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The PEARS Evaluation

Comprehensive integrated prevention and return-to-work program reduces time loss and compensation costs

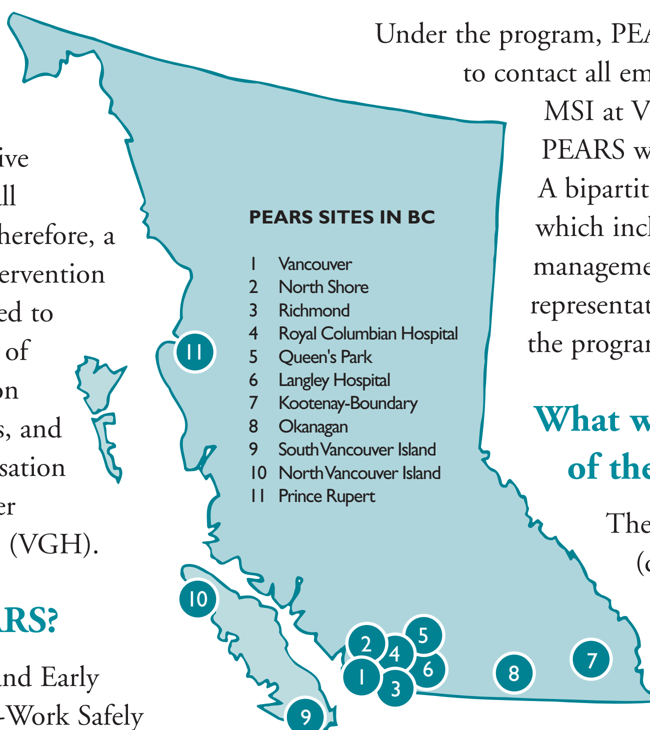
Healthcare workers are at high risk of workplace injury, especially musculoskeletal injury (MSI). There is increasing evidence that part of the solution to this problem lies in an integrated (prevention and prompt follow-up), workplace-based and work-focused approach. The success of such an approach also depends on an organizational culture of safety and the cooperative participation of all stakeholders.[1 2] Therefore, a 1-year "pilot" intervention study was designed to assess the impact of such a program on injuries, time loss, and workers' compensation costs at Vancouver General Hospital (VGH).

What is PEARS?

The Prevention and Early Active Return-to-Work Safely (PEARS) program integrates primary prevention activities with prompt on-site follow-up. PEARS combines three components:

1. Primary prevention, which built on the existing work of the musculoskeletal injury prevention team;
2. Secondary prevention, which involved prompt follow-up of injured workers with comprehensive measures for workplace modification and clinical treatment; and
3. Extensive data gathering to track the efficiency and effectiveness of various initiatives.

Under the program, PEARS staff attempted to contact all employees reporting a MSI at VGH. Participation in PEARS was entirely voluntary. A bipartite steering committee, which included hospital management and union representatives, oversaw the program.



With the success of the two PEARS pilots, the program has now expanded to eleven sites around the province.

What were the results of the pilot?

The participation rate (determined by the number who signed consent forms) in the PEARS program was 51% or less within any of the occupational groups.

Preliminary results of an extensive telephone follow-up suggest that among the reasons for non-participation were the perception that an injury was not severe enough and an incomplete understanding of what the PEARS

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A Message from the Executive Director

The issue of patient safety has received increased media attention over the last several months. Reports of adverse events in healthcare settings regularly appear in the news, and several major patient safety reports have been released. Understanding the wide range of root causes of human error in healthcare settings is of critical importance, including the recognition that attention to patient safety includes attention to the health and safety of healthcare workers themselves.

At OHSAH, we recognize that the health and safety of caregivers goes hand in hand with the quality of care given to patients. Evidence points to the negative impact on patient care resulting from the all too familiar cycle of time loss due to injury and stress, short staffing, and increased workload - which in turn results in higher risk of injury to both patients and healthcare staff. Examining this cycle and its specific relationship to patient outcomes is an important priority.

Tied to this is the need for a better understanding of the links between mental health of healthcare workers, organizational culture, and patient safety. The Auditor General's report made it clear that while musculoskeletal injuries (MSI) have long been a priority in this province, the mental stress of caregivers has lagged behind in terms of the attention it has received. These are important issues that will only improve if more attention and resources are directed to gathering evidence about what is effective in addressing the varied mental stressors experienced by the healthcare workforce. At OHSAH, this will be one of our new priorities in the coming months and years. We look forwarding to working with all our partners and stakeholders to address these important issues.

