# Health Care Triad of Safety:
*Patient, Provider and Environment*

**John M. Williams, Sr., MD, MPH**

August 18, 2010

# Introduction

- In the health care setting, the “Triad of Safety” is a continuum that is inextricably linked between patient, provider and environment
- Patient safety, health care worker safety and the environment where they interact and coexist are interdependent
- An unsafe workplace can lead to injuries and illnesses in health care workers as well as their patients.

# John Howard, MD, MPH, JD

***Director, National Institute for Occupational Safety and Health (NIOSH)***

- *"We need to care for the sick and at the same time, we need to care for those who care for the sick. Our attitudes, our policies, our laws, and our practices need to more clearly and emphatically reflect this duality in the 21st century delivery of healthcare."*

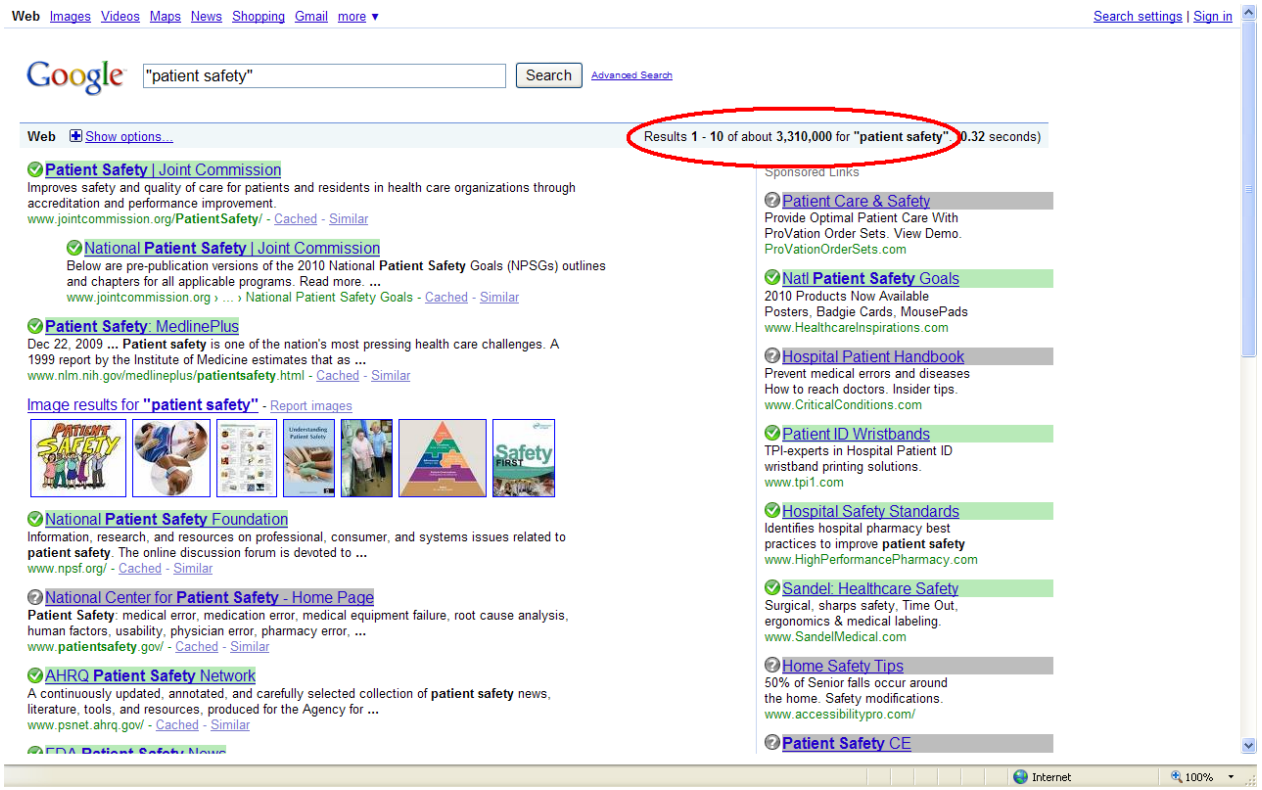
# Objectives

- Discuss the history of and current initiatives in patient and healthcare worker safety in hospitals
- Discuss stakeholder perceptions regarding safety
- Discuss how quality is measured in both areas
- Present results of a study looking at OSHA-identified “high hazard” hospitals and their characteristics
- Discuss recommendations for future research in the area of safety in the health care environment

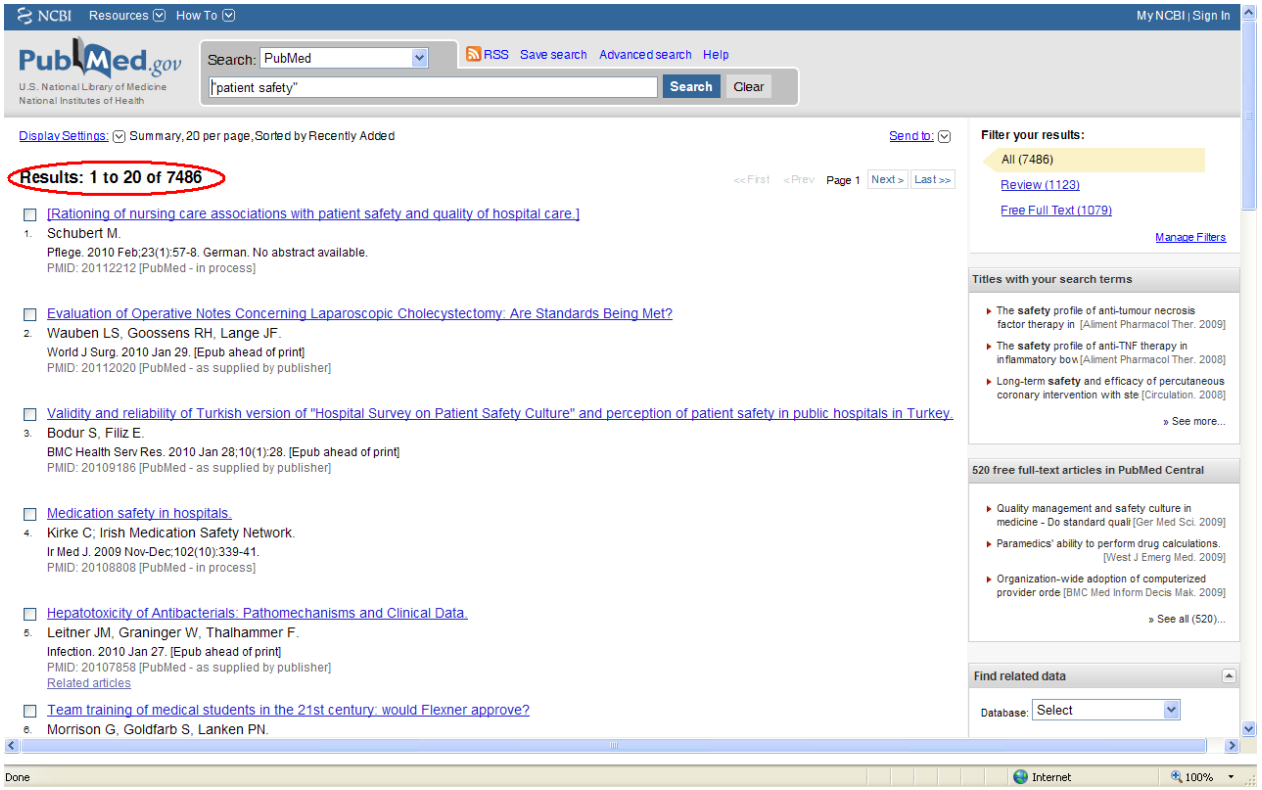
# Headlines

- “Infant twins were given massive overdoses of a blood thinner that nearly killed them”
- “Infections at hospital prompt reminder for doctors to wear masks”
- “Hospital has 5th wrong-site surgery”
- “Hearing to air medical mistakes”
- “Medical mistakes in Minnesota down 3.5 percent in 2009”

# Patient Safety



# Patient Safety



# IOM report

- Institute of Medicine
  - To Err is Human: Building a Safer Health System (1999)
    - Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim
      - Adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities
    - 44,000 to 98,000 excess deaths per year
    - Total cost: $17-$29 billion per year in hospitals nationwide

# Types of errors

## Types of Errors

**Diagnostic**
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

**Treatment**
- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

**Preventive**
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

**Other**
- Failure of communication
- Equipment failure
- Other system failure

SOURCE: Leape, Lucian; Lawthers, Ann G.; Brennan, Troyen A., et al. Preventing Medical Injury. Qual Rev Bull. 19(5):144–149, 1993.

