

The Safe Angle

Perspectives on Health & Safety
Health Care Health & Safety Association of Ontario

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Helping Organizations To Battle Bugs

Over the past ten years, the health care delivery system has undergone enormous changes. Service delivery has shifted, in many cases, to less costly settings, such as ambulatory clinics, work sites and clients' homes. The historic separations between the activities of hospitals, nursing homes, physicians and other care providers have become increasingly blurred. Infection control practices must now encompass infections that clients may acquire as a result of their care or treatment both in and outside of an acute care setting.

Enter a new resource from HCHSA. Written by Consultant Peggy Swerhun and Manager, Consulting Services Carol Small, *Developing Infection Control Policies & Procedures: Information for Care Providers*, is a guidebook that can be used by the range of care providers in the development of infection control policies and procedures. It contains information on infections commonly seen in health care and community care settings.

"Health care and community care organizations have a dual responsibility – they must work to prevent the transmission of infections from their clients to their workers **and** limit the introduction of infections by care providers to other workers and clients," says Carol Small. "It is essential that health care facilities and care providers, including social and community service facilities, home care, daycare and long term care facilities, retirement homes as well as medical and dental clinics, develop infection

control policies and procedures to control and manage the spread of infection. Infection prevention and control must be provided throughout the continuum of care."

The two authors developed a guidebook that provides information in a succinct and readable way with a focus on practical tips. Chapters cover

"Written policies and procedures are critical and should address all elements of care, including food handling, laundry handling and cleaning, visitation policies and direct client care practices like hand washing and immunization," says Peggy Swerhun. The following factors should be considered in the development

changes in the local epidemiology of infectious diseases. Public health agencies are important collaborators in infection control in terms of coordinating communication and intervention across the continuum of care. (Please note that care providers in hospitals should rely on the protocols for communicable disease surveillance provided by the Ontario Hospital Association/Ontario Medical Association in the development of their infection control policies and procedures.)

In addition to the guide, HCHSA has also developed a set of four precaution cards based on the Health Canada document, "Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care" (1999). These durable cards can be posted on the doors to clients' rooms or in their homes and used as a quick reference tool for care providers as well as visitors and family members.

Developing Infection Control Policies & Procedures: Information for Care Providers (LAP-260) is available to HCHSA members at a cost of \$15.00 (+ Shipping/Handling/GST/PST; Non-members \$20.00). A set of the four precaution cards is available at a cost of \$2.00 for members (+ Shipping/Handling/GST/PST; Non-members \$4.00). For further information about this resource, please contact your HCHSA Consultant or call our order desk at Tel. (416) 250-7444, ext. 136/ Toll Free 1-877-250-7444, ext. 136.



Peggy Swerhun and Carol Small review current resources on infection control.

blood borne diseases, airborne diseases, antimicrobial resistant organisms, sexually transmitted diseases, enteric and food borne diseases as well as emerging and re-emerging infectious diseases. Surveillance of infectious diseases and an immunization schedule for care providers are also part of this resource.

of these policies and procedures:

- type of facility or service
- risk of infection
- type of care provided
- education and awareness levels of the care providers.

Once developed, these policies and procedures need to be maintained and updated to reflect scientific advances and

More New Products From HCHSA

The Basics of Health & Safety Series expands with three new offerings:

- *Implementing a WHMIS Program - Training Package*, a ready-made basic WHMIS training program curriculum for health care and community care facilities. [LAP-259; Members \$12.00/ Non-members \$15.00 + Shipping/Handling/GST/PST].
- *Roles & Responsibilities in Occupational Health & Safety*, a publication that assists workplace parties to better understand their roles and responsibilities in terms of occupational health and safety. [LAP-255; Members \$12.00/ Non-members \$15.00 + Shipping/Handling/GST/PST].
- *Roles & Responsibilities in Occupational Health & Safety - Training Package*, a companion document to the one above, consisting of facilitator notes, overhead masters, a

participant workbook and an evaluation form.

[LAP-256; Members \$18.00/ Non-members \$25.00 + Shipping/Handling/GST].

We are also working on a new kit for North American Occupational Safety and Health (NAOSH) Week which runs from May 15-21. Details will be available on our web site by April 1, 2000. Our Workplace Wellness kit, which was introduced last year, will also be made available for those organizations that did not purchase one last year. This kit is comprised of:

- 10 copies of each of the following Fast Facts:
 - Physical Activity Promotion: What Health Care Organizations Can Do
 - Promoting a Comprehensive Approach to Workplace Wellness
 - Reducing Job Stress

- Substance Abuse: Information for Workers & Supervisors

- Tips for Shift Workers

- The document *Promoting Workplace Wellness: Strategies for Health Care Organizations*

- Three wellness posters:
 - What have you done for yourself today? Six dimensions of wellness
 - Workplace Wellness
 - Preventing Job Stress: A comprehensive approach.

The cost for this resource is \$40.00 or \$51.75 with shipping/handling, GST and PST. (LAP-601)

Like last year, HCHSA will be offering a contest for those organizations that both purchase one of the H&S kits and hold a health and safety week in either May or June. Eligible organizations are client members of HCHSA. While we recognize that the

Ontario Nursing Home Association (ONHA) provides an excellent promotional week in October, we want to encourage all health care organizations to consider the HCHSA week as yet another opportunity to profile workplace health and safety.

To enter, organizations must complete some paperwork (i.e., an entry form, participation records, an event calendar, a feedback form) and provide a photo of the activity/event that they consider to be the most innovative.

Submissions will be evaluated on the following criteria:

1. Level of participation
2. Number of events related to workplace wellness theme
3. Innovation of activities/events
4. Extent to which the activities/events held during the week led to commitments to further wellness initiatives.

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The Safe Angle is the newsletter of the Health Care Health & Safety Association of Ontario for its member organizations. The newsletter is printed three times per year and is available in both paper and electronic forms.

Individual issues of the newsletter can be downloaded from HCHSA's web site www.hchsa.on.ca and may be reproduced without permission for wider distribution.

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endorse any product mentioned herein with the exception of those produced by HCHSA.

We welcome member contributions in the form of articles, ideas, letters and photographs.

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Correction

Please note that there were two typos in the WSIB Year 2000 Preliminary Premium Rates as reported in the Fall 1999 issue of *The Safe Angle*. These were in the 1999 rates for Homes for Nursing Care (851) and the 2000 rates for Treatment Clinics and Specialized Services (861). The corrected information is provided below.

