



Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED INFECTIONS SUBCOMMITTEE

8-9am, February 22, 2016
Healthcentric Advisors, 235 Promenade Street, Suite 500

1. Welcome & today's meeting objectives (8am)

- Meeting chairs: L. Mermel, S. Viner-Brown
- Program staff: E. Cooper, V. Carroll, T. Mota
- Voting members in attendance (5/17): M. Fishman, J. Jefferson, J. Robinson, S. Turner, N. Vallande
- Non-voting members in attendance: D. Lewis, R. Reece, A. Mihalakos (via phone)
- Other attendees: M. Mimnaugh, L. Martino

2. Review of the previous meeting's action items (8:05am)

- Reschedule the February 15, 2016 meeting (Emily) – **Complete**
- Send out the final draft for the HCQP Hand Hygiene Agreement (Emily) – **Complete**
- Send out the CDC Assessment Tool and the Antimicrobial Stewardship Survey (Emily) – **Complete**
- Send out the link for the Shaving Cream Contamination video (Emily) – **Complete**

3. Hospital Acquired Flu (8:10am)

- *Methods for identifying and reporting hospital-acquired flu*

Emily opened the discussion by explaining that at the previous meeting the committee had discussed looking at hospital-acquired influenza rates, health-care worker immunization programs and how to reduce infections, including masking requirements, sick leave policies and visitor policies. The group discussed how to differentiate between hospital-acquired and community-acquired flu when a patient has a positive flu test while in the hospital.

The group discussed considering patients who showed no signs or symptoms until three days after admission, however it was noted that the incubation period for the flu virus can be up to four days. The committee tentatively decided to consider positive tests ordered on day five or later as potentially hospital-acquired. It was noted that patients who may have acquired flu in the hospital but did not have symptoms or undergo a flu test prior to discharge would not be accounted for. The group also discussed whether patients who were admitted with flu or flu like symptoms but did not get tested for flu in a timely manner could be falsely counted as hospital-acquired flu cases. In discussing possible data sources, the group suggested using the positive flu test data that is already reported to the Rhode Island Department of Health (RIDOH).

The group debated whether reporting hospital-acquired flu would be impactful. Dr. Mermel brought to the group's attention a recently published JAMA article that looked at how often,



and why, physicians and advanced practice clinicians go work when sick and how this impacts patient care and outcomes (article attached with minutes). He theorized that calling attention to hospital-acquired flu might drive change in these practices and norms. He also suggested that it might lead to changes in hospital policies around visitors who could be spreading infections such as flu germs in the hospital when visiting patients. The group wondered if rather than creating a new report, might a similar effect be achieved through providing recommendations to the hospitals about sick leave and visitor policies. Dr. Mermel made the point that people are more willing to change if there is evidence of a problem.

Emily suggested that as a first step the committee review the available data reported to RIDOH regarding flu cases to determine if it would be a viable data source to measure hospital-acquired flu and, if so, to determine whether this is a concern that needs to be addressed. If this data is available to us we will review it at our next meeting.

- *Handout: RIDOH Summary of Healthcare Worker Masking Requirement When Influenza is Widespread*

The committee reviewed the 'RI Department of Health Summary of Healthcare Worker Masking Requirement When Influenza is Widespread' document. The group felt that further clarification around masking requirements is needed, and that this document may need to be better aligned with the regulations. These concerns applied to both hospitals and nursing homes. The main points of concern were:

- The need to clarify the '4-Hour Rule' to include 'continuous wear', noting that masks should not be removed and worn on the worker's person or placed in a bag for re-use
- Clarify that masks are required "during each direct patient contact *in the performance of his or her duties* at any health care facility" (R23-17-HCW, section 5.4)

The committee proposed making written recommendations to the Immunization program regarding the summary document and the guidance shared with healthcare facilities. Draft recommendations will be shared at our next meeting.

