



ASSOCIATION OF NURSES IN AIDS CARE
POSITION STATEMENT
Requiring Annual Immunization of Health Workers Against Influenza
Adopted by the ANAC Board of Directors February 2011

Position:

Based on the evidence, it is the position of the Association of Nurses in AIDS Care that

- The health care consumer has the right to assume that health workers in all settings where service is provided, and the agencies that employ them, will take all measures to prevent transmission of communicable pathogens
- Health workers have a responsibility to prevent harm to those for whom they care and to their coworkers, and therefore must adhere to recommended primary prevention practices, including immunization against those for which safe and effective vaccines exist.
- Health workers should be immunized against seasonal influenza each year unless they have a medically documented contraindication to the available vaccines.
- Healthcare organizations should require staff, regardless of pay status (i.e., whether or not they receive remuneration for their services), to be immunized against seasonal influenza unless there is medical documentation of a contraindication. This recommendation applies to all types of facilities and services, including inpatient and outpatient acute and chronic care, long-term residential care, home care, rehabilitation, counseling and other services, including independent private practitioners. It applies to all staff who may come in contact with service recipients as well as staff who routinely come in contact with such staff (e.g., in staff cafeterias, administrative offices, etc.).
- Healthcare employers have the responsibility to offer vaccine to staff at no cost and to facilitate vaccine administration at worksites or other convenient locations and times. Thus, requirements should not place additional burden on workers, who should also be able to submit documentation of having received vaccination from other providers or facilities.
- Service providers should publicly post their staff vaccination policy.
- Getting vaccinated must be easier and more convenient for staff than opting out and, if exemptions are allowed, the procedures for obtaining one must be as rigorous as for getting the vaccine. Neither the perfunctory signing of a form nor online declination is adequate.
- Unvaccinated staff should be identified and, regardless of symptoms, when there is influenza in the community, should be reassigned or expected to implement barrier precautions (such as masks) when within a specified proximity of potentially susceptible service recipients.

Statement of Concern:

The responsibility to protect patients from nosocomial infection is shared by both health workers and the organizations that employ them. The rationale for making vaccination a condition of employment (or volunteering or consulting) in a healthcare organization is to enhance and ensure patient and staff safety. Requiring influenza vaccination is congruent with long-existing, widely used standards of prevention practice when health workers can be vectors of airborne or droplet infection.

Accumulated data demonstrating vaccine efficacy and safety support making annual vaccination a requirement, particularly since experience and research repeatedly demonstrate that knowledge is not enough to ensure either healthful behavior or consistent adherence to good infection control practice.



Thus, education remains a key component of both voluntary and mandatory vaccination programs, but even mandatory education cannot be expected to achieve adequate influenza vaccine uptake by health workers. Whereas health workers may choose to pursue other individual health behaviors, the potential impact of their vaccination choices is a critical concern for the populations and individuals they serve.

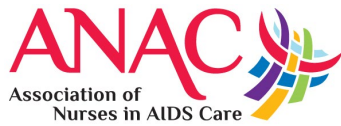
Influenza is a contagious respiratory infection that, despite the availability of safe and effective vaccines, remains a major cause of death and disease. It is the most common vaccine-preventable disease in the U.S. and around the world, with as many as 80,000 reported deaths in the U.S. in some years. People with immunocompromising conditions are especially susceptible to severe illness from influenza and influenza mortality is greater among people with chronic medical problems. Influenza can trigger the complications of diseases such as diabetes, cardiovascular disease, and renal and liver problems – conditions highly prevalent among people with HIV infection. With increasing age, the HIV-affected population experiences many chronic conditions that both heighten the risks associated with influenza infection and further reduce immune response to vaccine.

Hospitalized patients who develop nosocomial influenza have a high mortality rate. Unvaccinated healthcare workers have been implicated as sources of influenza infections in deadly outbreaks among adults and children in both acute and long-term care settings. It has been estimated that in some years, about 25% of health workers can be infected with influenza, which is readily spread from person to person when a host coughs or sneezes, and less efficiently by indirect contact – both by persons who have no symptoms and are unwitting vectors and also those who work while feeling ill, even with flulike symptoms during flu season, a well-documented occurrence among health workers. The National Patient Safety Foundation reports that institutions requiring staff influenza vaccination show an 88% reduction in workforce infection and a 41% lower influenza-related patient mortality.^x

While ensuring that symptomatic staff remain away from work until recovered is essential, it is even more important to prevent their infection since influenza's silent 1-to-4-day incubation period allows the host to infect others before feeling ill and often without being aware of having been exposed. About 20% of cases will remain asymptomatic but still be infectious. Since unvaccinated clusters within a work unit, facility, or other group setting may compromise a group's protection (herd immunity), allowing exemptions for other than the very small (< 0.1%) number of people who have medical contraindications to influenza vaccination limits the effectiveness of a vaccination program and should be discouraged. For this reason, allowing an individual to decline after education and individualized counseling should be regarded as a last resort, not a routine option. Primary prevention by vaccination is the most effective and efficient means of protection against influenza. Other measures, such as hand hygiene and barrier precautions, are complementary protective steps, not alternatives to pre-exposure immunization. Immunization of health workers against influenza is thus an essential part of healthcare providers' culture of safety – both for those seeking care and for those providing care.

Background:

Since 1984, the U.S. Centers for Disease Control and Prevention (CDC) and its Advisory Committee on Immunization Practices (ACIP) have recommended immunization against influenza for health care workers (HCWs), recognizing their risk of workplace exposure. The Hospital Infection Control Practices Advisory Committee (HICPAC) likewise made this recommendation to prevent nosocomial influenza transmission to patients, which has been documented in both acute care hospitals and long-term care facilities.



In 1989, the American Public Health Association (APHA) recommended requiring immunization of laboratory and healthcare workers and students against all vaccine-preventable diseases, including influenza. More recently, other professional associations, have similarly recommended influenza vaccination requirements for HCWs to protect workers themselves as well as the patients with whom they come in contact: American College of Physicians (ACP), Association of Practitioners of Infection Control (ACIP), National Patient Safety Foundation (NPSF), Infectious Diseases Society of America (IDSA), Society of Hospital Epidemiologists of America (SHEA), and the American Academy of Pediatrics (AAP).

These position statements highlight the ethical responsibility of healthcare providers to prevent harm to those for whom they care. Ethicists agree that mandates are appropriate when there is a clear public or community benefit and voluntary approaches are not adequate. With rare exception, they maintain that influenza vaccination is such a situation. Some ethicists emphasize that the bioethical principle of justice precludes conscientious objection to vaccination or refusal for personal reasons.

By 2008, 15 states had issued requirements for health worker influenza immunization and, by mid2010, over 60 institutions across at least 20 states reported successfully implementing mandatory programs. To maintain Joint Commission accreditation, hospitals, long-term care facilities, and home health providers must not only offer vaccine and monitor staff coverage each year, but also continually take steps to raise staff vaccination rates the following year.

Not surprisingly, mandatory approaches have yielded the highest reported rates for any intervention designed to improve vaccination coverage. Reports suggest that even the most successful voluntary programs, including those with aggressive campaigns that employ proven best practices confront a ceiling effect below 80%, much less the 98% coverage needed for herd immunity. CDC recently reported that staff vaccination rates against seasonal flu were twice as high when healthcare employers required vaccination as when they recommended but did not require it. Indeed, most researchers and journal editors conclude that mandatory approaches are needed to consistently achieve > 70% vaccination coverage.

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