# “Dead by Mistake: Within health care hides massive, avoidable death toll”

Crowley CF and Nadler E; SF Chronicle 8/10/09

- Estimated death toll from preventable medical injuries/infections at 200,000 per year in the US
- 20 states and the District of Columbia have mandatory reporting systems
- Only five of the 20 — Washington, Massachusetts, Minnesota, Colorado and Indiana — are transparent enough to be useful to consumers by revealing hospital names.
- California reveals some hospital-specific information. Illinois, New Hampshire and North Dakota will also reveal hospital-specific information once their systems are running.
- 20 states have no reporting whatsoever. The remaining five states have, or are setting up, voluntary reporting.

# Massachusetts National Quality Forum (NQF)-based reporting system

- **28 discrete adverse medical events grouped into 6 major categories**
  - Surgical
  - Product or device related
  - Patient protection related
  - Care management related
  - Environmental
  - Criminal

# Massachusetts Acute Care Hospital SREs by Number and Percentage:

*January through December, 2008*

| Event | Count | Percent |
|---|---|---|
| Fall | 224 | 66% |
| Retained Foreign Object | 32 | 9% |
| Wrong Site Surgery | 24 | 7% |
| Medication Error | 12 | 4% |
| Stage 3 or 4 Pressure Ulcer | 12 | 4% |
| Sexual Assault | 11 | 3% |
| Burn | 6 | 2% |
| Wrong Surgical Procedure | 5 | 1% |
| Device Malfunction | 3 | 1% |
| Suicide/Suicide Attempt | 3 | 1% |
| Air Embolism | 2 | 1% |
| Wrong Patient Surgery | 1 | 0% |
| Maternal Death / Disability | 1 | 0% |
| Hyperbilirubinemia in Neonate | 1 | 0% |
| Restraints/Bedrails | 1 | 0% |

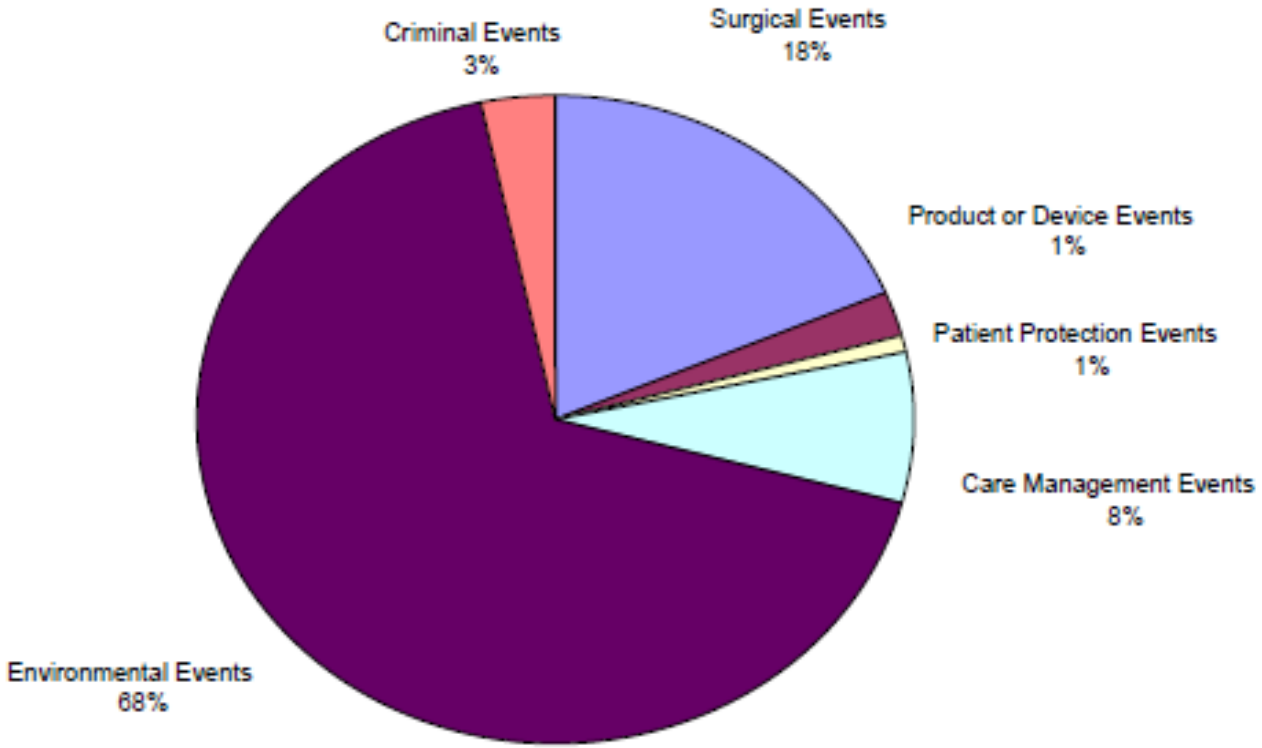
# Massachusetts Acute Care Hospital SREs by Number and Percentage:

*January through December, 2008*

| | | |
|---|---|---|
| Death < 24 Hours ASA 1 Patient | 0 | 0% |
| Contaminated Drugs or Device | 0 | 0% |
| Infant Discharged to Wrong Person | 0 | 0% |
| Elopement | 0 | 0% |
| Transfusion Error | 0 | 0% |
| Hypoglycemia | 0 | 0% |
| Spinal Manipulation | 0 | 0% |
| Artificial Insemination Error | 0 | 0% |
| Electric Shock | 0 | 0% |
| Oxygen or Gas Error | 0 | 0% |
| Physical Assault | 0 | 0% |
| Abduction | 0 | 0% |
| Impersonation of Health Professional | 0 | 0% |
| **Total** | **338** | **100%** |

# Distribution of Serious Reportable Events in Massachusetts Acute Care Hospitals:

*January 1, 2008 - December 31, 2008 (N=338)*



# Comparison of serious reportable events: *Massachusetts and Minnesota*

**Table 5**
**Comparison of SRE Rates – Massachusetts and Minnesota**

| | MA | | MN[11] | |
|---|---|---|---|---|
| **SRE** | # | Rate* | # | Rate* |
| Surgical Events | 62 | 1.53 | 77 | 2.69 |
| Product or Device | 5 | 0.12 | 3 | 0.10 |
| Patient Protection | 3 | 0.07 | 3 | 0.10 |
| Care Management | 26 | 0.64 | 130 | 4.54 |
| Environmental | 231 | 5.70 | 98 | 3.42 |
| Criminal | 11 | 0.27 | 1 | 0.03 |
| Total | 338 | 8.34 | 312 | 10.90 |

*Rate is SRE count per 100,000 patient days

# Patient Safety and Quality Improvement Act of 2005

- Encourages the development of Patient Safety Organizations (PSOs)
- Fosters a culture of safety by establishing strong Federal confidentiality and privilege protections for information gathered and analyzed by stakeholders
- Accelerates the speed with which solutions can be identified for the risks and hazards associated with patient care

# Patient safety metrics

- Joint Commission “Quality Check” (1996)
  - JC inspection data; 4250 hospitals; voluntary
- HealthGrades (1996)
  - CMS and state data; 5000 hospitals; involuntary
- Leapfrog Group (2000)
  - Voluntary surveys; 1206 hospitals
- HHS Hospital Quality Compare (2005)
  - CMS data; 4000 hospitals; voluntary participation

# 2010 Joint Commission National Patient Safety Goals

- 1 - Improve the accuracy of patient identification.
- 2 - Improve the effectiveness of communication among caregivers.
- 3 - Improve the safety of using medications.
- 7 - Reduce the risk of health care–associated infections.
- 8 - Accurately and completely reconcile medications across the continuum of care.

