



# Health Care Workers Unprotected

Insufficient Inspections and Standards Leave Safety Risks  
Unaddressed

## **Acknowledgments**

This report was written by Keith Wrightson, Worker Safety and Health Advocate for Public Citizen's Congress Watch division, and Taylor Lincoln, Research Director of Congress Watch. It was edited by Congress Watch Director Lisa Gilbert. The Service Employees International Union provided expertise on the landscape of worker safety regulation.

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Public Citizen's Congress Watch  
215 Pennsylvania Ave. S.E.  
Washington, D.C. 20003  
P: 202-454-5139  
F: 202-547-7392  
<http://www.citizen.org>

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## Preamble

The Occupational Safety and Health Act (Public Law 91-596) declared it a national policy “to assure so far as possible every working man and woman in the Nation safe and healthful working conditions.”<sup>1</sup>

The Act mandates that each employer in the United States “shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees” and “shall comply with occupational safety and health standards promulgated under this Act.”<sup>2</sup>

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<sup>1</sup> The Occupational Safety and Health Act, 29 U.S.C. § 651(2)(b) (1970).

<sup>2</sup> *Id.*, § 651(5)(a) (1970).

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“It is unacceptable that the workers who have dedicated their lives to caring for our loved ones when they are sick are the very same workers who face the highest risk of work-related injury and illness.”

—Assistant Secretary of Labor David Michaels

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## I. Introduction

On March 8, 2012, John Shick walked into Western Psychiatric Institute and Clinic at the University of Pittsburgh with one motive on his mind, to cause harm to others. Upon his arrival, Shick opened fire in the lobby. His shooting rampage left one person dead and six others wounded.<sup>3</sup>

Although we cannot know for certain, the incident might have been prevented if the Western Psychiatric Institute were required to have a plan to prevent violence, as recommended nearly two decades ago by the Occupational Safety and Health Administration (OSHA).<sup>4</sup>

But OSHA never issued a rule to require employers to create such a plan. The Western Psychiatric Institute, in turn, had no “policy or procedure that specifically addresses the risk of patient on staff violence,” according to a draft report on the shooting.<sup>5</sup>

The insufficiency of OSHA’s actions to prevent workplace violence is emblematic of overall shortcomings in the agency’s efforts to protect health care workers. The government’s responsibility, as written in law, is “to assure so far as possible every working man and woman in the Nation safe and healthful working conditions.”<sup>6</sup> But OSHA is not fulfilling that obligation for health care workers, who suffer more injuries than workers in any other sector in the United States.<sup>7</sup> In 2010, for instance, health care employers reported 653,900 workplace injuries and illnesses,<sup>8</sup> more than 152,000 more than the next most afflicted industry sector, manufacturing.<sup>9</sup>

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<sup>3</sup> *The Western Psych Shooting, One Year Later*, PITTSBURGH POST-GAZETTE (March 8, 2013), <http://bit.ly/WbdrvY>.

<sup>4</sup> *Workplace Violence Prevention-Health Care and Social Service Workers*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/12rwWAN> (viewed on May 20, 2013).

<sup>5</sup> Draft UPMC/WPIC Report to Occupational Safety and Health Administration, obtained through Freedom of Information Act request by the *Pittsburgh Post-Gazette*) (Aug. 31, 2012), at 4.

<sup>6</sup> The Occupational Safety and Health Act, 29 U.S.C. § 651(b) (1970).

<sup>7</sup> *Health Care*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/9i0XAH> (viewed on June 3, 2012).

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

The *rate* of injuries and illnesses per worker, as opposed to absolute totals, is slightly less in the health care sector than in some others. But for certain types of injuries, the rates of affliction of health care workers (as well as the absolute totals) are by far the highest among all industries.<sup>10</sup>

Of all workplace violence incidents in the United States that result in lost workdays, 45 percent are in the health care sector.<sup>11</sup> Meanwhile, the rate of work-related musculoskeletal disorders for nursing aides, orderlies and attendants was the highest in the nation in 2011, and more than seven times the national rate for all employees.<sup>12</sup> As in the case of workplace violence, no specific rules are on the books to protect health care employees from hazards that cause musculoskeletal disorders.

Health care is one of the largest industries in the United States, and is growing rapidly. In 1997, the health care and social assistance sector (the category used by the government that encompasses medical care and other forms of social assistance) employed 13.6 million people.<sup>13</sup> By 2010, the sector employed 18.1 million people.<sup>14</sup> By 2020, it is expected to add another 5.6 million jobs.<sup>15</sup>

Officials at OSHA are well aware of the risks facing health care workers. The agency has documented problems in advisory publications and has taken some actions, such as establishing a program focusing on risks in nursing homes.

But OSHA has devoted relatively little effort to addressing the safety risks at health care facilities compared to its work in other highly afflicted industries. For example, health care workers outnumber construction workers more than two-to-one, but OSHA conducts only about one-twentieth as many inspections of health care facilities as construction sites.<sup>16</sup>

The paucity of inspections is only part of the problem. Enforcement efforts also are frustrated by a dearth of safety rules relating to the types of risks facing health care

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<sup>10</sup> *Id.*

<sup>11</sup> DRAFT UPMC/WPIC REPORT TO OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (Aug. 31, 2012), at 1-2 (obtained through Freedom of Information Act request by the Pittsburgh Post-Gazette).

<sup>12</sup> Press Release, U.S. Department of Labor, Occupational Safety and Health Administration, *Statement from Assistant Secretary of Labor for OSHA on Increase of Nonfatal Occupational Injuries Among Health Care Workers: OSHA to Focus on Improving Safety and Health at Nursing Home Facilities* (Nov. 9, 2011), <http://1.usa.gov/sNKSSV> and *Health Care*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/9i0XAH> (viewed on June 3, 2012).

<sup>13</sup> *Industry Statistics Sampler-NAICS 62 Health Care and Social Assistance*, U.S. DEPARTMENT OF COMMERCE, U.S. CENSUS BUREAU <http://1.usa.gov/177Z2qY> (viewed on May 19, 2013).

<sup>14</sup> *Statistical Abstract of the United States: 2012*, U.S. DEPARTMENT OF COMMERCE, U.S. CENSUS BUREAU (2012), <http://1.usa.gov/UEy4gy>.

<sup>15</sup> *Economic News Release Table 2. Employment by Major Industry Sector, 2000, 2010, and Projected 2020*, U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS (Feb. 21, 2012), <http://1.usa.gov/15jhxES>.

<sup>16</sup> *Id.* and OSHA Enforcement Inspections Search Results: (2010). Search function available at <http://www.osha.gov/pls/imis/industry.html>.

workers. This gives inspectors a limited menu of choices to cite facilities for safety violations. A last resort for the agency is to rely on its catch-all “general duty” clause, which requires employers to provide conditions that are “free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employee.”<sup>17</sup> But the evidentiary standard for the general duty clause is so high that few cases are brought pursuant to it.

