authorization For The Release Of Medical Information By The Hospital's Laboratory Or Emergency Department/Occupational Health Services

E. Refusal To Submit To Medical Assessment

F. Attachment F
Attachment A - Procedures To Be Followed By Supervisor Who Suspects An Employee Is Unfit For Duty.

In an effort to establish if a violation of Hospital rules and regulations occurred, all inquiries should conform to the following procedure:

1. Determine, in person, if an employee's behavior appears to be unfit for duty using Attachment B.

2. When possible, get another supervisor or management representative to assist in escorting the employee to a private area. Never use force in order to obtain agreement from the employee. Contact Police and Security if necessary.

3. If requested by the employee, bring in any other MGH employee readily available that the employee chooses to be present during the investigation.

4. The supervisor's role at this point is to determine if the employee should be referred to Occupational Health Services for further assessment. Ask only those questions necessary to determine the employee's fitness for duty, and avoid questions and/or statements that diagnose if a drug test is needed. The employee should be asked if he or she has consumed any alcohol and/or drugs in the last 24 hours. If possible, contact the Human Resources generalist to assist you in determining the proper line of questioning. At all times, give the employee a chance to respond to all allegations.

5. During the investigation with the employee, and with representative still present, complete the "Opinion Based on Observation and Questioning" (Attachment B), sign and have management witness.

6. If you conclude that the employee appears to be fit for duty, and is able to perform work duties, then have the employee return to his/her workstation.

7. If you have reasonable suspicion that the employee is unfit for duty, and the employee admits to being under the influence, then pending final determination, place the employee on Investigatory Absence. Indicate that appropriate corrective action, up to and including discharge, may be taken. With respect to a member of the professional staff, the employee shall be placed on Medical Leave of Absence or Summary Suspension and told that corrective action may be taken in accordance with the bylaws. At all times, give the employee a chance to respond to all allegations.

8. If you have reasonable suspicion that the employee is unfit for duty and denies this, then ask the employee to consent to a medical assessment, including the taking of the appropriate specimen for drug and alcohol screen. From that point, until arrival at the medical assessment site, the supervisor should remain in the presence of the employee at all times. For screenings outside of the regular office hours of Occupational Health Services, contact the Paging Operator to reach the Occupational Health Nurse Practitioner on-call.

9. If the employee refuses the medical assessment, drug/alcohol screen, and/or test, the employee should be placed on Investigatory Absence and be told that, after further investigation, appropriate corrective action may be taken, up to and including
discharge. With respect to a member of the professional staff, the individual shall be placed on Medical Leave of Absence or Summary Suspension and told that corrective action may be taken in accordance with the bylaws.

10. A manager and/or supervisor is never to use force in seeking compliance with requests. Both the drug and alcohol screen, and the signing of any forms, are voluntary on the part of the employee. Police and Security should be called if the supervisor determines that the employee should not be allowed to remain in the work area and the employee refuses to leave.

11. Make the necessary arrangements to have the employee taken home. Do not permit him/her to go home or drive alone. If the employee refuses assistance, make sure you can document that the employee refused such assistance. The management witness should co-sign any documentation. However, if an employee represents a danger to him/herself or others, then all good faith efforts should be made so as not to allow the employee to leave without assistance. You must call Police and Security for assistance and they will handle the matter pursuant to established procedures.
Attachment B – Visual Observation Checklist

**DIRECTIONS:**
Check pertinent items based on your visual observation of the employee. This section must be completed regardless of the outcome of the interview conducted pursuant to 3.5.1.

<table>
<thead>
<tr>
<th>1. <strong>Walking/Standing</strong></th>
<th>Normal</th>
<th>stumbling</th>
<th>staggering</th>
<th>falling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>swaying</td>
<td>unsteady</td>
<td>holding on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unable to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Speech</strong></td>
<td>Normal</td>
<td>shouting</td>
<td>silent</td>
<td>whispering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>slow</td>
<td>rambling/incoherent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>slurred</td>
<td>slobbering</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Demeanor</strong></td>
<td>Normal</td>
<td>sleepy</td>
<td>crying</td>
<td>silent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>alkative</td>
<td>excited</td>
<td>fighting</td>
</tr>
<tr>
<td>4. <strong>Actions</strong></td>
<td>Normal</td>
<td>resisting communications</td>
<td>fighting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>threatening</td>
<td>drowsy</td>
<td>hostile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>profanity</td>
<td>hyperactive</td>
<td>erratic</td>
</tr>
<tr>
<td>5. <strong>Eyes</strong></td>
<td>Normal</td>
<td>bloodshot</td>
<td>watery</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>glassy</td>
<td>droopy</td>
<td>closed</td>
</tr>
<tr>
<td>6. <strong>Face</strong></td>
<td>Normal</td>
<td>flushed</td>
<td>pale</td>
<td>sweaty</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Appearance/Clothing</strong></td>
<td>Normal</td>
<td>unruly</td>
<td>dirty</td>
<td>messy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>partially dressed</td>
<td>stains on clothing</td>
<td></td>
</tr>
<tr>
<td>8. <strong>Breath</strong></td>
<td>Normal</td>
<td>alcohol odor</td>
<td>faint</td>
<td></td>
</tr>
<tr>
<td></td>
<td>no alcoholic odor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. <strong>Movements</strong></td>
<td>Normal</td>
<td>fumbling</td>
<td>jerky</td>
<td>slow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>nervous</td>
<td>hyperactive</td>
<td></td>
</tr>
<tr>
<td>10. <strong>Eating/Chewing</strong></td>
<td></td>
<td>gum</td>
<td>candy</td>
<td>mints</td>
</tr>
<tr>
<td></td>
<td>Other-identify if possible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. <strong>Other Observations:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attachment C - Opinion Based On Observation And Questioning By Supervisor

1. Appears unfit for work: _____Yes _____No _____Uncertain

2. Recommend for medical assessment which may include a drug/alcohol screen: _____Yes _____No

If yes, ask the employee the following questions:
Would you submit to a medical assessment to include a blood and urinalysis by Hospital staff, if the clinician deems it necessary? _____Yes _____No

If yes,
1. Have employee sign Agreement to Submit to Medical Assessment (Attachment D).
2. Contact Occupational Health Services. For screenings outside of the regular office hours of Occupational Health Services, contact the Paging Operator to reach the Occupational Health Nurse Practitioner on-call.
3. Take, or make appropriate arrangements for, employee to be taken to Occupational Health Services/Emergency Department.
4. Send completed attachments to the testing site in a sealed envelope.

3. If the employee refuses to sign the Statement for Medical Assessment (Attachment D), the employee should be told that by refusing s/he may be submitted to further corrective action, up to and including discharge. (See Attachment E)

REMARKS:

Signed: ___________________________ Date: __________________________
Supervisor

Witnessed by: ___________________________ Date: __________________________
Attachment D: This Should Be Read Aloud To The Employee

AGREEMENT TO SUBMIT TO MEDICAL ASSESSMENT
AND AUTHORIZATION FOR THE RELEASE OF
MEDICAL INFORMATION BY THE HOSPITAL’S LABORATORY
OR EMERGENCY DEPARTMENT/OCCUPATIONAL HEALTH SERVICES

I have been informed that the Massachusetts General Hospital, based on my behavior and appearance, is concerned that I may be unfit for duty. My ability to perform my job duties is therefore in question; and as a result, I have been requested to submit to a Medical Assessment which may include a drug and/or alcohol screen by blood and/or urine tests which is to be administered by the Occupational Health Services/Emergency Department and Laboratory. I have been informed and I understand, that my agreement to submit to the Medical Assessment is completely voluntary on my part, and that I have the right to refuse to submit to a drug/alcohol test, as deemed appropriate by Occupational Health Services. I understand that my refusal to submit to the Medical Assessment or drug and/or alcohol screen by blood and/or urine tests may be grounds for corrective action against me, up to and including discharge.

I have also been informed, am aware, and hereby authorize that the results of this Medical Assessment and related tests may be released to the Senior Vice President of Human Resources and/or his/her designee, who may determine it is necessary to disclose such information. I understand that the information so released to the Senior Vice President of Human Resources will be used to determine whether I was fit to perform my job duties, and/or whether I had violated the Hospital’s policies concerning substance abuse and that the results of such test(s) may form the basis for corrective action against me, up to and including discharge. With respect to a member of the professional staff, this information will be released to the chief of service, or the Head of the Department for their handling.

With full knowledge of the above information, I have decided to voluntarily submit to the requested Medical Assessment which may include a drug and/or alcohol screen by Occupational Health Services/Emergency Department Physician and Laboratory and in recognition of this agreement do sign this consent.