Annalee Yassi, MD, MSc, FRCPC

New Face at OHSAH

Dr. Elizabeth Smailes joins OHSAH as the Director of Mental Health and Organizational Development. Dr. Smailes is an occupational health psychologist with a wide range of clinical experience. In addition, she is a well-trained researcher with interests in occupational stress, safety climate, job-related decision making and workers' mental health. She has expertise in questionnaire design, interviewing, leading focus groups, and program evaluation. This work led to the development and evaluation of work stress interventions for healthcare workers and on-line educational programs for improving healthcare worker response to emergencies. She also was a co-investigator on a project on the World Trade Center evacuation, as well as a bioterrorism training evaluator with the US Center for Public Health Preparedness.

YOUR COMMENTS PLEASE!

Please send your comments, ideas or suggestions to editor@ohsah.bc.ca, or by mail to OHSAH, Health & Safety News, 301-1195 West Broadway, Vancouver BC, V6H 3X5.

OHSAH MISSION STATEMENT

- To work with all members of the healthcare community to develop guidelines and programs designed to promote better health and safety practices and early return-to-work
- To promote pilot programs and facilitate the sharing of best practices
- To develop new measures to assess the effectiveness of programs and innovations in this area

... continued from page 1

THE PEARS EVALUATION

program offered. Recent provincial legislation overrode segments of negotiated healthcare labour contracts for Facility Support Services (FSS) staff and it is reasonable to assume that low participation among this group was related to impending layoffs and the distrust this created.

Although participation rates were low, considerable savings in compensation costs were achieved during the PEARS year for injuries to Registered Nurses (up to 44%) and Health Science Professionals (up to 73%). It is difficult to determine how much of these savings was a direct result of PEARS, rather than a result of the activities of the MSIP team or other factors known to impact time loss.[3 4 5]

There were significant reductions in MSI-related total time loss per productive hour for RNs at VGH (up to 40% in total time loss) and the control hospital, and for HSPs at VGH (up to 67%) – although not for FSS employees, again likely related to the lower than optimal participation. It is likely, however, that PEARS did not have a major influence on this decline in the MSI time loss rate at VGH, as it was already declining before PEARS started. Interviews with program personnel at VGH revealed that the MSIP team activities remained somewhat isolated from the secondary prevention efforts of PEARS. This may have limited the primary prevention spin-off expected when workplace modifications were put in place to bring injured workers back to work more quickly. With better integration, as is currently occurring at VGH, further reductions in MSI can be expected.

While 92% of the individuals who entered the PEARS program received physiotherapy, only 44% received work practice modifications and 26% received workplace modifications. Perhaps had more participants received work environment or work practice changes, there may have been a greater reduction in injuries during the PEARS year.

Once a time loss injury occurred, it was clear that PEARS was successful in returning employees to their regular duties more quickly than prior to the program. Both RNs and HSPs had significant reductions in the time to return to work during PEARS. At the control hospital there were no significant changes in the time to return to work, which lends support to the notion that PEARS did account for the changes observed at VGH.

Conclusions

The PEARS program marked a shift from what was previously occurring at VGH in several important ways:

1. It attempted to integrate prevention and prompt follow-up of people who were injured;
2. PEARS had strong union involvement in its design, implementation and evaluation. The goodwill created by the bipartite governance, despite the tense political times, was instrumental to the success of the program; and
3. There was a commitment to evidence-based decision-making.

The PEARS program was successful at reducing the time loss and associated costs related to injuries for RNs and HSPs. It is recommended that return-to-work programs incorporate the features included in the PEARS program.

PEARS pilots are currently underway at ten other sites across the province. This article is a condensed version of an in-depth summary of the evaluation of the VGH pilot, which is available on the OHSAH website (www.ohsah.bc.ca), or in hard copy by contacting OHSAH.

1 Williams RM, Westmorland M. Perspectives on workplace disability management: a review of the literature. Work 2002;19(1):87-93.

2 Yassi A, Ostry A, Spiegel J. Injury prevention and return to work: Breaking down the solitudes. In: Sullivan T, Frank J, ed. Preventing and managing injury and disability at work. London: Taylor & Francis, 2003:75-86.

