An alternate perspective

By Janice L. Spivey, RN, ENC(C), CEN

Recently, I sustained an injury during the performance of my role as an emergency nurse. Medical assessments, discomfort and diagnostic investigations determined that I would be unable to perform my regular duties for an indeterminate period of time.

Many phone calls, emails, discussions and meetings took place over a couple of very short days. I found myself in a totally unfamiliar situation, with the overwhelming sense of having lost any control. And I was in constant pain!

Many parties were involved in determining what to ultimately do with me. These included my ED nurse manager, an occupational health nurse, the hospital's WSIB administrator, my union representative, my assigned WSIB case worker, my family physician, WSIB's assessment physician, my physiotherapist and myself.

The proposed plan was for me to work in the infection control department. They were short two infection control practitioners (ICPs), thus had many duties within their busy department that could be delegated to an injured worker. The modified duties and flexible hours were intended to accommodate my discomfort, physiotherapy and functional limitations during my rehabilitation. I had, however, gone from 12 hours to eight-hour shifts, resulting in my being at work more days weekly than usual.

I was warmly welcomed to the infection control department by the director, the manager, the physician head, all of the infection control practitioners and the surveillance assistants, each expressing appreciation for whatever assistance I would be providing. On my arrival in infection control, I needed orientation and training to my many new roles and the assorted aspects of my interim job. It quickly became clear that I was totally unfamiliar with the true inner workings of this department and the huge scope and responsibilities of my new colleagues. I had never even been in their part of the hospital previously!

I quickly settled into my "home away from home" within my own hospital. I learned so much in a very short time in order to perform all of my new and varied roles. My duties changed weekly and sometimes even daily, as determined by the immediate needs and priorities of the hospital and, thus, those also of the infection control department.

Over several months, I conducted frequent hand hygiene audits of all inpatient floors and departments throughout the hospital, as had been mandated by the provincial government. This surveillance included the use of alcohol-based hand rub or the performance of hand washing pre and post exposure to each individual patient and their immediate environment. The separate contact precautions audit monitored the use of alcohol hand rub or hand washing, as well as proper use of isolation gowns, gloves and masks in all rooms containing patients who had been identified as requiring these precautions and practices. Of course, it was also required that all data, as obtained, be input into the computer in a timely manner.

I also conducted environmental services audits of the furniture in patient rooms or ED cubicles, as well as the bathrooms in every unit and on every inpatient floor throughout the hospital. My shifts were staggered during daytime, evening and weekend hours. "Potty patrol" consisted of me doing an environmental (cleaning) audit of every commode chair found, while on "pump patrol", I audited intravenous pumps both in use and "clean, ready for use". The process for these various audits involved the application of invisible Glow Germ lotion to pre-designated locations on specific furniture (bedside table, over bed table, side rails) and pre-selected surfaces (sink, toilet seat, toilet handle, bathroom door knob, as well as commode seats [upper and lower surfaces] and handle bars) within all patient rooms. This Glow Germ application was followed by me doing a scan with an ultraviolet light over the same areas in a minimum of 25 hours from application. Since the environmental services department is a vital partner in the control, transmission and prevention of infection within the hospital, it was essential to evaluate the housekeeping practices.

Three months into my time as a modified worker in the infection control department, I was seconded to the occupational health department for two weeks. H1N1 had come to Ontario, and it had taken priority within the hospital and over my placement in the infection control department! My new role allowed me to assist with the administration of the H1N1 vaccine injections, as well as the dispensation of Tamiflu antiviral, as it was being offered to all hospital employees.

When I was not working in the H1N1 clinic, which had been set up in our staff wellness centre, I met many other colleagues with my "travelling H1N1 vaccine and Tamiflu road-show". My cart was loaded with vaccine, antiviral, consent forms and Halloween treats. Once again, I found myself discovering many unfamiliar areas within our hospital. All departments appreciated having this health and safety initiative brought directly to their staff, thus eliminating time away from their units due to the long line-ups in the wellness centre.

In an attempt to understand the increasing transmission of VRE throughout my hospital, I was next asked to conduct patient mobility audits for the infection control department. This process included me conducting a personal interview with every current patient (if they were awake and they agreed, were coherent, and were able to communicate) who had tested positive for VRE. The patients responded to specific questions from me about whether they had ambulated independently out of their room in the past 48 hours, did they ambulate independently off their unit ever, had they been instructed in hand hygiene for entering or leaving their room, and any general infection control comments they wished to share.