4. Infection Prevention Assessments

- *Update on plan*

Emily opened by explaining that the CDC created assessment tools for acute-care hospitals, long-term care facilities, dialysis providers and ambulatory care centers. These assessments are meant to be performed onsite at the facilities by RIDOH. In Rhode Island, all hospitals and nursing homes will be asked to complete the tool as a self-assessment. We are requesting that the responses should be submitted to Emily without facility names so that the blinded data can be aggregated before being sent to the RIDOH. This data will be used by RIDOH and other stakeholders so that we can better understand infection prevention practices and capacity at the state level. Once that phase is complete, three hospitals and fifteen nursing homes will be asked to participate in an onsite visit where a representative from RIDOH. The self-assessment tool should roll out in March, with a four-week turnaround time; the on-site visits will be done in the fall.

- *Review request letter*



Emily explained that the cover letter to be sent with the tool would be coming from RIDOH, not the Healthcare Quality Reporting Program, as it is important that facilities understand that their responses will not be used for public reporting. One of the goals of the cover letter is to make it clear to the facilities that this is not a punitive process. These assessments are meant to gather information and provide direction for next steps that can be taken at either the facility or state-level. It was suggested that in addition to the Infection Preventionists, the letter should also be sent to the CEO/President of the facility so that they are aware of the process. It was also suggested that it be made clear in the letter that if it is found that, as a state, current practices do not meet the standards of RIDOH or the CDC, possible next steps could include changes to regulations.

5. Program Updates (8:40am)

- *New data available through Hospital Compare*
Emily noted that the Hospital Compare is now reporting CAUTI and CLASBI data for both *ICU* and *ICU and Select Wards*. Currently there is only one quarter of data available in this format. The group can discuss which we would like to use for our reports once more data is available..
- Hand Hygiene Agreement
Emily informed the committee that the Hand Hygiene Agreement document went out to hospitals last week and is due to be returned by March 4th.

6. Action Items (8:55am)

- Request hospital flu data from State Epidemiologist (Emily)
- Draft recommendations for Immunization Program (Emily)
- Review Infection Prevention Assessment request letter (all)

Next Meeting: April 18, 2016 at Healthcentric Advisors



Summary of Healthcare Worker Masking Requirement When Influenza is Widespread

Immunization regulations in Rhode Island require healthcare workers who are not vaccinated against seasonal influenza to wear a surgical face mask during direct patient contact if the Director of the Rhode Island Department of Health (HEALTH) declares influenza to be widespread. When the Director of Health declares this period to be over, the masking requirement is no longer be in effect (unless a new declaration is made at a later time).

Rhode Island Regulations Pertaining To Immunization, Testing, And Health Screening For Health Care Workers can be found at:

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7083.pdf>

- Unvaccinated healthcare workers do not have to wear a mask for an entire shift unless they have direct patient contact the entire shift. Infectious disease experts recommend using a new mask at least every four hours or sooner if the mask becomes too moist or soiled. The mask may be removed if no patients are near, or approaching near, the healthcare worker.
- Infectious disease experts also recommend that those wearing a mask should replace it if damaged; avoid touching the inside or outside of a mask that could be dirty; and remove a worn mask, discard into general trash, and then perform hand hygiene before touching any items.
- The regulations define “direct patient contact” as all routinely anticipated face-to-face contact with patients, such as when:
 - speaking with a patient in person
 - transporting a patient throughout facility
 - performing a procedure on a patient
 - participating in group patient activities
 - entering a patient’s room
 - handing out medications
 - in a cafeteria line
 - serving food to patients

The definition does not include times when a healthcare worker is in areas such as breakrooms or personal work stations that no patients approach.