__________________________________________
Date Employee Signature

(NOTE: A witness other than the supervisor who has requested that the employee submit to a medical assessment should also sign the consent form)

__________________________________________
Date Witness
Attachment E: Refusal To Submit To Medical Assessment

I hereby refuse to submit to a Medical Assessment, which may include testing of my blood and urine for alcohol or drugs. I understand that such refusal will require a review of the facts by management, which may necessitate corrective action, up to and including discharge.

___________________  ____________________
Employee Signature    Witness

___________________  ____________________
Date                  Supervisor

Employee refused to sign form.

___________________
Supervisor

___________________
Witness
Attachment F

The undersigned parties (Massachusetts General Hospital) and ____________

Employee’s Name

herein referred to as "employee" hereby agree as follows:

1. The employee recognizes that the Massachusetts General Hospital has assisted
him/her by its Human Resources policies to deal with his/her substance abuse
problem.

2. The Massachusetts General Hospital will conditionally reinstate the employee
after s/he successfully completes an approved rehabilitation program. The
Employee will be conditionally reinstated provided she/he agrees to perform the
following:

   • (Here insert conditions applying to rehabilitation treatment).
   • Meets requirements of state board for licensed personnel.

3. If within the next three (3) years, the employee becomes unfit for duty due to
substance abuse, or fails to continue his alcohol/drug rehabilitation program or
meet the conditions set forth above as outlined in item 2, s/he will be discharged.

4. Employee understands and agrees that if s/he has to be admitted to a hospital or
rehabilitation center again within the next three (3) years for substance abuse,
s/he may be discharged.

__________________________  ______________________________
Employee Signature        Senior Vice President of Human
Resources

__________________________
Date

OR

__________________________  ______________________________
Professional Staff Employee  Chief of Service or Department Head
1. **Policy**

   1.1. Prospective employees must report to the Occupational Health Services before beginning employment for a work health clearance. Existing employees must report to the Occupational Health Services for a work clearance if they have an infectious disease or a potentially infectious disease, have been out of work due to any illness or injury for five or more calendar days, or have sustained a work-related injury or illness and have been out of work one day or longer. An employee must not begin his/her work until s/he has been assessed by Occupational Health Services.

2. **Definitions And Regulations**

   2.1. All employees must report to the Occupational Health Services for a nondiscrimination health screening. The employee must have a medical record number before reporting to Occupational Health Services.

   2.2. All employees who have been out of work five or more calendar days must report to Occupational Health Services for a return to work clearance assessment. At this time, the employee must present documentation from his/her treating provider that s/he is capable of returning to work and what work restrictions, if any, are recommended. The Occupational Health Services is responsible for reviewing all documentation and ensuring that the employee's clearance is appropriate.

   2.3. All employees who have been out of work one day or longer due to a work-related injury or illness must be evaluated by the Worker's Compensation Staff of the Occupational Health Services for a return to work clearance. A Determination will be made as to whether the employee is able to return to work and whether any accommodations are necessary.

   2.4. All employees who have been exposed to an infectious disease or have a condition which might place them at increased risk of being exposed (refer to Isolation Precautions- Infection Control Policies), think they might have an infectious disease, or have been diagnosed with an infectious disease must report to Occupational Health Services for a work clearance and/or exposure assessment.

   2.5. Infectious diseases and conditions include, but are not limited to, the following common diseases which are potentially transmissible to patients and/or employees:

   2.5.1. Childhood diseases: e.g. chickenpox, measles, and German measles;
2.5.2. Strep throat;
2.5.3. Gastrointestinal infections (including diarrhea that lasts more than two days without a known cause);
2.5.4. Open and/or exposed skin lesions, gashes, or any other condition resulting in non-intact skin; e.g., boils, herpes, skin abscesses, contact dermatitis;
2.5.5. Conjunctivitis, both bacterial and viral;
2.5.6. Hepatitis;
2.5.7. Meningococcal meningitis;
2.5.8. Scabies and lice;
2.5.9. Tuberculosis.

2.6. The Infection Control Unit will be available for consultation with the Occupational Health Services in evaluating exposures as they relate to the above.

2.7. Employees with a suspected or confirmed diagnosis of an infectious disease will be restricted or removed from work, as deemed appropriate by Occupational Health Services, to prevent potential transmission to patients and/or employees. Unless advised by Occupational Health Services that the exposure was work-related, the employee will be paid under the guidelines of the Earned Time Policy.

2.8. If the employee is advised by Occupational Health Services to remain out of work and the infectious disease exposure was deemed to be work-related, the employee will be paid his/her regular pay during any known incubation period. If the employee develops an infectious disease after a work-related exposure, the employee will be eligible for Worker’s Compensation benefits pursuant to the Worker’s Compensation Policy.

2.9. Employees requiring immediate evaluation regarding work clearance for an infectious disease when the Occupational Health Services is closed should page the on-call Occupational Health Nurse Practitioner through the page operator and may be directed to the Medical Walk-In Unit or Emergency Services for this evaluation. The employee must follow-up with Occupational Health Services during the next business day.

2.10. Employees with an infectious disease deemed not to be work-related will be obligated to obtain care and follow-up with their primary care provider (or other choice of provider) dependent upon their health insurance plan. These employees will still need to report their disease to Occupational Health Services and obtain a work clearance prior to returning to work.

2.11. Occupational Health Services will observe all pertinent regulations regarding
medical confidentiality.

2.12. Occupational Health Services will provide written documentation to the employee’s supervisor regarding his/her ability to return to work and any restrictions or special accommodations that may apply.

2.13. Refer to the Health and Safety Policy for more information regarding Fit-for-Duty qualifications.

3. Procedure

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>1. Reports to Occupational Health Services for new employee health screening.</td>
</tr>
<tr>
<td></td>
<td>2. Reports to Occupational Health Services for suspected or confirmed diagnosis of infectious disease.</td>
</tr>
<tr>
<td></td>
<td>3. Follows recommendations of Occupational Health Services regarding work restriction or removal.</td>
</tr>
<tr>
<td></td>
<td>4. Provides documentation from treating provider, if appropriate for a return to work clearance.</td>
</tr>
<tr>
<td>Occupational Health Services</td>
<td>1. Provides health screening and work assessment.</td>
</tr>
<tr>
<td></td>
<td>2. Provides the employee’s department with written documentation of return to work clearance.</td>
</tr>
<tr>
<td>Supervisor</td>
<td>1. Refers employee to Occupational Health Services and does not allow the employee to work until cleared by the Occupational Health Services.</td>
</tr>
</tbody>
</table>

Related Policies:
Corrective Action
Health and Safety
Leaves of Absence
Motor Vehicle Operator Safety
Recruitment, New Hire and Termination Process
Substance Abuse
Workers’ Compensation

Last Revision: 2009
David Hooper called the meeting to order at 12:01 pm.

**AGENDA ITEM**

**DISCUSSION SUMMARY**

**Minutes from 1/24/2012**

- Posted on SharePoint site for member review.

**Actions/Recommendations:** Minutes approved. Power Point Presentation of the meeting is made a part of these minutes.

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**STANDARD AGENDA**

**SSI Data Q4, 2011**

(Mandatory reporting)

- **Hip Arthroplasty (HPRO)**
- **Knee Arthroplasty (KPRO)**
- **Coronary Artery Bypass Graft (CABG)**
- **Hysterectomy (HYST)**

Presented by Paula Wright and Kathie Hoffman

**SSI = Surgical Site Infection**

**Rate = # HA cases per 1000 patient-days**

**SIR = Standardized Infection Ratio: # Occurred/#Expected infections, based on NHSN data.**

- \( >1 = \) more than expected
- \( <1 = \) less than expected

**NHSN = National Healthcare Safety Network**

**DPH = Dept. of Public Health**

**Hip Arthroplasty (HPRO)**

SIR: 0.45 Decreased from 1.93 in Q3. SIR is based on NHSN data. This reflects a single superficial incisional infection. Deep incisional and organ space infections occurring up to one year after surgery must be included for all cases involving an implant, so infection rates and SIR are subject to change.

**Knee Arthroplasty (KPRO)**

SIR: 0.86. Lower than expected for Q4, and for second consecutive quarter. This reflects a single superficial incisional infection. Subject to change due to 1 year monitoring of cases involving implants.

**Coronary Artery Bypass Graft (CABG)**

SIR: 0.77 Lower than expected for second consecutive quarter, and reflects a single superficial incisional infection. Subject to change due to 1 year monitoring of cases involving implants. (Sternal wires are implants.)

The number of procedures included in surveillance is expected to rise in 2012, based on a recent clarification of the NHSN criteria for cases to be included. In the past, cases involving only CABG were reported. Going forward, all cases that include the ICD9 code for CABG will be reported, including cases that involve other cardiac procedures e.g. valve procedures.