WSIB Year 2000 Preliminary Premium Rates

Rate Group	Description	2000 Premium Rate	1999 Premium Rate	% Change 2000/1999
851	Homes for Nursing Care	\$3.21	\$3.81	-16%
852	Homes for Residential Care	\$3.05	\$3.72	-18%
853	Hospitals	\$0.93	\$0.91	2%
857	Nursing Services	\$2.10	\$2.36	-11%
858	Group Homes	\$2.63	\$3.32	-21%
861	Treatment Clinics and Specialized Services	\$0.87	\$1.18	-26%
875	Professional Offices and Agencies	\$0.60	\$0.60	0%

For more information about the premiums for your Rate Group, you may wish to access the WSIB Premium Estimator available to the health care sector at the WSIB's web site:

<http://www.wsib.on.ca/wsib/wsibsite.nsf/Public/healthCare>

Winter Safety & The Workplace



By: Patricia Boucher, R.N., C.O.H.N.(C), CRSP, Consultant

Employees of every workplace may be at risk to the various hazardous conditions associated with our cold winter months. Whether employees work outdoors, drive a car, or just walk into the workplace, they may be at risk of one or more of the following:

- Cold stress or hypothermia
- Frostbite
- Slips and falls due to slippery conditions
- Other physical injuries
- Hazardous driving conditions.

Cold Stress or Hypothermia

'Cold' itself is a potentially hazardous physical agent, although it may be difficult to accurately identify the point at which it may become hazardous to the worker. The *Occupational Health & Safety Act* reflects this uncertainty since it does not

clearly define a specific exposure limit to cold. The Regulations for Industrial Establishments and Health Care and Residential Facilities make reference to temperature extremes but do not establish a maximum cold exposure limit to which workers can be exposed.

Determining How Cold it is

Air temperature alone cannot accurately measure the degree of coldness. Adding wind to the cold can significantly lower the temperature. The equivalent chill temperature takes into account the cooling of air temperature and the wind speed or wind cooling rate. The wind chill cooling rate is the rate of heat loss from an exposed body due to air temperature and wind velocity. The combination of effects from cold air and wind speed is known as the "wind-chill temperature" or index. It is the most commonly used measure of cold stress.

Signs & Symptoms

Cold stress occurs when the body temperature falls below 36°C. Even when the body temperature falls slightly below

normal (37° C), the body can begin to shiver uncontrollably and the lips and extremities may turn blue. More profound hypothermia impairs mental functioning resulting in weakness, drowsiness, disorientation and an inability to make decisions, followed by unconsciousness. Hypothermia decreases the heart rate and a pulse can be difficult to detect. People with certain pre-existing conditions such as diabetes, epilepsy, arthritis and kidney conditions are more susceptible to hypothermia. Loss of body heat or hypothermia can be life threatening.

If Someone is Cold Stressed...

- Seek medical attention immediately. While waiting for medical attention:
- Remove any wet clothes and apply dry clothing. If no dry clothing is available, cover the person with material such as a plastic sheet or raincoat.
- Carry the person to a warm shelter.
- Warm the person with a blanket and body-to-body heat.

- Administer a small amount of warm fluids (non-alcoholic) if the person is conscious.
- Do not warm a person with hot water. This may result in "rewarming shock," which can be fatal.
- Keep the person still and quiet. Do not allow the person to exert any physical energy such as walking, lifting, and climbing, as this may cause heart failure.

Prevention

The key points to prevention of hypothermia are preventing loss of body heat by staying dry and warm, and understanding what you can do to protect against conditions that may cause hypothermia. Persons who work outdoors should be provided with regular warming periods and must protect themselves against loss of body heat. The following tips can help to avoid the dangerous consequences of hypothermia:

- Wear layers of light, loose-fitting clothes.
- Wear cotton, polypropylene or lightweight wool next to your

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Schedule of Certification Training for the Year 2000*

Basic Training	Workplace Specific Hazard Training	
	Long-term Care Sector	Acute Care Sector
Jan. 18-20 Barrie	Jan. 5-6 Windsor	Jan. 13-14 Ottawa
Feb. 22-24 Kingston	Feb. 2-3 Barrie	Feb. 15-16 Toronto
Mar. 28-30 Toronto	Mar. 14-15 London	Mar. 1-2 Kitchener
Apr. 11-13 Pembroke	Apr. 4-5 Toronto	Apr. 17-18 Windsor
May 10-12 Fort Frances	May 17-18 Ottawa	May 29-30 Niagara Falls
June 5-7 Guelph	June 15-16 Sudbury	June 12-13 Fort Frances
July 12-14 Sarnia	June 27-28 Toronto	July 6-7 Toronto
Aug. 23-25 Toronto	Aug. 9-10 Huntsville	Sept. 7-8 Sudbury
Aug. 29-31 Sault Ste. Marie	Sept. 5-6 Kingston	Oct. 18-19 London
Sept. 13-15 London	Oct. 26-27 Fort Frances	Nov. 15-16 Ottawa
Oct. 3-5 North Bay	Nov. 8-9 Toronto	
Nov. 1-3 Peterborough	Dec. 4-5 Owen Sound	
Dec. 6-8 Toronto		

*For more information, please contact Comp Advantage Inc., at Tel. (519) 688-7784/Toll Free 1-800-361-2667. Note that onsite private sessions can be arranged for joint health and safety committees when there are 10 or more participants.

Snow Shovelling

Snow shovelling is a physically demanding job. Using incorrect body mechanics, techniques or methods and improper equipment can increase the risk of injury. The following safety tips can prevent an injury:

- Use the right shovel. Snow pushers push the snow; snow throwers are to be lifted.
- Use shovels that are ergonomically-designed.
- Step forward when you load the shovel and bend at the knees, keeping your back straight. Do not twist your back as you lift the snow – move your feet.
- Do not overload your shovel.
- Take frequent rest breaks.

Use of Snow Blowers

Snow blowers can be a potentially serious threat to the safety of an employee if not used safely. Here are some safety tips for the safe operation of a snow blower:

- Become familiar with the snow blower by reading the manufacturer's manual.
- Wear approved safety footwear during the operation of the snow blower.
- Do not pull a snow blower unless the model is designed to be pulled. Most snow blowers are designed to be pushed rather than pulled.
- Perform regular preventative maintenance on snow blowers. Regularly check and maintain all built-in safety features of the snow blower.
- If the snow blower becomes clogged, stop the engine and disconnect the spark plug before clearing the snow blower.
- Stop the engine before refuelling. The engine should be allowed to cool prior to refuelling.
- Store fuel in an approved container.
- Never leave a running snow blower unattended.
- Adjust the height of the snow blower so that it is at one inch from the surface to prevent the snow blower from picking up debris such as stones and shooting them into the air.

skin such as long undergarments. Wool is the most effective natural insulating fibre against cold.

- Wear outer garments that are both waterproof and windproof.
- Protect your head and ears with a warm hat (up to 40% of body heat can be lost from an unprotected head.
- Wear mittens as opposed to gloves.
- In windy conditions, wear face protection such as a scarf or face mask.
- Wear dry, waterproof insulated footwear that is slip-resistant.

- Keep dry! Wetness enhances the transfer of cold to the body.
- Eat high energy snacks such as nuts and raisins.
- Avoid alcohol, tobacco and caffeine-based drinks.

Frostbite

Exposure to the extreme cold can cause frostbite. The cheeks, nose, ears, fingers and toes are at increased risk for frostbite. Frostbite occurs when the fluids and tissues of the skin freeze. Often victims of frostbite are unaware of the injury immediately. This increases the importance of knowing the

signs and symptoms as well as first aid treatment.

