Sometime in late January or early February, James Garb, MD, expects to receive his smallpox vaccination. He will take the treatment along with about 100 coworkers at Baystate Medical Center in Springfield, MA.

“It’s not just for show—we need to be vaccinated,” says Garb, director of occupational health and safety at Baystate, who is also certified in occupational and internal medicine.

The vaccine’s “hit list” at Baystate includes emergency department (ED) personnel, clinicians in the intensive care and pediatric intensive care units, staff members at inpatient adult units with isolation rooms, environmental services workers, respiratory therapists, radiology technicians, engineers, infection control officers, and infectious disease specialists.

The hospital will ask up to 40 nurses to take vaccine in the ED alone—enough to have a vaccinated nurse on hand 24 hours a day.

The White House says so

Like many of you, Garb is on the front line of volunteer hospital workers who will receive the vaccine as part of President Bush’s

Patients assaulting employees

The push to develop violence response levels at one OR facility

Not too long ago, Jose Hernandez, the safety officer at Mercy Medical Center in Roseburg, OR, had a bad day after a patient kicked and pinched him.

Hernandez and his colleagues face what many of you do every day: the potential for assaults from patients.

Mercy Medical provides acute care and behavioral health services. Hernandez is trying to convince his administrators to adopt a new use of force policy that spells out exactly what steps security officers should take when confronted by a violent patient.

“Unfortunately, a lot of hospitals don’t have [this type of policy] and should have it for legal reasons,” says Hernandez, adding that in a courtroom, you don’t want a lawyer badgering a hospital on why its security team didn’t observe such a policy.
Smallpox vaccinations

initial plans to prepare for a possible smallpox attack.

“We’re asking people to step up to the plate . . . and take [the vaccine] to protect all of us,” says Julie Gerberding, MD, MPH, the director of the Centers for Disease Control and Prevention (CDC). She spoke during a Webcast in December 2002.

About two-thirds of those who responded to an online poll on BHS’ sister Web site, healthsafetyinfo.com, say they will volunteer for the vaccine if the option is open to them (see Fig. 1 on p. 3).

Regardless of a hospital worker’s decision, safety officers should act as information sources for their colleagues. The following are some areas to look at:

✔ Emphasize voluntary actions
A hospital can’t force an employee to take the vaccine because Bush made the doses voluntary for everyone but the military.

Garb encourages potential volunteers to talk to their family members and their personal physicians about the vaccine. “This is voluntary in every sense of the word,” he says. “There is no stigma and no penalty [at Baystate] if they don’t want to be vaccinated.”

In fact, some hospitals already declined to offer the vaccine to anyone. Though it’s within the facility’s right to do so, Garb wonders whether it’s a reactionary stance.

“I think the [federal plan] is a reasonable approach,” he says. A hospital that doesn’t want to offer the vaccine takes that decision-making power away from health care workers who might want the protection, he adds.

✔ Find out about workers’ comp
Speculation surrounds the question of who will pay for any illnesses or lost workdays due to the vaccine.

The following are two key factors to this debate:

1. Individual state workers’ compensation laws, which vary greatly
2. Hospitals that are self-insured for workers’ comp

There is further confusion about liability v. compensation as it relates the vaccine, Gerberding says. Liability refers to manufacturers and those people who administer the vaccine.

The new Homeland Security Act, which goes into effect January 24, offers some liability protection for health care workers who administer the inoculation in the event of a recipient’s adverse reaction, she says. A person who suffers a reaction would have to prove negligence in the handling or administering of the vaccine, which could be difficult, according to federal health officials.

Nonetheless, hospitals should ensure that their legal and human resources departments stay involved in smallpox inoculation plans, says William Smith, director of environmental health and safety at the University of Pittsburgh Medical Center.

“There will definitely be litigation” stemming from the vaccine and hospitals need to protect themselves, Smith says.

The Homeland Security Act has no provisions for compensation if a health care worker needs time off to recover from the vaccine’s effects, Gerberding says. In that case, providers must look to their insurance coverage or state workers’ comp programs, she adds.

Baystate is self-insured, and as such will cover medical care due to vaccine complications and any related lost time from day one, paying employees “excused time with pay” for the first days until workers’ comp

The JCAHO began conducting random unannounced surveys at hospitals; the NFPA made major changes to its medical gas requirements; OSHA unveiled a tuberculosis enforcement policy.