**Hysterectomy (HYST)**

Quarterly infection rates for 2011 were zero in all but Q3. The Q3 infection rate was 6.6, based on 1 infection in 15 procedures, and exceed the number expected (0.2). The SIR is not calculated by NHSN if the number expected is less than 1.0.

The number of procedures included in surveillance is expected to rise in 2012, based on a recent clarification of the NHSN criteria for cases to be included. In the past, cases involving only removal of the uterus alone. Going forward, all cases that include the ICD9 code for uterine removal will be reported, including cases that involve removal of other organs (e.g. salpingectomy or oopherectomy) including complex cases that have a higher risk of infection.

**Actions/Recommendations:** Next report date May 22, 2012
## AGENDA ITEM

### Ventilator-Associated Pneumonia (VAP) Data, Q4-2011

<table>
<thead>
<tr>
<th>SICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Q4 VAP rate is 3.71/1000 vent-days, based on 3 VAP cases occurring in 808 ventilator days, and slightly above the Q3-2011 rate of 2.24. This is the first time the rate has increased since Q3-2010 when it peaked at 13.13. It exceeds the recently-adjusted NHSN pooled mean of 3.5, but it is below the previous pooled mean of 3.8.</td>
</tr>
<tr>
<td>Trauma VAP rates are typically higher than Surgical VAP rates. When measured separately, the rates and NHSN pooled mean comparisons for each are:</td>
</tr>
<tr>
<td>• Trauma VAP rate = 7.04. Exceeds the pooled mean of 6.0</td>
</tr>
<tr>
<td>• Surgery VAP rate = 3.00. Below the pooled mean of 3.5</td>
</tr>
<tr>
<td>SICU leaders actively review each VAP case to ensure that the complex VAP definition is applied consistently in all cases, and to ensure the consistent interpretation of chest x-ray results.</td>
</tr>
</tbody>
</table>

**Actions/Recommendations:** Next report date May 22, 2012

---

### Line-associated Bloodstream Infection Data (LABSI) Q4-2011

<table>
<thead>
<tr>
<th>CLABSI=Central line-associated bloodstream infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>All line types (central, peripheral, arterial)</td>
</tr>
<tr>
<td>LABSI cases: 51, Rate: 0.71. Rate is similar two previous quarterly rates, and high when compared to rates recorded between 2008 and 2011.</td>
</tr>
<tr>
<td>CLABSI in ICUs</td>
</tr>
<tr>
<td>Cases: 11, Rate: 1.67. Rate is above the recently-adjusted NHSN pooled mean of 1.4 for a medical-surgical ICU in a major teaching hospital.</td>
</tr>
<tr>
<td><strong>Analysis of CLABSI data</strong></td>
</tr>
<tr>
<td>• CLABSI cases (40) exceeded Peripheral line cases (8)</td>
</tr>
<tr>
<td>• 53% of all CLABSI cases (17) were associated with PICC lines. The CLABSI rate for PICC lines increased from 0.93/100 lines placed to 1.43/100 lines placed between Q1 and Q4-2011.</td>
</tr>
<tr>
<td>• No common factors or causes were identified.</td>
</tr>
<tr>
<td>• True pathogens (Criterion 1) were identified in 60% of CLABSI cases. Remainder were caused by skin flora (Criterion 2)</td>
</tr>
<tr>
<td>• Most CLABSI occurred in patients in high-risk units (oncology) with long-term lines.</td>
</tr>
<tr>
<td>As noted in quarter 3 a high percentage of CLABSI are related to PICC lines. As a result a budget proposal was put forward to implement the use of Biopatch for PICC lines. This was approved and education and implementation began early this month.</td>
</tr>
</tbody>
</table>

**Actions/Recommendations:** Next report date April 24, 2012

---

### Infection Control Program: Annual Summary, 2011

<table>
<thead>
<tr>
<th>Program/Policy Changes in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contact Precautions Plus: Now required for suspect cases of <em>Clostridium difficile</em>-associated disease if treatment is initiated- case is flagged with red “P”</td>
</tr>
<tr>
<td>• High-level disinfection policy re: use of Cidex OPA was revised to include temperature monitoring and clarification of rinsing</td>
</tr>
<tr>
<td>• Use of new low-temperature, hydrogen peroxide based, high-level disinfection technology for ultrasound equipment was approved (Trophon)</td>
</tr>
</tbody>
</table>
## AGENDA ITEM

#### HAI=Healthcare-associated Infection

<table>
<thead>
<tr>
<th>DISCUSSION SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HAI Data</strong></td>
</tr>
<tr>
<td>- Annual HAI rates remained stable for the following:</td>
</tr>
<tr>
<td>- MRSA (Number of present-on-admission cases remains high)</td>
</tr>
<tr>
<td>- VRE</td>
</tr>
<tr>
<td>- C. difficile</td>
</tr>
<tr>
<td>- MDRO: Increased from 0.29 in 2010 to 0.57 in 2011, but increase also due to change in marker (formerly reported HA rate of resistant gram-negatives (RGN) + aztreonam-resistant <em>Klebsiella</em>; in 2011 reported RGN + ESBL positive <em>Klebsiella, E. coli and Proteus</em>. Thus additional organisms were included this year, so rate is considered stable.</td>
</tr>
<tr>
<td>- ESBL: Testing began for 3 gram-negatives (<em>Klebsiella, E. coli and Proteus</em>) in 2011; increase in Q3 noted, but returned to baseline in Q4.</td>
</tr>
<tr>
<td>- CARB: A 10% increase was anticipated due to changes in breakpoints for antibiotic susceptibility testing. Increase exceeded that but there was not clustering identified or areas of concern.</td>
</tr>
<tr>
<td>- LABSI: Low overall rate achieved in Q1, but exceeded baseline in remaining quarters. It was noted that SICU had zero CLABSI cases in 2011.</td>
</tr>
</tbody>
</table>

### CLABSI analysis

- ICU and Oncology units = 69% of cases
- Medicine patients = 66% of cases
- PICCs = 46% of cases: Increased numbers of PICC lines are being used, but increased rate of infection was noted. Use of Biopatch currently being rolled out.
- Tunneled/Implanted lines = 24% of cases
- Long term lines = higher risk: (for cases where insertion date was known; the median time to infection was 11 days)
- Gram positive organisms were predominant cause

It was noted that MDPH audited MGH CLABSI data for 2009-2010. Audits were also conducted at hospitals across the state. The MGH audit found only 2 CLABSI cases that were not reported and all reported cases were verified to meet criteria. In comparison, DPH audits across Massachusetts triggered a 33% increase in cases reported for that time period. As a result of the CLABSI audit, MGH moved to a stricter adherence to NHSN criteria for identifying a bloodstream infection as secondary to another infection site.

### SSI

- Surveillance for 6 surgical procedures completed in 2011. Overall SIR’s were less than or no different than expected as compared with NHSN data.
- Clarification of inclusion criteria for CABG and Hysterectomy is expected to result in an increase in the number of HYST and CABG procedures included in surveillance in 2012.

### Hand Hygiene (HH)

- Annual rates of “90/90” or greater were achieved for the third consecutive year.
- Inverse correlation between HH and HA-MRSA rate continues

### IC Consultations, Collaborations and Investigations

- Collaborated with OHS on 90 communicable disease exposures
- Exposure follow-up 2 cases of confirmed rabies-collaboration with MDPH
- NICU NEC cluster 6-11- reported to BPHC/DHCQ (Dept. Health Care Quality)
- 1 Norovirus Cluster requiring unit closure- reported to BPHC/DHCQ
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Investigated cluster of same <em>Klebsiella pneumoniae</em> isolates r/t bronchoscope</td>
</tr>
<tr>
<td></td>
<td>• Completed Infection Control Risk Assessments (ICRA) for -116 construction/renovation projects</td>
</tr>
<tr>
<td></td>
<td>• Content expert for IC Tiger Team focused on regulatory readiness</td>
</tr>
</tbody>
</table>

**IC Program Goals - Assessment**

**Goals met**

- Daily cleaning of high-touch surfaces (validated with use of a marker agent)
- Reportable SSIs – All SIRs below 1 or above 1 but not statistically significant
- Decrease BBP exposures: Trending downward

**Goals partially met**

- VAP prevention: Standard validation via QuadraMed rolled out, report generation pending.
- CAUTI prevention: Data collection and feedback methods established. Progress made toward establishing POE template orders for catheter removal, but efforts still ongoing.
- HH: Method for measuring HH compliance in Ambulatory Care was established, but proved to be unsustainable. Efforts will now be focused on establishing self-monitoring systems at large Ambulatory Care sites.