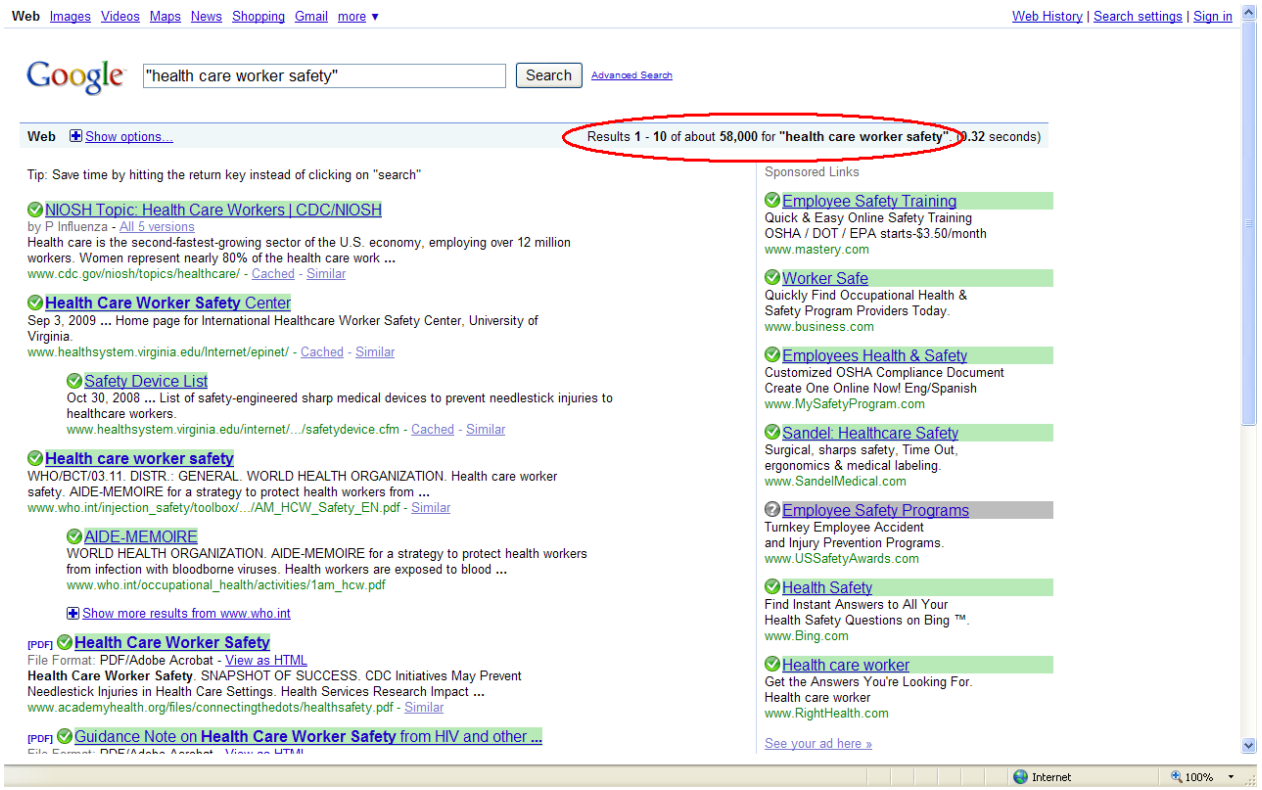
# 2010 Joint Commission National Patient Safety Goals

- 9 - Reduce the risk of patient harm resulting from falls.
- 14 - Prevent health care–associated pressure ulcers (decubitus ulcers).
- 15 - The organization identifies safety risks inherent in its patient population.
- #4-6, 10-13, 16: N/A for hospitals

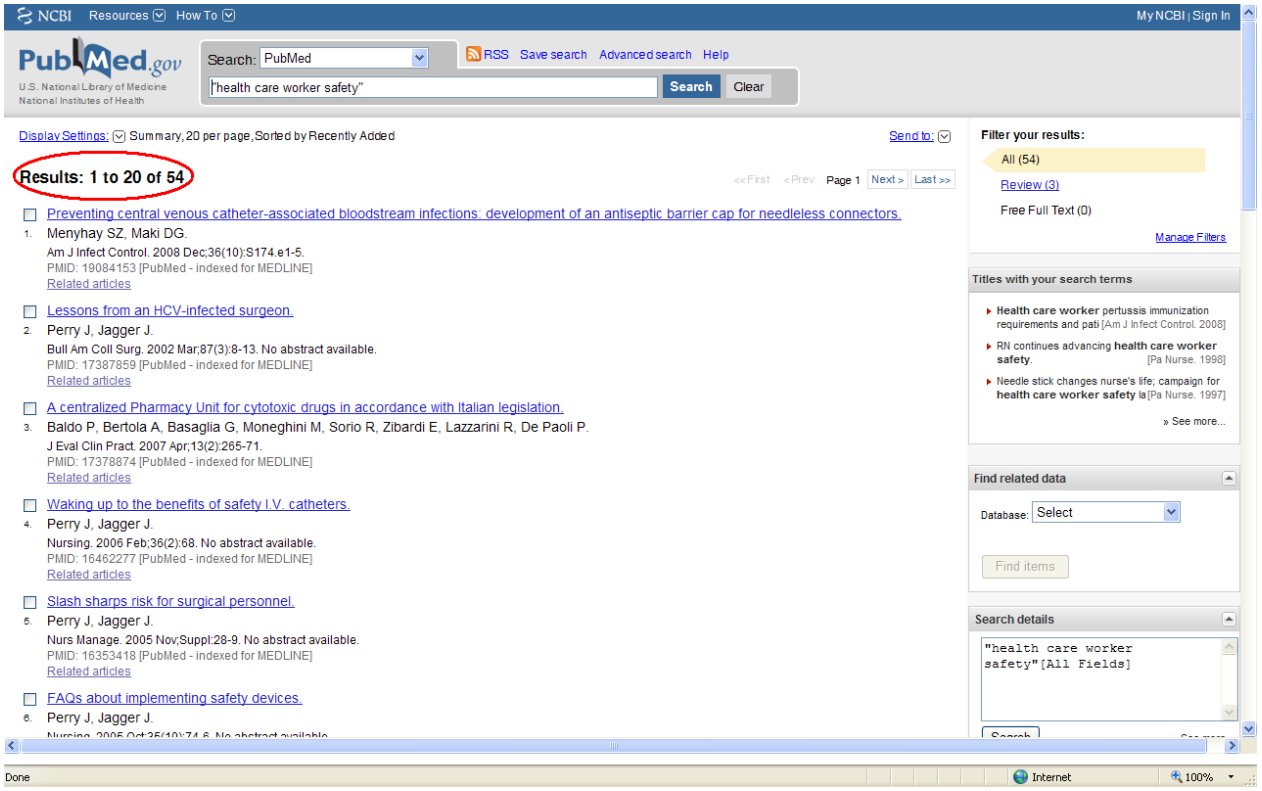
# Work-related injuries and illnesses in general medical/surgical hospitals

- Bureau of Labor Statistics reports (2008) show an 82% higher incidence rate for work-related injuries and illnesses for workers in general medical/surgical hospitals (NAICS Code 6221) when compared to all industries combined.
- Over 258,000 OSHA recordable cases of injury and illness were reported in 2008 in these hospitals, and this was the second highest number for all industries reporting more than 100,000 cases.

# Health care worker safety



# Health care worker safety



# Healthcare worker safety metrics

- OSHA
  - OSHA 300A reports (annual)
  - OSHA Work-Related Injury and Illness Data Collection Form
  - Inspections
  - Complaints
- Joint Commission
  - Environment of Care Standards
  - Joint Commission-OSHA partnership
    - First established in 1996.

# Joint Commission Standards
*Environment of Care (EC) Requirements*

- **EC.01.01.01**
  - Plans activities to minimize risks in the environment of care.
- **EC.02.01.01**
  - Manages safety and security risks.
- **EC.02.02.01**
  - Manages risks related to hazardous materials and waste.
- **EC.02.03.01**
  - Manages fire risks.
- **EC.02.03.03**
  - Conducts fire drills.

# Joint Commission Standards
*Environment of Care (EC) Requirements*

- **EC.02.03.05**
  - Maintains fire safety equipment and fire safety building features.
- **EC.02.04.01**
  - Manages medical equipment risks.
- **EC.02.04.03**
  - Inspects, tests, and maintains medical equipment.
- **EC.02.05.01**
  - Manages risks associated with its utility systems.
- **EC.02.05.03**
  - Has a reliable emergency electrical power source.

# Joint Commission Standards
*Environment of Care (EC) Requirements*

- **EC.02.05.05**
  - Inspects, tests, and maintains utility systems.
- **EC.02.05.07**
  - Inspects, tests, and maintains emergency power systems.
- **EC.02.05.09**
  - Inspects, tests, and maintains medical gas and vacuum systems.
- **EC.02.06.01**
  - Establishes and maintains a safe, functional environment.