Tip you can still use: Consider training employees on light work duty for fire watches.
developing symptoms, you could be talking several weeks before you’d be able to let them come back to work,” MacArthur says.

“Our EDs are in the front line but definitely cannot afford to have any percentage of their staff off duty [due] to infectious status or side effects,” Smith says.

✔ Determine how far you go
Hospitals should remember that smallpox teams do not only include physicians and nurses. Safety committees should also consider other, nonclinical positions, such as security guards and housekeepers, MacArthur says.

Even an employee who merely greets incoming people at the admissions desk might be appropriate for the vaccine since he or she could be among the first people a smallpox victim comes in contact with, he adds.

However, Garb is somewhat skeptical of this strategy; he feels hospitals could directly admit smallpox patients to the ED—similar to trauma cases—and avoid exposures to clerks and receptionists.

✔ Offer educational help
Within a week of Bush’s announcement, Garb conducted seven presentations on the smallpox vaccine to top administrators and middle managers. He provided written material about the vaccine to attendees. Volunteers will see more detailed information when the hospital asks them to consider receiving the vaccine.

Though Baystate had material of its own prepared, other hospitals shouldn’t feel the need to mirror those efforts, Garb said.

“I’m not sure people have to develop their own [materials],” he says. Instead, look to free, readily available information about smallpox on the CDC’s Web site (www.cdc.gov). He also recommends a

1994
The EPA began phasing out the use of halons and chlorofluorocarbons; the JCAHO previewed its new EC chapter, which replaced the plant, technology, and safety management standards; the CDC published tuberculosis guidelines. Tip you can still use: Photograph good and bad safety practices to show during training.
Smallpox vaccinations

new site from the Department of Health and Human Services at www.smallpox.gov.

There’s widespread discussion about possible side effects of the vaccine. No one can truly be sure what will happen with the first round of doses, Garb says.

He recently spoke with a physician who inoculated 500 workers in a commercial laboratory that develops smallpox vaccines. The physician told him there were few adverse reactions.

Volunteers must correctly care for the wound created by the inoculation in order to prevent any spread of the vaccine’s virus to other workers and patients, Gerberding says.

Recipients should cover the site with a dry gauze dressing, cover that with a semi-permeable dressing, and then wear long-sleeved clothing.

People who have concerns about this care should practice the dressings on healthy skin before receiving the vaccine to see what it’s like, Gerberding suggests.

Further, hospital workers who have a handful of medical conditions shouldn’t receive the vaccine. They include pregnancy, current or past skin conditions such as eczema or atopic dermatitis, weakened immune systems, HIV, or prior allergies to the smallpox vaccine.

These same precautions apply to workers seeking vaccination if their household members have any of the listed conditions.

If workers have doubts about the vaccine, they shouldn’t receive it, Gerberding says.

Another point: People who previously received a smallpox vaccination and showed no serious side effects may be less likely to experience adverse reactions if they take the vaccine again, Garb says.

✔ Question volunteers
An important step will be to question all volunteers about various health issues to make sure they aren’t susceptible to the side effects.

Though a sensitive topic, asking folks whether they have HIV is necessary because of the vaccine’s ability to prey upon immunocompromised patients, such as AIDS sufferers.

Baystate will take the matter a step further by offering confidential HIV testing to volunteers who have any concerns that they may have been exposed to that virus.

Also, people who might be pregnant should take a test to determine this before receiving the vaccine, Gerberding says.

1995
The Oklahoma City bombing raised awareness of bomb threats in hospitals; the JCAHO announced its intents to collaborate more with hospitals about the EC standards; OSHA released its new asbestos regulations. **Tip you can still use:** Cross-reference your safety documents against current EC standards.

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Patient violence

Former police officer J. Buford Tune agrees. It’s best to aim such policies at security officers and not clinicians, says Tune, who is the owner of the Academy of Personal Protection and Security Inc. in Nashville, TN.

Otherwise, a hospital raises too many murky questions and risks someone asking why a nurse needs a use of force policy, he adds.

A need for more
Currently, Mercy Medical has a management policy on assault behavior. It discusses how to restrain patients, but doesn’t go beyond those actions if a situation escalates.