**Goals not met**

- CLABSIs in ICUs: Overall rate was 1.35; goal was 0.6. Note: Moved to strict application of the surveillance definition in 2011 following DPH audit. A 33% increase in reporting was seen across Massachusetts as result of the statewide audits.
- Track and maintain CARB RGN rates, allowing for 10% increase due to reporting changes: Rate increased to 0.9, but remains low. Patients are flagged for isolation during hospitalization and readmission.

**Actions/Recommendations:** The full written report will be posted for review on the ICC SharePoint site prior to next meeting. Committee will vote to accept report at next meeting.

---

**Bloodborne Pathogens (BBP) Exposure Control Plan: Annual Review, 2011**

*Presented by Paula Wright*

The plan was reviewed by Infection Control, Occupational Health and the department of Pathology. The changes were approved.

**Changes in 2011 include:**

- Updated language for clarification (not policy change)
- HealthStream added as a method used for training documentation

**Actions/Recommendations:** Next Report Date: February 26, 2013

---

**TB Task Force: Annual TST Compliance report, 2011**

*Presented by Andy Gottlieb*

**Compliance with TB Testing (see PP)**

- Employee reminders sent 4 weeks and 2 weeks before testing is due
- PCS Managers receive monthly report of overdue employees
- Physicians – Email reminder is sent 3 months before re-credentialing date, and repeated at 2 months if non-compliant

**T-Spot**

Now being used for post-exposure testing and for testing of select new hires

**Results**

16,211 tests completed in 2011, versus 14,616 in 2010
## AGENDA ITEM

### Ongoing challenges include:

Employees not returning for TB reads; Data may be available in outside platforms (LMR/OnCall) that are not accessed by OHS; Incomplete data sent to OHS (missing dates, results, etc.); Pregnant/IVF employees ask to defer testing; MDs are re-credentialed only every two years; Department of Nursing compliance is 78%, prefer to achieve 80% or better.

Goal for 2012 is to boost compliance further, maintain success already achieved, and accomplish that with less “chasing” of staff by OHS.

**Actions/Recommendations:** Next Report Date: February 26, 2013

### Construction Surveillance - 2011 Annual Report

A multidisciplinary team including IC, B &G, Planning, U&E, EH & S conducts tours of active sites bi-weekly. Elements monitored include adequacy of construction barriers, negative airflow, cleanliness and safety issues. Failures are reported immediately to responsible person- usually Construction Manager and a plan for failure correction is in place before the team leaves. Overall compliance with control measures was 87% for the year, See Power Point presentation for full data.

**Actions/Recommendations:** Next Report Date: March 26, 2013

### OLD BUSINESS

#### Infection Control Program: 2012

- Annual Plan Review
- Surveillance Plan
- Reporting Changes
- Hazard Vulnerability Analysis
- Goals

See minutes of the January 2012 meeting and PowerPoint presentation for full details. Full Plan was posted for Committee review prior to this meeting.

Changes and updates made since the January meeting include the following:

**Hazard Vulnerability Analysis**

Risk level for potential failure related to equipment sterilization was decreased, based on discussion and actions taken for improvement in 2011.

**Goals (added)**

- CLABSI: Reduce CLABSI on Lunder 10 (Heme/Onc/BMT) to NHSN pooled mean for both temporary and permanent lines
- Flu Vaccination: Increase overall staff vaccination rate from 82% to 85%.

**Actions/Recommendations:** Motion to accept the 2012 Infection Control Plan as presented was made, seconded, and approved by unanimous vote.

#### Environment of Care: Inpatient Team Surveillance Rounds

Total number of areas surveyed: 19

**Indicator categories by compliance rate**

- **100% compliance**
  - PPE available; Knowledge of precautions; Clean supply room closed; Clean supplies only (in clean supply room); Soiled utility room closed; No clean supplies in soiled utility.

- **84% compliance**
  - No food or drink: Tray at OR control desk; Drinks on surfaces where specimens collected
  - Supplies protected from potential contamination: Supplies on windowsills; Supplies near sinks.
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION SUMMARY</th>
<th>Actions/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change made to environmental surveillance indicators</strong></td>
<td>“PPE available” will be changed to “PPE worn correctly”. IC staff will observe staff and note if PPE worn correctly. Nurse Directors will be given immediate feedback and completion of survey.</td>
<td><strong>Next report date March 27, 2012</strong></td>
</tr>
</tbody>
</table>

**Joint Commission Resources (JCR) visit 11/11 Follow-up**

Presented by Paula Wright

The Committee was updated on findings from a JCR consultative visit last November. The ICC meeting was cancelled in December and time ran out at last month’s meeting, thus these slides were not covered. Most Committee members have heard of these finding at other meetings. The major issues that need work include the following.

- Flash sterilization in the OR
- Correct use of PPE i.e. ensuring gowns are worn correctly
- Correct use of low level disinfectants, ensuring staff know required contact times
- Food and Drink – ensuring they are found only areas where allowed
- Torn linen cart covers

**Actions/Recommendations:** *A PDCA approach is being used to address these issues.*

**Policy review**

Department-specific Infection Control Policies for 8 locations were reviewed and approved without major changes since the last report.

**Actions/Recommendations:** *None*

Meeting adjourned at 12:59 pm. Next meeting: 3/27/12
# 2012 Surveillance Plan

<table>
<thead>
<tr>
<th>Surveillance Component</th>
<th>What is tracked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Epimarkers</td>
<td>HAI-MRSA, VRE, C. diff., CARB-R, CTX-R E. coli, Klebsiella, Proteus, MGH defined MDRO gram neg.</td>
</tr>
<tr>
<td>Select Pathogens in ICU’s</td>
<td>HAI-Acinetobacter, S. Maltophilia</td>
</tr>
<tr>
<td>Device-associated infections</td>
<td>CLABSI- housewide, VAP- all ICUs , CAUTI</td>
</tr>
<tr>
<td>Surgical Site Infection</td>
<td>Hip &amp; Knee Arthroplasty (state)</td>
</tr>
<tr>
<td></td>
<td>CABG (state)</td>
</tr>
<tr>
<td></td>
<td>Hysterectomy (Abd &amp; Vag.) (state/CMS new)</td>
</tr>
<tr>
<td></td>
<td>Colon (CMS) NEW</td>
</tr>
<tr>
<td>Prevention Measures</td>
<td>Hand Hygiene</td>
</tr>
<tr>
<td></td>
<td>Correct use of Personal Protective Equipment</td>
</tr>
</tbody>
</table>
## 2012 IC Program Goals

<table>
<thead>
<tr>
<th>Goal/Priority</th>
<th>Link to MGH Goals</th>
<th>Measurable objectives</th>
<th>Methods/Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure daily cleaning: high-touch surfaces patient rooms</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>Sustain MRSA/C. diff/MDR gm neg. rate Stabilize VRE rate</td>
<td>PCS QA process for Env. Cleaning. Report to ICC Feedback VRE data to EOC OM group</td>
</tr>
<tr>
<td>Track select CARB “R” and CTX-R gram -negatives</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>CARB R-Re-set goal- sustain rate of 0.08/1000 pt. days. ESBL-Sustain rate of 0.4/1000 pt days</td>
<td>Monitor rate, Isolation, respond to clusters.</td>
</tr>
<tr>
<td>Prevent CLABSI in ICUs</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>Target &lt; 1/1000 line days across ICUs</td>
<td>Monitor rate, data feedback, CHG dsg. for PICC/PA HR pts ICU analysis of cases</td>
</tr>
<tr>
<td>Prevent SSI CABG,HPRO,KPRO,HYST, COLON</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>SIR rate &lt; 1</td>
<td>SSI surveillance data/ feedback, Pt. education, pre-operative bathing implementation</td>
</tr>
<tr>
<td>Prevent VAP Standardize bundle implementation in ICUs</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>≥ 95% compliance with bundle</td>
<td>Standardize method for compliance measurement and reporting to CCC</td>
</tr>
<tr>
<td>HH-Ambulatory Care HW for Contact Plus</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>Focus on large sites/ self monitoring programs Collect data</td>
<td>Data to ICC</td>
</tr>
<tr>
<td>Prevent CAUTI</td>
<td>Reduce HAI risk Promote Efficiency, affordability, effectiveness</td>
<td>Initiate CAUTI surveillance and feedback data.</td>
<td>Est. POE order for removal</td>
</tr>
<tr>
<td>Decrease BBP exposures</td>
<td>Reduce risk of work-related infection</td>
<td>Minimize needlesticks from non-safety needles. Monitor exposure data</td>
<td>Cont. to work with MM on eliminating non-safety needles and enforce waiver rec.</td>
</tr>
</tbody>
</table>
The minutes of the February 2012 meeting were approved without amendment.