Signs & Symptoms

The skin initially becomes red then turns blotchy white, gray, or yellow. In the final stages, the skin becomes completely white and may blister. The body part may feel cold or numb. In advanced stages, there is no feeling at all in the exposed skin.

If Someone has Frostbite...

- Keep the person warm and dry.
- Warm the affected body part with warm blankets or warm water (not hot water).
- Elevate the affected area.
- Do not allow the person to sit close to a stove, fireplace or heater. If the affected area gets too hot, damage may worsen.
- Once the area is thawed, the area should be gently exercised to increase circulation to the area.
- Do not rub the area.
- Do not break the blisters that form as a result of frostbite.
- Consult a physician as soon as possible.

Prevention

- Do not expose the hands, feet, ears, nose, etc. to cold for any extended period of time.
- Do not touch cold metal such as metal fences or door handles with exposed skin.
- Wear suitable hand protection. Skin contact with cleaning fluids or gasoline left outdoors can cause instant frostbite.
- Protect all exposed skin with protective clothing. Wear layers of light, loose-fitting clothes.
- Wear cotton, polypropylene or lightweight wool next to your skin such as long undergarments.
- Protect your head and ears with a warm hat.
- Wear mittens as opposed to gloves.

- In windy conditions, wear face protection such as a scarf or face mask.

Slips & Falls Due to Slippery Conditions

Employers must ensure that the paths and walkways on their grounds are free from snow and ice and adequately lighted. Main entranceways should be regularly patrolled for slippery conditions. Approved snow removal compounds should be used. Sand should be avoided around entrances where it can be tracked indoors requiring additional cleaning and increasing the risk for slips and falls. Mats should be used at all entrances to prevent slippery conditions on floors caused by melting snow or ice. Mats should be properly secured to the floor so they do not become possible trip hazards.

Employees should wear slip resistant winter footwear. Walking slowly and taking small steps on slippery surfaces improves traction.

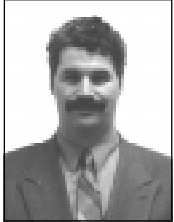
Other Physical Injuries

Working in cold environments can increase the risk of musculoskeletal injuries by reducing muscle power and endurance. It is advisable that all workers warm up their muscles with stretching exercises before engaging in physical work in cold environments. Workers should be careful never to overexert themselves.

Cold temperatures also affect the mobility of our fingers and the grip force of our hands. They can also decrease our mental alertness and coordination. Workers should exercise extreme caution when operating power tools and equipment.

It is important that workers who will be shovelling snow or operating snow-removal equipment are well informed about how to do this safely. (See sidebar.)

Fragrance Sensitivity: An Issue For Health Care Workplaces?



By: Tom Smith,
O.H.S.T.,
R.O.H.T.,
A.S.P.,
Consultant

Fragrances are found everywhere in our environment. Consumer products of all types are fragranced. Workplace exposures to fragrances are common. Many products that we regularly use contain fragrances for a variety of reasons like enhancing their appeal (e.g., the lemony smell of some cleaners), for safety reasons (i.e., the additive to natural gas that is unpleasant at very small concentrations is a warning that a leak may be present), or to mask a scent that could be perceived as unpleasant (e.g., air fresheners that mask certain cooking odours). Some products that are advertised as “low” or “no

odour” actually have chemicals added to mask their original odour.

Some people differentiate between added scents (i.e., fragrances) and natural scents (i.e., odours). In this article, we will use the term “scent” in a generic way.

Our response to scents is very individual. Some scents may invoke certain memories or remind you of special times or places (e.g., the smell of freshly baked bread, or a sea breeze). You may find other scents objectionable (e.g., certain by-products of farming operations). Some people may experience minor irritation of the nose or eyes, headache, sense of nausea, feeling of respiratory irritation, etc. from certain scents. These reactions may be caused by one particular component in one particular brand of product or a component that is common to many products. There are many theories about why people may

Web Sites

American Academy of Dermatology - Allergic Contact Rashes
www.aad.org/aadpamphrework/allergic.htm

Asthma & Allergy Information & Research (AAIR) - Correspondence page on allergy to perfume in the air
www.users.globalnet.co.uk/~aair/perfume_corr.htm

Contact Dermatitis Info Site – Fragrances
www.uwcm.ac.uk/uwcan/dm/contact/fragranc.html

Environmental Health Network (EHN)
users.lanminds.com/~wilworks/ehnindex.htm

Fragranced Products Information Network
www.ameliaww.com/fpin/fpin.htm

Job Accommodation Network - Worksite Accommodation Ideas for Individuals Who Experience Limitations Due to Fragrance Sensitivity (Nov. 1999)
janweb.icdi.wvu.edu/english/pubs/OtherPubs/fragrance.html

Mining Co. Guide to Fragrance Sensitivity
allergies.miningco.com/library/weekly/aa022299.htm

National Institute of Environmental Health Sciences - Article: Fisher, B.E. (1998). Scents and sensitivity. *Environmental Health Perspectives*, Vol. 106.
members.aol.com/enviroknow/perfume/EHPscents.htm

Selected Abstracts on the Health Effects Of Perfume
members.aol.com/chemxpose/abstracts.html

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Winter Safety & The Workplace (continued)

Hazardous Driving Conditions

Snow and ice pose hazards for even the most cautious and experienced driver. It is important for everyone to prepare for winter driving and the possible emergencies associated with travelling in the cold weather.

Driving your car in winter conditions may be risky. Winterizing your car can help to prevent winter-related car breakdowns. Prior to the winter months, ensure that your car is in good working order. Get a complete tune-up and ask that your mechanic check the functioning of the brakes, battery, and exhaust system. Fluid levels should be checked and anti-freeze added.

During freezing conditions, start your car and let it warm up for a couple of minutes before

driving. This allows the oil to circulate to all moving engine parts. The tire pressure should be checked every one to two weeks during cold weather as tire pressure can decrease one pound per square inch for every 10° F that the temperature drops. Proper tire inflation ensures optimal handling. Keep your vehicle's fuel level more than half full. This will prevent tank condensation and frozen gas lines.

The following emergency items should be added to your car:

- sand/salt
- shovel
- snow-scraper/brush
- booster cables
- blankets
- flashlight
- car phone

Winter Driving Tips

- Know your cars braking system. Braking techniques vary from ABS brakes to conventional braking systems.
- Perform routine circle checks before you operate your vehicle.
- Ensure that the front and rear windshields are clear and that the wipers and defrosters are in working condition.
- Do not follow too close behind another vehicle. Keep a safe following distance to allow sufficient braking time during icy and slushy conditions.
- If you skid, do not brake. Take your foot off the accelerator and steer your vehicle. Use a gentle steady motion while turning the wheel as extreme steering can worsen the situation.
- When travelling on slippery surfaces, especially hills, use low gears to add traction.
- Remember that ice forms more quickly on overpasses and bridges. Reduce your speed.
- If you get stuck, use sand/salt around the wheels to add traction. Snow can also be cleared from the wheels using a shovel.
- If weather and road conditions are truly hazardous, stay home!