The Occupational Safety and Health Administration supports the idea of a written program on patient violence in its Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. (For more about how the agency can use these guidelines, see the story on p. 6.)

Hernandez’s draft use of force policy would apply to his security team and includes the following sequential steps to take if faced with a combative patient:

1. Contact backup security officers for help
2. Follow the previously mentioned assault behavior policy
3. Use defensive tactics to block kicks and blows
4. Use physical holds and takedown techniques to control the patient
5. Handcuff the patient to control him or her

Stay within reason
Step five is “about as high as I’d want my guys to go,” Hernandez says. If things become worse even with handcuffs in use, it’s probably time to call the police for assistance if staff members haven’t already done so.

Also, once a patient is under control with handcuffs, staff members should replace the cuffs with soft restraints, he says. Remember, employees must receive proper training on restraint use in order to keep up with accreditation and Medicare requirements.

Any use of physical force or handcuffs should also trigger an incident report. “I want it documented,” Hernandez says.

Keep things simple
That being said, don’t weigh down your use of force policies, says Tune, who wrote several of these documents for hospitals in Tennessee.

“The biggest problem I see [with use of force policies] is that they want to make it too complicated,” he says.

For example, if the policy states that a security officer must fill out a form every time he or she touches a patient, then paperwork becomes necessary even when an officer merely helps a patient out of a car.

The law can help you
One good idea is to use local or state regulations to serve as your policy’s backbone.

“What I try to do . . . is refer to state law as much as possible, so people can’t say I made it up,” Lane says. He often mentions Tennessee’s self-defense statute in policies he authors.

Local law enforcement authorities can assist in developing your policy since many police stations already use them, Hernandez says. However, police officers have the ability to use a greater degree of force with weapons.

1996

The JCAHO added the new EC.4 “social environment” standards; OSHA released its workplace violence guidelines; the JCAHO and ASHE capped off months of negotiations about troublesome EC requirements. Tip you can still use: Use an improved disaster plan as a performance improvement project.
OSHA’s workplace violence guidelines have a bite

In its 1998 Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, the Occupational Safety and Health Administration (OSHA) seeks to reduce the risk of patient violence toward medical staff members.

The guidelines aren’t mandatory, though they do reference the agency’s general duty clause, which says employers must provide a safe workplace for employees. (You can read the guidelines at www.osha.gov/SLTC/workplaceviolence/guideline.html.)

An inspection conducted in 2002 by Alaska’s Department of Labor and Workforce Development (which operates under a state OSHA plan) proves the guidelines have some force behind them.

Eye gouging alleged
The state received a complaint alleging, among other things, that the Alaska Psychiatric Institute (API) in Anchorage exposed workers to violent patients.

Specific examples listed on state records include an incident where a patient attacked a worker, broke the employee’s ribs, and attempted to rip the person’s eye out. The state also noted that at one point, employees brought in a brochure detailing protective vest choices that management allegedly didn’t review.

OSHA’s guidelines establish four broad areas for a violence prevention program, including management commitment and employee involvement, worksite analysis of existing or potential risks, hazard prevention and control, and safety and health training.

Attempts to reach the API’s safety officer for comment were unsuccessful at presstime.

A list of troubles
The state inspector examined API’s workplace violence plan using the guideline’s four elements and concluded the following alleged problems:

- Based on a review of records and committee meeting minutes, the hospital did not complete some previously identified goals related to patient safety (including proposed policies on contraband and identifying patients with violent behaviors)
- Some employees were not aware of what various committees discussed in terms of worker safety, partially because frontline staff members don’t always sit on them
- Hazard analyses didn’t focus on specific workplace violence concerns
- Workplace violence was not a listed topic of review for employee orientation
- While frontline staff members and nurses underwent annual training on deescalation techniques, basic self-defense, and patient lifting, managers didn’t receive this

Citations handed out
The state concluded that the hospital didn’t fully meet the four elements outlined in OSHA’s workplace violence guidelines. It cited the hospital in the following three areas:

1. Violation of the general duty clause—proposed penalty of $3,500
2. Violation of the personal protective equipment standard (1910.132), which states employers should assess hazards on the job and provide protective equipment as needed—no penalty
3. Minor problems with incorrect entries into the OSHA 200 and 300 worker injury logs—no penalty

The hospital had until December 31, 2002, to correct the first two violations, according to material available on OSHA’s Web site.