All data were compiled and reviewed, along with any general comments shared by patients and their families. This VRE audit led directly to a change in practice throughout my hospital, resulting in the restriction of VRE patients to their individual rooms. This practice now seems like a "no brainer" with the audit data supporting the travel by some patients out of their isolation rooms, off their units, down the elevators, and into the cafeteria, cafe or gift shop. Although VRE information pamphlets were created for patients and visitors, this new "rule" did meet with some resistance from some patients.

I also frequently assisted the infection control practitioners by performing the daily isolation rounds throughout our hospital. This "walk about" involves the verification that all patients requiring isolation precautions actually do have the necessary signage notification and the appropriate PPE supplies stocked outside their rooms in order to facilitate proper infection control practices. As a registered nurse, it has been easy for me to often conduct spontaneous "point of care" infection control education with patients, visitors and hospital colleagues, whenever the opportunities arose, wherever I was throughout the hospital.

Following the objective collection of the large volumes of data from each audit, an assessment of the percentage of compliance is determined. The risks of infection transmission to our patients, our families and ourselves are extremely high. The countless audits that I have performed accurately reflect all of our compliance with infection control protocols, while also identifying opportunities where we all need to improve.

I have met many hospital employees and have been in various areas of our hospital that were previously unknown to me, including the office of the president and CEO. I have witnessed and learned so much about the diverse working lives and countless challenges of so many varied health care professionals and allied personnel in all patient care areas of my hospital. I admire each of them in their countless and equally important roles.

While carrying out my various modified duties over several (10) months, I gained a new and extensive understanding of the infection control department and the hugely demanding roles and responsibilities of the infection control practitioners. Throughout my tenure, everyone in the infection control department served as mentors, guides and knowledgeable resources for me. I have developed a genuine respect and admiration for these dedicated professionals and the important jobs they perform, all in a very busy and short-staffed department. It is no surprise that the work and assistance by this modified worker were so greatly appreciated!

I had found myself in need of a temporary work "home". Infection control long-term, and occupational health short-term, both needed assistance. Together, my injury and recovery time became a positive experience for all. It has been a genuine pleasure and a personal honour for me to meet, to learn from and to work with all of these dedicated professionals during my lengthy rehabilitation. I am told that my shoulder is "at maximum recovery or 90%" and that I can always expect to have "some discomfort and limited use."

I do, however, find myself in the most fortunate position of having many new and respected friends in the expansive world of health care. I have taken all that I have learned or have come to better understand while I was "away", back to my emergency department and my colleagues there. I learned so much and I was treated so well, but it is so good to be home!

About the author

Jan Spivey job shares as a staff RN in the ED of Kingston General Hospital, works as a Legal Nurse Consultant for Wise Owl Legal Nurse Consulting, is the current President of the Emergency Nurses Association of Ontario, is a member of the NENA Board of Directors and a Past President of NENA, is a member of the Medical Advisory Committee for PHAC—Emergency Preparedness Division, serves on the Board of Directors of the Centre for Excellence in Emergency Preparedness, is a member of the ED Asthma Care Pathway Steering Committee for the Ontario Lung Association, serves on the Hospital Associated Infections Working Group for the Ontario Southeast LHIN, is a member of the PHAC Medical Receivers Working Group, and has been recently appointed by CNA to serve on the Emergency Certification Exam Committee, Eastern Region.

outlook
Kids' Corner

Management system coming

Memo to: **Course directors** of ENPC/TNCC

eCourseOps are developing a new course management system!

In response to your feedback, ENA has been working with a course director focus group, consisting of your peers, to develop an online course management system, which will facilitate the scheduling and management of ENPC and TNCC. Some key features of Phase 1 of the new online system:

- Direct entry of online course applications, resulting in an immediate course number
- "Cut and paste" an existing course into a new course application
- Pay open invoices online, or reprint your invoice whenever you need to
- View full history of your courses and invoices
- Reschedule the course dates, or cancel a course
- Report the actual number of students after the course completion.

During the ENA conference in Tampa, Florida, I attended one of the demonstrations of the system. For someone who is technically challenged, I found it very easy to work with and look forward to the launch. A demo should be available on the ENA website in the next couple of weeks for course directors to trial.

Sharron Lyons