For instance, in 2012, OSHA initiated a “national emphasis program” to focus on risks faced by employees of nursing homes and residential care facilities. “Ergonomic stressors” was the first hazard listed in the announcement of the program.<sup>18</sup> But OSHA has issued nursing homes and residential facilities just seven citations for unsafe ergonomic conditions in the past two fiscal years.<sup>19</sup> (The agency reports that it also has issued at least 56 Hazard Alert Letters “outlining ergonomic hazards and providing employers examples of feasible abatement methods they can implement to help prevent ergonomic related injuries to workers.”<sup>20</sup>)

OSHA’s leader, Assistant Secretary of Labor David Michaels, acknowledges that health care safety problems need to be addressed. “It is unacceptable that the workers who have dedicated their lives to caring for our loved ones when they are sick are the very same workers who face the highest risk of work-related injury and illness,” Michaels said in a 2011 statement accompanying the release of data showing rapidly increasing injury rates among health care workers.<sup>21</sup>

When OSHA has created standards to protect health care workers, as it did in recent decades to address hazards posed by bloodborne pathogens and ethylene oxide, its actions have generated laudable results. Its rules have greatly reduced the threat of cancer to health care workers, reduced the incidence of hepatitis B by 95 percent and virtually eliminated workers’ risk of contracting HIV/AIDs.

But OSHA has not begun to create standards to address health care workers’ susceptibility to ergonomic hazards or workplace violence. For its part, OSHA said in response to questions posed by Public Citizen to Michaels’ office that it “does not have resources to

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<sup>17</sup> The Occupational Safety and Health Act, 29 U.S.C. § 654, 5(a)1 (1970).

<sup>18</sup> *OSHA Instruction-National Emphasis Program-Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311), Directive Number, CPL 03-00-016*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (April 5, 2012), <http://1.usa.gov/1aZMjA>.

<sup>19</sup> E-mail from Occupational Safety and Health Administrator staff to Taylor Lincoln, Research Director of Public Citizen’s Congress Watch division (June 4, 2013). On file with author.

<sup>20</sup> OSHA response to questions from Public Citizen relating to this report (June 10, 2013). (The full response is printed in the Appendix.)

<sup>21</sup> *Statement From Assistant Secretary Of Labor for OSHA on Increase of Nonfatal Occupational Injuries Among Health Care Workers, OSHA to Focus On Improving Safety and Health at Nursing Home Facilities*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (Nov. 9, 2011), <http://1.usa.gov/1blUtnb>.

move forward on all rulemaking necessary to address all the pressing workplace health and safety hazards.”<sup>22</sup> [OSHA’s complete response to the questions is published in the Appendix of this report.]

In fairness to OSHA, the adversity it faces goes well beyond a shortage of resources. The process for creating standards has become so cumbersome and subject to interference that the agency could not possibly fulfill its mandate. For instance, the agency published a rule in 2000 to protect workers in all industries from ergonomic hazards, but Congress repealed the rule before it took effect.<sup>23</sup> During the first term of the Obama administration, OSHA proposed a rule that merely would have added a column to reporting logs for employers to indicate whether an injury was a musculoskeletal disorder. Even that modest step was first delayed by the administration, then blocked by Congress.<sup>24</sup>

But, regardless of where one places the blame, the record in the health care arena plainly indicates that the government is failing to fulfill its obligation to provide adequate protection to workers. To comply with the law that authorizes its existence, OSHA needs to dramatically increase the number of inspections of health care facilities and issue binding standards to ensure that workers are protected from widely acknowledged hazards.

Doing so will require significantly more funding, as well as more cooperation from both Congress and the executive branch in developing needed safety rules. A failure to do so would amount to an acknowledgement that the nation’s promise to protect workers from serious hazards is an empty one.

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<sup>22</sup> OSHA response to questions from Public Citizen relating to this report (June 10, 2013). (The full response is printed in the Appendix.)

<sup>23</sup> *Bush Signs Repeal of Ergonomic Rules into Law*, CNN (March 20, 2001), <http://bit.ly/IzZzOB>.

<sup>24</sup> Don MacIntosh, *OSHA Pulls Rule on Reporting Ergonomics Injuries*, NWLABORPRESS.ORG (Feb. 8, 2011), <http://bit.ly/10Lb5X7> and *Congress Blocks OSHA Plan to Gather Data on Worker Musculoskeletal Disorders*, INSIDE HEALTH REFORM (Jan. 4, 2012).

## II. Data and Methods

Much of the data in this report is from the Bureau of Labor Statistics (BLS); the 2013 edition of the AFL-CIO's annual report *Death on the Job: The Toll of Neglect*; and U.S. Census Bureau, *Statistical Abstract of the United States: 2012*.

Additional source information used for this discussion comes from the U.S. Occupational Safety and Health Administration and the Kaiser Family Foundation.

This report relies on the Standard Industrial Classification (SIC) system to report data as it pertains to industry workers found in the BLS data systems. For health care workers, we have used SIC code 80 to search for our results. For construction workers, we have used SIC codes 15-17. For manufacturing workers, we used SIC codes 20-26 and 28-39.

The majority of the BLS data used in this paper considers a five-year period from Jan. 1, 2007, to Dec. 31, 2011.

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In 2010 (the most recent year for which comprehensive data are available), nursing aides, orderlies and attendants suffered higher rates of musculoskeletal disorders than workers in any other occupation.

—*Bureau of Labor Statistics data*

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### **III. Statistics Show That More Injuries Occur to Health Care Workers Than Those in Any Other Industry**

According to OSHA, health care workers are confronted with job hazards including “bloodborne pathogens and biological hazards, potential chemical and drug exposures, waste anesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, workplace violence, hazards associated with laboratories, and radioactive material and x-ray hazards.”<sup>25</sup>

More workers are injured in the health care and social assistance sector than in any other sector. OSHA publicizes this fact on its Web site.<sup>26</sup>

Reported health care injuries were up 6 percent in 2011.<sup>27</sup> The Centers for Disease Control and Prevention (CDC) notes that the rising rate of health care injuries is an exception to occupational health trends. “By contrast, two of the most hazardous industries, agriculture and construction, are safer today than they were a decade ago,” notes the CDC’s Web page devoted to health care workers.<sup>28</sup>

In 2011, the incidence rate of injuries requiring days away from work among the subset of health care employees encompassing nursing aides, orderlies and attendants was 489 cases per 10,000 workers, more than four times the rate for all workers.<sup>29</sup>

Musculoskeletal disorders, which often result from manual patient handling activities, are the leading source of injuries for health care workers, especially for nursing aides, orderlies

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<sup>25</sup> *Health Care*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/9i0XAH> (viewed on June 3, 2012).

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Workplace Safety and Health Topics: Health Care Workers*, CENTERS FOR DISEASE CONTROL AND PREVENTION (viewed on May 20, 2013), <http://1.usa.gov/125UDy>.