1997

OSHA and the JCAHO moved forward with a partnership to highlight overlapping requirements; OSHA released its draft tuberculosis standard; NIOSH warned of latex allergy concerns; the EPA published new incinerator regulations. Tip you can still use: Post safety strategies in employee bathrooms for a captive audience.
Where can employees use portable space heaters?

For many regions, the cold winds and snow have settled in, which sometimes tempts chilly staff members to bring in their own portable space heaters for office or workstation use.

Following up on a recent “Ask the Expert” posting on healthsafetyinfo.com, we wanted to take a more in-depth look at the regulations surrounding space heaters in hospitals.

There are clear fire risks with these items, including the following problems:
- Accidentally knocking heaters over
- Pushing them against flammable items such as paper or clothing
- Forgetting to turn them off

Dig into your SOC
The Joint Commission on Accreditation of Healthcare Organizations limits space heater use in its Statement of Conditions (SOC).

Question 6D in part 3A of the SOC—question 6C of part 3B for newly constructed hospitals—asks whether the organization prohibits portable space heaters in patient treatment and sleeping areas.

The SOC ties its space heater requirement to the Life Safety Code (LSC), which as a rule prohibits space heaters in health care occupancies.

However, the LSC makes an exception by allowing portable heaters in nonsleeping staff and employee areas as long as the heating elements of these devices don’t exceed 212 degrees Fahrenheit.

This potentially allows space heaters in areas such as the business office, employee lounge, and admissions lobby. However, some hospitals choose to enforce a complete ban on the heaters everywhere.

Keep warm and safe
If your hospital decides to allow portable heaters in the exempted areas listed by the LSC, here are some ideas to help you stay in compliance:
- Don’t let employees bring in their own space heaters. Instead, some hospitals have found success by having workers go through the purchasing department.
- Ensure that the hospital’s electrical or maintenance crew checks all heaters for good working conditions.
- Check with your local or state authorities to see whether they have more stringent requirements than those of the Joint Commission.

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Employees who steal “as needed” medications commonly undertake this activity during a night shift when there are fewer coworkers on duty.

The scenario starts when a physician orders pain medications for a patient as needed. The employee will chart the medication as having been administered at all minimum intervals, when in fact, the patient receives little, if any, drugs because he or she refused them, was asleep, or didn’t request any.

Instead, the suspected employee keeps all of the signed-out narcotics for personal use. This particular method of stealing medication often goes undetected for a long period.

Don’t despair, though
Fortunately, this type of theft is easy to thoroughly investigate. Take the following steps:

1. Assemble a paper trail
   First, study the information on the patient’s medication record and narcotics sign-out sheets. Compare this with the charting that occurs before and after the suspect’s shift.

   Some obvious differences may emerge. As patients recover, they usually require fewer pain medications. When the employee in question is on the job, look for higher doses of pain medication given to a recovering patient compared to what other staff members dole out to the same patient. Be careful, though: Never consider this documentation by itself as sufficient evidence to justify taking action against an employee.

2. Talk to the patients
   The next step is to interview patients who are under the suspect’s care.

   Ask them whether they received pain medication during the shift in question. It’s not unusual for coherent adult patients to quickly admit they didn’t receive any pain drugs during the shift and further report that they had been uncomfortable without them.

3. Seek help from staff members
   Once you gather this information, arrange for investigators to meet at the hospital while the suspect is at work. It is helpful for investigators to enlist the cooperation of an employee who works alongside the suspect.

   However, not all coworkers are either willing or capable to assist. Instead, it may be more appropriate to manipulate the work schedule to ensure that a capable employee works beside the suspect during this stage of the investigation.

   Instruct the assisting coworker to carefully watch the charting of controlled substances administered by the suspect.

4. Meet with the suspect
   At a point when the employee in question signs out scheduled narcotics and the coworker verifies that the patient didn’t receive them, approach the suspect with this evidence.
Be sure not to jump too quickly, however. The suspect may simply say he or she forgot to give the drug or encountered delays. Instead, wait until close to the end of the shift to confront this employee.