3 Frank JW, Kerr MS, Brooker A-S, et al. Disability resulting from occupational low back pain. Part I: What do we know about primary prevention? A review of the scientific evidence on prevention before disability begins. Spine 1996;21(24):2908-17.

4 Frank JW, Brooker A-S, DeMaio SE, et al. Disability resulting from occupational low back pain: Part II: What do we know about secondary prevention? A review of the scientific evidence on prevention after disability begins. Spine 1996;21(24):2918-29.

5 6. Krause N, Frank JW, Dasinger LK, et al. Determinants of duration of disability and return-to-work after work-related injury and illness: Challenges for future research. Am J Ind Med 2001;40:464-84.

Healthcare Ergonomics Conference

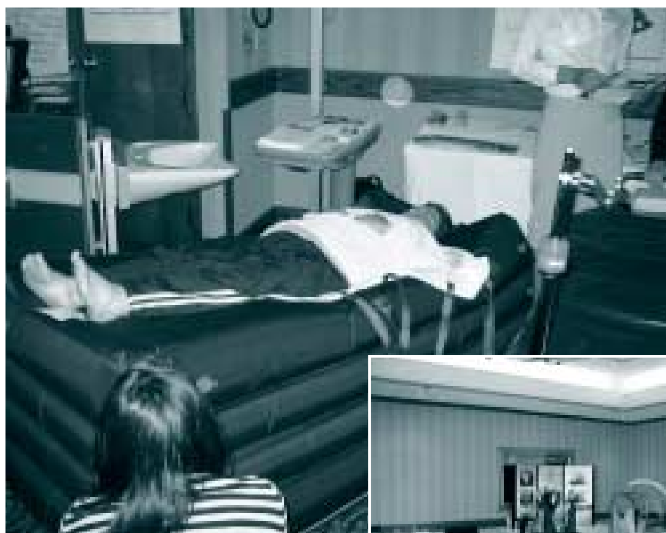
Healthcare industry shares best practices, tools, and information to improve health and safety

OHSAH ergonomist, Chris Back, attended the Healthcare Ergonomics Conference held in Portland, Oregon in July and presented about the work being done at OHSAH. The goal of the conference was to facilitate the sharing of information and best practices in healthcare from the US and internationally, including presentations from Canada, Australia and Denmark.

Back's presentation, titled *'Using a Joint Union and Management Approach to Effectively Implement Ergonomics Solutions in Patient Care and Non-patient Care Departments to Improve Workplace Health and Safety'*, described several ergonomic initiatives that have taken place within the BC healthcare industry to reduce workplace injuries and costs, and improve productivity, job satisfaction, and system efficiencies.

Conference attendees, who consisted of managers, front line employees, joint occupational health and safety committee members, occupational health and safety professionals, physiotherapists and nurses, shared strategies to address employee and patient safety issues related to healthcare ergonomics, in a cost-effective and practical manner.

The Healthcare Ergonomics Conference was a great success with plenty of information sharing and networking opportunities. OHSAH would like to share as much of this with the BC healthcare industry as possible. Listed on page 11, and on the OHSAH website, you will find links to a number of useful resources for the sharing of best practices in the healthcare industry.



To read more about specific OHSAH ergonomics initiatives, visit the Ergonomics program section of the OHSAH website.

CHANGING TO A "NO-LIFT" FACILITY: CHALLENGES AND OPPORTUNITIES

One of the highlights of the two-day ergonomics conference was a keynote session given by Joe Jolliff, former Administrator for Wyandot County Nursing Home in Ohio. Mr. Jolliff's presentation focused on the barriers that prevent a facility from implementing a "no manual lift" program and strategies to overcome these barriers. He also discussed the success his organization had when a "no-lift program" culture was established, along with the reduction in patient handling related injuries and costs. To read more about this story and view short video clips visit **http://home.earthlink.net/~nolifting/**.

Barriers and Facilitators to Implementing Protective Measures Against SARS and Other Existing and Emerging Infections for Healthcare Workers

Collaborative interdisciplinary study underway to understand healthcare worker attitudes towards respiratory infectious diseases.

BACKGROUND

The willingness and ability of healthcare workers to effectively provide care, while at the same time appropriately and safely protecting themselves and others from exposure to emerging infections, has enormous public health and healthcare implications. This was amply demonstrated in the spring of 2003 when Severe Acute Respiratory Syndrome (SARS) became both a serious public health concern and an occupational health issue.