- The regulations do not require healthcare workers to wear a mask for seven days after vaccination. However, it is still recommended practice to do so.
- The regulations clearly state in section 5.5 that “No healthcare worker shall be required to explain his or her refusal to obtain an annual seasonal influenza vaccination, nor shall any healthcare facility inquire into the basis of such refusal.” Nothing in the regulation allows or mentions that healthcare workers should or must be identified to the public. The requirement is to wear a mask -- not a badge or a colored dot, or anything but a surgical face mask. No explanation must be provided to employers or patients.
- Unvaccinated healthcare workers who do not sign a refusal or medical exemption form, and/or refuse to wear a mask, may be reported to the HEALTH complaint line at 222-

5200. Facilities that wish to take further action may consider consulting legal counsel and human resources staff, but must understand that the HEALTH regulations do not call for further discipline other than what HEALTH and/or the licensing board issues.

- Each year, December 15 is the deadline for healthcare workers reporting to the facility that employs them that they have received the influenza vaccination, have a medical exemption, or are refusing to get vaccinated. At a later date, healthcare facilities are required to report the numbers (not names) of healthcare workers who have received the influenza vaccination, who have a medical exemption, and who refuse.
- By December 15 of each year, any healthcare worker who refuses to obtain the influenza vaccine must file a form with their employer that must state: “I refuse to obtain the annual seasonal influenza vaccination. I understand that, by refusing such vaccination, it is my professional licensing obligation to wear a surgical face mask during each direct patient contact in the performance of my professional duties at any healthcare facility during any declared period in which flu is widespread. I understand that the consequence for failing to do so shall result in a one hundred dollar (\$100) fine for each violation. Failing to do so may also result in a complaint of Unprofessional Conduct being presented to the licensing board that has authority over my professional license. I understand that such licensing complaint, if proven, may result in a sanction such as reprimand, or suspension or revocation of my professional license.”
- Regulations section 3.5.4 (d) states that each healthcare facility is responsible for reporting to the Department:
 - The number (but not names) of healthcare workers who are eligible for influenza vaccination;
 - The number (but not names) of healthcare workers who received influenza vaccination; and
 - The number (but not names) of healthcare workers who decline annual influenza vaccination for medical or personal reasons, reported by each of the two (2) categories.

Reporting shall occur according to procedures and format required by the Department of Health. Specifics about those procedures and format shall be sent to health care facilities in the coming weeks.

- The regulations apply only to healthcare workers in a healthcare facility in Rhode Island (see regulation sections 1.6 and 2.1). Private practices and assisted living centers are not healthcare facilities. Unvaccinated doctors with privileges at healthcare facilities must wear a mask at the facilities during direct patient contact during the widespread influenza period, even though they need not wear a mask at their private offices.
- A surgical face mask must be worn by unvaccinated healthcare workers even if they have filed a medical exemption certificate or a refusal form with their employer. Filing a medical exemption certificate or refusal form is the only vehicle that may exempt healthcare workers from obtaining an influenza vaccination; but the medical exemption

certificate or refusal form does not exempt such workers from wearing a surgical face mask during direct patient contact during a declaration of widespread influenza.

- Medical exemption certificates should not be sent to the Department of Health. The health care facility must keep the medical exemption certificates in the healthcare worker's file.
- Unvaccinated licensed healthcare workers who violate the masking requirement during the widespread influenza declaration period are subject to a \$100 fine per violation and disciplinary action. The \$100 fine is not payable to the facility. It will be levied only after a complaint is filed with HEALTH, investigated, referred to the appropriate licensing board, and after an opportunity for a hearing. If the fine is levied, it will be payable to the General Treasurer.
- When unvaccinated EMTs employed by a private ambulance service enter a healthcare facility, they must wear a mask during direct patient contact (during a widespread influenza period, see sections 1.6, 5.3 and 5.4), but nothing in the regulation indicates the wearing of the mask must be continuous or outside of a facility. Regulations do not permit a facility to stop an unmasked and unvaccinated EMT from entering it.
- If you are an unvaccinated healthcare worker in one of the following types of healthcare facilities, this new regulation about surgical face masks applies to you: hospital, nursing home, home nursing agency, rehab center, kidney treatment center, HMO, hospice, freestanding emergency facility, and some ambulatory surgical centers.
- The term "healthcare worker" includes any person who is temporarily or permanently employed by (or at) – or who is a volunteer in – or who has an employment contract with – a healthcare facility, as defined in the previous paragraph. This includes physicians (while working at such a facility, but not in their private offices), physician assistants, nurses, CNAs, therapists (psychotherapist, occupational, physical, speech), technicians, clinicians, behavior analysts, social workers, EMTs (while at a facility), dental personnel, pharmacists, lab personnel, students, trainees, those with privileges at a facility, and staff who have patient contact such as clerical, dietary, housekeeping, laundry, security, maintenance, administrative, and billing.