<sup>29</sup> Press Release, U.S. Department of Labor, Occupational Safety and Health Administration, *Statement from Assistant Secretary of Labor for OSHA on Increase of Nonfatal Occupational Injuries Among Health Care Workers: OSHA to Focus on Improving Safety and Health at Nursing Home Facilities* (Nov. 9, 2011), <http://1.usa.gov/sNKSSV>.

and attendants.<sup>30</sup> In 2010 (the most recent year for which such specific data are available) nursing aides, orderlies and attendants suffered a higher rate of musculoskeletal disorders than workers in any other occupation.<sup>31</sup> The incidence rate of work-related musculoskeletal disorders for nursing aides, orderlies and attendants was 249 per 10,000 workers compared to an average rate for all workers in 2010 of just 34 per 10,000 workers.<sup>32</sup>

These injuries carry an enormous price tag. Costs associated with back injuries in the health care industry are estimated to be more than \$7 billion annually. Nearly 11,000 nurses missed days of work due to back injuries in 2000, according to one study.<sup>33</sup>

Workplace violence, which the National Institute for Occupational Safety and Health defines as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty,” is another major hazard for health care workers.<sup>34</sup> Health care workers are exposed to a variety of dangerous workplace situations that may include working alone, in isolated areas or late at night. The Bureau of Labor Statistics reports that there were 37 homicides in the health care and social service industry in 2011.<sup>35</sup>

In 2011, nursing care facilities workers had an injury-incidence rate of 27.2 per 10,000 from assaults and violent acts, seven times the overall private-sector workplace violence injury rate of 3.8 per 10,000 workers.<sup>36</sup>

Also of concern for health care workers are percutaneous injuries cause by surgical instruments and needles. Although OSHA issued a rule in 1991 to reduce injuries caused by sharp objects, far too many injuries still occur. Nearly 400,000 percutaneous injuries are reported by health care workers in the United States annually, placing workers at risk of exposure to human immunodeficiency virus, hepatitis B virus and hepatitis C virus.<sup>37</sup>

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<sup>30</sup> *Health Care*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/9i0XAH> (viewed on June 3, 2012).

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> James W. Collins, Testimony to Subcommittee on Employment and Workplace Safety Committee on Health, Education, Labor and Pensions United States Senate, *Safe Patient Handling Lifting Standards for a Safer American Workforce*, 110th Congress (May 11, 2010), <http://1.usa.gov/14uNILL>.

<sup>34</sup> *Violence Occupational Hazards in Hospitals*, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://1.usa.gov/ijUuUB> (viewed on May 30, 2013).

<sup>35</sup> *A-1. Fatal Occupational Injuries by Industry and Event or Exposure, All U.S., 2011*, U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, (Table), at 34 <http://1.usa.gov/Sd9xgY>

<sup>36</sup> *Occupational Injuries/Illnesses and Fatal Injuries Profiles* (2011), U.S. DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS (searched on June 3, 2013). Search function available at: <http://1.usa.gov/11U9Qrd>.

<sup>37</sup> Mario Saia, et al., *Needlestick Injuries: Incidence and Cost in the United States, United Kingdom, Germany, France, Italy, and Spain*, 1 *BIOMEDICINE INTERNATIONAL* 41 (2010), <http://bit.ly/12Bf0H9>.

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Health care workers outnumber construction workers more than two-to-one, yet OSHA conducts just one-twentieth as many inspections of health care facilities as construction sites.

—*Bureau of Labor Statistics and OSHA data*

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## IV. OSHA Fails to Conduct Enough Inspections to Protect Health Care Workers

To put OSHA's efforts into context, one needs to consider the disparity in the effort the agency puts forth in the health care sector compared to two sectors that traditionally have garnered the most attention for posing risks to employees: construction and manufacturing.

In 2010:

- The **construction sector** employed **9.1 million** workers while its employers reported that their workers suffered **74,950 injuries** involving days away from work;
- The **manufacturing sector** employed **14.1 million** workers while its employers reported that its workers suffered **127,140 injuries** requiring days away from work; and
- The **health care and social assistance sector** employed **18.9 million** workers while its employers reported that its workers suffered **176,380 injuries** requiring days away from work.<sup>38</sup>

But OSHA's inspections do not correspond to the high number of injuries in the health care sector. Specifically, in 2010, it conducted:

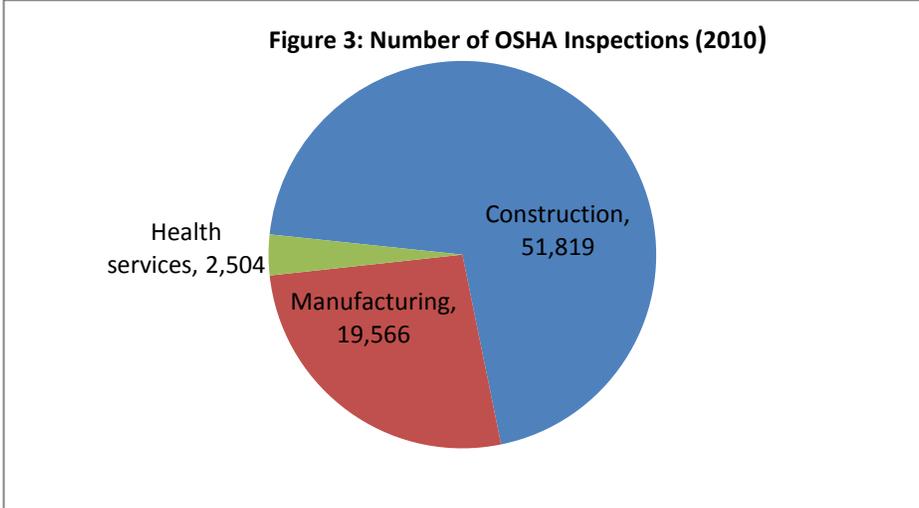
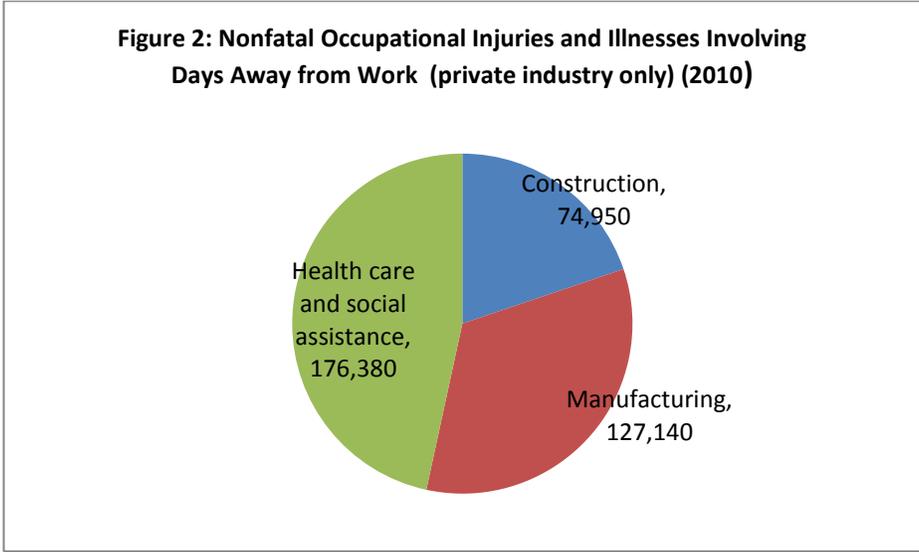
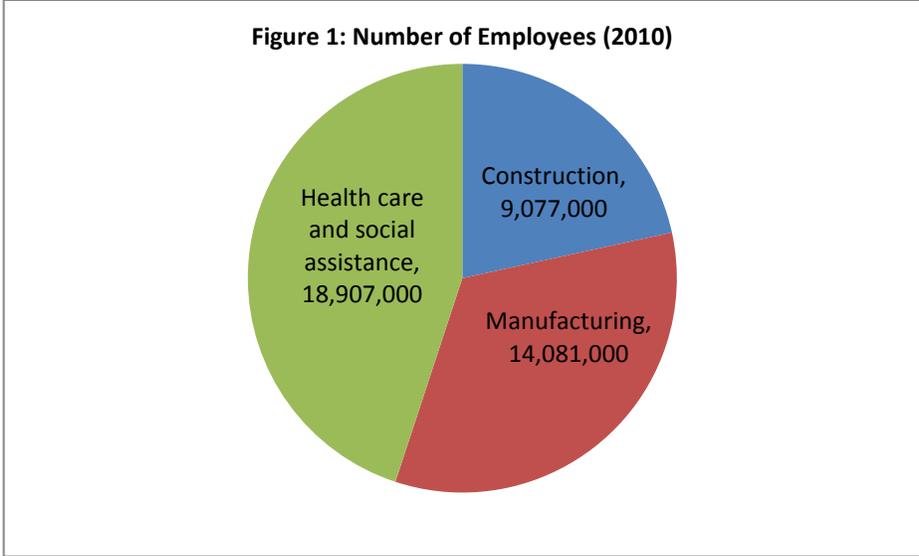
- **52,179** inspections of **construction** sites;
- **19,566** inspections of **manufacturing** sites; and
- **2,504** inspections of **health care and social assistance** facilities.<sup>39</sup>

[See Figures 1, 2 and 3]

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<sup>38</sup> *Economic News Release Table 2. Employment by Major Industry Sector, 2000, 2010, and Projected 2020*, DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS (Feb. 21, 2012), <http://1.usa.gov/15jhxES> and *Number of Injury and Illness Cases (Thousands) by SP2HSA, Cases Involving Days Away From Work, Private Industry, All U.S. Private Industry, 2010*, DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS. (Injury data does not include employees of public sector entities.)

<sup>39</sup> OSHA Enforcement Inspections Search Results (2010): SIC Codes 1500-1799 (construction), SIC Codes 2000-2699, 2800-3999 (manufacturing) and SIC Codes 8000-8999 (health care and social assistance). Search function available at <http://www.osha.gov/pls/imis/industry.html>.



Sources: Figure 1: U.S. Census Bureau; Figure 2: Bureau of Labor Statistics; Figure 3: Occupational Safety and Health Administration.

A partial explanation for the greater number of inspections in construction and manufacturing likely has to do with the severity of the injuries those employees tend to suffer.

In 2010, fatalities claimed the lives of 774 U.S. construction workers and 329 manufacturing workers, compared to 141 workers in the health care and social assistance sector.<sup>40</sup> These figures indicate that there are about one-fifth as many fatalities among health care employers as among those who work in construction, which has traditionally been viewed as the most dangerous sector.

But OSHA conducts fewer than one-twentieth as many inspections in health care as in construction. Even if fatalities were the only factor considered, health care inspections would need to be increased by about a factor of four to bring them into parity with construction sector inspections.

In fairness to OSHA, its budget is minuscule compared to its mandate. The agency was allocated \$535.2 million for 2013 and is charged with ensuring safety at about 7 million work sites, as well as fulfilling other program missions.<sup>41</sup>

OSHA needs to increase inspections across-the-board, not just for health care facilities. It will need more resources to do so. The facts in this section simply illustrate that the agency has further to go in health care than other sectors.

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<sup>40</sup> *Death On The Job: The Toll Of Neglect*, AFL-CIO, at 42 (2012), <http://bit.ly/ITBSV8>

<sup>41</sup> See, e.g., Remarks by David Michaels, Occupational Safety & Health Review Commission Annual Judicial Conference (Sept. 14, 2010), <http://1.usa.gov/9bmoGV> and *Commonly Used Statistics*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (viewed on June 10, 2013), <http://1.usa.gov/wygBx6>.

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OSHA issued just seven citations to nursing homes and residential facilities for unsafe ergonomic conditions between October 2011 and June 2012.

—Data provided by OSHA

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## V. OSHA Suffers From a Shortage of Standards to Enforce Unsafe Conditions in Health Care Facilities

OSHA is hindered in its efforts to ensure safe health care environments because regulations to fully address issues in the health care industry are limited. This is a matter of significant concern because setting standards is the agency's primary method for ensuring that workers are protected from occupational hazards.<sup>42</sup>

Since the creation of OSHA in 1970, it has created only nine standards that are primarily aimed at protecting health care workers. Most of these were created in the 1990s. They are:

- 1910.132 General requirements (Personal protective equipment) (1974)
- 1910.1096 Ionizing radiation (1974)
- 1910.1047 Ethylene oxide (1984, updated in 1988)
- 1910.1450 Occupational exposure to hazardous chemicals in laboratories (1990)
- 1910.1048 Formaldehyde (1991)
- 1910.1030 Bloodborne pathogens (1991)
- 1910.1200 Hazard communication (1994)
- 1910.133 Eye and face protection (1994)
- 1910.134 Respiratory protection (1998)<sup>43</sup>

Granted, many other regulations affect all industries, and the health care industry is required to abide by those standards.

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<sup>42</sup> *Workplace Safety and Health: Multiple Challenges Lengthen OSHA's Standard Setting*, GOVERNMENT ACCOUNTABILITY OFFICE, at 37 (2012), <http://1.usa.gov/HWhR56>.

<sup>43</sup> *Health Care*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/15jP15b> (viewed on June 3, 2012).

But specific rules to protect health care workers from workplace violence and hazards from unsafe ergonomic conditions simply do not exist.