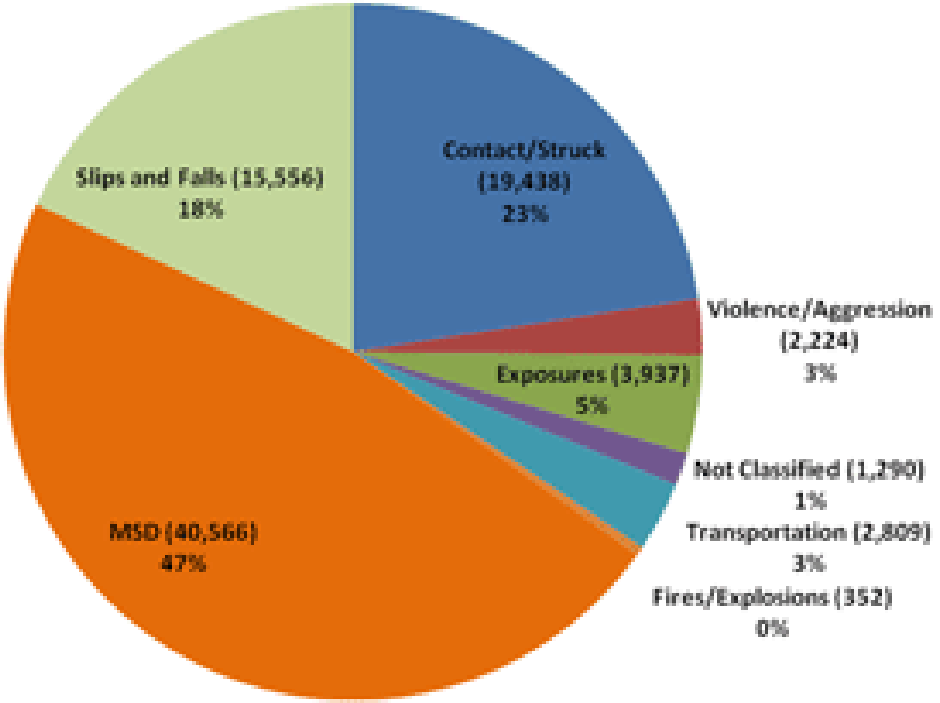
# Joint Commission Standards
*Environment of Care (EC) Requirements*

- **EC.02.06.05**
  - Manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.
- **EC.03.01.01**
  - Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.
- **EC.04.01.01**
  - Collects information to monitor conditions in the environment.

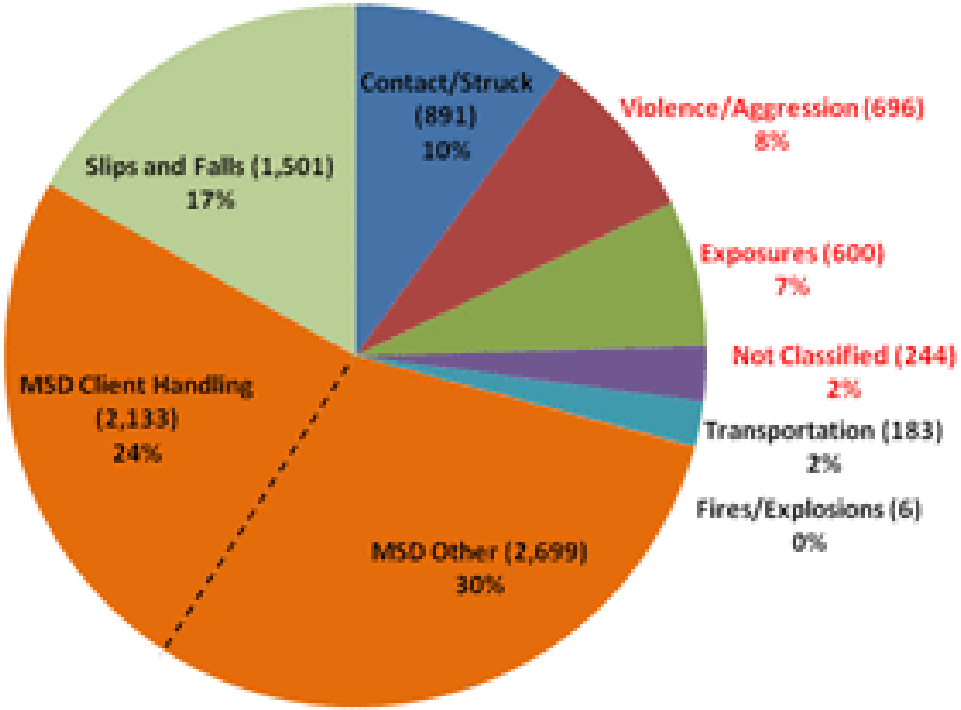
Ontario Safety Association for Community & Healthcare

# Lost Time Injury Categories 2007

## Ontario




## Health Care & Community Services




**MSD**
**4,802 (54%)**

Data Source: PDM Injury Analysis by SWA cube, July 31 2008 snapshot

Date: September 2008

# Occupational Deaths among Healthcare Workers

Sepkowitz KA and Eisenberg L. Emerging Infectious Diseases, Vol. 11, No. 7:1003-8, July 2005

- The fundamental ethic of health care is that sick persons must receive care. This premise carries an unstated consequence: an occupational risk to healthcare workers who respond to the needs of other contagious patients.

# Occupational Deaths among Healthcare Workers

Sepkowitz KA and Eisenberg L. Emerging Infectious Diseases, Vol. 11, No. 7:1003-8, July 2005

Table 1. Occupation-specific death rates for US healthcare workers*

| Occupation | Number employed (× $10^3$) | Total deaths | Death rate |
|---|---|---|---|
| Emergency medical services | 116–170 | 11 | 64–95 |
| Physicians | 340–820 | 10 | 12–29 |
| Registered nurses | 2,300 | 18 | 8 |
| Technologists and technicians | 650 | 18 | 28 |
| Home nursing aides, orderlies, and attendants | 1,700 | 13 | 8 |

*Rates expressed per 1 million workers. Numbers reflect 3-year average (2000–2002) of violent deaths and do not include infectious causes. Emergency medical services deaths reflect 4-year average (1999–2002) and exclude deaths sustained in the collapse of the World Trade Center towers in 2001. Range of number employed reflects 2 different federal databases (see text) (12,13,16,17).

Table 2. Occupational deaths among US healthcare workers (HCW), 2002*

| Cause of death | No. deaths | HCW death rate, excluding support occupations (N = 6.2 million) | HCW death rate, including support occupations (N = 9.1 million) |
|---|---|---|---|
| Injury | 77–93 | 12–15 | 8–10 |
| Infection-related† | 80–260 | 13–42 | 9–29 |
| Total | 157–353 | 25–57 | 17–39 |

*Rates expressed per 1 million workers. Estimates based on incidence and natural history of specific infections. Number of deaths by injury reflect 3-year average (2000–2002) (12,13,16,17).
†Includes deaths from hepatitis B virus (75–250) and hepatitis C virus, HIV, and tuberculosis (5–10 total).

# H.R. 2381:Nurse and Health Care Worker Protection Act of 2009

- “To direct the Secretary of Labor to issue an occupational safety and health standard to reduce injuries to patients, direct-care registered nurses, and all other health care workers by establishing a safe patient handling and injury prevention standard, and for other purposes.”
  - Sponsor: Rep. John Conyers, 35 co-sponsors

# H.R. 2381:Nurse and Health Care Worker Protection Act of 2009

- Requires the Secretary of Labor to propose a standard on safe patient handling and injury prevention to prevent musculoskeletal disorders for nurses and all other health care workers
- Requires health care employers to:
  - Develop/implement a safe patient handling/injury prevention plan
  - Provide training on safe patient handling and injury prevention
  - Post a notice explaining the standard and the procedures to report patient handling-related injuries.

# H.R. 2381:Nurse and Health Care Worker Protection Act of 2009

- Allows health care workers to:
  - (1) refuse to accept an assignment in a health care facility that violates safety standards or for which such worker has not received required training; and
  - (2) file complaints against employers who violate this Act.
- Prohibits employers from taking adverse actions against any health care worker who in good faith reports a violation, participates in an investigation or proceeding, or discusses violations.
- Requires the Secretary to conduct unscheduled inspections to ensure compliance with safety standards.

# H.R. 2381:Nurse and Health Care Worker Protection Act of 2009

- Authorizes health care workers who have been discharged, discriminated, or retaliated against in violation of this Act to bring legal action.
- Requires the Secretary of Health and Human Services (HHS) to establish a grant program for purchasing safe patient handling and injury prevention equipment for health care facilities.

# Differences in Safety Climate between Hospital Personnel and Naval Aviators

Gaba DM et al. Human Factors, Vol 45, No. 2:173-185, Summer 2003.