ACTION REQUESTED

Dear colleague,

The Rhode Island Department of Health (RIDOH) is collecting information to better understand infection prevention practices in acute-care hospitals in the state. This information will be used to inform state-wide activities to improve infection prevention and control. We are requesting your participation in these efforts. While the information collected will be reviewed in aggregate form only, our goal is to collect information from all acute-care hospitals in the state. This will ensure a true picture of acute-care hospital infection prevention activities in the state.

The attached infection prevention assessment tool was developed by the Centers for Disease Control and Prevention (CDC) as part of a nation-wide effort to improve infection prevention. This tool will help identify current capacity and practices and to provide direction for future improvements. The tool is designed as a functional Word document. That means, as you complete the questions, it will provide you with a summary of your current practices and gaps (found at the end of the document).

The CDC has asked states to visit acute-care hospitals and use this document to perform an onsite assessment. Over the coming months, RIDOH will be visiting three (3) hospitals in Rhode Island to perform this onsite assessment. These onsite assessments will be conducted by Rhode Island's state Healthcare Associated Infection Coordinator and an Infectious Disease Consultant from RIDOH. The information will be collected without identifying information and this blinded data will be shared with the CDC. Other states will be using the same tool and process, providing the CDC with a national look at infection prevention activities.

Prior to the onsite assessments, we are asking ALL acute-care hospitals to complete this tool as a self-assessment. We feel that this tool will provide you with valuable information about your hospital's current practices and potential gaps. Healthcentric Advisors will aggregate your results with those of other hospitals in the state to create a state-wide picture of infection prevention activities in acute-care hospitals. Individual facility results will not be shared with the RIDOH and no identifying information will be kept by Healthcentric Advisors. As previously mentioned, this will help to inform the infection prevention activities of the RIDOH and its partners.

Directions:

1. Open the attached document
2. If asked, enable editing of the document (this allows you to enter information)
3. If asked, enable the content of the document (this allows the document to create a summary of your responses)
4. If asked, mark this as a trusted document
5. Working with infection prevention staff, clinical staff and leadership, complete the assessment tool
6. Email the completed version to ecooper@healthcentricadvisors.org

Please submit your completed self-assessment by [Date].

After completing the tool, you will have a comprehensive summary of your facility's infection prevention activities. The tool also includes resources that you can use to address any gaps that the tool identifies.

RIDOH will use the aggregate data to inform our infection prevention activities to provide direction to community partners working to improve infection prevention. We will also reach out to hospitals in regard to participation in the onsite assessment process. Neither your participation in the self-assessment process, nor your answers to the assessment questions, will be used to determine which facilities are selected for the onsite assessment process.

If you have any questions, please contact Emily Cooper at ecooper@healthcentricadvisors.org or (401) 528-3233.