Although transmission of SARS is not yet fully understood, it is suspected that failure to follow recommended infection control precautions may have resulted in SARS being transmitted to healthcare workers (HCWs). These events focused attention on infection control, yet little is known about the environmental and organizational factors that need to be addressed, as well as the understanding and attitudes of healthcare workers towards infectious diseases.

In collaboration with Vancouver Coastal Health, Fraser Health, the BCCDC, and WCB, OHSAH is working on a project funded by the Canadian Institutes of Health Research (CIHR). The project aims to characterize respiratory infectious diseases – especially SARS – by way of the knowledge, beliefs, attitudes, perceptions, and behavioural intentions of HCWs as well as their environmental and organizational determinants.

NEXT STEPS

The project has been approved by the relevant ethics committee and work has begun on the first two phases of this four-phase project. The research team is finalizing a workplace needs assessment form and a front-line healthcare worker questionnaire. The workplace assessment will be given to infection control practitioners and occupational health and safety specialists at each of the participating facilities, then followed up by a site visit to assess the workplace. The questionnaire will be provided to front-line staff. This phase is expected to be completed in early 2005. Project updates will be made available on the OHSAH website (in the funded research section) as well as in future editions of the newsletter.

OHSAH AND FRASER HEALTH TO CONDUCT A STUDY TO REDUCE EXPOSURES DURING SPILL CLEAN-UP

The WCB Research Secretariat recently notified OHSAH that it was successful in our joint application for a development grant. The project is titled *"Are Mathematical Models an Appropriate Surrogate for Exposure Monitoring when Establishing Respiratory Protective Requirements for the Clean-up of Small Indoor Chemical Spills?"* The purpose of this research is to determine if mathematical models can accurately predict airborne exposure levels due to indoor chemical spills.

Joint Committee Effectiveness – What Does the Evidence Say?

While Occupational Health and Safety (OHS) joint committees have been in existence in most medium and large sized workplaces for over a quarter of a century, only a few studies have attempted to measure their effectiveness. Even fewer have attempted to measure the impact of education programs on these committees, despite the fact that information, education, and training of OHS joint committee members has been identified as key to producing effective committees.

International Studies

In the UK, a sample of manufacturing plants revealed that those with a joint committee had, on average, 5.7 fewer injuries per 1000 employees than those without a functioning joint committee.[1] A US study of occupational health and safety committees in public sector workplaces concluded that some evidence existed that the committees were associated with fewer reported injuries and that this was due to a greater involvement of workers on the job in solving health and safety problems.[2]

In another US study, although the presence of a joint committee did not reduce the number of Occupational Safety and Health Agency (OSHA) complaints or serious citations, interviews with members of joint committees rated as effective by respondents showed fewer OSHA inspections and serious OHS complaints.[3] This study indicates that the mere presence of a joint committee is likely not enough to improve health and safety outcomes; the key to success seems to lie in ensuring the effectiveness of the committee.

Assessing Joint Committee Effectiveness in Canada

In Canada, an Alberta study was undertaken in the 1970s, soon after passage of legislation establishing joint committees.[4] Interviews were conducted with worker and management joint committee representatives from 36 randomly selected joint committees. Both labour and management committee members agreed that joint committees had successfully improved health and safety conditions in the workplace.[5]

Several other large empirical studies have been undertaken in Canada on the role of joint committees. In 1994, a mailed survey of labour and management representatives at 1500 Ontario workplaces showed that improvement in occupational health and safety were predicted by good communications, high employee job satisfaction, worker participation in decision making, and emphasis on teamwork in the company.[6] The major outstanding need noted in this study was for improvement in training of joint committees.

A study of Québec and Ontario workplaces found that joint committees with equal numbers of union and management representatives had lower injury rates and demonstrated enhanced problem solving compared to workplaces without these committees.[7] As well, it showed that the capacity of joint committees to function effectively was correlated with the amount of training and information available to members.

The conclusion of a recent comprehensive review of many of these and other studies is that OHS joint committees do seem to play a role in improving workplace health and safety. It seems, however, that the presence of an OHS committee is a necessary, but not sufficient, condition to achieve an improvement in injury rates.[8] As the review states, "the critical factor is the capacity of these committees" and "key determinants of joint committee capacity are access to information by joint committee members as well as effective mandatory training".