The agency is attempting to partially address the frequency of injuries to health care workers with the aforementioned “national emphasis program” focusing on nursing homes and residential care facilities. Through targeted enforcement efforts, this program aims to address ergonomic stressors in patient lifting, and risks of bloodborne pathogens, tuberculosis, workplace violence, and slips, trips and falls.<sup>44</sup> Albeit a step in the right direction for some health care workers, this program does not cover hospitals or other health care settings, where high injury rates also have been reported.

The results from the program illustrate the limitations of OSHA’s power to act in the absence of specific standards on safety hazards. OSHA has issued just seven citations to nursing homes and residential facilities for ergonomic hazards since October 2011.<sup>45</sup>

Each of the citations was issued pursuant to the catch-all general duty clause, which OSHA must rely on to police unsafe conditions that are not covered by a specific standard. The general duty clause requires an employer to furnish employees with conditions that “are free from recognized hazards that are causing or are likely to cause death or serious physical harm.”<sup>46</sup> The paltry number of citations for unsafe ergonomic conditions is due to the high evidentiary burden required to issue citations issued under the general duty clause.

OSHA has tried in the past to provide protections to workers in all industries from the dangers of ergonomic stressors. In November 2000, OSHA published an ergonomics standard that required employers to implement ergonomics programs in response to employee complaints about work-related musculoskeletal disorders.<sup>47</sup> But the rule never took effect. In early 2001, the House and Senate passed a joint resolution repealing it.<sup>48</sup>

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<sup>44</sup> *OSHA Instruction-National Emphasis Program-Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311), Directive Number, CPL 03-00-016*, U.S. DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (April 5, 2012), <http://1.usa.gov/laZMjA>.

<sup>45</sup> E-mail from Occupational Safety Health Administrator Deborah Berkowitz to Taylor Lincoln, Research Director of Public Citizen’s Congress Watch division (June 4, 2013).

<sup>46</sup> General Duty Clause Search Results: SIC Code 8000-8999 01/01/2007 to 12/31/2011 DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS (viewed on May 28, 2013), <http://1.usa.gov/12PwjRI>.

<sup>47</sup> 65 Federal Regulation 68261.

<sup>48</sup> *Bush Signs Repeal of Ergonomic Rules Into Law*, CNN (March 20, 2001), <http://bit.ly/IZzzOB>.

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“The standard encouraged the development of improved sterilizers, which achieved compliance with the standard and cost less than other sterilizers. This reduced costs for all employers including small businesses.”

—*OSHA Analysis of Rule Limiting Workers’ Exposure to Carcinogenic Ethylene Oxide*

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## VI. OSHA Standards Have a Proud Record of Success

Standards to protect health care workers often have exceeded their goals and, at times, have yielded unexpected innovations and financial benefits to employers.

The bloodborne pathogens standard (1991), ethylene oxide standard (1984, updated in 1988) and the Needlestick Prevention and Safety Act of 2000 (which amended the bloodborne pathogens standard) addressed well-recognized problems. In two of three cases, these rules generated excellent results. In the third case, results have been less spectacular, but appear positive on the whole.

### **Bloodborne Pathogens Standard (1991)**

In 1991, responding to epidemic rates of hepatitis B infections among health care employees and the terrifying specter of HIV/AIDS risks, OSHA issued a standard to combat occupational exposure to bloodborne pathogens. The rule required employers to develop exposure control plans, to ensure that sharp instruments (such as needles) were stored in puncture-resistant containers, to prohibit recapping of needles, to ensure safe disposal of sharp instruments, to offer follow-up counseling and medical treatment to employees in case of exposure, and, vitally, to provide employees with free hepatitis B vaccinations.<sup>49</sup> The new rule codified guidelines that had been issued by the Centers for Disease Control and Prevention in 1987 that OSHA had endorsed in an advisory notice to employers the same year.<sup>50</sup>

The rule and resulting increase in hepatitis B vaccinations resulted in a dramatic reduction of hepatitis B infections. The incidence of occupational hepatitis B infections declined from 17,000 cases in 1983 to 400 in 1995, a 95 percent reduction.<sup>51</sup> In 2010, there were only 10

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<sup>49</sup> *OSHA’s Final Rule on Occupational Exposure to Pathogens*, MORGAN, LEWIS AND BOCKIUS (January 1992) <http://bit.ly/10NA88S>.

<sup>50</sup> Janine Jagger, Jane Perrya, Elayne Kornblatt Phillips, & Ahmed E Gomaa, *The Impact of U.S. Policies To Protect Healthcare Workers From Bloodborne Pathogens: The Critical Role of Safety-Engineered Devices*, JOURNAL OF INFECTION AND PUBLIC HEALTH (NOV. 26, 2008), at 62-71, <http://bit.ly/1a7XKl6>.

<sup>51</sup> Janine Jagger, Ramon Berguer, Elayne Kornblatt Phillips, Ginger Parker & Ahmed E Gomaa, *Increase in Sharps Injuries in Surgical Settings Versus Nonsurgical Settings After Passage of National Needlestick Legislation*, JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS (April 2010), at 496, <http://bit.ly/ZefNy3>.

reported occupational exposures to hepatitis B among employees who worked in professions involving contact with human blood.<sup>52</sup>

Incidents associated with “recapping” needles fell from 23 percent of all needlestick injuries in 1986 to 5 percent of such injuries from 1992 to 1994, a study found.<sup>53</sup>

Meanwhile, the requirement for post-incident treatment combined with the development of anti-retroviral drugs significantly reduced the risk of health care workers contracting human immunodeficiency virus (HIV). The odds of health care workers contracting HIV after exposure were reduced by about 81 percent if they took a particular drug after exposure to the virus, the CDC reported in 1997.<sup>54</sup> There were 54 documented cases of occupationally transmitted HIV cases among health care workers between the discovery of AIDs in the 1980s through 1998. Since 2001, there has been only one.<sup>55</sup>

### **Needlestick Safety and Prevention Act (2000)**

The promulgation of the bloodborne pathogens standard and other federal guidelines prompted significant technological gains in the development of needles and other sharp instruments that are safe to use. “Safety-engineered” needles and other devices were not available in 1987. By 1996, more than 1,000 patents had been issued for sharp medical devices with safety features such as automatically retracting needles.<sup>56</sup> The patents ran the gamut of health care devices, including injection devices, vascular access and blood-drawing devices, surgical instruments and laboratory equipment.<sup>57</sup>

The development of new technology coincided with dramatic reductions in injuries relating to sharp instruments, various studies showed. “Between 1993 and 2001, there was a 100 percent drop in injuries from I.V. line connectors, previously one of the most common causes of injury, and a 62 percent drop in injuries from prefilled syringes,” Janine Jagger et al. reported in a 2008 study.<sup>58</sup> (Jagger in 2003 received a MacArthur Fellowship, often referred to as the “genius” award, for her work to combat transmission of bloodborne diseases.<sup>59</sup>)

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<sup>52</sup> CENTERS FOR DISEASE CONTROL AND PREVENTION, VIRAL HEPATITIS SURVEILLANCE UNITED STATES, 2010 (2010), at 3, <http://1.usa.gov/12WNWzw>.