- Safety climate surveys compared from healthcare respondents and naval aviators (HRO)
  - 15 hospitals (n=2125)
  - 226 squadrons (n=6901)
  - Problematic response=absence of safety climate
  - Problematic response rate
    - 5.6%-aviators (overall)
    - 17.5%-hospital personnel (overall)
    - 20.9%-high hazard domains; ED and OR

# Patient Safety – Worker Safety:

***Building a Culture of Safety to Improve Healthcare Worker and Patient Well-Being***

Yassi A and Hancock T. Healthcare Quarterly, Vol. 8:32-38, October 2005.

- Canadian Adverse Events Study:
  - Approximately 7.5% of Canada's 2.5 million hospital patients experienced at least one adverse event in 2000 and up to 23,750 patients died as a result
- Access to healthcare is regularly impeded
  - Inadequate availability of qualified staff due to time loss from injuries, illness, long-term disability
  - Infection-control required quarantines

# Patient Safety – Worker Safety:

***Building a Culture of Safety to Improve Healthcare Worker and Patient Well-Being***

Yassi A and Hancock T. Healthcare Quarterly, Vol. 8:32-38, October 2005.

- Workplace Health Indicator Tracking and Evaluation (WHITE) database
  - Developed by OHSAH-tracks health indicators among the BC healthcare workforce
- Incident management and reporting information system (IRIS)
  - Tracks adverse events and other patient incidents
- Linkage of the 2 databases discussed

# Keeping Patients Safe:
## *Transforming the Work Environment of Nurses*

Committee on the Work Environment for Nurses and Patient Safety
Ann Page, ed. National Academies Press: 2004

- The committee found “strong” evidence that prolonged work hours and fatigue affect worker performance.
- No evidence to suggest that any amount of training, motivation, or professionalism is able to overcome the performance deficits associated with fatigue, sleep loss and the sleepiness associated with circadian variations in alertness

# Keeping Patients Safe:
## *Transforming the Work Environment of Nurses*

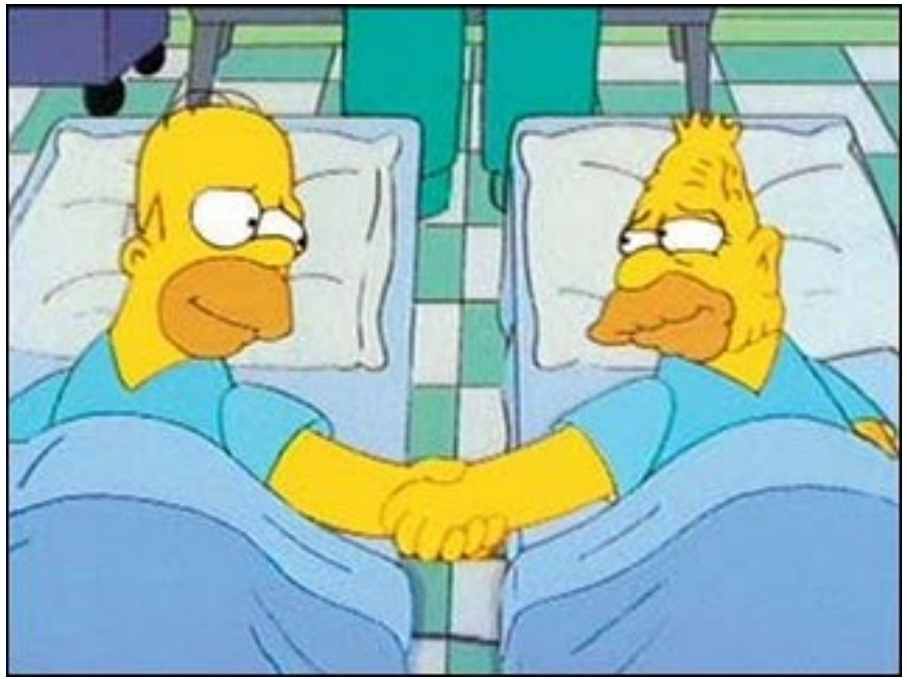
Committee on the Work Environment for Nurses and Patient Safety
Ann Page, ed. National Academies Press: 2004

- The committee adhered strictly to its charge to identify “potential improvements in health care working conditions that would likely increase patient safety.”
- They repeatedly noted how often patient safety practices identified from the evidence reviewed for the study were the same as those recommended by organizations studying the nursing shortage, worker safety, and patient satisfaction.

# Work hour limitations in safety-sensitive industries

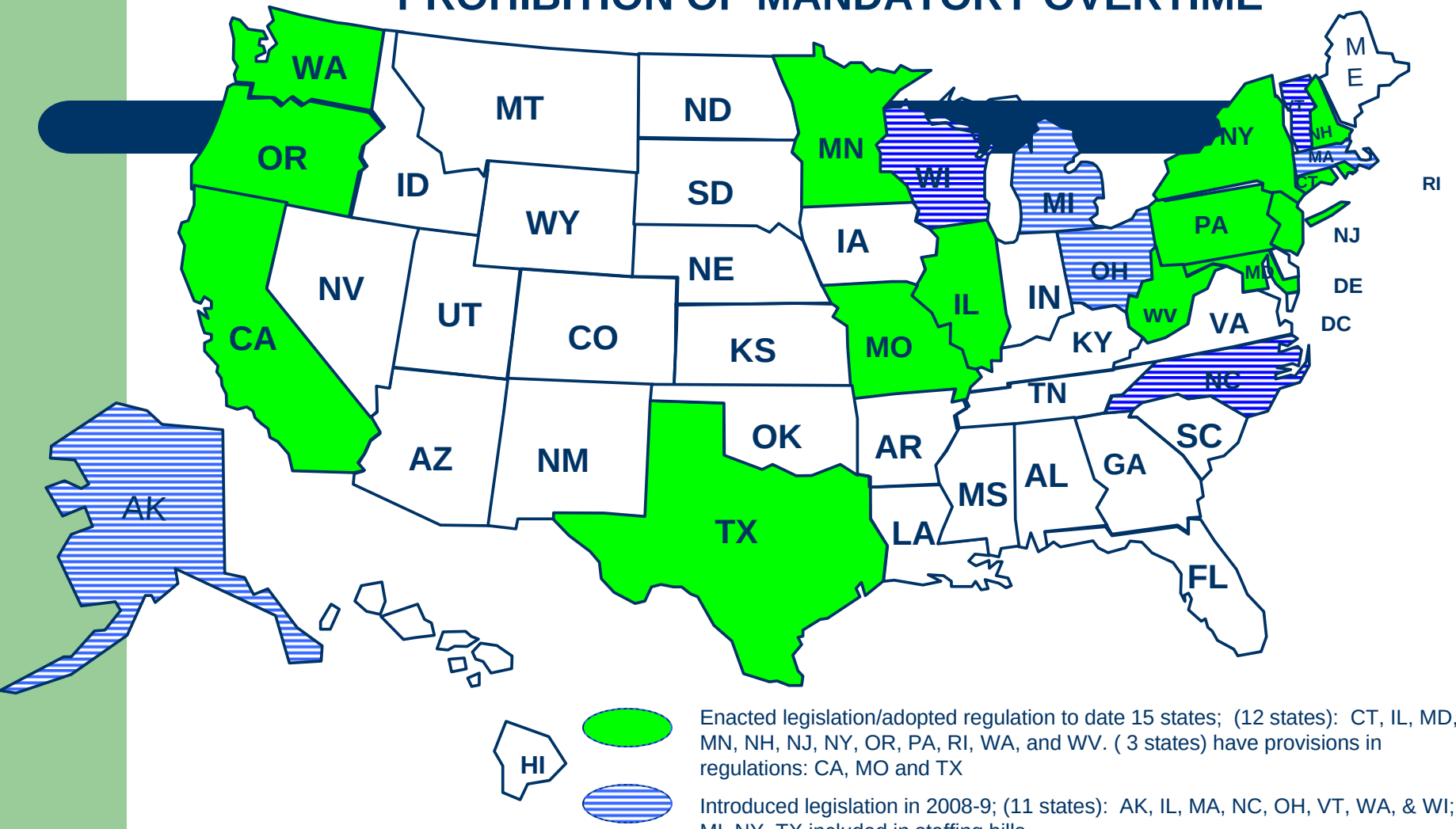
| Occ group | Regulations | Max hrs | Min rest |
|---|---|---|---|
| RN | No | 15 states | ME,NH,WV,IL |
| Physicians | No | NY | NY |
| Pilots (mil) | Guidelines | Yes | Yes |
| Pilots (civ) | DOT/FAA | Yes | Yes |
| Air traffic controllers | DOT/FAA | Yes | Yes |
| Truckers | DOT/FMCSA | Yes | Yes |
| Maritime | DHS/USCG | Yes* | Yes* |
| RR engr | DOT/FRA | Yes | Yes |
| Nuclear Pwr | NRC | Yes | Yes |

# Where is Homer safer?

# The American Nurses Association's Nationwide State Legislative Agenda

## PROHIBITION OF MANDATORY OVERTIME




Enacted legislation/adopted regulation to date 15 states; (12 states): CT, IL, MD, MN, NH, NJ, NY, OR, PA, RI, WA, and WV. ( 3 states) have provisions in regulations: CA, MO and TX

Introduced legislation in 2008-9; (11 states): AK, IL, MA, NC, OH, VT, WA, & WI; MI, NY, TX included in staffing bills.