This literature review summarizes a part of a forthcoming article appearing in the October-December special issue of the International Journal of Occupational and Environmental Health.

references are listed on page 9...

IMPROVING JOINT COMMITTEE EFFECTIVENESS: HELP IS ON ITS WAY!

Where can your joint committee obtain the education that the literature shows is key to improving committee effectiveness? OHSAH is pleased to announce that HELP is on its way! All of OHSAH's education activities, including the Joint Committee Education and Development (JCED) program, will now be coordinated under the Healthcare Education and Learning Program (HELP), which establishes a consistent healthcare education program for joint committees, front line workers, community health workers, management, and union representatives.

The anticipated launch of HELP for Joint Committees is Winter 2005, and will feature regular training sessions in each Health Authority. This new program will allow greater numbers of joint committees to take part in education sessions on a regular basis.

To receive updates on the launch of HELP, sign up for the Health and Safety Update, our monthly e-mail newsletter (sign up at www.ohsah.bc.ca), periodically check the OHSAH website, or check the next issue of Health and Safety News.

Online Infection Control Module in Development

Influenza, SARS, and the emergence of antibiotic-resistant organisms all highlight the continued importance of good infection control practices. But when was the last time you received infection control training?

OHSAH, in collaboration with the Provincial Health Services Association (PHSA) and Vancouver Coastal Health (VCH), was recently awarded funding by the Canadian Nurses' Advisory Committee to update VCH's current online infection control module to encompass issues related to rural and community practice as well as occupational health principles.

A provincial working group will ensure that the content meets the needs of healthcare workers in all parts of the province. This group will include representatives from acute care, community care, long term care, and those in office-based and allied services (e.g. doctor's offices).

Online education has several benefits: 1) it is readily accessible to anyone with internet access; 2) the modular format allows learners to enter and exit at any point in the course; 3) it is much more cost-effective than traditional classroom sessions; 4) learners can obtain real-time feedback through self-assessment quizzes; and 5) if the content requires modification, it can be done in one central location yet all learners will receive the same updated information. The structure of the infection control module will resemble the online WHMIS education module, which has already been developed and reviewed and is now a successful tool used by healthcare organizations throughout the province. A version able to run on the existing VCH/PHSA platform is also in development. Visit our website for progress updates on all existing and upcoming online education modules.

The ABC and D's of Fire Extinguishers

Fire Extinguishers: Do YOU know how to use one?

We all know what a fire extinguisher is, but do YOU know how to use one? Used properly, a fire extinguisher can save lives and property by extinguishing a small fire or containing it until the fire department arrives. Used improperly, an extinguisher can endanger you and those around you by making the fire worse! It is therefore very important to understand which type of fire extinguisher to use for each type of fire and how to use it.

There are 3 main types of fire extinguishers:

1. Water Extinguishers should be used on Class A fires (ordinary combustibles such as wood, paper, cloth and rubber).
2. Carbon Dioxide extinguishers are designed for Class B (flammable liquids such as gasoline, grease, oil and paint) and Class C (energized electrical equipment such as wiring, computers, fuse boxes and appliances) ONLY.
3. Dry Chemical fire extinguishers usually come with "ABC" labels, which can put out most types of fires. They are sometimes labelled "BC" which indicates it can put out more of a grease/electrical fire than a Class A fire.

The best technique to fight a fire can be remembered by the acronym "PASS":

1. Pull the pin
2. Aim the extinguisher
3. Squeeze the handle to release the extinguishing agent
4. Sweep the nozzle, aiming at the base of the fire with a side to side motion and working towards the center of the fire.

If you see a fire: Activate a local fire alarm (pull station). Assist anyone in immediate danger. Only when the first two are completed should you attempt to put out the fire. Remember to keep your back to an escape route! If you have any doubt about fighting a fire – DON'T! Instead, get out, closing doors and windows behind you to slow the spread of the fire, and let the professionals do their job.

Please take Fire Safety seriously, a fire doubles in size every 30 seconds! The life you save may be your own!