For questions about this article, please contact Patricia Boucher, HCHSA Consultant at Tel. (905) 574-7075/1-800-537-7221/E-mail: pboucher@hchsa.on.ca

Fire Code Retrofit Requirements For Health Care Facilities



By: Dora Pender, B.Sc., CRSP, Consultant

This article provides some general information regarding Retrofit requirements for health care facilities in the Ontario Fire Code. Note that there may be exceptions to the rules below if approval has been granted by local fire officials.

The Ontario *Fire Code*, in conjunction with the *Building Code Act*, provides requirements for fire and life safety. The *Building Code* classifies major occupancies into various groups and divisions depending on their use or occupancy. Requirements for building integrity, water pressure, fire alarm system and exits are determined

by first establishing the major occupancy and the size of the building. Many of HCHSA's member organizations are classified as B2, "Care and Treatment Occupancies," under the 1997 Ontario *Building Code*.

The *Fire Code* is applicable once a building is completed and approved under the *Building Code Act*. (Essentially, the *Fire Code* cannot be enforced before a building is occupied.) When a building maintains the same occupancy over an extended period of time, retrofit requirements are used to update fire prevention methods and help ensure that they conform to minimum life safety standards in the case of fire emergencies. For health care facilities, Retrofit Section 9.4 of the *Fire Code* applies.

Requirements of the retrofit legislation fall under four main

areas:

- Containment
- Means of Egress
- Detection and Early Warning
- Suppression.

Containment

There are two main directives served by complying with containment requirements: the structural integrity of a building and the control of fire from spreading. Requirements that deal with these two issues relate to fire resistance ratings. The fire resistance rating is the length of time a wall, door or window can withstand intense heat and flame before it is compromised to the point of failing. Typically, fire resistance ratings range from 20 minutes to two hours.

When considering life safety, the longer a building remains standing, the longer the occupants have to escape.

Similarly, the longer the fire can be isolated by these "barriers," the more smoke-free and fire-free the area will be and the more time occupants have to safely flee the fire. Not all doors, windows and wall constructions comply with these standards. The *Building Code* specifies those materials that meet these standards.

Health care facilities have an additional requirement. These facilities must have protected areas of refuge where occupants, who cannot exit via stairwells to the outside of the building, can wait safely. This is commonly achieved by having a ward or floor divided by doors that have the appropriate fire resistance rating as specified by the *Building Code*. Room for additional clients seeking refuge must be available. Again, there

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Fragrance Sensitivity: An Issue for Health Care Workplaces? (continued)

respond to scents in certain ways...we don't have the whole answer yet!

What is "scent sensitivity"?

"Scent sensitivity" is a hypersensitivity to common chemical and environmental stimuli. Even low levels of a stimuli may trigger reactions in people. A wide range of symptoms have been reported, including fatigue, migraine headaches, rashes, difficulty breathing and dizziness.

What triggers these reactions?

Triggers are products or stimuli that induce symptoms in people reporting scent sensitivity. Common triggers include (but are not limited to) cologne, perfume, scented body sprays, scented hair spray/gel/mousse and other leave-in hair products, lotions, scented powders, after-shave, richly-scented deodorants/antiperspirants, air fresheners (solid or

spray), bathroom deodorizers, potpourri, and many cleaning products used for floors, carpets and other surfaces.

It is important to recognize that not all scented products or perfumes may cause concerns for people with scent sensitivities.

Is scent sensitivity considered a "real" condition?

There is no clear consensus regarding the status of scent sensitivity (chemical sensitivity and environmental illness) as a medical condition or disability. There is ongoing research to study the nature of these conditions and to better define them.

How can I effectively manage this issue if it is a concern at my workplace?

The elimination of scented product usage at your workplace may not be achievable, or even desirable, let alone enforceable. Scents are not legally regulated

in the workplace or public buildings in the way that tobacco smoking may be banned. However, there are some practical steps that can be taken:

- Develop an organizational policy for a reduced scent or establishing a scent-free environment. One example of a policy is: "Employees working in patient care areas and in non-patient care areas shall not wear cologne, perfume, aftershave lotions, scented lotions or body washes in this facility" (Job Accommodation Network, 1999).
- Post Signs that appeal to empathy: "For the comfort and health of our clients, staff and visitors, please support a fragrance-free environment."
- Communicate – if a certain scent bothers you, let the person responsible for that scent know.

- Where possible, purchase cleaning products that are unscented.

Instituting an organizational policy for a scent-free environment, or even a reduced scent environment can be a challenge. At the initial stages of policy development and enforcement resistance may be encountered. The key to an effective policy in this instance is consistent communication and delineating of clear responsibilities for implementation, monitoring and enforcement. Those health care organizations that have instituted a reduced scent policy have been able to overcome these barriers.

For questions about this article, please contact Tom Smith, HCHSA Consultant at Tel. (519) 380-9554/ 1-800-489-7304/
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The Aging Health Care Worker: Myths & Realities



*By: Lisa Marie Rezler
May, BScOT
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Consultant*

Exactly who qualifies as an “older worker”? According to the literature, an older worker is defined as those individuals aged 45 years or over, or those who have reached the stage when simply because of advancing years, they begin to have difficulty either doing their work or finding/keeping a job.

The Aging Process

There are many different theories of aging, ranging from the “biological time clock” theory to the “Error Catastrophe” to the “Free Radical Theory.” Despite differing theories, two definitions of aging are widely accepted: (1) “the total of all changes an organism undergoes from conception to death” and (2) “the complex phenomenon of non-reversible, deteriorative changes predisposing to fatal disease and death in aged organisms.” Regardless of how it is defined, it is also generally accepted that the effects of aging include a progressive decrease in the efficiency and vitality of all physiologic functions, atrophy of all organs and tissues, increased vulnerability to trauma and infections, and malfunctioning of the immune system.

Myths & Assumptions

Information and research of the relationship between occupational performance and aging is often misconstrued. The propagated myths and assumptions regarding the older worker generally have a negative connotation. The following assumed characteristics are commonly attributed to older workers:

- poor health and low energy

- higher rates of accidents and illnesses
- rigid behaviour and attitudes
- inability to learn new skills
- lower productivity due to working slower, being less committed to the employer, and higher rates of absenteeism.

These negative social stereotypes can hinder aging health care workers physically, economically, socially and emotionally, and limit the opportunities they are afforded. An aging worker's ability to continue to make valuable contributions in the workplace is often hindered by factors unrelated to the actual physical process of aging.

Employment Trends

There has been a trend during the past 20 years of declining participation in the labour force by older workers. These individuals may leave voluntarily for personal reasons. This in part is due to the increased affluence of the older generation and the provision of government and private pension plans. Early retirement is now more socially acceptable and affordable, making it attractive for people to pursue their individual desires. Unfortunately, not all leave the work force voluntarily and face lay-off, pressure to make way for younger workers and the lack of opportunities for promotion and/or retraining. Persistent unemployment or poor health may become so discouraging that this group withdraws from the workplace.