**Announcements and Updates**

- Patrick Adams has distributed a listing of documents that he would like to have centrally compiled for our Joint Commission survey and has requested that they be sent to Maria Forcellati. Please contact Patrick with questions regarding this request.
- Lela Holden announced “Patient Safety Awareness Week” and that information tables will be set up in the White main corridor. Also, On Thursday at noon this week Dr. Betty Rafferty, Director of Breast Imaging, will be the keynote speaker at a presentation on “New Dimensions in Breast Health: Tomosynthesis” in the O'Keeffe Auditorium.
- Tuesday and Wednesday of next week a Joint Commission Resources Consultant will be on site and will focus with the EOC Committee on performance and quality improvement.
- A construction safety pilot training program will be presented at the end of the month to selected in-house personnel in an effort to get additional feedback before roll out to contractors.

**Critical Incidents**

Non-critical but notable incidents last month included the following:

- A power outage in CNY caused by a transformer incident resulted in several MGH occupied buildings, not including Building 149, to be evacuated for 1 hour and 40 minutes. There were no reports of injuries or property loss.
- We have recently received two letters of complaint from OSHA. One involved a workplace violence complaint and the other was an employee complaining about not receiving chemical hazard communication training. Both complaints were investigated and responded to and OSHA has closed both files.
- A water main break on Cambridge Street forced the 165 Cambridge Street site to operate without domestic water for about an hour. Due to the relatively brief duration of this incident, no serious repercussions were reported.

**Reports and Presentations**

Occupational Health Annual Report for 2011 – Andy Gottlieb
Ergonomics Report for 2011 – Terry Snyder

Highlights – Occupational Health Report

- There were more than 29,000 visits to Occupational Health including 2,165 employee incident reports of which 705 were OSHA reportable.
- The MGH/MGPO injury and illness rate was about 40% less than the national average for hospitals.
- 87.9% of MGH employees received the seasonal flu vaccine compared with MA hospitals vaccine rate of 70.8% and the national average for healthcare workers of 63.5%.
- Lost work days were reduced for second straight year.
- The hospital completed its study to establish the baseline level of chemotherapeutic drugs in the workplace environment and found it to be an insignificant source of potential employee exposure.
- Goals for 2012 include addressing causes and aiming to reduce the number of slips, trips and falls, reducing the number of needle sticks and further minimizing the number of lost work days.
Highlights – Ergonomics Report

- Ergonomic support was provided throughout the transition into the new Lunder facility.
- Targeted service was directed to the needs of the Radiology/Ultrasound and Buildings and Grounds departments.
- The Safe Patient Handling Pilot Program was conducted on Ellison 6 and 8, Blake 8 and White 6. The program included the development of training and support tools, refining laundry handling and tracking, extending the use of ceiling-mounted patients lift options and completing a sling usage survey.
- Some of the goals of 2012 include revisiting the EOC dashboard PI items relative to ergonomics programming, refining a lab bench computer prototype, developing ergonomics programs in new work environments and departments and continuing cross-department/multi-disciplinary solutions to ergonomic concerns.

The full report of these presentations is on file with these minutes.

### Regulations Update

- None

### 30 Day Review

- May 2012
  - In-Patient Surveillance & Patient Safety Initiatives
  - Ambulatory/Outpatient/Health Centers & Offsites
  - Regulation Update: OSHA Hazard Communication Standard

### 60 Day Review

- June 2012
  - Hazardous Materials
  - Radiation Safety & Radiation Safety Committee

### 90 Day Review

- July 2012
  - Construction Safety Program
  - Center for Quality and Safety overview
## Agenda for Next Meeting - Tuesday, April 3, 2012; 9-10 AM; Bulfinch, Room 225A

- Approval of Minutes

- General Announcements and Updates
  - Safety Manual Review
    - Sections 3 (Chemical Safety), 4 (Biosafety) and 5 (Construction Safety) and section on Specific Standards
  - Summary of EOC Performance Improvement Exercise with Joint Commission Resources
  - Construction Safety Training Pilot Presentation

- Critical Incidents Report

- Sub-Committee Reports
  - Clinical Laboratories
  - Support Services
**INFECTION CONTROL / OCCUPATIONAL HEALTH SERVICE**
**INVESTIGATIVE REPORT RABIES EXPOSURE**

**DATES OF EXPOSURE:** 9/14/11-10/12/11

**SOURCE PATIENT/UNIT #:** Removed to protect patient confidentiality

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This report was initiated by Infection Control

<table>
<thead>
<tr>
<th>ICP:</th>
<th>Heidi Schleicher, RN</th>
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<tr>
<td>OHS NP:</td>
<td>Andy Gottlieb, NP</td>
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</table>

**REFERRAL SOURCE:**

10/19/11 MDPH paged David Hooper M.D. of the MGH Infection Control Unit during the evening to notify him that a sample from the source patient was positive for rabies at the MDPH lab

10/20/11 in the morning the OHS was notified of the exposure situation. Inpatient at MGH, during dates listed at the top of the page, identified as being infectious for rabies by MDPH and confirmed by CDC. Patient expired on 10/12/11 from rabies infection. Patient was on standard precautions while an inpatient.

**DESCRIPTION OF PROBLEM:**

Will utilize the exposure definition provided by the Boston Public Health Commission to determine if any employees actually exposed and if so will offer post-exposure prophylaxis including Rabies Immune Globulin and Rabies Vaccination. Exposure will be considered possible if there was unprotected contact to the patient’s tears, saliva, CSF, or brain tissue. Will require counseling and health education to involved areas due to the unusual exposure and high level of concern that will likely occur once employees are notified of the possible exposure. Will develop handout to provide to assist with counseling.

**PLAN:**

- Since a rabies exposure is uncommon and not seen before at MGH, the OHS and Infection Control met to review the exposure circumstances & develop a plan
- Infection Control and OHS contacts (Heidi Schleicher & Andy Gottlieb) will be in communication with the Boston Public Health Commission (BPHC) to ensure the plan for evaluation and prophylactic treatment meets their standards
- The clinical areas involved were identified & an email was sent to leadership in each area instructing them to identify staff that could have been exposed to the source patient and to forward the list to OHS
- The OHS populated a spreadsheet with the names of possibly exposed employees. This will also include outcome data regarding whether exposed and whether received prophylaxis. This information is to be shared with BPHC.
Given the large number of potentially exposed employees, a survey was developed by OHS, Infection Control, and BPHC providing some info about rabies and exposure to rabies and asking several questions which would identify those actually exposed. It is presumed that while many employees had contact with the patient, if standard precautions were followed, very few would have actually been exposed. Leadership in the clinical areas involved is instructed to provide the survey to the employees on their list as having contact. Surveys are to be returned directly to the OHS for review to identify any employees with an actual exposure.

The OHS will review surveys to identify exposed employees and contact them. Employees with actual exposure will be seen immediately, assessed for exposure, counseled, and offered prophylaxis following established OHS protocol using Rabies Immune Globulin and Rabies Vaccine. The OHS will consult with an Infectious Disease MD at MGH prior to providing prophylaxis.

The OHS will review the spreadsheet and identify any employees who have not returned a survey to ensure that 100% of the employees identified as potentially exposed complete a survey.

Review of patient documentation indicated that during an almost one month period of inpatient care the source patient had contact with many employees and underwent numerous tests and procedures.

Areas involved are:
**Lunder 6, Lunder 7** - Employees with contact include MDs, RNs, PCAs, CCTs, PTs, OTs, Case Manager

**OR** on 9/23/11 and 9/27/11. Employees with contact include MDs, RNs, Scrub Techs, OR Techs, Anesthesia Techs

**Imaging including X-ray, MRI, Ultrasound, & Cardiac Ultrasound, EEG, and EVK**. Employees with contact include Techs in each area.

**Pathology including Autopsy on 10/13/11, Surgical Pathology on 9/27/11, and Microbiology for multiple sputum and lung tissue cultures**. Employees with contact include MDs and Medical Techs.

It was determined that 221 employees had probable contact with this patient. None of these employees during the patient’s hospitalization reported an exposure to blood or body fluids. Based on survey responses and interview by OHS, there were 16 employees for whom exposure could not definitively be ruled out and who requested prophylaxis.
CHIEFS’ COUNCIL MEETING
MINUTES
June 6, 2012
8:00 a.m. – 10:00 a.m.

MEMBERS PRESENT: Dr. Austen in the Chair, Drs., Ausiello, Blute, Conn, Cudkowicz, Ferris, Fisher, Haber, Kaban, Lillemoe, Loeffler, Martuza, Miller, Mort, Nadol, Nicholson, Rosenbaum, Rubash, Schiff, Sundt, Thrall, Torchiana, Vacanti, Wiener-Kronish and Zafonte.