<sup>53</sup> Janine Jagger, Jane Perry, Elayne Kornblatt Phillips, & Ahmed E Gomaa, *The Impact of U.S. Policies To Protect Healthcare Workers From Bloodborne Pathogens: The Critical Role of Safety-Engineered Devices*, JOURNAL OF INFECTION AND PUBLIC HEALTH (NOV. 26, 2008), at 62-71, <http://bit.ly/1a7XKJ6>.

<sup>54</sup> *Id.*, at 62.

<sup>55</sup> *Id.*, at 64.

<sup>56</sup> *Id.*

<sup>57</sup> *Id.*

<sup>58</sup> *Id.*

<sup>59</sup> *Janine Jagger Wins ‘Genius’ Award*, INSIDE UVA ONLINE (Sept. 27 to Oct. 10, 2002), <http://bit.ly/10MuPVM>.

Still, at the turn of the century, health care workers were suffering nearly 600,000 injuries annually from contaminated sharp devices.<sup>60</sup> The demonstrated success of safety-engineered sharp devices combined with the continuing problem of injuries caused by sharp devices put pressure on regulators to take steps to mandate universal adoption of practices incorporating safer technology.

The Needlestick Safety and Prevention Act of 2000 directed OSHA to revise the Bloodborne Pathogens standard to require employers to implement new developments in safety technology, to require employers to solicit their employees' input in the selection of sharp devices, and to require employers to maintain a log of injuries from contaminated sharp devices.

The law has been a qualified success. Between 1993 and 2006, injury rates from sharp devices in non-surgical settings fell 31.6 percent, according to a study of percutaneous injury surveillance data from 87 hospitals in the United States.<sup>61</sup> But injury rates in surgical settings increased 6.5 percent.<sup>62</sup> Notably, nearly all of the injuries in surgical settings involved conventional devices, not safety-engineered devices.<sup>63</sup> This appears to indicate that a failure to adopt new technology, rather than shortcomings in the technology's effectiveness, is the reason that risks in surgical settings have not declined.

In a 2008 survey of nurses by the American Nurses Association and Inviro Medical Devices (which manufactures retractable needles), 64 percent of respondents said they had been accidentally stuck by a needle while working; of these incidents, nearly three-fourths involved contaminated needles. Meanwhile, three-fourths of respondents said they believed that incidents involving sharp devices were underreported.<sup>64</sup>

### **Ethylene Oxide Standard (1984)**

In 1979, two studies found high cancer rates among workers who were exposed to ethylene oxide (often used as a sterilization agent in health care settings) at levels far below the permissible limit of 50 parts per million (ppm) as a time-weighted average. In January 1981, the National Institute for Occupational Safety and Health (NIOSH) published

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<sup>60</sup> *Occupational Exposure to Bloodborne Pathogens; Needlestick and Other Sharps Injuries*, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET (Spring 2001), <http://1.usa.gov/14z1oLj>.

<sup>61</sup> Janine Jagger, Ramon Berguer, Elayne Kornblatt Phillips, Ginger Parker and Ahmed E. Gomaa, *Increase in Sharps Injuries in Surgical Settings Versus Nonsurgical Settings After Passage of National Needlestick Legislation*, JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS (April 2010), at 496, <http://bit.ly/ZefNy3>.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*, at 498.

<sup>64</sup> *2008 Study of Nurses' Views on Workplace Safety and Needlestick Injuries*, AMERICAN NURSES ASSOCIATION AND INVIRO MEDICAL (Summer 2008), <http://bit.ly/Z0CbZq>.

a study finding that exposure to ethylene oxide at levels of between 30 and 35 parts per million (ppm) caused leukemia and other cancers in rats.<sup>65</sup>

That news prompted Public Citizen and the American Federation of State, County and Municipal Employees to petition OSHA to establish a new standard of permitting a maximum exposure of 5 ppm and a time-weighted average exposure of no more than 1 ppm.<sup>66</sup>

Apparently due to little more than the Reagan administration's reflexive opposition to regulations, OSHA strongly resisted developing a new standard. But, after a protracted court battle, the agency was compelled to issue a standard mirroring the recommendations in the petition. Acting on a court order, OSHA in 1984 issued a standard calling for maximum time-weighted exposures of 1 ppm, as requested in the petition.<sup>67</sup> In 1988, again under a court order, OSHA issued an amended standard limiting short-term exposure to ethylene oxide to 5 parts per million, which also was called for in the original petition.<sup>68</sup>

A 2005 OSHA analysis found the rule to be highly successful in protecting workers, with isolated exceptions, while not imposing a negative economic effect on businesses.

"EtO poses significant health and safety risks to workers exposed to the substance," the OSHA regulatory review said. "While the standard has resulted in dramatic reductions in occupational exposures to EtO, OSHA continues to document overexposures and non-compliance in the workplace."<sup>69</sup>

Much of the success resulted from technological innovations that the rule had prompted. "Improvements in sterilizer technology, the growth in number and use of alternative sterilants and sterilizing processes, and use of contract sterilizers to perform EtO sterilization have contributed to an observed reduction in occupational exposure to EtO," OSHA wrote in its review of the rule. "None of the comments received by OSHA indicated

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<sup>65</sup> *Unreasonable Delay, Unreasonable Intervention: The Battle to Force Regulation of Ethylene Oxide*, GEORGETOWN UNIVERSITY LAW CENTER PUBLIC LAW & LEGAL THEORY WORKING PAPER SERIES RESEARCH PAPER NO. 634865 (December 2004), at 1-2, <http://bit.ly/14SnUyE>.

<sup>66</sup> *Id.*, at 2.

<sup>67</sup> *Ethylene Oxide (ETO)*, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET (Spring 1985), <http://1.usa.gov/16P3w5C>.

<sup>68</sup> *Ethylene Oxide (EtO)*, OFFICE OF INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET (Spring 1988), <http://1.usa.gov/195c4Vf> and DAVID VLADECK, GEORGETOWN PUBLIC LAW RESEARCH PAPER NO. 634865, UNREASONABLE DELAY, UNREASONABLE INTERVENTION: THE BATTLE TO FORCE REGULATION OF ETHYLENE OXIDE (December 2004), at 42, <http://bit.ly/14SnUyE>.

<sup>69</sup> *Regulatory Review of OSHA's Ethylene Oxide Standard* [29 CFR 1910.1047], OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, U.S. DEPARTMENT OF LABOR (March 2005), <http://1.usa.gov/1a87aEI>.

that technological feasibility problems prevented affected businesses from complying with the EtO standard.”<sup>70</sup>

OSHA’s reviewers also found that the standard had reduced costs. “The standard encouraged the development of improved sterilizers, which achieved compliance with the standard and cost less than other sterilizers,” OSHA’s reviewers wrote. “The newer equipment costs about half the cost of the older equipment with add-on controls. This reduced costs for all employers, including small businesses.”<sup>71</sup>

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<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

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The use of mechanical lifts reduced injuries by 36 to 86 percent and saved enough money in reduced workers compensation claims to recoup the costs of purchasing the equipment within three years.

