Occupational Health Surveillance in Health Care: A report from the Morocco working group

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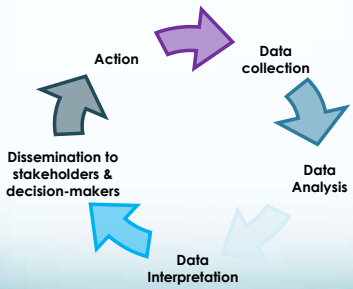
ICOH 2012 Cancun

Why is Surveillance for Healthcare Workers Important?

- The health care workforce is central to advancing health in all health systems.
- Occupational surveillance is necessary to help ensure safe working environments.

Health Surveillance



The Current State of Occupational Health Surveillance

- Classifications developed mainly for two purposes; notification for labour safety and health surveillance and compensation.
- Variations among countries exist
- Result= a diversity of situations in countries
- The absence of unified diagnostic criteria, coding systems and classifications reduce the compatibility and comparability of national statistics on occupational diseases both within and between countries.

The 2010 Workshop

- Proceedings of a Workshop within the 8th International Conference on Occupational Health for Health Care Workers in Casablanca, Morocco in October 2010
- Organized by ICOH-HCW committee, the International HCW Safety Center at the University of Virginia, NIOSH, University of British Columbia, and WHO
- 19 participants from 8 countries- from various organizations with a common interest in this area.
- Formation of small working groups

The Objectives of the Workshop

- While there seems to be a growing consensus that having a set of common indicators for occupational health surveillance is a desirable goal, a path for achieving this has not been established.
- The formation of working groups led to a consensus around 22 indicators; a starting point for further refinement and work towards our common vision.

Synthesis of Some Existing Classifications

- ILO Code of practice on the recording and notification of occupational accidents and diseases (1994)
- Resolution concerning statistics of occupational injuries (1998)
- International statistical classification of diseases and related health problems (ICD-10) in occupational health (1999)
- WHO Family of international classifications: definition, scope and purpose (2007)
- Health Level 7 (HL 7)
- European Union Health and Safety
- Others?

The Document

Objectives of the document produced from the workshop were to:

1. develop an international consensus on what data all healthcare organizations should be collecting with respect to occupational health

2. define the terms associated with the above – i.e. create a data dictionary – that is consistent with other international efforts

3. develop standardized protocols, methods, instruments to be able to share data to allow international comparisons.

Workshop Reflections

- This section provides documents the main themes of discussions that arose during the workshop
- Workshop participants shared experiences related to occupational health from Japan, USA, Tunisia, South Africa, Canada, Morocco, Switzerland and Germany

Occupational Classification Specific to the Health Care Setting

Physician & Surgeon	Nurse	Allied Health	Administration	Support Services	Other
Physician	Professional Nurse	Physical Therapist/ Occ Therapist	Manager/administrator	Cleaner	Student
Surgeon	Care Aide /LPN	Therapist/ Social worker	Clerical	Laundry	Volunteer
Resident/ registrar	Other nurse	Technologist/ technician		Kitchen	Other
Dentist		Other		Security	
				Porter	
				General assistant	

Occupational Health Indicators

- Workshop participants decided to classify indicators as **leading and trailing**.
- "**Leading**" occupational health and safety measures are indicators of where the organization is headed; they are measures of future performance.
- "**Trailing**" indicators, are indicators of past performance and do not accurately indicate present and future safety conditions.
- Both are essential for workplace safety. A safety program striving for excellent performance will use a mix of leading and trailing indicators.

Occupational Health Indicators

LEADING:

1. **OHS Policy** – written and accessible on each unit (yes/no)

2. **Trained person in charge of OHS** (yes/no)

3. **Health and Safety Committee** – meeting at least quarterly, with members trained, keeping minutes and addressing action items, (yes/no), plus % of **H&S committee recommendations implemented.**

4. **Training in safe practices** - % of patient care staff (or all Staff) who received training on safe practices during previous 12 months/ % of all staff trained.

5. Workplace assessment conducted (# of workplace assessments done/% with recommendations written (including need for equipment, supplies, repairs, training, policies or procedures, improved environment)

Occupational Health Indicators

LEADING (continued):

6. Return-to-Work Safely program - presence of a program (yes/no)

7. Immunizations -- % of patient care staff immunized for Hep B, MMR, and others; overall staff % of staff immunized for Hep B, MMR, and others.

8. **Worker Assessment** (biological monitoring if needed) annually or biannually

9. Availability of Personal Protective Equipment

Occupational Health Indicators

TRAILING

(Number, Rate, Duration plus Time Loss, and Cost -if possible for the following)

10. **Overall injuries** (per full-time equivalent staff)

11. **Overall time-loss injuries** (per full-time equivalent staff)

12. **Musculoskeletal injuries** (per full-time equivalent staff)

13. **Needlestick injuries** (per full-time equivalent staff)

14. **Violent incidents against staff** (per full-time equivalent staff)

15. **Occupational disease** (e.g. cases of asthma or other respiratory irritant or allergic reaction, systemic toxic reaction. as well as well as cases of dermatitis – irritant or allergic.)

Occupational Health Indicators

TRAILING (continued):

16. **Workers** who had to be quarantined

17. **New cases of TB** among health workers

18. % of staff accepting **HIV Counselling and Testing (HCT)**

19. % of staff screened for **TB**

20. **Deaths** of health care workers (occupational AND non-occupational?)

21. **Permanent disability/loss to workforce** of health care workers (noting from both occupational AND non-occupational)

22. **Worker Retention**

Example #1: OHS Policy – written and accessible on each unit (yes/no)

- There should be a written policy at the national level that applies to health workforce and evidence of the policy in the workplace.
- The policy/procedure at the workplace should include a list of all the hazards specific to work categories/tasks.
- Measures to prevent and control risk according to specific risk of worker category should be included.
- If there is a national policy, "Does it do certain things?"
- Minimums must be customized according to the workplace.
- Policies must be applicable at the national level, but may also go beyond this level.
- Policies should be multi-level and the responsibility varies from country to country (i.e. at the provincial level in Canada).

Example #19: % of staff screened for TB

- HCWs are at greater risk of infection with *M. tuberculosis*
- Regular monitoring for TB to identify those who have latent TB and to offer them IPT when appropriate.
- Monitoring allows for rapid detection of HCWs with active TB and ensures timely treatment.
- Screening for latent TB is recommended in areas where TB is not endemic whereas screening for active disease is recommended for endemic areas.
- Type of facility, occupation and frequency of performance of aerosol-generating procedures should be considered when determining occupational TB risk.
- Frequency and method of TB screening will depend on national policy.

Special Thanks to:

- Dr. Annalee Yassi (UBC)
- Ms. Susan Wilburn (WHO)
- Dr. Bill Buchta (Mayo Clinic)
- Dr. Jerry Spiegel (UBC)
- Dr. Ahmed Gomaa (NIOSH)
- All workshop participants

Thank you!

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