This article was contributed by Jason Baerg, who is in the Maintenance Department of Maplewood House and MSA Manor Society in Abbotsford, BC. He is also a seven-year member of their joint occupational health and safety committee. The Fire Extinguisher Training program that Jason developed has been reviewed and authorized by the Abbotsford Fire Rescue Service, and all employees at Maplewood and MSA Manor are required to take the program. For more information, please contact Jason at mwhmaint@telus.net.

Joint declaration of the International Commission on Occupational Health (ICOH) and the International Social Security Association (ISSA)

Recommendations for policy makers, managers, healthcare professionals and occupational health and safety specialists

The following recommendations were adopted by the International Commission on Occupational Health (www.icoh.org.sg) and the International Social Security Association (http://www.prevention.issa.int) at the 6th ICOH International Conference on Occupational Health for Healthcare Workers, which took place at the beginning of October.

- Occupational risk prevention needs to be an integral part of management, administration and assessment processes, particularly healthcare procedures and healthcare quality assessment.
- Occupational health and safety services must be available for all healthcare workers (HCWs) in all healthcare facilities.
- All HCW occupational risks must be regularly assessed, covering physical, chemical, ergonomic, biological and psychosocial work environment.
- Systematic occupational risk prevention programmes must be defined, allocating specific means required. HCWs must actively participate in planning and implementation of these programs.
- All healthcare staff must receive information and training on occupational risks and preventive means, including hygiene.
- Collective protective measures, including those related to hand washing and other personal hygiene facilities, must be implemented. Appropriate personal protective equipment must be provided to staff.
- Occupational infectious risk prevention must be integrated into each organization's hygiene policy: fighting nosocomial infection includes protective measures for healthcare workers.
- Implementing healthcare staff immunization programmes is necessary. Access to medical advice, vaccination and, if needed, post-exposure prophylaxis must be provided free of charge.
- Prevention programmes must be reviewed, and risks regularly reassessed to improve prevention.

... continued from page 6

JOINT COMMITTEE EFFECTIVENESS

1 Reilly B, Paci P, Holl P. (1995) Unions, Safety Committees and Workplace Injuries. British Journal of Industrial Relations, 33(2):276-288.

2 Eaton, Adrienne E. and Thomas Nocerino (2000) "The Effectiveness of Health and Safety Committees: Results of a Survey of Public-Sector Workplaces" Industrial Relations, Vol. 39, No. 2, April.

3 Boden L, Hall J, Levenstein C, Punnet L. (1984) The Impact of Health and Safety Committees" A Study Based on Survey, Interview, and Occupational Safety and Health Administration Data. Journal of Occupational Medicine, 26(11):829-834.

4 Bryce G, and P. Manga. (1985) The Effectiveness of Health and Safety Committees. Relations Industrielles, 40(2):257-283.

5 Government of Alberta (1978) An Initial Review of the Joint Work Site Health and Safety Committee Program in Alberta. Research and Education Branch, Occupational Health and Safety Division, Alberta Workers' Health, Safety and Compensation, August.

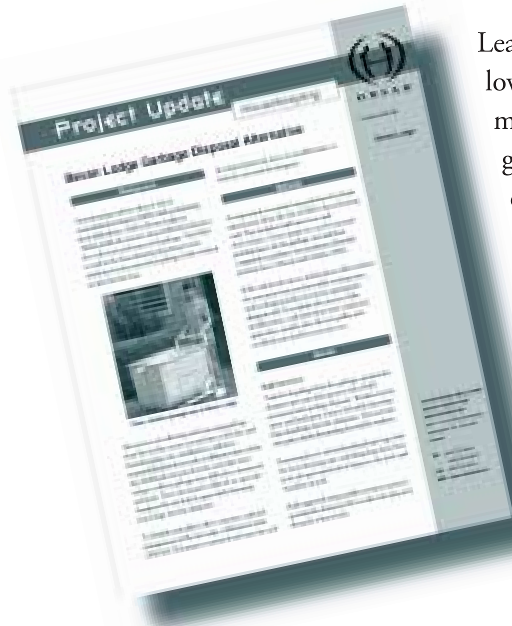
6 SPR Associates Highlights of the 1994 Survey of Occupational Health and Safety and Joint Health and Safety Committees: A Benchmark Study of the Internal Responsibility System., Toronto:SPR Associates, November, 1994.

7 Tuohy C and M. Simard (1993) The Impact of Joint Health and Safety Committees in Ontario and Quebec. Study Prepared for the Canadian Association of Administrators of Labour Law. Toronto:CAALL, January.