—2004 study reviewing 3.7 million hours of work  
by employees of six nursing homes

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## VII. Isolated Safe Patient Handling Laws in States and Use of Safe Practices by Some Employers Have Protected Workers

Overexertion incidents are the leading source of workers' compensation claims and costs in health care settings.<sup>72</sup> The primary injuries associated with such incidents are musculoskeletal disorders.<sup>73</sup> Musculoskeletal disorders risks are found when workers manually handle heavy, awkward loads or perform repetitive, forceful hand work.<sup>74</sup> The single greatest risk factor for musculoskeletal disorders in health care workers is the manual moving and repositioning of patients.<sup>75</sup>

Ten states have instituted safe patient handling laws, and these laws have made health care work much safer.<sup>76</sup> Such laws typically require that health care providers furnish mechanical lifting and transfer devices so that employees do not have to lift and move patients manually.

For instance, safe patient handling is defined in the state of Washington as “the use of engineering controls, lifting and transfer aides, or assistive devices, by lift teams or other staff, instead of manual lifting, to perform acts of lifting, transferring, and repositioning health care patients and residents.”<sup>77</sup>

Washington's safe patient handling law was the first in the country to require employers to implement a safe patient lifting program that relies on the use of mechanical lifting and transfer devices, except in limited circumstances where it would be medically contraindicated for specific patients.

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<sup>72</sup> *Workplace Safety & Health Topics, Safe Patient Handling*, CENTERS FOR DISEASE CONTROL AND PREVENTION (viewed on May 30, 2013), <http://1.usa.gov/riITD6>.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Safe Patient Handling*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (viewed on June 3, 2013), <http://1.usa.gov/ZrCQyx>

<sup>77</sup> *Safe Patient Handling*, The State of Washington, 70.41.390 1 (b) (2006) <http://1.usa.gov/17MhIwB>.

The law has dramatically reduced injuries, according to the available data. Washington health care employers in 2003 reported 1,030 injuries due to overexertion, a term for injuries that are caused by ergonomic stressors. Washington's safe patient handling law was implemented in 2006. Only 630 injuries due to overexertion of Washington health care employees were reported in 2010.<sup>78</sup>

Maryland passed a safe patient handling law in 2007. It also has yielded positive results. In 2003, Maryland health care employers reported 960 injuries due to overexertion. In 2010, three years after the Maryland law took effect, only 240 injuries due to overexertion were reported.<sup>79</sup>

These states likely have realized enormous savings due to their safety rules. A study published in 2004 that examined injury rates and costs in six nursing homes over a six-year period (covering 3.7 million hours worked for the employees studied) found that the use of mechanical lifts to move patients reduced injuries by 36 to 86 percent, depending on the category of activity. Just the amount of money saved by reduced workers' compensation claims recouped the cost of installing the mechanical lifting equipment in three years.<sup>80</sup>

Other states to implement safe patient handling laws include Texas and New York (2005); Ohio and Rhode Island (2006); Minnesota (2007); New Jersey (2008); Illinois (2010); and California (2011).<sup>81</sup>

It is often said that states make fine laboratories. But they are not empowered to enact comprehensive solutions. In the area of safe patient handling, the states have given OSHA all it needs to conclude that solutions exist to a well-documented problem. It is time for OSHA to take the next step.

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<sup>78</sup> *Number of Nonfatal Occupational Injuries and Illnesses Involving Days Away From Work by Selected Worker and Case Characteristics and Industry, State of Washington, Private Industry, 2003-2010*. Searchable function available at: <http://www.bls.gov/iif/data.htm>.

<sup>79</sup> *Number of Nonfatal Occupational Injuries and Illnesses Involving Days Away From Work by Selected Worker and Case Characteristics and Industry, Maryland, private industry, 2003-2010*. Search function available at: <http://www.bls.gov/iif/data.htm>.

<sup>80</sup> James W. Collins, L Wolf, J Bell, B Evanoff, *An Evaluation of a 'Best Practices' Musculoskeletal Injury Prevention Program in Nursing Homes*, 10 INJURY PREVENTION 206 (2004), <http://1.usa.gov/15Ua7bp>.

<sup>81</sup> *Safe Patient Handling*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (viewed on June 3, 2013), <http://1.usa.gov/ZrCQyx>.

## VIII. Recommendations for New Regulations

### Safe Patient Handling

OSHA should promulgate a safe patient handling standard to address ergonomic stressors and musculoskeletal disorders. The standard should:

- Require the use of engineering controls, lifting and transfer aides, or assistive devices, operated by lift teams, to perform acts of lifting, transferring, and repositioning health care patients and residents;
- Require the use of mechanical lifting devices even in cases in which lifting is conducted by teams, as opposed to individuals;
- Cover all shifts and units in all areas of health care, including hospitals and nursing home facilities.

### Workplace Violence

Additionally, OSHA should promulgate a standard to address the hazardous situations of workplace violence. The workplace violence standard should:

- Require employers to create a policy of zero tolerance for workplace violence, verbal and nonverbal threats;
- Require workplace policies that encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks;
- Provide protections to employees to deter employers from retaliating against those who report workplace-violence incidents; and
- Require employers to develop a comprehensive plan for maintaining security in the workplace.

### Bloodborne Pathogens

OSHA should amend the current bloodborne pathogens standard to ensure that:

- Employers' logs of injuries caused by sharp devices are comprehensive and are carefully reviewed by management and workers to assess potential hazards;
- Employers' purchases of needles and other sharp objects encompass the best available technology within practical limits; and
- Employees are consulted in the purchase of needles and other sharp objects and their advice is fully considered in purchasing decisions.

## IX. Conclusion

OSHA needs to expend more effort to ensure that the workers in health care facilities are adequately protected.

Such efforts should include dramatically increasing its number of inspections of health care facilities and developing standards to protect against recognized hazards, particularly in the areas of repetitive motion injuries, workplace violence and injuries caused by sharp objects.

Until such standards can be implemented, OSHA should vastly expand its use of the general duty clause to cite health care facilities for hazards that are not documented in existing rules.

To address the needs of health care workers and the industry, additional funding will be required. OSHA's budget is minuscule in comparison to the size of its mandate. OSHA's budget for fiscal year 2012 was just \$535 million to oversee 7 million employers, and fulfill other functions.<sup>82</sup>

The health care industry has grown rapidly due to baby boomers reaching retirement age, technological innovations and other factors, and it is going to continue to expand steadily. The government's deficit in protecting health care workers will continue to grow in coming years unless it takes aggressive action.