Overall, however, older workers are less likely than their younger counterparts to become unemployed. Unfortunately, if older workers do lose their jobs, they are likely to be out of work for a longer period of time than younger workers and experience a greater drop in pay when they find a new job.

For the older worker, re-employment is not a simple matter of going back to a familiar job (it will likely involve acquiring new skills). The new employer commonly will not compensate the individual for their organization-specific skills and seniority. Typically employers still seek to hire less expensive labour, those young and female.

Ability & Occupational Performance

Nursing staff and others involved in client care, whether it be directly, such as porters and health care aids, or indirectly, such as dietary and laundry staff, are continuing to work into their later years. Their ability to cope is based on their capacity to meet the following work demands: physical functioning; experience; and motivation. The factors which may interfere or reduce workers' ability to meet their work demands are multiple and may be related to the physiology of aging, job design, work environment and workplace culture. Poor ergonomics, for example, is a primary occupational cause of premature decline in work ability.

It is widely accepted that the different systems of the body are vulnerable to deterioration as the individual ages. One of the earliest signs of advancing age is the sudden awareness that the page being read is now being held almost at arm's length. As the lens of the eyes become more opaque, less elastic, and less able to focus, many aspects of vision begin to diminish. These changes include deterioration of visual acuity, accommodation, contrast sensitivity, stereopsis, reduced colour discrimination and vulnerability to glare. In a research survey, these losses in vision were

found to be the most dreaded consequence of aging.

It is difficult to determine when hearing loss is due to normal aging deterioration or other causes. Hearing is affected by many factors such as: exposure to noise throughout the life span; genetic influences; and dietary influences. On average, by the age of 50 years, hearing loss is significant enough to be considered impairment in more demanding listening situations such as faint sounds, background noise and multiple sources of sound. The ability to interpret and respond to complex auditory information is also affected. Consequently, as we age, listening requires more concentration and effort and therefore becomes more tiring and subject to error.

Quite commonly, the physical work demands of an aging individual remain unchanged. This puts the worker at risk of injury since muscle strength plateaus by the age of 40. After this, there is a gradual decline in strength until about the age of 60. After the age of 60 years, muscle strength rapidly decreases. The strength of muscle groups in the upper and lower extremities as well as the back may decrease by as much as 60% between the ages of 30 and 80 years. Declining strength during the aging process can be attributed to many factors: atrophy of muscle fibres; loss of muscle fibre; replacement of muscle fibres with fat; decrease in muscle fibre area; and loss of up to one-half of a body's motor neurons.

Common Barriers to Optimum Performance

The process of declining strength due to aging can negatively effect an individual's work ability for certain work tasks, especially those involving

The Aging Health Care Worker: Myths & Realities (continued)

the following:

- static muscular work like positioning client in bed
- lifting and carrying loads like lifting and transferring clients
- sudden peaks in load like breaking a client's fall if they faint
- repetitive movements like dietary work in the dish room
- simultaneously bent and twisted work postures like transferring clients
- tasks requiring speed
- use of instruments and equipment such as small font sizes on computers and monitors.

Other barriers may include:

- Work Environment - level of lighting, glare from shiny floors and surfaces, use of small font sizes, colour schemes, indistinguishable alarms and cues and the failure to apply sound ergonomic principles.
- Job Design - lack of or insufficient use of task rotation resulting in repetitive strain injuries and work boredom. This is particularly common in laboratories, diagnostic imaging departments, and medical records and transcription services.
- Benefits - inflexible benefit plans do not allow an aging worker to utilize this support according to their changing needs. Retirement, lay-off, or

loss of work can be very stressful yet many employers do not support and prepare these individuals for the change.

- Job Satisfaction - lack of learning opportunities and/or opportunities for promotion.

Breaking Down the Barriers

On the more encouraging side, there are many positive contributions an older worker can bring to an organization. Contrary to the stereotypical assumptions, the aging worker is willing and able to learn new skills. Older workers also tend to be very loyal and committed to their employers, and actually have a lower rate of absenteeism overall. Their experience can be a valuable asset for both their younger peers and their employers. The aging worker has much to contribute and should be celebrated. By breaking down the barriers, the culture of an organization can be enhanced, and all will "win" - older employees, younger employees, and the employer themselves.

Unfortunately, employers create or sustain barriers that interfere with the aging work forces' ability to continue to make valuable and meaningful contributions in their workplace. For example, in a study conducted a few years ago,

72% of the businesses surveyed admitted to not having practices that encourage older workers to remain on the job.

Barrier Busters

The challenge of breaking down barriers does not have to be costly or impractical. It may involve creativity, sensitivity and "thinking out of the box." Below are some examples of barrier busters:

- Avoid age discrimination. Re-evaluate mandatory retirement policies and monitor hiring patterns. Provide equal access to training and accommodate different learning styles.
- Allow flexible employment. Support flexible hours and/or job sharing opportunities.
- Use older workers as mentors. Capitalize on their wisdom and experience. They can be very good mentors for their younger or less experienced peers.
- Reduce boring, repetitive tasks. Job design can influence productivity. Decreasing boredom and increasing interest can improve employee satisfaction and motivation.
- Implement task/job rotation. Rotating the tasks of workers, especially in areas where the work is very repetitive, routine or monotonous, not only makes the job more interesting but it can also help in the prevention and reduction of

repetitive strain injuries.

- Maximize the use of automation and technology. Where possible, eliminate heavy manual lifting and repetitive demands. This could include upgrading to electric patient lifting devices, either mobile and ceiling mounted models. Implementation of electric beds is also recommended. There is a growing trend towards "zero lift policies" for not only caregivers but in other operations (i.e., use of tow motors in materials management and food services).
- Support career management. Encourage and support employees in pursuing new skill development or skill upgrading. Prepare older workers for their transition to retirement through counseling and financial planning and by allowing a gradual adjustment through reduced work hours and flexible shifts.

Celebrate the aging worker! Do not let ageism infiltrate your facility. There is no replacement for the wisdom and experience of an older worker.

For questions about this article, please contact Lisa Marie Rezler May, HCHSA Consultant at Tel. (416) 250-7444, ext. 127/1-877-250-7444, ext. 127/E-mail:

lrezlermay@hchsa.on.ca

Conference Update

Congratulations to Sue Murray, Executive Director, **tele-touch** in Hamilton. Sue won our draw at the OANHSS/OCSA Convention (October 24-26, 1999) for a free copy of the resource, *Transfers and Lifts for Caregivers (TLC): An Ergonomic Approach to Client Handling*.

Fran Groves, Quality Improvement Coordinator at the Haldimand War Memorial Hospital, also won a copy of the TLC Package. She was the winner of our draw at the Ontario Hospital Association Convention (November 22-24, 1999).