Remove the suspect from the clinical unit and immediately conduct an interview. Confiscate the narcotics sign-out sheets and patient medication records, along with any medications in the suspect’s possession. Keep in mind that this worker could have discarded the drugs in or near the unit.

Some closing thoughts
No matter what type of investigation you put forth, consider the following guidelines:

- Establish a desired outcome and how you’ll report the incident before confronting a suspect
- Be consistent in how you treat employees who steal medication
- Determine whether and when the hospital should change any policies or procedures regarding access to narcotics
- Establish who will lead an investigation
- Do not act until you obtain sufficient evidence
- Consider only the facts, not undocumented evidence

Source: This excerpt is based on material in HCPro’s new book, Drug Diversion in Health Care: A Guide to Identification and Prevention, by Donald Bogardus, MPA, CHPA, CPP.

For more information or to order your own copy, go to www.healthsafetyinfo.com or call our Customer Service Center at 800/650-6787.

‘Significant loss’ of drugs is your call, but be wary

As part of any theft prevention efforts, you should always send in reports of missing pharmaceuticals to the Drug Enforcement Administration (DEA), even if you aren’t sure they constitute a significant loss, suggests Donald Bogardus, MPA, CHPA, CPP, safety/security director for the Arizona-based Banner Health System. The DEA must receive direct notification of any theft or significant loss of drugs your hospital experiences.

But the agency purposely avoids defining the term “significant loss” so it can determine what the threshold is on a case-by-case basis, Bogardus says. Investigators don’t want any limitations, he adds.

In general, significant loss depends on the size of your hospital. A small hospital would likely notice missing drugs faster than a large hospital. It’s up to you to decide whether missing drugs constitute a significant loss. Think carefully before you make this decision because you’ll need to justify it to the DEA.

“Always err on the side of sending the report in to the DEA. When in doubt, go ahead and report,” Bogardus says. “In the long run, you’ll probably be better off doing that.”

If a patient or staff member dies from a drug overdose at your hospital, the DEA may use the missing drugs report in its investigation. If no one files a report, your hospital could have a serious problem and may even be held liable for the death.

“They will certainly say this is a significant loss that you should’ve reported, and now you’ve got a disaster on your hands,” Bogardus says.

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Briefings on Hospital Safety—February 2003

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Spill plan deadline may change
The Environmental Protection Agency (EPA) plans to change an upcoming deadline for its revised oil spill prevention law. We wrote about the new regulations in a special report included in your January BHS.

As of this writing, hospitals open for business on or before August 16, 2002, that fall under the EPA’s requirements have until February 17, 2003, to review and update their existing oil spill plans. However, the agency anticipates granting a six-month extension due to concerns from industries about meeting the original timeline.

We’ll keep you posted if this temporary reprieve becomes official.

As further evidence of the importance of an oil spill plan, the EPA recently entered into a proposed consent agreement with Napa (CA) State Hospital for alleged oil violations. The hospital will pay $40,000 to a trust fund as a penalty for discharges of oil into nearby waters and for failure to prepare a spill prevention plan, according to the EPA.

Drop the E and add an I
Good news: The environment of care (EC) standards are out of the crosshairs when it comes to random unannounced surveys in 2003. This past year, EC concerns topped the list of fixed-grid elements for random surveys in hospitals.

However, if infection control (IC) is part of your domain, then be ready for surveyors to target that area during random unannounced visits, according to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Reinforcing this IC focus, the JCAHO recently sent a letter to providers encouraging them to voluntarily report sentinel event cases relating to hospital-acquired illness; such reports appear to be disproportionately low compared to other sentinel event information.

The JCAHO selects 5% of organizations accredited under various manuals for random unannounced surveys. These one-day visits occur nine to 30 months after a full survey, and are different than validation surveys from the Centers for Medicare & Medicaid Services. Hospitals don’t receive prior notice of the random surveys.

In addition to IC, the other top fixed elements for 2003’s random visits are initial assessments, the hospital’s role in performance improvement (which could affect EC), medication use, and human resources planning.

OSHA looks to 2004 already
The Occupational Safety and Health Administration (OSHA) delayed two portions of its recordkeeping rule that were going to be effective January 1, 2003.

The first concerns the definition of musculoskeletal disorder (MSD), a term frequently tied with ergonomic hazards. OSHA decided to continue reviewing this definition with the hopes of reaching a decision by January 1, 2004.