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<sup>82</sup> *Commonly Used Statistics*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, <http://1.usa.gov/wygBx6> (viewed on July 9, 2013).

## **Appendix: OSHA's Responses to Public Citizen's Questions**

Public Citizen submitted questions to the office of Assistant Secretary of Labor for OSHA David Michaels. The questions and the agency's answers, which were provided to Public Citizen on June 10, 2013, are printed here.

### **Could we have a statement for the record on why there are so few ergonomic citations in a program that was purportedly largely intended for the purpose of reducing violations from ergonomic stressors?**

The nursing home National Emphasis Program (NEP) was initiated to address several hazards. The initiative expresses a focus on exposure to bloodborne pathogens, tuberculosis, workplace violence, slips/trips/falls, and ergonomic stressors.

With regard to the number of citations issued for ergonomic hazards, it is important to note that the Agency does not have a standard for ergonomics and therefore must demonstrate that an employer failed to comply with Section 5(a)(1) of the Occupational Safety and Health Act of 1970, also known as the General Duty Clause...This clause from the OSH Act is utilized to cite serious hazards where no specific OSHA standard exists to address the hazard, as is the case with ergonomic stressors. When OSHA elects to use the General Duty Clause to issue a citation (because no specific standard is violated) the agency must meet a high evidentiary burden.

In addition, citations are not the only tools OSHA has at its disposal. In many cases where OSHA identifies hazards relating to ergonomic risk factors, but believes the conditions do not meet the evidentiary threshold required to cite under the general duty clause, OSHA has issued Hazard Alert Letters (HALs) to those employers. Since the NEP was initiated, we have issued more than 55 such HALs outlining ergonomic hazards and providing employers examples of feasible abatement methods they can implement to help prevent ergonomic related injuries to workers in nursing and residential care settings.

### **More broadly, why didn't the NEP also involve hospitals? Aren't hospital workers also highly susceptible to musculoskeletal injuries?**

We agree that hospitals have also reported high injury rates. Indeed, OSHA has major concerns about workplace safety in the health care industry. As mentioned in the previous response, the Agency initiated the NEP to address several hazards (not just one) in nursing and residential facilities, a sector of healthcare with an overall [Days Away, Restricted, Transferred, or DART] rate approximately two-and-a-half times the rate for all private sector industries. It should also be noted that the Agency has been promoting the issue of musculoskeletal disorders in nursing homes since issuing our "Guidelines for Nursing

Homes: Ergonomics for the Prevention of Musculoskeletal Disorders” in 2003 (revised March 2009).

In response, OSHA has begun a series of ground-breaking initiatives, using outreach and education, along with enforcement, to encourage employers in hospital and health care facilities to reduce hazards. For example, Assistant Secretary for OSHA David Michaels launched an OSHA initiative to work with hospitals and nursing homes to recognize the close link between patient safety and worker safety. Dr. Michaels is a member of the roundtable on Joy and Meaning in Work and Workforce Safety of the Lucian Leape Institute at the National Patient Safety Foundation (NPSF)—which issued a recent report asserting that patient wellbeing is closely tied to the safety and health of the workers who care for them.<sup>83</sup> Its report calls upon health care organizations to initiate broad organizational changes to reduce physical and psychological harm to healthcare workers.

Last month, Dr. Michaels carried this important message of improving worker safety—and the link between improving patient and worker safety—to a plenary session at the 2013 NPSF Congress in New Orleans. And, in November, Dr. Michaels led OSHA’s very successful and well-attended health care stakeholder meeting at the University of Texas in Arlington to highlight what leading hospitals are doing to address worker health and safety, and how the industry can better collaborate in the region.

OSHA also has an Alliance with the Joint Commission (the organization that accredits hospitals and many other health care facilities) focusing on protecting health care employees’ health and safety, particularly in reducing and preventing exposure to biological and airborne hazards in health care and addressing emergency preparedness, ergonomics, and workplace violence issues. We have also worked with the Joint Commission on the link between improving patient and worker safety. In collaboration with our sister agency NIOSH, the Joint Commission just issued an important monograph, “Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation.”<sup>84</sup> Most recently, OSHA worked with the Joint Commission to publish an article in its Environment of Care newsletter underscoring the importance of the OSHA 300 log as a tool to help employers find and fix hazards to protect workers.<sup>85</sup>

In another very significant initiative to improve worker safety in hospitals, OSHA is currently working in collaboration with the Centers for Medicare and Medicaid Services’ (CMS) Partnership for Patients, a cooperative program created and funded under President

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<sup>83</sup> THROUGH THE EYES OF THE WORKFORCE CREATING JOY, MEANING, AND SAFER HEALTH CARE, LUCIAN LEAPE INSTITUTE (2013), <http://bit.ly/YJFLSH>.

<sup>84</sup> IMPROVING PATIENT AND WORKER SAFETY: OPPORTUNITIES FOR SYNERGY, COLLABORATION AND INNOVATION, JOINT COMMISSION (Nov. 19, 2012), <http://bit.ly/RRp2Nt>.

<sup>85</sup> *Health Care Joint Commission Article Calls OSHA 300 ‘A Log to Live By’*, OSHA QUICK TAKES (Oct. 1, 2012), <http://1.usa.gov/179fkMV>.

Obama's signature initiative, the Affordable Care Act.<sup>86</sup> Through this partnership, we are gathering real, relevant best practices and lessons learned, and developing guidance products on healthcare work environments, with a particular focus on hospitals, to be disseminated through the CMS Hospital Engagement Network. The two issues we are focusing on are improving safety culture through injury and illness prevention programs and improving safe patient handling to reduce musculoskeletal disorders. The agreement aims to produce several work products, including assessment and education tools that target administrators, safety managers and workers in hospitals.

We welcome you to also view recent updates to OSHA's Healthcare Industry Safety and Health Web page.<sup>87</sup> The page includes information on the "Culture of Safety", a huge area where the agency is attempting to effect change in the healthcare industry as a whole.<sup>88</sup>

**Are we correct that OSHA is not pursuing a rule on ergonomic safety standards for health care workers and, if so, why not?**

At this time, OSHA is not pursuing a rule on safe patient handling for health care workers. We continue to be concerned about this serious issue and promote sensible solutions through the NEP, guidance, and outreach activities. However, OSHA does not have resources to move forward on all rulemaking necessary to address all the pressing workplace health and safety hazards.

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<sup>86</sup> See, *Partnership for Patients*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (viewed on July 12, 2013), <http://1.usa.gov/VH6h2j>.

<sup>87</sup> *Health Care*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (viewed on July 11, 2013), <http://1.usa.gov/9i0XAH>.

<sup>88</sup> See, *Organizational Safety Culture—Linking Patient and Worker Safety*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (viewed on July 11, 2013), <http://1.usa.gov/1au3Kld>.