March 2009

# **Nursing Staffing and Quality of Patient Care.** Kane RL, Shamliyan T, Mueller C, Duval S, Wilt T. AHRQ Publication No. 07-E005. March 2007.

- Observational studies of relationship between nurse staffing and outcomes (associations, not causality)
- Higher registered nurse staffing – less hospital-related mortality, failure to rescue, cardiac arrest, hospital acquired pneumonia, and other adverse events (esp. surgical and ICU)
- Greater registered nurse hours on direct patient care - decreased risk of hospital-related death and shorter lengths of stay
- More overtime hours - increased hospital related mortality, nosocomial infections, sepsis

# Effect of Reducing Interns' Weekly Work Hours on Sleep and Attentional Failures

Lockley et al, N Engl J Med. 2004 Oct 28;351(18):1829-37.

- Intervention crossover among 20 residents comparing traditional on call schedule with modified
- Validated sleep logs, work logs and weekly polysomnography
- 84.9 hrs vs. 65.4 hrs
- 5.5 attentional failures/night shift vs. 2.6 (p=.02)

# Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units

Landrigan et al, N Engl J Med. 2004 Oct 28;351(18):1838-48.

- Prospective randomized control trial
- 2203 patient-days, 634 admissions
- Intervention vs. control schedule
- 136.0 vs. 100.1 error/1000 patient days, (p=.001)
- 20.8% more medication errors
- 5.6 times the number of diagnostic errors
- A single night of continuous sleep deprivation causes decrements in performance similar to those induced by a blood alcohol level of 0.10 percent.

# Healthcare worker safety metrics

- OSHA
  - OSHA 300A reports (annual)
  - OSHA Work-Related Injury and Illness Data Collection Form
  - Inspections
  - Complaints
- Joint Commission
  - Environment of Care Standards
  - Joint Commission-OSHA partnership
    - First established in 1996.

# OSHA Cooperative Compliance Program/Site-Specific Targeting

- In 1997, OSHA began a program to identify workplaces (under Federal OSHA jurisdiction) that had more than 2X the national average of injuries or illnesses resulting in lost work days.
- In 1999, 12,500 letters were sent to these employers, urging them to take action to remove hazards causing the high rates.
- These letters have been sent to 12,500 to 14,000 employers each year since that time
- These employers are included in an annual database published by OSHA
  - http://www.osha.gov/as/opa/foia/hot-15.html

# Work-related injuries and illnesses in general medical/surgical hospitals

- This study reviewed all of the med/surg hospitals (SIC Code 8062/NAICS Code 622110) that received cautionary letters from OSHA, covering the years 1998-2007 inclusive.
- 677 letters were received by 351 unique institutions in 29 different states.
  - 79 of these institutions received 3 or more letters
  - 16 received 6 or more
  - 24 received 3 letters from the years 2005-2007 inclusive
- Pennsylvania, New York, Massachusetts, New Jersey and Florida (in that order) had the highest numbers of institutions receiving letters and the states of South Dakota, North Dakota, Delaware, Alabama and Louisiana had the lowest.

# Cohort

- 79 institutions receiving 3 or more letters during the 10 year period from Jan 1, 1998-Dec 31, 2007. Parameters studied were:
  - Number of beds
  - Type of hospital
  - OSHA Citations
  - Union status
  - Joint Commission certification status
    - Quality awards

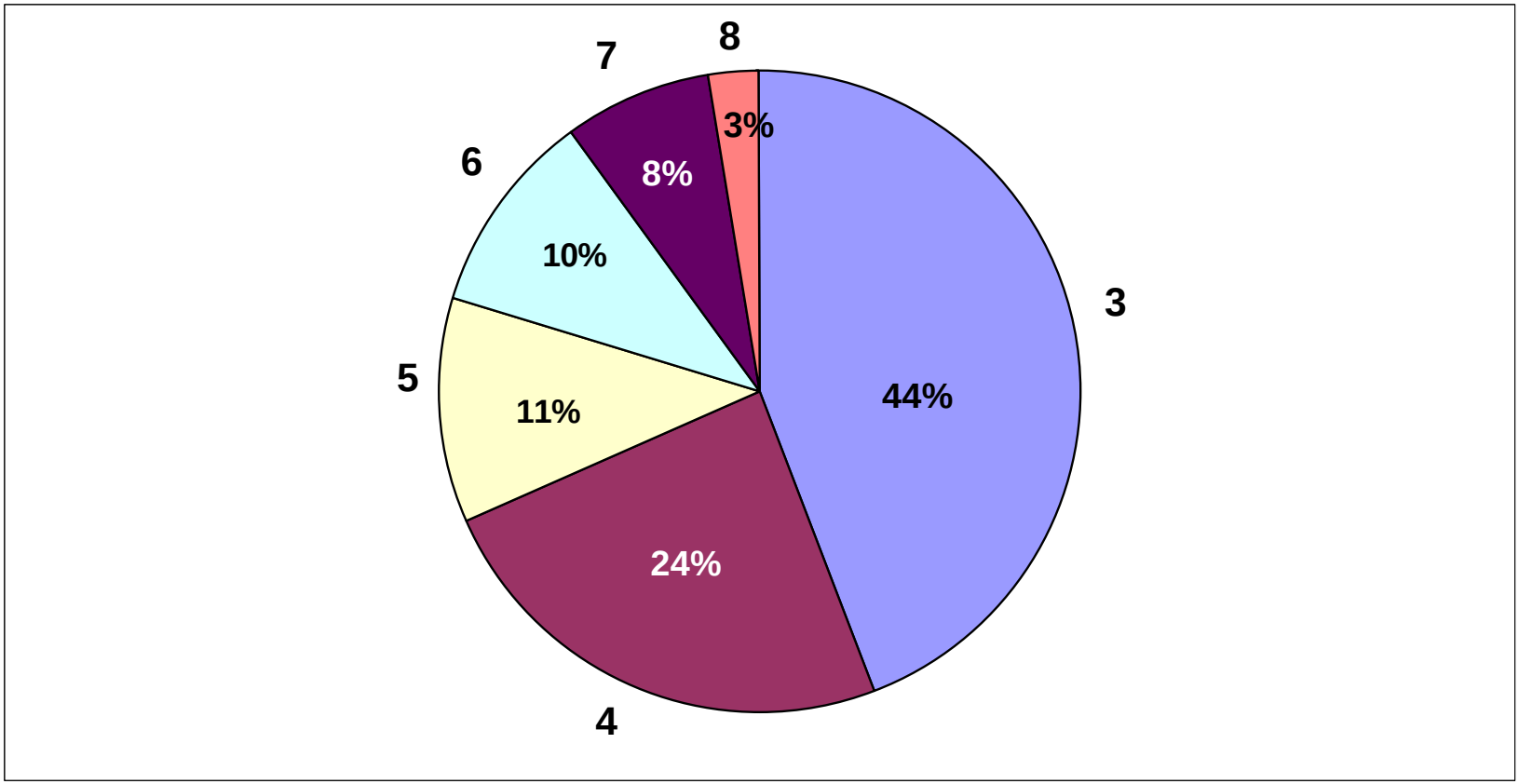
# Hospital demographics:

*Letters received x≥3 yrs 98-07; n=79*

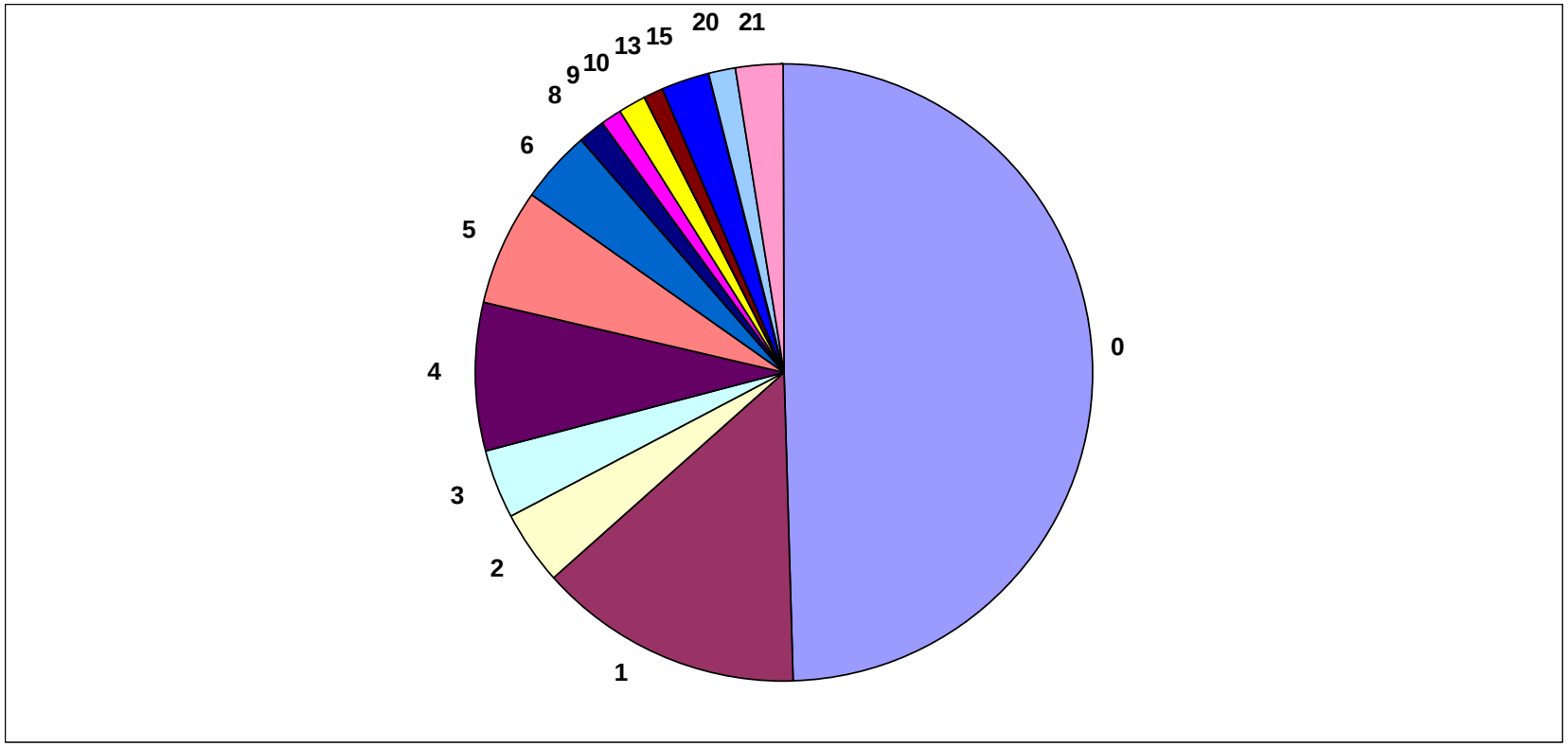
| | Non profit | For profit | CAH | JC accredited |
|---|---|---|---|---|
| STUDY | 83% | 17% | 19% | 73% |
| AVG (US) | 82% | 18% | 26% | 80% |

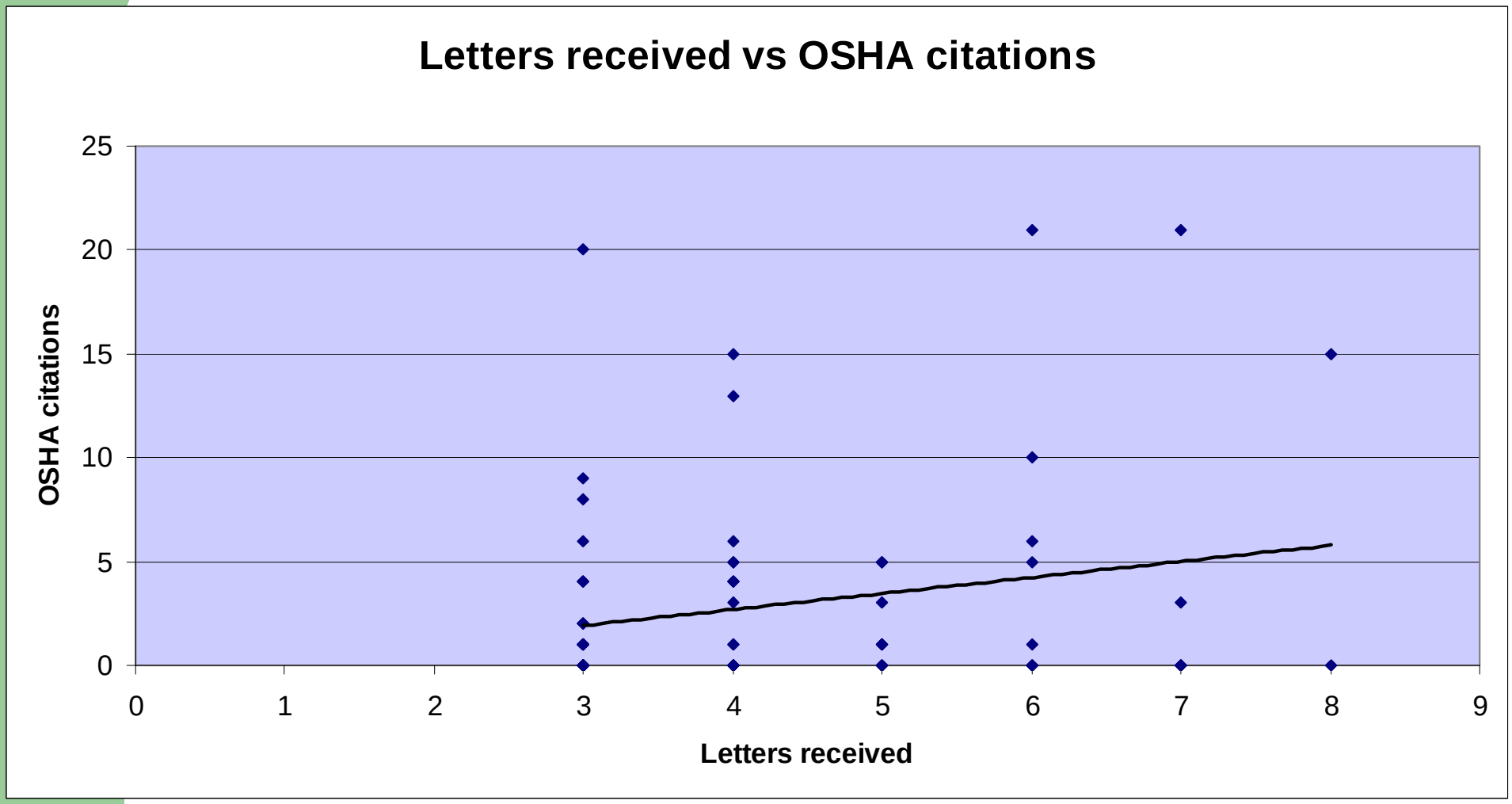
Beds: 10-619 (180±155)
Union: 25%
Non union: 50%
Indeterminate: 25%

# Number of OSHA letters received
*n=332*



# Number of OSHA citations received
*n=229*




Letters received vs OSHA citations
OSHA citations
25
20
15
10
5
0
0
1
2
3
4
5
6
7
8
9
Letters received

# Work-related injuries and illnesses in general medical/surgical hospitals

- Institutions receiving at least 3 consecutive letters from 2005-2007, were selected for further analysis.
- 24 institutions met this criterion
  - 17 had active accreditation by the Joint Commission
  - 1 was accredited by the Healthcare Facilities Accreditation Program (HFAP)
  - 6 were unaccredited.