OTHER ATTENDEES PRESENT: Drs, Elrick, Klibanski, Orf, Ms. Colton, Ms. Ives Erickson, Ms. Mason Boemer, Mr. Pauly, Ms. Prespitino, Ms. Slasman, Ms. Saraf (staff) and Mr. Thompson

ABSENT: (Members): Drs., Crowley, Jellinek, Klienman, Kingston, Kimball, Louis, and Slavin, (Other attendees): Mr. Higham and Ms. Sapir

GUESTS: Drs. Doody, Hooper, and Troulis, and Yeh, Ms. Asfaw, Mr. Pecoraro and Ms. Weinstien

The minutes dated May 16, 2012 were approved.

ANNOUNCEMENTS AND UPDATES

DR. GOTTLIEB
Dr. Gottlieb announced that the Senate and House have each passed payment reform legislation in the past few weeks. The House was considering its bill yesterday and we are still analyzing the changes that were made on the floor. He said that he felt as though we had made some progress making it appear that it is less likely that we would sustain severe adverse effects. Dr. Gottlieb said that the trigger for the GSP is no longer there but that the luxury tax is still in the bill. Although the bill requires ACOs to be licensed by the state, the total number in the ACO has been capped. The bill also requires public and private payers to negotiate separate contracts for each facility within a system. Each facility must have a separate negotiating team and “firewalls” that prevent them from sharing information. Dr Gottlieb said we are protected as we were able to get language that allows the state to grant waiver, meaning we should be able to contract together. Last month, the Senate passed a more moderate, market centered bill. Discussion ensued.

DR TORCHIANA
Dr. Torchiana reported that 84% of those who have been assigned the Joint Commission Training module have completed it and that 94% of clinically active physicians have done so. He announced that the deadline has been extended for the 15% that have not finished. Dr. Torchiana then mentioned that meaningful use registration and attestation will begin this fall. A plan for distributing 60% of the funds to physicians is being developed. Dr. Torchiana then recalled that in a prior meeting Dr. Slavin had shared the latest hand hygiene data showing a consistent 90% before and 90% after rate of compliance with hand hygiene policies but showing variation among role groups and persistently lower performance by physicians. He and others wondered about what kinds of failures are preventing scores that are closer to 100%. Using data supplied by Dr. Hooper and his team Dr. Torchiana showed that the 2nd most common failure, especially on surgical floors, was related to glove issues. He explained that you must Calstat before and after donning the gloves. Dr Torchiana then went on to describe mid-task failures, which occur in the midst of patient care. This can happen if the healthcare worker moves from a dirty task to a clean one without using HH, or leaves the patient to run for additional supplies and then returns – without using HH. Hand hygiene is required before and after contact with the patient’s environment. The third most common failure is communication devices. Communication devices include green books, charts, phones, pagers, and desk-area computers. These are all part of the “office” environment - NOT the patient’s environment. After using any of these items, hands must be disinfected before contact is made with the patient or patient’s environment and then again after contact. Dr. Torchiana said that he believes it is just a matter of educating everyone to these risks and asked the chiefs to present this subject in their
department meetings saying that the Joint Commission expects a minimum of 90% compliance with these hand hygiene guidelines.

**DR. AUSTEN**

Dr. Austen asked Dr. Torchiana to convene the GEC meeting to review 26 resident, research associate, and fellow appointments. Dr. Austen said that none of these proposed appointments was problematic. Ms. Ives-Erickson then proposed the nursing appointments. There was a motion to approve, the motion was seconded; there was no dissent. The Trustee Committee on Appointments and Privileges approved all of the above. Dr. Austen then reconvened the Chief’s Council meeting.

**DEPARTMENT OVERVIEW-RADIOLOGY**

Dr. Thrall began by telling the group that he has been thrilled by the all of the other chief’s departmental presentations and he hoped that his would have the same effect on his colleagues. He began by saying that there are 2,000 people in the Radiology department and they perform over 800,000 exams per year or 21/2 thousand per day, with about 100,000 occurring in the ER. Dr. Thrall then praised the opening of the Lunder building and said with its high technology, advanced imaging, it has provided the department with ability to bring the best imaging “to the patient instead of bringing the patient to the technology” allowing for better patient care. He also mentioned that MGH is the only hospital in the US with PET/CT and Highfield MRI embedded in the Neurology Unit. Dr. Thrall described some novel research from his department on brain imaging/mapping, breast tomosynthesis and radiation dose research and education being conducted at the MGH Webster Center. The chiefs were fascinated and asked many questions. Dr. Thrall concluded with some of the concerns for his department such as how they can respond effectively to decreases in reimbursement for radiology services and restrictions on utilization by third party payers, if they can continue capital funding for the renewal of the installed base imaging equipment and the acquisition of new modalities and the management of the research portfolio with diminished funding from the NIH. Finally, he thanked the chiefs, announcing that this would most likely be his last presentation but said his department is looking forward to the next 200 years!

**IMPROVING VALUE IN CORONARY INTERVENTION**

Dr. Robert Yeh (interventional cardiology) presented efforts that are occurring in the cardiac catheterization laboratory, supported by the MGPO, to improve the individualized treatment of patients undergoing coronary intervention. These efforts focus on exploiting heterogeneity in the magnitude of benefit that patients are expected to receive from treatment alternatives. The research involves developing accurate risk prediction models from large clinical databases, and then applying these models at the point of care (imbedded within the informed consent process) to serve as decision aids for clinicians and improve shared decision making. These methods may be useful in both improving patient outcomes and decreasing costs, ultimately improving the value of clinical care, and are broadly applicable across many areas in medicine.

**MGH APPROACH TO REQUESTING & CHARGING FOR PRIVATE ROOMS**

Ms. Mason-Boemer introduced an effort to put a clear policy and set of guidelines in effect that would be consistently and fairly applies to avoid any customer service issues. The opening of the Lunder Building required our private room charging methodology to be reviewed as private rooms are the standard for patients placed in the Lunder Building, as well as Gynecology patients placed on Phillips 21, and it is not appropriate to hold patients liable for our bed allocations and placement methodology. Formal – requests made for patients who would like a private room as a key priority to placement may make a request and will incur the self-pay liability if a private room is available. Standby – requests made for patients who would like to have a private room considered for placement, however recognize it is not a key priority in placement; if a private room happens to be available the patient will be placed accordingly and will not incur a liability. Lastly the cost of these requests will be lowered and a 25% discount will be applied for prompt payment. Discussion ensued.

Details on all presentations are available at the following link:  

The Executive Session began at 9:50 AM
Massachusetts General Hospital
Infection Control Committee Minutes

Date: January 24, 2012

Members Present: Mallory Davis, John Branda, Peter Dunn, Irene Goldenshtein, Andy Gottlieb, Fred Hawkins, Kathleen Hoffman, David Hooper, Katherine Kakwi, Kathy Kelly (for Ed Raeke), Laura Listro, Janet Molina, Brit Nicholson, Heidi Schleicher, Nancy Swanson, Judith Tarselli, Dawn Tenney, Paula Wright, JiYeon, Kim, John Dekker

David Hooper called the meeting to order at 12:00 pm.

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION SUMMARY</th>
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<tbody>
<tr>
<td>Minutes from 11/22/2011</td>
<td>Posted on SharePoint site for member review. (Note: The December 2011 meeting was cancelled.)</td>
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<td>Actions/Recommendations: Minutes approved. Power Point Presentation of the meeting is made a part of these minutes.</td>
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STANDARD AGENDA

Epimarkers Q4, 2011
- HA-MRSA
- HA-VRE
- HA-C. difficile
- LABSI/CLABSI
- HA-MDRO Enterics and Non-enterics

Presented by Paula Wright

Abbreviations
HAI = Healthcare-associated infection
MDRO = Multiply drug-resistant organisms
POA = Present on Admission
Rate = # HA cases per 1000 patient-days

HA-MRSA
Q4: 43 cases, rate 0.60. This rate represents a slight increase for the second time since Q2-2011 when the rate reached an historic low. Despite that, the current rate is still considered low, and no factors for the slight increase in Q3 and Q4 have been identified.

Annual # of HA-MRSA cases: slight increase from 142 cases in 2010 to 147 cases in 2011

The number of POA cases that were reported in the past was adjusted downward due to a change in what is included in the data. Past reports included colonized patients (positive nasal swab only) and outpatients. These cases have been removed from the POA data. Only inpatients identified with a positive clinical isolate are included. Based on these new parameters, a total of 413 patients were identified with MRSA-POA in 2011; a decrease from 463 cases identified in 2010.

HA-VRE
Q4: 45 cases, rate 0.63. This rate has varied periodically but otherwise remained near 0.60 since the late 1990s.

Annual # of cases: Decreased from 197 cases in 2010 to 188 cases in 2011.