8 O'Grady In T. Sullivan (ed.) (2000) Injury and the New World of Work. Vancouver: UBC Press. (quote p. 198)

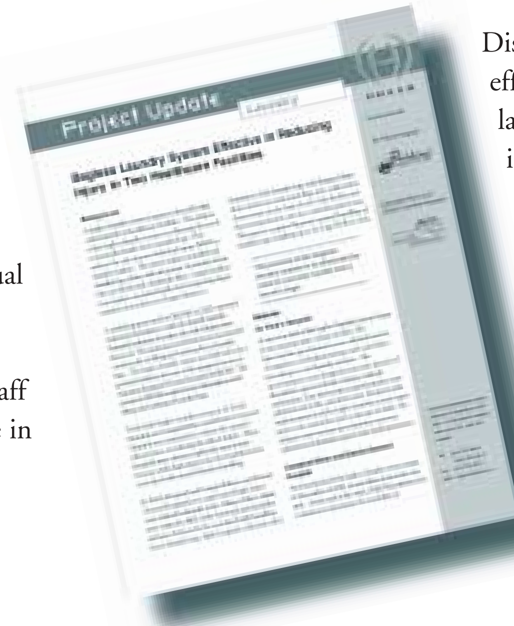
What's Happening with that Project?

Find out by reading OHSAH's Project Updates


Project Update

Bevan Lodge Garbage Disposal Alternative

Learn about how low-cost modifications to garbage carts and dumpsters greatly reduced both perceived and actual risk of injury and discomfort to housekeeping staff at Bevan Lodge in Abbotsford.


Project Update

Bagless Laundry System Effective in Reducing Injury in Two Healthcare Facilities

Discover how effective a bagless laundry system was in reducing injury in two healthcare facilities, St. Paul's Hospital, and Campbell River and District Regional Hospital.

OTHER PROJECT UPDATES INCLUDE:

1. Pill Crusher and Medication Cart Update
2. Bevan Lodge Garbage Disposal Alternative
3. Scheduled Toileting Program in Long-Term Care
4. Laundry Cart and Bin Modifications
5. Ceiling Lifts in an Extended Care Facility Reduce Injury
6. Evaluation of Portable Ceiling Lifts for Patient Handling in Diagnostic Imaging
7. Bagless Laundry System Effective in Reducing Injury at Two Healthcare Facilities
8. Design of an Ergonomic Workstation to Reduce Risk of Musculoskeletal Injury in Diagnostic Medical Sonographers
9. Evaluating the Effect of an Automated Pot Washer on Reducing the Risk of Musculoskeletal Injury in a Healthcare Kitchen
10. Evaluating the Effect of Rolling Stock Equipment Modifications and Maintenance Practises on Reducing the Risk of Injury
11. Evaluation of the George Pearson Repositioning Draw Sheet
12. The Ceiling Lift Project at St. Joseph's General Hospital: Follow up Evaluation August 2002
13. Histology Workstation Redesign
14. Low-Cost Food Cart Modification
15. Reducing the Risk of Musculoskeletal Injury Through an Adaptive Clothing and Dressing Program
16. Reducing the Risk of Musculoskeletal Injury in Healthcare Laboratory Technologists Performing Pipetting Tasks

Shield Yourself

Proper protection will shield you from blood and body fluids as well as chemical exposures to the eyes and mouth.

This recently redesigned 11"X17" informational poster highlights the importance of using facial protective equipment in healthcare workplaces. It also presents three kinds of protective equipment commonly used in healthcare settings. To order your copy, contact OHSAH.

BBF Resources on the Web!

There are numerous useful online resources about blood and body fluid exposure control. In addition to those listed below, others can be found through OHSAH's website:

What are needlestick injuries and their hazards? Visit the Canadian Centre for Occupational Health and Safety. (http://www.ccohs.ca/oshanswers/diseases/needlestick_injuries.html)

Learn about bloodborne pathogens and see animated safer needle devices using the OSHA e-tool – Needlestick / Sharps injuries. (http://www.osha.gov/SLTC/etools/hospital/hazards/sharps/sharps.html)

From the National Institute for Occupational Safety and Health (NIOSH) in the United States, uncover a wide range of information about needlestick injuries, personal protective equipment, and bloodborne pathogens. (http://www.cdc.gov/niosh/topics/bbp/)

From the International Healthcare Worker Safety Center at the University of Virginia, obtain resources to aid your facilities in addressing needle-stick safety and prevention. (http://www.healthsystem.virginia.edu/internet/epinet/)

Explore the Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program from the US Centre for Disease Control. (http://www.cdc.gov/sharpssafety/index.html)

Health and Safety Update

Get health and safety news, updates, and tips delivered once a month to your inbox!