CALL POLICE sign winners, as part of the draw held at the Canadian Home Care Association conference (November 28-30, 1999), were as follows:

- Claudia Blumberger, Manager, Toronto Rehab Services, COTA
- Jan Coward, Case Manager, North York Community Care Access Centre

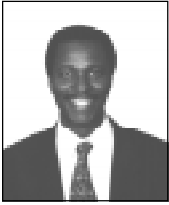
- Carol Farkas, Director, Community Care & Quality Assurance, **carecor**TM
- Julia Fuchs, student, University of Guelph
- Dela Wilkins, USANA

UPCOMING CONFERENCES

Look for HCHSA staff at the following conferences:

- OHNA/ORCA/OHHCPA Convention & Trade Show 2000, "The Power of Choice...Consumers of a New Century," to be held February 29 to March 3, 2000 at the Metro Toronto Convention Centre.
- OANHSS 2000 Conference: "Beyond 2000 - Pride in Our Past - Confidence in Our Future" to be held April 2-4, 2000 at the London Convention Centre.
- IAPA Health & Safety 2000 Conference & Trade Show, "People Creating Solutions," to be held April 10-12, 2000 at the Metro Toronto Convention Centre.

Organizational Factors & Workplace Safety Excellence



*By: Trevor
Blake, B.Sc.,
ARP,
Consultant*

The Province of Ontario is undergoing a revolution in the area of occupational health and safety. With its new mandate for accident prevention, the WSIB has the vision to eliminate workplace injuries and illnesses in Ontario. There is a concerted and pro-active effort underway by provincial accident prevention partners, inspired by this shared vision, to support workplace parties to achieve this outcome. These accident prevention partners include the following:

- the WSIB
 - the Designated Entities (12 Safe Workplace Associations, a training centre and four workers' health clinics)
 - the Ministry of Labour.
- Other partners include the following:
- the Office of the Employer Adviser
 - the Office of the Worker Adviser
 - the Safe Communities Foundation
 - the Institute for Work and Health
 - federal agencies such as the Canadian Centre for Occupational Health and Safety (Hamilton), and the Canadian Institute for Radiation Safety (Toronto).

A common goal shared by all accident prevention partners is to help Ontario employers provide environments where work-related illnesses and injuries do not occur. Recent studies have pointed to several organizational factors that produce safety excellence. These factors include the following:

- leader vision, commitment and drive

- ownership of the safety agenda by line managers
- the involvement of all workplace parties in safety activities (supported by training)
- "Comprehensive Safety Practices"
- the role of the safety organization and specialist
- the social environment of the workplace.

Leader Vision, Commitment & Drive

The leader of an organization must facilitate the development of a shared vision with respect to occupational health and safety. This objective is best accomplished by having safety as an integral part of the strategic planning of the organization. Beyond the establishment of a vision, the leader must demonstrate commitment to the vision through observable behaviour.

Examples of demonstrated commitment include the following: during bi-weekly management meetings, the president of DuPont leads discussions on safety as the first item on the agenda; at Shell Canada, safety is the first item on the agenda at board of directors meetings and the top 50 people in the organization meet four times per year to review corporate safety.

Ownership of the Safety Agenda by Line Managers

The line accountability system in an organization consists of workers, managers and senior managers and the relationships and communication between them. When this system takes ownership of safety as one of its mandates, safety tasks and outcomes are assigned the same importance as tasks and outcomes associated with productivity. This accountability is shown when safety-related activities and desired outcomes

appear in job descriptions, and are part of the performance evaluation system for line managers.

The Involvement of All Workplace Parties in Safety Activities

Organizations that achieve safety excellence were found to have individuals from all levels who were engaged in safety activity.

Comprehensive Safety Practices

Successful organizations were found to have comprehensive safety-related rules and practices. Members of the organizations are held accountable for compliance with these rules.

The Role of the Safety Organization & Specialist

Organizations that achieve safety excellence are notable for the fact that most of the safety-related activities are done by line managers and workers rather than safety specialists or organizations.

The Social Environment of the Workplace

Findings from recent studies conducted by the Institute for Work and Health have demonstrated the importance of the social environment in the workplace to the incidence of

work-related accidents. These studies have indicated that the degree to which workers feel control over their work and feel supported by supervisors and co-workers has an impact on the incidence of work-related injuries.

In summary, it is possible to achieve safety excellence in all Ontario workplaces. We must view each workplace as a whole with inter-related parts. Each part must demonstrate commitment to safety through observable behaviour. A clear vision that is part of the strategic plan of the organization must be the principle that governs the behaviour of everyone in the workplace.

Traditional approaches to accident prevention have focussed on the physical aspects of safety. We must look beyond this aspect and develop strategies that create an environment of mutual support, where workers are empowered to make appropriate decisions regarding their work.

For questions about this article, please contact Trevor Blake, HCHSA Consultant at Tel. (905) 562-3612/ 1-800-489-7303/E-mail: tblake@hchsa.on.ca

More New products from HCHSA (continued)

A total of five prizes are available. These are: a one-day onsite ergonomic consultation valued at \$700.00; a one-day onsite hygiene consultation valued at \$700.00; and three coupons redeemable for \$100.00 of HCHSA products. For more information, please call Kim Badovinac at 1-877-250-7444, ext. 136/(416) 250-7444, ext. 136.

To keep up-to-date regarding HCHSA products, please refer to the Product Catalogue on our web site: www.hchsa.on.ca

and watch for upcoming announcements in future newsletters. Please note that as of Sept. 1, 1999, we now require pre-payment for all product orders. Payments must be made in full by cheque or money order and made payable to: Health Care Health & Safety Association. Please ensure that appropriate shipping/handling and taxes (GST/PST) are calculated. Please note that training packages and the Pocket Guide of Acts/Regulations are PST-exempt.

How Job Strain Factors Relate To Injuries – By Institute for Work & Health

In the health care sector, work-related musculoskeletal injuries are the most common and costly occupational health and safety issue. Mieke Koehoorn, from the Institute for Work & Health, has examined how biomechanical issues, individual factors, as well as job strain characteristics, can contribute to musculoskeletal injuries in the health care sector. Her research links injuries to reduced job control, a non-supportive work environment and higher workload levels, especially during times when there is increased absenteeism in a department or unit.

There is no doubt that health care workers do a lot of necessary but repetitive and physically demanding tasks in a health care setting. Many of these tasks lead to awkward postures and back and neck problems. Yet Koehoorn believed there was a need to look beyond the biomechanical causes of injuries. “There were

certainly biomechanical reasons, but factors relating to job strain, organizational structuring, and individual factors, are also important.”

For four years, Koehoorn followed 4,020 health care workers in an acute care hospital in British Columbia. At the organizational level, her research found that the changing health care system with its organizational restructuring, including hospitals merging and departments closing, was a source of stress. In particular, the layoffs in the health care industry have led to feelings of job insecurity. “The more global influences of work structures and processes may affect the health of workers.”

At the work level, Koehoorn looked at job strain factors such as low control over work decisions, low support from co-workers and supervisors, high job demands or time pressures and high workload levels. “The way in which work is organized,

including control and social structures or support can be a risk factor,” says Koehoorn.