Thank you,

Dr. Alexander-Scott, MD, MPH
Director
Rhode Island Department of Health

Dr. Rebecca Reece, MD
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Rhode Island Department of Health

From The JAMA Network

Changing the “Working While Sick” Culture Promoting Fitness for Duty in Health Care

Audrey L. Tanksley, MD; Rachel K. Wolfson, MD; Vineet M. Arora, MD, MAPP

JAMA PEDIATRICS

Reasons Why Physicians and Advanced Practice Clinicians Work While Sick: A Mixed-Methods Analysis

Julia E. Szymczak, PhD; Sarah Smathers, MPH, CIC; Cindy Hoegg, RN, CIC; Sarah Klieger, MPH; Susan E. Coffin, MD, MPH; Julia S. Sammons, MD, MSCE

IMPORTANCE When clinicians work with symptoms of infection, they can put patients and colleagues at risk. Little is known about the reasons why attending physicians and advanced practice clinicians (APCs) work while sick.

OBJECTIVE To identify a comprehensive understanding of the reasons why attending physicians and APCs work while sick.

DESIGN, SETTING, AND PARTICIPANTS We performed a mixed-methods analysis of a cross-sectional, anonymous survey administered from January 15 through March 20, 2014, in a large children’s hospital in Philadelphia, Pennsylvania. Data were analyzed from April 1 through June 1, 2014. The survey was administered to 459 attending physicians and 470 APCs, including certified registered nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives.

MAIN OUTCOMES AND MEASURES Self-reported frequency of working while experiencing symptoms of infection, perceived importance of various factors that encourage working while sick, and free-text comments written in response to open-ended questions.

RESULTS Of those surveyed, we received responses from 280 attending physicians (61.0%) and 256 APCs (54.5%). Most of the respondents (504 [95.3%]) believed that working while sick put patients at risk. Despite this belief, 446 respondents (83.1%) reported working sick at least 1 time in the past year, and 50 (9.3%) reported working while sick at least 5 times. Respondents would work with significant symptoms, including diarrhea (161 [30.0%]), fever (86 [16.0%]), and acute onset of significant respiratory symptoms (299 [55.6%]). Physicians were more likely to report working with each of these symptoms than APCs (109 [38.9%] vs 51 [19.9%], 61 [21.8%] vs 25 [9.8%], and 168 [60.0%] vs 130 [50.8%], respectively [$P < .05$]). Reasons deemed important in deciding to work while sick included not wanting to let colleagues down (521 [98.7%]), staffing concerns (505 [94.9%]), not wanting to let patients down (494 [92.5%]), fear of ostracism by colleagues (342 [64.0%]), and concern about continuity of care (337 [63.8%]). Systematic qualitative analysis of free-text comments from 316 respondents revealed additional reasons why attending physicians and APCs work while sick, including extreme difficulty finding coverage (205 [64.9%]), a strong cultural norm to come to work unless remarkably ill (193 [61.1%]), and ambiguity about what constitutes “too sick to work” (180 [57.0%]).

CONCLUSIONS AND RELEVANCE Attending physicians and APCs frequently work while sick despite recognizing that this choice puts patients at risk. The decision to work sick is shaped by systems-level and sociocultural factors. Multimodal interventions are needed to reduce the frequency of this behavior.

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The recent Ebola outbreak has drawn attention to the threat of spreading communicable disease between patients and health care workers. However, other infectious diseases are much more prevalent: for instance, a disease like influenza represents a more



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common cause of morbidity and mortality among patients in the United States and is more likely to be transmitted between patients and health care workers. The risk of health care workers infecting patients is real because many health care workers tend to continue working when they are ill, a finding documented in the report by Szymczak and colleagues¹ in the September 2015 issue of *JAMA Pediatrics*. Based on a survey of 536 clinicians, Szymczak et al found 83% reportedly continued to work even while they were ill. More than half (55.6%) reported that they con-

tinued working while having acute onset of significant respiratory symptoms, as did 30% with diarrhea and 16% with fevers.¹ Prior studies have described this phenomenon, dubbed “presenteeism,” in which health care workers report to work despite feeling ill or not well rested.²

In one prior study, 57.9% of resident physicians reported working while sick at least once.² The study by Szymczak et al¹ confirmed that the problem persists after training is finished, with attending physicians continuing to work while they are ill. Although this commitment to patient care may be commendable, health care workers who are ill impose risks to patients. The contradiction between dedication to patient care and risking transmission of disease to patients requires more in-depth understanding.³ Szymczak et al¹ found that 1 reason clinicians continue to work while they are ill relates to their fear of disappointing

patients. Clinicians also believe that adequate coverage for patient care will not be found while they are absent. Institutional culture also contributed to presenteeism, including not wanting to disappoint colleagues, fear of ostracism from colleagues, unsupportive leadership, and coming to work while ill because their colleagues do the same.

