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

- Data collection
- Data Interpretation
- Action
- Dissemination to stakeholders & decision-makers

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

- 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
- Nurse
- Allied Health
- Administration
- Support Services
- Other

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.

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)
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 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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