“It is difficult for workers to negotiate their schedule or to moderate the demands of the job over the work day. They end up having peak times during the day when they are extremely busy and must meet organizational deadlines, and this may be associated with musculoskeletal injury.”

“For example, organizational scheduling that determines when you have to do certain functions by a specified time can relate to back injuries. Within a hospital or long-term-care nursing home, patients have to be bathed, fed, and exercised. They must take their naps, receive medication, or go for tests within specified time periods, and that puts a lot of strain on health care workers during certain times of the day.”

Interestingly, Koehoorn found a difference between the factors associated with lower body

injuries and those related to upper body injuries. Lower body injury seems to be primarily associated with ergonomic factors (e.g., too much lifting at awkward angles), although job strain factors are also important. But upper body injury (neck, shoulders and arms) seems to be equally associated with a combination of ergonomic factors, individual factors and job strain factors.

Koehoorn’s research has highlighted the relationship between musculoskeletal injuries and the amount of control health care workers have over their work activities and tasks, the support they receive from co-workers and supervisors, and how stretched they are during periods of high sick time within their departments.

For more information on this study, please contact Dee Kramer at the Institute for Work & Health
Tel. (416) 927-2027, ext. 2146.

Fire Code Retrofit Requirements For Health Care Facilities (continued)

are specific requirements for this space allowance. Also, each area of refuge must have access to an exit in the event that a full evacuation is necessary.

Means of Egress

Means of egress requirements ensure that the building is designed to allow for acceptable exits and routes of exit to the outside of the building. These routes of exit must be protected to maintain a safe and smoke-free environment for exiting occupants. The doors themselves must never be locked or blocked and must swing out in the direction of external environment. The doors must be of adequate size and number to accommodate the number of occupants.

Elevators are never considered a means of egress. They

must stay off-limits during a fire for use by the fire department. In many cases when fire alarms are initiated, the elevators are programmed to lower or rise to the main floor.

All exits and exit routes must be clearly identified using signage specified in the *Building and Fire Codes*. Schematic diagrams marking exit routes are also required in most cases. Emergency lighting, to ensure that the means of egress can be seen, is also a requirement under the *Fire Code*.

Detection & Early Warning

Smoke detectors, heat detectors, fire alarms and the system(s) that interconnect them all fall into this category. The air handling system is also connected to the fire alarm and detection system so that it shuts

down. This ensures that hazardous smoke from the fire source is not spread via the air handling system. Stairwells, however, are often pressurized with outside air to help keep them smoke-free.

Detection devices and alarms that warn occupants early enough for them to escape the fire are specified in both the *Building and Fire Codes*. Some of this legislation specifies that the fire department is automatically notified if a fire is detected and an alarm sounds. Fire alarms must be loud enough and placed in such a way as to ensure they are heard. In most cases, the fire alarm system must be interconnected to ensure that all potentially affected occupants are warned of a potential fire emergency.

In health care facilities that involve the regular treatment and care of occupants who have sensory limitations, alarms that will warn these occupants must be installed. For example, flashing lights of specific intensity can be required to ensure that hearing impaired individuals are duly informed of a potential fire emergency.

In larger buildings, announcement is required so that the fire department and other authorized personnel can communicate with occupants and/or fire fighters.

Suppression

Should a fire occur, suppression requirements ensure that the fire department can access the fire and the tools necessary to safely and effectively extinguish the fire.

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Products/Resources/Research

REVISED OCCUPATIONAL EXPOSURE LIMITS

The Hon. Chris Stockwell, Minister of Labour, announced on November 16, 1999 that Ontario will be revising its occupational exposure limits. Occupational exposure limits restrict the amount and duration of workers' exposure to hazardous chemicals in the workplace. The updated exposure limits will correspond to the latest exposure limits recommended by the American Conference of Governmental Industrial Hygienists' (ACGIH). Affected substances include asbestos, benzene, silica and lead. For more information, contact the OEL Update Project at the Ministry of Labour Tel. (416) 326-9299/ Fax (416) 326-9299.

INFECTION CONTROL Bioterrorism Readiness

New from the Association for Professionals in Infection Control and Epidemiology (APIC) and the Centers for Disease Control and Prevention (CDC) is a reference document, "Bioterrorism Readiness Plan: A Template for Healthcare Facilities." This article is available in a downloadable format at: www.cdc.gov/ncidod/hip/Bio/13apr99APIC-CDCBioterrorism.PDF

In a recent article in *The Toronto Star* (January 17, 2000, pages A1 & A12), it was reported in documents obtained under the *Access to Information Act* that Canadians are increasingly likely to face threats of biological terrorism, hoaxes or an actual event. Specifically, it was revealed that Health Canada officials believe that there is an urgent need to increase awareness in the medical community in Canada about the special requirements for managing the consequences of a biological event, regardless of size, and whether it is real or not. These

special requirements include the need to train medical personnel on how to respond to the release of a biological agent, how to identify and diagnose it, and the importance of working closely with security, intelligence and communication officials.

Preventing Needlestick Injuries

A new NIOSH publication, "Preventing Needlestick Injuries in Health Care Settings," is available for download from the NIOSH Web Site: www.cdc.gov/niosh. In this document, health care workers are recommended to take the following steps to protect themselves and their co-workers from needlestick injuries:

- Avoid the use of needles where safe and effective alternatives are available.
- Help employers select and evaluate devices with safety features.
- Use devices with safety features provided by your employer.
- Avoid recapping needles.
- Plan for safe handling and disposal before beginning any procedure using needles.
- Dispose of used needles promptly in appropriate sharps disposal containers.
- Report all needlestick and other sharps-related injuries promptly to ensure that appropriate follow-up care is provided.
- Tell employer about hazards from needles observed in the work environment.
- Participate in blood borne pathogen training and follow recommended infection prevention practices, including Hepatitis B vaccination.

An excellent review of the literature on needlestick injuries among health care workers is found in: Porta, C., Handelman, E. & McGovern, P. (1999). Needlestick injuries among health care workers:

A literature review. *AAOHN Journal*, 47(6), 237-244.

Hepatitis A

A recent article in the British publication, *Health & Safety at Work*, indicates that childcare workers are particularly vulnerable to Hepatitis A. This is due to the fact that children under 6 years of age, often exhibit no symptoms of the disease. Many workers can pass along the virus, unaware that they have ever been infected. HAV immunization is recommended. Citation: Barker, R. (1999). What is Hepatitis A? *Health & Safety at Work*, 21(8), 15-16.

Hepatitis C

Hepatitis C is considered the most prevalent blood borne pathogen in U.S. healthcare workplaces. A recent article in *Nursing Forum* describes this disease as well as prevention and treatment issues. Citation: Dillman, C.M. (1999). Hepatitis C: A danger to healthcare workers. *Nursing Forum*, 34(2), 23-28.

Compliance an Ongoing Issue!