To protect patients from communicable disease and fatigued, ill clinicians, health care institutions should discourage clinicians from continuing with patient care responsibilities while they are ill. One approach might be to institute organizational triage policies for ill health care workers. This strategy was successfully used during influenza season at the University of Chicago. Institutional policy required that health care workers with fever or upper respiratory symptoms undergo evaluation and viral testing. A positive test result for influenza led to mandated absence from work duties for at least 7 days. Although testing was voluntary, frequent communication from hospital leaders emphasized that adherence was expected and honesty encouraged for reporting illness. In some cases, colleagues encouraged their sick peer to report for testing. This approach reoriented institutional culture away from concerns about unfavorable perceptions from colleagues to one of promoting healthy workers who can safely provide care for patients.

Involuntary exclusion of clinicians from work may challenge the ability of institutions to cover all their patient care needs. Residency training programs usually have backup systems in place, although such systems are underused because presenteeism is prevalent during training.² In the study by Szymczak et al,¹ attending physicians and advanced practice clinicians, unlike trainees, reported difficulty in finding coverage when they were ill. One reason for this may be that a systematic approach is lacking for addressing coverage for patient care responsibilities when clinicians are unexpectedly absent. For example, more than 90% of clinicians cite not wanting to let patients down as a reason for working while sick, and 64% of clinicians feared being ostracized. There is a need not only for a culture change among health care workers but also for institutional policies creating and enforcing systems of attending physician coverage for when they are unexpectedly absent. Policies like these are especially important during periods of anticipated absences due to illness, such as flu season.

Arranging backup coverage for attending hospitalists could be similar to so-called jeopardy systems for residents, in which one clinician is held in reserve to function as the backup clinician when another clinician is unable to work because of illness or other circumstances. This approach may help remove the burden of clinicians needing to arrange for their own coverage when ill. Instituting such systems for subspecialists, such as pediatric oncologists, will likely be much more difficult given the narrowed scope of expertise and the constrained supply of subspecialists to constitute a jeopardy system.

Institutional culture and organizational policy may address some aspects of presenteeism, but ultimately, professionalism should be sufficient to address the problem. Professionals have an ethical responsibility to not work while they are sick and risk transmission of disease to patients. Not working when ill is one aspect of ensuring one's "fitness for duty," which is the mental and physical capacity to work safely. However, the concept of fitness for duty is not routinely used for health care workers, as it often is for other professionals, such as airline pilots.⁴

Progress is being made in medicine. The Accreditation Council for Graduate Medical Education (ACGME) now requires that both residents and faculty "must demonstrate an understanding and acceptance of their personal role in assurance of their fitness for duty; and recognition of impairment, including illness and fatigue, in themselves and in their peers."⁵ There is uncertainty regarding how this is being implemented, but adopting self-assessment strategies or checklists such as "I'M SAFE" from airline pilots may promote routine self-assessment and peer assessment of fitness for duty.⁶ It is hoped that this approach will foster greater personal responsibility for each clinician to ensure that he or she is healthy enough to care for patients.

It is time to be sick of "working while sick" culture. Because ACGME standards for ensuring fitness for duty have been extended to faculty, academic health centers should promote a culture and institute organizational policies that can prevent all health care professionals from working while being ill. The pervading culture that attending physicians must continue to work while ill must change so that instead of "doing what they say and not what they do" changes to "doing both what they say and what they do."

ARTICLE INFORMATION

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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