Related to this matter, the agency also delayed the consideration of MSDs as privacy concern cases and the requirement that employers check an MSD column on the OSHA 300 Log. For now, they must check the column for “injury” or “all other illness” depending on the circumstances of a given case.

Further, OSHA delayed for one year the criteria for work-related hearing loss that would trigger an entry in the associated column of the 300 Log. Frankly,
trying to explain the criteria is too much for us, so we won’t embarrass ourselves.

But if you’d like full details on either delay, go to www.osha.gov/prevwutsnew/dec02.html and scroll down to the December 17 link.

**Survey reveals bad needle habits**
In response to an October outbreak of hepatitis C in Oklahoma allegedly caused by reusing needles, the American Association of Nurse Anesthetists (AANA) surveyed providers about needle and syringe practices and found some disturbing trends.

Three percent of the anesthesiologists who responded said they reuse needles/syringes on multiple patients, according to the AANA. One percent each of other physicians, certified registered nurse anesthetists, and nurses also said they reused needles.

While the percentages may seem low, the numbers translate into almost 1,000 providers from all of the disciplines combined, says Rodney Lester, CRNA, PhD, president of AANA.

The survey also found areas of disagreement when it comes to reusing needles on the same patient. Thirty-one percent of respondents said they reuse needles and syringes on the same patient—but that practice is not permissible by AANA standards, Lester says. “Plain old common sense dictates that the safest practice is single-use, then disposal,” he adds. Go to www.aana.com/press/2002/111302.asp to read more about the survey.

**Generator fails during a blackout**
In mid-December, a backup generator failed to start during a power outage at Greater Southeast Community Hospital in Washington, DC.

The loss of electricity forced clinicians to manually care for some patients on ventilators or dialysis machines. Power returned in about 75 minutes.

If that wasn’t bad enough, about a week later the JCAHO declined to remove the hospital’s conditional accreditation status. Among the reasons given was a lack of preventive maintenance on equipment, according to the *Washington Times*.

The emergency generator may have failed due to poor maintenance, a source told the newspaper.

**Spare us more SUD regulations**
There is no need for further regulation of single use devices (SUDs) that staff members open but don’t use, the American Hospital Association (AHA) and three other organizations concluded after recent research into the matter.

The groups’ comments went to the Food and Drug Administration (FDA), which is contemplating new guidance on the topic. The FDA wants to know whether hospitals have written policies about handling these devices, how workers determine whether an opened-but-unused SUD is contaminated, and what types of SUDs employees resterilize because someone opened but didn’t use them.

The AHA’s research included a survey that found the following:

- 76% of hospitals discard all or some opened-but-unused SUDs
- More than half of the sites have written policies on handling these devices
- None of the hospitals that resterilized their own opened-but-unused SUDs reported any patient safety problems associated with this activity

Go to www.hospitalconnect.com and search for the term “SUD” to read the AHA’s November 26 letter to the FDA. The other organizations that participated in the research are the Association of Professionals in Infection Control and Epidemiology, the American Society for Healthcare Central Service Professionals, and the Federation of American Hospitals.
The Environmental Protection Agency (EPA) recently issued a best practices paper that looked at the benefits of using microfiber mops instead of traditional cotton mops.

Made of polyester and nylon, microfiber mops hold six times their weight in water, making them more absorbent than cotton mops. The vendors design these mops with the idea that a housekeeper changes the mop head after every room.

This frequent changing of mop heads eliminates the need to wring a mop or switch cleaning solutions after every few rooms; both conditions are a constant part of working with a cotton mop and a potential ergonomic hassle.

On the other hand, changing so many microfiber mop heads also means more laundering and a significant initial cost to purchase them.

The EPA concludes, though, that using microfiber mops reduces the amount of cleaning chemicals used and subsequently poured down the drain, based on information the agency gleaned from trials conducted by University of California Davis Medical Center in Sacramento.

In terms of worker safety, the medical center’s program also determined the following benefits:

- Microfiber mops weigh 5 lbs less than traditional mops
- Because housekeepers don’t dip used microfiber mop heads back into cleaning solutions, they don’t have to heft and dump the 30-lb buckets every few rooms

Further, UC Davis found it could assign housekeepers on light duty to use microfiber mops because they are easy to use.