The number of POA cases that were reported in the past was adjusted downward due to a change in what is included in the data. Past reports included colonized patients (positive rectal swab only) and outpatients. These cases have been removed from the POA data. Only inpatients identified with a positive clinical isolate are included. Based on the new parameters, a total of 163 inpatients were identified with VRE POA in 2011; a decrease from 463 cases identified in 2010.

HA-Clostridium difficile disease
Q4: 44 cases, rate 0.61. This rate marks a substantial decrease from Q3 when a spike was observed in both number and rate. The current rate is comparable to rates observed in most quarters since late 2009.

Annual # HA-C.diff cases: Increased from 165 cases in 2010 to 185 cases in 2011.
The number of POA cases that were reported in the past was adjusted downward due to a change in what is included in the data. Past reports included outpatients. These cases have been removed from the POA data. Based on the new parameters The number of POA cases per year also increased from 134 in 2010 to 174 in 2011.

Positive *C. difficile* toxin test results identified among outpatients are excluded from both of these counts.

**Line-associated bloodstream infections (LABSI) and central line-associated bloodstream infections (CLABSI)**

Report deferred to next meeting; cases are still being reviewed.

**HA-MDRO enterics and non-enterics**

The numbers and rates for MDRO-Enterics and MDRO-Non-enterics decreased in Q4, following a spike in Q3. Highlights include:

- **RGN All + ESBL**: 36 cases, rate 0.50 (compared to Q3: 76 cases, rate 1.05)
- **ESBL only**: 20 cases, rate 0.28 (compared to Q3: 56 cases, rate 0.78)
- **ESBL Klebsiella**: 6 cases, rate 0.08 (slight decrease in Q4)

These rates are currently at or near their baselines. No changes in testing, factors, or strong associations were identified to explain the spike seen in Q3.

*See PowerPoint presentation for all rates*

All ICU patients identified with an ESBL are placed on Contact Precautions; non-ICU patients are not. After the increase in Q3, consideration was given to adding a requirement for all ESBL+ patients to be “flagged” and require Contact Precautions. An assessment of the impact that might have in terms of additional patients requiring a flag for the month of September was completed, using resistance to ceftriaxone as a marker for ESBL cases. It was identified that an additional 105 patients would have been flagged, 49 of which would have been inpatients. A change of precautions status for these patients could potentially have a substantial impact on capacity management. Thus, a decision was made to wait for Q4 data. Q4 data demonstrated a return to prior rate so at this point will continue to limit requirements for Contact Precautions to the ICU setting due to high-risk nature of ICU patients.

**Actions/Recommendations:** Next report date April 24th, 2012

**STOP Task Force Q4, 2011 Compliance surveys**

- **Hand Hygiene**
- **Personal Protective Equipment (PPE)**

*Presented by Judy Tarselli*

**Hand Hygiene**

Annual HH compliance rates averaged “90/90” or better for the third consecutive year, despite a slight decline in 2011. (“90/90” = 90% or better, both before and after contact.) Monthly rates “before contact” dipped below 90% periodically in Q3 and Q4, but the Q4 data closed with average rates of 90/95.

As HH compliance rates remained above 90% for 10th consecutive quarter in early 2011, the HA-MRSA rate reached an historic low. As HH rates “before contact” began to dip below 90% in the second half of 2011, however, the HA-MRSA rate began to increase. An inverse correlation between these rates has been observed and will continue to be monitored.

HH improvement efforts in 2012 will be focused on locations and groups that have lagged behind others historically, or that slipped below 90% compliance more recently. Efforts will also continue to expand the program and establish compliance...
measurement systems in additional areas, including test sites, procedural areas and ambulatory care practices. Current results from several locations that have adopted a self-monitoring program based on the hospitalwide program were presented. The new HH poster series, which features selected individuals from various role groups and historical MGH images, was also presented.

**PPE Survey results**
Purpose: to measure the correct use of gloves and gowns by healthcare workers (HCWs) when they are working with a patient who is on Contact Precautions or Contact Precautions Plus.

The PPE compliance rate for Q4 was 75%. The most common types of failures, in order of frequency, were: “Gown not tied” (minimally, at neck); “Gown, improper wear” (usually due to slippage resulting from a failure to tie the gown); “No gloves” (required upon entry, even when no contact is intended); “Improper removal or disposal of gowns” (usually due to saving of gown for reuse.) These results were comparable to previous quarters. A shift in the major categories of failure was noted in 2011: “Failure to use PPE” dropped from 32% to 15%, while “Improper use” rose from 55% to 75%. This pattern indicates more HCWs are wearing PPE when indicated, but are not consistently using it correctly.

**Actions/Recommendations:** This information was sent to unit leaders and HH Champions, and will be presented to PCS Combined Leadership. Data are also reported to EED Committee, and a focused messaging campaign is planned. Next report date April 24th, 2012

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<tr>
<th>AGENDA ITEM</th>
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<tr>
<td>OHS Report Q4, 2011</td>
<td>TB Skin Testing Q4 testing included routine, pre-placement, booster, and post-exposure testing. # Exposure conversions: None.</td>
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<td>T-Spot Test: Cost is $50/test. Use of this test is recommended by MDPH for employment testing of all persons who: are from TB endemic countries; have received BCG at any time; have had positive skin test in past; or had recent TB exposure. Approximately 200 tests have been done to date, mostly for pre-placement of persons from other countries. This number includes 75 non-employees (e.g., visiting physicians or researchers) who may work here temporarily. It was noted that even those who are expected to work here for short periods of time are included in the standard employment screenings.</td>
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<td>Reportable disease activity GI illness: A total of 59 cases of GI illness were reported in staff across 38 worksites in Q4, but no clusters were observed. The MDPH issued an alert of GI illness last week. Employees are routinely reminded to notify OHS if they have symptoms of GI illness or other communicable diseases.</td>
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<td>Influenza-like illness (ILI): 19 (very low numbers for influenza season)</td>
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<td>Other illnesses: No significant reports.</td>
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<td>Exposures Mumps: 3 potential exposures, including 1 suspect case, 1 low-suspect-but-confirmed</td>
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case, and 1 revoked case. All potentially exposed employees were already immune, so no furloughs were needed. This outcome reflects improvements made in confirming or establishing immunity through vaccination prior to potential workplace exposure. It was noted that OHS must respond to exposures to suspect cases as well as confirmed cases, so these improvements have reduced the OHS workload and the need to furlough exposed workers unnecessarily.

Varicella: 1 varicella case and 4 confirmed disseminated zoster cases, which resulted in 232 exposures in 13 areas. Of those, only 3 employees required furlough. See related topic: Policy changes (below)

_N. meningitidis:_ 1 confirmed case, which resulted in 26 exposures in 3 locations. 24 employees were given prophylaxis, and 2 employees did not respond to OHS.

TB: 3 cases, with 36 exposures in 5 areas. Exposure conversions: None.

Rabies: Two cases.  
Patient #1 (October) resulted in 215 employee assessments for possible exposure, zero confirmed exposures, and post-exposure prophylaxis (PEP) for 16 employees.  
Patient #2 (December) resulted in 147 possible exposures, 110 assessments for exposure, zero confirmed exposures, and PEP for 9 employees.  
It was noted that there have been no documented cases of human-to-human rabies transmission in history, and most workers responded “I don’t know” when assessed for exposure, but a conservative approach was taken in regards to providing PEP due to the serious and most-often fatal outcome of rabies. Most workers given PEP worked in the autopsy suite where risk was increased due to potential tissue exposure.

Influenza Vaccination (2011-2012)  
Flu vaccination numbers and rates for employees are higher this season (17,714 employees; 85%) than last season (17,392 employees, 82.8%) despite the lack of incentives, requirements, or employee warnings. The numbers and percentages of employees who declined the vaccine are also lower: 2472 (11.8%) declined this season, compared to 3033 (14.4%) last season. It was noted that two other Boston hospitals now require flu vaccination for all direct care providers.

Flu vaccine is still available and will be offered to employees through March. The circulating influenza A H1N1 and H3N2 strains are in over 90% of cases the same as those in the vaccine. Two influenza B strains are circulating in approximately equal numbers, one of which is included in the vaccine.

OHS Policy Changes  
Varicella exposures: Employees who received two varicella vaccinations will no longer be automatically furloughed if exposed to a person with varicella disease. Instead, a varicella titer will be done. If titer is positive, the worker will not be furloughed but will still be required to wear a mask while caring for the varicella patient. If negative, the worker will be furloughed per OHS protocol. Pre-employment varicella titers will NOT be routinely done on previously vaccinated employees because it is not known how long immunity through vaccination lasts.
AGENDA ITEM  | DISCUSSION SUMMARY
--- | ---
Herpes simplex: Direct care providers with herpes simplex lesions on their face were previously furloughed until the lesion was dry. Now, they will be allowed to work with a mask.