Would you like more frequent health and safety updates than these quarterly OHSAH newsletters? Now you can by subscribing to the Health and Safety Update, OHSAH's new e-newsletter. Delivered directly to your inbox once a month, this e-newsletter keeps you up-to-date on occupational health and safety news from OHSAH and around the province. Sign up at www.ohsah.bc.ca or email update@ohsah.bc.ca.

Healthcare Ergonomics Conference Resources	Web Link
California OSHA	http://www.dir.ca.gov
New Zealand OSH Labour Dept. of Te Tari Mahi	http://www.osh.dol.govt.nz
Washington State Dept. of Labor and Industries	http://www.lni.wa.gov
Worksafe Victoria	http://www.workcover.vic.gov.au
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health (NIOSH)	http://www.cdc.gov/niosh
Occupational Safety & Health Administration, US.	http://www.osha.gov
Patient Safety Center of Inquiry, Veterans Health Administration	http://www.patientsafetycenter.com
Oregon State Association of Occupational Health Nurses	http://www.osaohn.org
SAIF Corporation	http://www.saif.com

OHSAH WEBSITE A-Z DIRECTORY

Looking for something on the OHSAH website (www.ohsah.bc.ca)?

Use the new A-Z Directory. Topics covered on the website are arranged alphabetically to make it easier for you to find the information and resources you need.

The A-Z Directory can be found on the upper right hand corner of the OHSAH website.

Don't Forget to Get Your Flu Shot!

Do you know healthcare workers (HCWs) are at higher risk for flu than any other group?

While the influenza vaccination (the flu shot) is the most effective way of reducing the chance of getting ill from the flu and decreasing the likelihood of passing an infection on to patients and coworkers[1], many healthcare workers don't get flu shots.

Influenza is passed from person to person, primarily by coughing or sneezing and occasionally by direct contact. Every year, thousands of people across the country contract influenza or an influenza-like illness; in 2003, there were 66 influenza-related deaths in BC.[2]

For healthy people under the age of 65, the flu shot is 70-90% effective in preventing influenza.[3] The side effects from the shot are most commonly mild arm soreness and swelling that can last 1-2 days. You cannot catch influenza from the vaccine as it contains killed or inactivated viruses that are unable to cause influenza.

The flu shot is provided free of charge to all HCWs in BC.[4] All HCWs may take advantage of this so as to not become ill themselves or pass the virus to high risk patients, (e.g. those over 50 years old or of any age with chronic medical conditions). Although the flu shot is the most effective way of reducing your chance of getting ill, good handwashing and other infection control techniques can also minimize the risk.

It is not too late to get a flu shot; consult your Occupational Health Nurse for more details.

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1 Centre for Disease Control. Influenza Vaccination Information for Healthcare Personnel. 2000, July [cited 2004, Oct 4]. Available from: URL: http://www.cdc.gov/ncidod/hip/flu_vac.htm

2 BC Centre for Disease Control. 2003 BC Annual Summary Reportable Diseases. 2004, Jan 19.

3 Centre for Disease Control. Influenza Vaccination Information for Healthcare Personnel. 2000, July [cited 2004, Oct 4]. Available from: URL: http://www.cdc.gov/ncidod/hip/flu_vac.htm

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Meet the Board

Frances Kerstiens is an Occupational Health and Safety Consultant with the Health Employers Association of BC (HEABC). Frances has been involved in health and safety for fifteen years, in a variety of roles and industries. Her work as an OH&S Consultant at HEABC involves helping its members with all issues pertaining to health and safety. Frances is an alternate on the Board of OHSAH and sits on the sub-committees for Joint Committee Education and Development (JCED) and Prevention and Early Active Return-to-Work Safely (PEARS) programs.

The Occupational Health and Safety Agency for Healthcare in British Columbia is a non-profit bipartite organization, dedicated to providing excellence in caring for caregivers.

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