A recent study found that while improvements in compli-

ance with recommended infection control procedures had been noted among Canadian dentists, procedures like handwashing and appropriate use of barriers were common practices only among a minority of respondents. Citation: McCarthy, G.M., Koval, J.J. & MacDonald, J.K. (1999). Compliance with recommended infection control procedures among Canadian dentists: Results of a national survey. *American Journal of Infection Control*, 27(5), 377-384.

Emergency department personnel, including physicians, nurses and technicians, were also found to have inadequate knowledge of blood borne pathogen infection risk, to underreport exposures and to underuse personal protective devices during trauma cases. Citation: Kim, L.E. et al. (1999). Compliance with Universal Precautions among emergency department personnel: Implications for prevention programs. *American Journal of Infection Control*, 27(5), 453-455.

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WEB RESOURCES ON HEPATITIS

Center for Disease Control and Prevention, National Center for Infectious Diseases

www.cdc.gov/ncidod/diseases/hepatitis

CDC, Hepatitis Branch - Slide show "Epidemiology & Prevention of Viral Hepatitis A to E: An Overview"

wdhfs.state.wy.us/epi/slideshows/hepatitis/hepbcdc/sld001.htm

Health Canada, Division of Blood-borne Pathogens

www.hc-sc.gc.ca/hpb/lcdc/bid/bbp/viral.htm

The Hepatitis Information Network

www.hepnet.com/hepa/hepafact.htm

GlaxoWellcome

www.healthyives.com

Merck

www.merck.com/disease/preventable/hepa/

www.merck.com/disease/preventable/hepb/

National Digestive Diseases Information Clearinghouse - Hepatitis Publications

www.niddk.nih.gov/health/digest/pubs/hep/index.htm

U.S. Food & Drug Administration, Center for Food Safety & Applied Nutrition Bad Bug Book - Hepatitis A Virus

vm.cfsan.fda.gov/~mow/chap31.html

LATEX ALLERGY

Two recent articles that may be of interest to readers: Karvonen, C.A. (1999). Latex allergy in health care workers: What are the risks? *AAOHN Journal*, 47(11), 519-525; and Rego, A. & Roley, L. (1999). In-use barrier integrity of gloves: Latex and nitrile superior to vinyl. *American Journal of Infection Control*, 27(5), 405-410.

WORKPLACE VIOLENCE

A recent article in *Nursing Forum*, outlines a plan for reducing violence in health care environments. This includes developing a policy and supporting it with appropriate enforcement as well as taking preventive measures to ensure the potential for violence is reduced. Citation: Smith-Pittman, M.H. & McKoy, Y.D. (1999). Workplace violence in healthcare environments. *Nursing Forum*, 34(3), 5-13.

OFFICE ERGONOMICS**Proposed Regulations**

Legislation currently before Canadian Parliament would give cabinet the power to enact regulations that would seek to prevent repetitive strain injuries and other forms of "soft tissue" injuries in federally regulated businesses. In late November of 1999, ergonomic regulations were unveiled in the U.S. These require that all manufacturers and companies that have workers who do repetitive motions or manual lifting - including health care employees who lift clients - institute a program to identify ergonomic issues and teach workers how to avoid injury. In addition, when a worker reports an ergonomic injury, the employer would be required to improve conditions in the workplace site where the injury occurred. British Columbia and Saskatchewan are the only two Canadian provinces that have ergonomic regulations. (Source: *The Globe and Mail*, November 23, 1999, B5).

Worthwhile Articles

An excellent summary of the essential elements of a successful office ergonomics program is provided in: Martin, C. & Andrew-Tuthill, D.M. (1999). Office ergonomics: Measurements for success. *AAOHN Journal*, 47(10), 479-492.

A second article contains a useful computer stations checklist. Blais, B.R. (1999). Visual ergonomics in the office workplace. *Chemical Health & Safety*, 6(4), 31-38.

"Deskexercises"

Looking for some simple exercises which can be done to ease tension in various body parts during your work day?

Try this resource at the Johns Hopkins Health Information web site: www.intelihealth.com. You can select from a number of quick and easy exercises.

NEW EMPLOYEE FIRE SAFETY TRAINING PROGRAM

The Office of the Ontario Fire Marshal, in partnership with the Fire Marshal's Public Fire Safety Council and with the participation of fire service professionals and care and treatment industry stakeholders, developed a training package called, "Fire Safety Training for Employees of Care and Treatment Occupancies." This training package is designed for use by fire safety educators in nursing homes, homes for the aged, private and public hospitals, convalescent hospitals, residential care facilities and group homes.

The training package contains valuable reference materials, a sample teaching outline, case studies, sample handout materials, sample visual aids and guidelines on relevant important issues. The training package can be purchased through the Fire Marshal's Public Fire Safety Council for a total cost of \$182.50. To obtain more information, contact Anne

Miller at Tel. (416) 325-3152 or Bruce Weaver at Tel. (416) 325-3175.

LOOKING FOR READY-MADE POWERPOINT PRESENTATIONS?

The Vermont Safety Information Resources, Inc. has a web site of 72 PowerPoint presentations that can be viewed or downloaded. Topics range from things like accident investigations to hazard assessment to task analysis. Check out this site: <http://siri.uvm.edu/ftp/ppt/powerpt.html>

HELPING INJURED WORKERS

The Iron Ore Company of Canada and the United Steelworkers of America have

developed a program called "Together We Can Win." Consisting of a workbook and video, this resource is designed to increase awareness and improve services and support to workers injured on the job and help injured workers to better understand their situation and how to navigate the workers' compensation system. For more information about this resource, call Toll-Free 1-877-787-7010; E-mail: ciwa@norlink.net; or check out the Canadian Injured Workers Alliance web site at: www.ciwa.ca

Fire Code Retrofit Requirements (continued)

Generally, health care facilities are required to be sprinklered. When a building is sprinklered, suppression of the fire can begin even before fire fighting personnel arrive at the scene. The *Building Code* outlines in detail how this is to be done. Different fire hazards and different environments require specific sprinkler systems. Adequate water must be available and a specific number of sprinkler heads must be installed to ensure coverage of the area. Professional engineers are normally required to ensure compliance with the *Building Code*.

Access routes to buildings are also determined by the *Building Code*. Properly laid out access routes ensure that fire fighting equipment can access the building from all necessary angles. Fire trucks have a wide turning radius so access routes must be designed to accommodate this. Ladders and aerial equipment also require clearance of a certain distance from the building. In addition, fire

trucks are very heavy - access routes must be designed to support their weight.

Firefighters' elevators are required for buildings with over six storeys. At least one elevator must be available for use by firefighters. This elevator must be key-operated for manual emergency recall operation and have key-operated emergency service switches. This elevator must be easily identified by firefighters responding to the fire.

Maintenance is vital to the safe operation of any emergency system. The fire prevention system is required to be tested and monitored on a regular basis. Regular fire drills performed by trained staff and informed occupants are a critical part of the fire safety plan of any building.

For questions about this article, please contact Dora Pender, HCHSA Consultant at Tel. (705) 534-6329/1-800-490-3980/E-mail: dpender@hchsa.on.ca [occuhandling system](http://www.hchsa.on.ca/occuhandling_system).