Both of these changes should prevent unnecessary worker absences without compromising patient safety and will standardize the policy for both BWH and MGH.

**Actions/Recommendations:** Next report date April 24th, 2012

**Infection Control Program**
- **Annual Plan Review**
- **Hazard Vulnerability Analysis (HVA)**

Presented by Paula Wright

CAUTI = Catheter-Associated Urinary tract Infection

CLABSI = Central Line Associated Bloodstream Infection

CMS = Centers for Medicare & Medicaid Services

DPH = Dept. of Public Health

NDNQI = Nursing Database of Nursing Quality Indicators

NHSN = National Healthcare Safety Network

SSI = Surgical Site Infection

VAP = Ventilator-Associated Pneumonia

**Changes to the Infection Control Program for 2012**

Changes required by new surveillance and reporting mandates and new definitions to align with CDC and other Partners hospitals include the following:

- **CLABSI surveillance:** expanded to general care units, except for Maternal/Child units, beginning 4/1/11 (Magnet requirement).

- **CAUTI surveillance:** new NHSN reporting mandate, effective 1/1/12. Includes surveillance in ICUs by Infection Control Unit (CMS requirement) and surveillance on general care units by PCS staff (Magnet requirement).

- **VAP surveillance:** New NDNQI reporting, effective 1/1/12. Includes surveillance in all ICUs plus RACU by PCS dedicated staff (Magnet Requirement). VAP surveillance in SICU will continue to be done by Infection Control Unit staff.

- **SSI surveillance:** Will only target procedures mandated by CMS and/or DPH.

**Additional changes include:**
1) New HAI definitions for MRSA, VRE, MDRO, *C. difficile*. Beginning on 1/1/12, cases identified on or after day 4 will be considered an HAI. Previous definition was cases identified ≥ 48 hours after admission were considered an HAI.
2) A 3-month pilot of Active Surveillance Culturing (ASC) for MRSA and VRE on E7 and W7 will begin in February, in response to identified higher rates on these 2 units.
3) Expanded MRSA and VRE culturing in NICU.

**HAI Surveillance Plan will include:**
- Standard epimarkers (*MRSA, VRE, C. difficile, CARB R, ESBLs, and MGH-defined MDRO gram negatives*).
- Select pathogens in ICUs: *Acinetobacter, Stenotrophomonas maltophilia*.
- Device-associated infections, including those required for mandatory reporting as previously described: **CLABSI, VAP, CAUTI**.
- SSI, as mandated by MDPH or CMS: *hip and knee arthroplasty, hysterectomies, colon surgeries*.

**Process/Practice Surveillance Plans will include:**
- Autoclaves: biological testing, preventive maintenance and repair
- Personal Protective Equipment (PPE) correct use
- SCIP 1, 2, 3 measures (CQS)
- Hand hygiene compliance: *inpatient, ambulatory care, and special settings (as required for Contact Precautions Plus)*
- Environmental: *Routine inpatient and ambulatory surveillance rounds; construction; isolation rooms and OR airflow*
### AGENDA ITEM

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<th><strong>DISCUSSION SUMMARY</strong></th>
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| **Hazard Vulnerability Analysis (HVA)**  
*(See PowerPoint slides for details.)* The IC Program HVA was evaluated and scoring revised by the Infection Control Unit staff. It was then distributed in advance of the meeting to Committee members for review. Recommended changes were highlighted, presented, and discussed at the meeting. There was agreement with scoring for all except the risk assessment related to sterilization. The Infection Control Unit increased the risk score on this function due to the operational challenges that were encountered as part of the transition to the new CSPS space in the summer of 2011. OR leadership members of the Committee felt the change in risk scoring was not warranted as considerable efforts and improvements have since been made to address the issues. The matter will be reviewed, the risk level will be reassessed, and final recommendations for the 2012 HVA will be presented at the next meeting. HVA scoring is used to direct surveillance and program goals.  

**Infection Control Program Goals: Supporting the MGH Mission and Goals**  
The Annual Goals for 2012 are focused on reducing healthcare-associated infections; promoting efficiency, affordability, and effectiveness; and reducing the risk of work-related infection. *(See PowerPoint presentation for list of goals)*  
The goals are aligned with the MGH Mission and linked to our institutional goals to deliver safe, compassionate, and excellent care to our patients and to achieve outstanding accreditation as a hospital.  

**Actions/Recommendations:** Next report date January 22, 2013 |

### OLD BUSINESS

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<td><strong>Isolation Rooms report</strong></td>
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| Preventive maintenance was completed on all 124 isolation rooms. Corrective maintenance was needed for 6 rooms and included 1 damper repair, 3 room pressure checks, 1 alarm repair, and 1 thermostat replacement. All rooms were identified as meeting HVAC requirements.  

**Operating Rooms (1/1/11 to 12/1/11)**  
Preventive maintenance was completed on 63 of 63 scheduled OR rooms, including those in Boston, Waltham, and Danvers sites. All rooms were identified as meeting HVAC requirements.  

A total of 10 ORs were removed from Wang ACC.  

**New rooms: Opening of Lunder Building, 2011**  
The following rooms were opened after completion of the new Lunder Building: 42 Protective Environment (PE) rooms, including 6 with anterooms; 32 Airborne Infection Isolation (AII) rooms, including 27 with anterooms; and 29 Operating Rooms on three separate floors (Floors 2, 3, and 4). All rooms were validated as meeting HVAC requirements as part of building commissioning.  

**Actions/Recommendations:** Next report date June 26, 2012 |

### DEFERRED AGENDA

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| The following topics were deferred to the next meeting due to limits on agenda space and time:  
  - Environment of Care (EOC) report  
  - JCR Visit follow-up  
  - Policy Review Update  
  - Ventilator-Associated Pneumonia (VAP) Q4,2011  
  - Bloodstream Infection data |

Meeting adjourned at 1:00pm. Next meeting: 2/28/12.
Announcements and Updates

- Committee members were requested to review the 2012 schedule for annual reporting and to contact Bob Castaldo to resolve any scheduling conflicts.
- The reviewed and updated section 2 of the safety manual, covering fire and life safety, and including recent changes to the ILSM section, was approved and will be reposted in the Trove Library.
- Members were asked to review the Construction Safety section of the safety manual and submit comments to Bob Castaldo prior to the February meeting, at which time changes will be summarized and committee approval will be requested.

Critical Incidents

- An elderly patient in Geriatric Services at 165 Cambridge Street mistook the stairwell door for the restroom access door and fell and injured herself in the stairwell. Building managers and MGH EH&S staff have evaluated the space and made adjustments that include new signage. Alarming the stairway door is also under consideration to alert staff in the reception area when elderly patients attempt to access the stairway.
- Discussions following a recent code red incident in the White Building OR area have pointed out the lack of alarm annunciation at the Gray OR Control Desk. B&G is currently looking into the best way to rectify this condition.

Open Agenda and Discussion

- Follow up on JCR:
  - Corridor clutter and storage remains a key target for improvement. A task group with representation from Patient Care Services, Materials Management and EH&S has been formed to readdress this concern. A facility wide survey of corridor conditions has already been completed and the group will now proceed to categorize floors by degree of risk and noncompliance and define and implement an improvement strategy.
  - EH&S is working with Pharmacy to review the current system for disposal of hazardous pharmaceutical wastes and identify and address any gaps in compliance with relevant standards and best practices.
  - Biomedical Engineering is leading a group to address a comprehensive management plan for sterilization management.
  - The Planning Office is working on improving the record keeping and tracking of ILSM and ICRA measures for all construction and renovation work.
- Laura Listro, Clinical Pathology, initiated a discussion regarding eyewash station requirements and management. EH&S will work with Ms. Listro to comprehensively evaluate needs and current compliance status in the labs and address any concerns.
- Lela Holden, Office of Quality and Safety, inform the committee of a survey will be going out at the end of February regarding the MGH safety culture.

Regulations Update

- None
### 30 Day Review
- March 2012
  - Occupational Health – Annual Employee Injury/Illness Report
  - Ergonomics Program

### 60 Day Review
- April 2012
  - Ambulatory / Outpatient / Health Centers & Offsites
  - Support Services

### 90 Day Review
- May 2012
  - In-Patient Surveillance & Patient Safety Initiatives
  - Clinical Laboratories

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**Agenda for Next Meeting - Tuesday, February 7, 2012; 9-10 AM; Bulfinch, Room 225A**

- Approval of Minutes
- General Announcements and Updates
- Critical Incidents Report
- Committee Report
  - Fire & Life Safety
  - Construction Safety