# Hospital demographics:

*Letters received 3 consecutive yrs 05-07; n=24*

| | Non profit | For profit | CAH | JC accredited |
|---|---|---|---|---|
| STUDY | 79% | 21% | 13% | 71% |
| AVG (US) | 82% | 18% | 26% | 80% |

Beds: 20-619 (222±184)
Union: 29%
Non union: 50%
Indeterminate: 21%

| 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | TOTAL | #YRS IN A ROW | JC CERT | AWARDS | OSHA CITATIONS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| X | | | X | X | X | X | X | X | X | 8 | 7 | 11/13/08 | 2 | 15 |
| | | | X | X | X | X | X | X | X | 7 | 7 | 1/17/09 | 1 | 3 |
| | | | X | X | X | X | X | X | X | 7 | 7 | 1/27/06 | 0 | 0 |
| | | | X | X | X | X | X | X | X | 7 | 7 | HFAP | 0 | 21 |
| | | | X | X | X | X | X | X | X | 7 | 7 | 7/18/08 | 0 | 0 |
| | | | X | X | X | X | X | X | X | 7 | 7 | None | 0 | 0 |
| | | | X | X | X | X | X | X | X | 7 | 7 | None | 0 | 0 |
| | | | | X | X | X | X | X | X | 6 | 6 | 6/21/08 | 3 | 0 |
| | | | | X | X | X | X | X | X | 6 | 6 | None | 0 | 0 |
| | | | | X | X | X | X | X | X | 6 | 6 | 9/19/2009 | 0 | 10 |
| | | | | X | X | X | X | X | X | 6 | 6 | 2/10/07 | 0 | 6 |
| | | | | X | X | X | X | X | X | 6 | 6 | 7/4/08 | 0 | 0 |
| | X | X | X | X | | X | X | X | X | 8 | 4 | 1/26/08 | 6 | 0 |
| | | | | | | X | X | X | X | 4 | 4 | None | 0 | 0 |
| | | | | | | X | X | X | X | 4 | 4 | 2/12/09 | 3 | 0 |
| | | | | X | | X | X | X | X | 4 | 4 | None | 0 | 6 |
| | | | | | | X | X | X | X | 4 | 4 | 8/13/08 | 8 | 1 |
| | | | X | X | | X | X | X | X | 6 | 4 | 9/28/07 | 0 | 21 |
| | | | | | | X | X | X | X | 4 | 4 | 10/6/08 | 0 | 1 |
| | | | X | | | X | X | X | X | 5 | 4 | 12/13/08 | 4 | 5 |
| | | | | | | | X | X | X | 3 | 3 | 7/10/07 | 2 | 8 |
| | | | | | | | X | X | X | 3 | 3 | None | 0 | 2 |
| | | X | | | | | X | X | X | 4 | 3 | 1/26/08 | 0 | 3 |
| | | | | | | | X | X | X | 3 | 3 | 11/10/07 | 0 | 4 |

# OSHA citation breakdown:
*Top 10*

1. Bloodborne pathogens
   - 1910.1030
2. General requirements-electrical systems
   - 1910.0303
3. Guarding floor/wall openings
   - 1910.23
4. Lockout/tagout
   - 1910.147
5. Hazard communication
   - 1910.1200

# OSHA citation breakdown:
*Top 10*

6. Abrasive wheel machinery
   - 1910.215
7. Hand and portable power tools
   - 1910.241-247
8. Mechanical power transmission apparatus
   - 1910.219
9. Medical services/first aid
   - 1910.151
10. PPE general requirements
    - 1910.132

# NIOSH National Occupational Research Agenda (NORA)

- Healthcare and Social Assistance Sector
  - Comprised of four NAICS subsectors:
    - Ambulatory health care services (621)
    - Hospitals (622)
    - Nursing and residential care facilities (623)
    - Social assistance (624)
- An estimated 16.6 million people, about 11% of the US workforce, are employed within the HCSA sector.
- About 80% of the workers are in health care industries and 20% in social assistance industries.
- Growth of the HCSA sector through 2014 is projected to be more than any other industrial sector.

# NIOSH National Occupational Research Agenda (NORA)

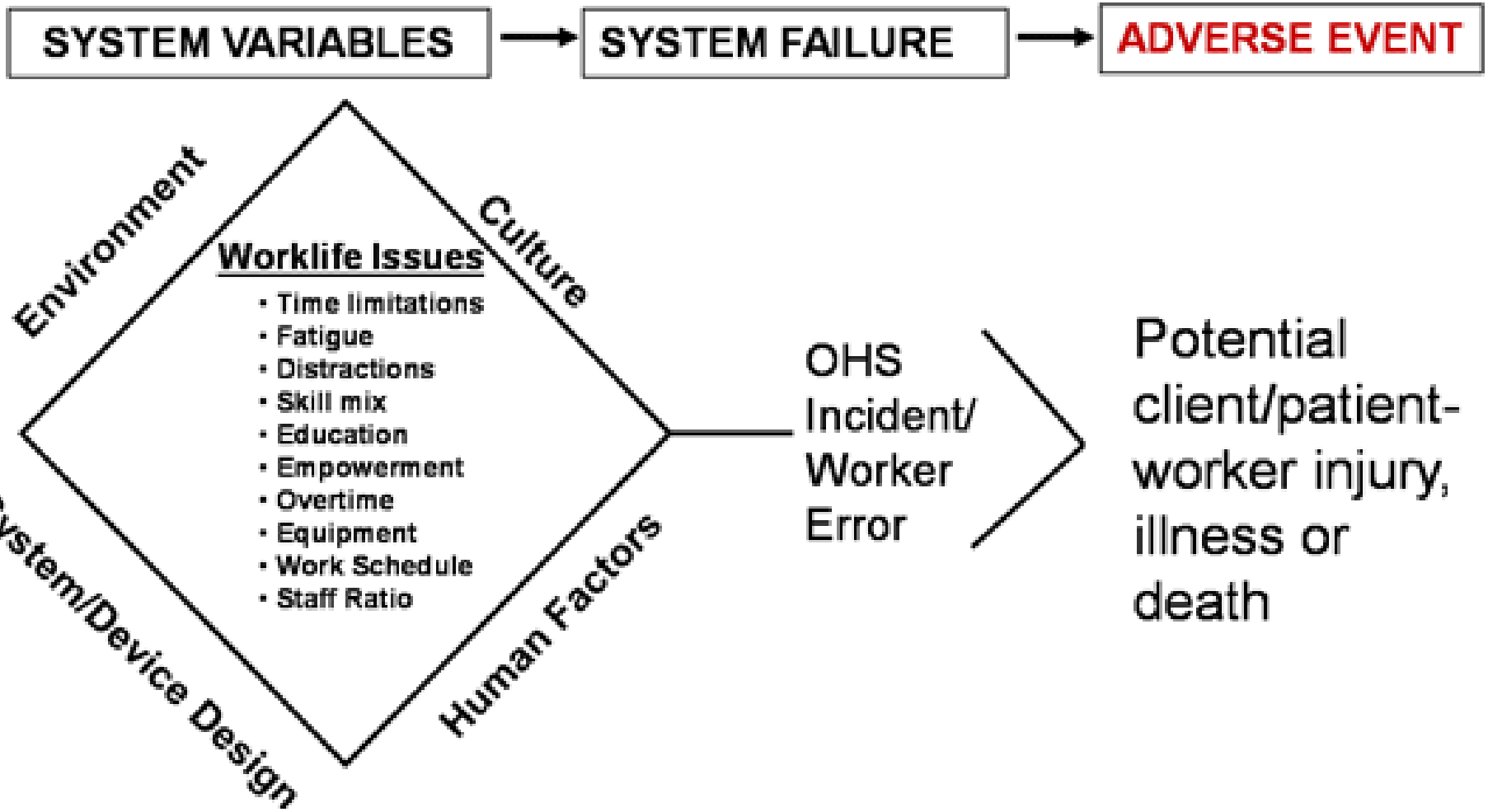
- 5 strategic goals designed to address top safety and health concerns
  - Safety and Health Programs
  - Musculoskeletal Disorders (MSDs)
  - Hazardous Drugs and Other Chemicals
  - Sharps Injuries
  - Infectious Diseases
- http://www.cdc.gov/niosh/nora/councils/hcsa

# Conclusions

- Site specific targeting may not correlate with receiving an OSHA citation
- General duty clause citations for MSD's were not seen in this study
- OSHA 300 logs should be reviewed during JC inspections as an EC component
- Improved state reporting of SRE's would allow comparison with OSHA data.
- Quality measures of healthcare organizations need to include how safe the workplace is from an employee standpoint.

Ontario Safety Association for Community & Healthcare

# The Patient – Worker Safety Relationship



# Acknowledgement

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Occupational Safety and Health Administration

# OSHA Enforcement

- New emphasis on enforcement
- Increase in FTE and budget for enforcement
- General Duty Clause
- National Emphasis Programs
- Active standard-setting agenda
- Consideration of Generic Safety and Health Programs; enhanced Hazard Communication; other

# Questions?

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