

Health and Safety

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RESOURCE



*Oregon*OSHA

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Hermiston firefighters use an inflatable mat to transfer a patient from a gurney to a hospital bed. The device helps them save their backs when moving patients.

On the cover: Hermiston firefighters use safe lifting equipment to transition patients from an ambulance into the hospital.

RESOURCE

Oregon Health and Safety Resource

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Those who care for us deserve protection

By Michael Wood



At times, I have been troubled by the seeming acceptance of risk as “just part of the job” in many different industry sectors. Workplace health and safety professionals frequently push back on that attitude, and we have done so with some success over the years. But the health care industry provides its own special challenges.

Health care does not readily jump to the “hazardous industries” list for most of us. But there are very real risks throughout the industry. Health care is the front line in combatting infectious diseases of all sorts. And it is the place where the old adage “the dose makes the poison” may have the most validity – the drugs that help patients in specific and controlled circumstances can present considerable risks for those exposed to them unnecessarily and in excessive quantities. The risks of violence,

discussed elsewhere in this publication, often present themselves in settings where caregivers are at their most nurturing, whether it's the memory-care facility or the emergency room. Whether in surgery, dentistry, or any number of other health care settings, the combination of stress, awkward postures, and intensive work provides ergonomic challenges that can often be avoided in other contexts.

And then there is patient handling, another issue addressed elsewhere in this issue of *Resource*.

One of the common elements in both patient handling and violence is the tension (sometimes real and sometimes imagined) between protecting patients and protecting caregivers. The truth is that mutual protection is often easier to achieve than we

realize (safe patient handling techniques and equipment, for example, generally make both the caregiver and the patient safer). But the tension exists nonetheless, if only because we are dealing with a population that has become accustomed to a level of self-sacrifice in dealing with those under their care.

That's a reality with which we must deal, and we cannot simply disregard it. But we can remind ourselves and others that those who care for us, at our most needy and most vulnerable, themselves deserve protection. And we can certainly do a better job of providing it. ■

A handwritten signature in black ink, appearing to read "Michael Wood".

Safe lifting

A small hospital builds a model program

By Melanie Mesaros

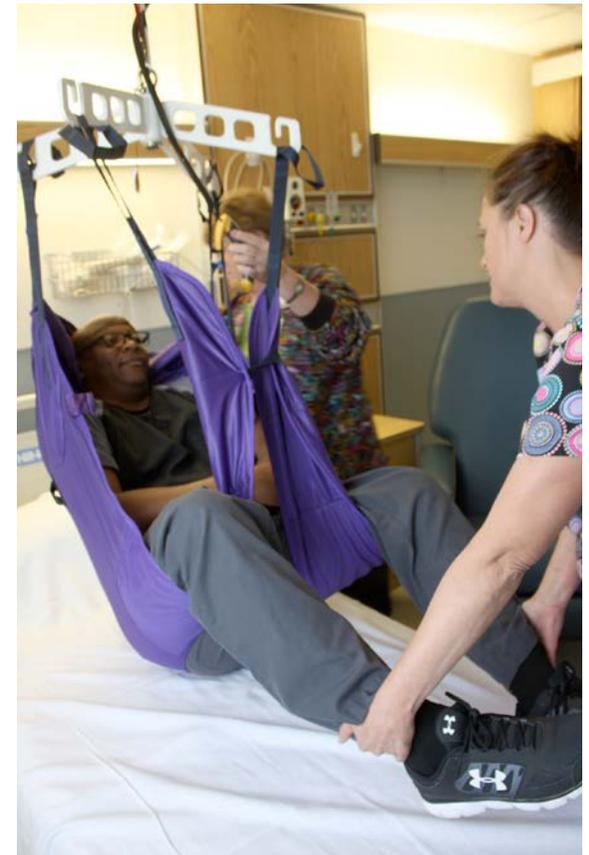
Whether a patient is coming in for care in the ER or a routine physical therapy appointment, staff members at Good Shepherd Medical Center in Hermiston are using an array of tools to safely lift patients, who may not be capable of controlling their own body.

“It’s part of our routine to use the equipment when we have a patient we need to lift or reposition,” said Laurie Schulz, a registered nurse at the hospital for 12 years. “I’m not the strongest person, and I rely on the equipment to help.”



Nurses Vicki Horneck (left) and Laurie Schulz worked together to promote the value of the safe patient lifting program to fellow staff members at Good Shepherd Medical Center in Hermiston.

Safe lifting



Nursing Assistant Jennie Wedding (left) and Vicki Horneck move a patient from a chair to the hospital bed using an overhead lift sling.

The risk of musculoskeletal injuries is among some of the highest for workers in health care. Nurses, aides, and other attendants face sprains and strains from lifting awkward or heavy patients and the tasks can be repetitive.

Since Good Shepherd Medical Center implemented its safe patient handling program in 2008, musculoskeletal injuries have decreased significantly – with the hospital reporting only one claim over the past three years. Vicki Horneck, a nurse who spearheaded the hospital's safe patient lifting program in 2008 following receipt of an Oregon OSHA grant, said the hospital is using ceiling lifts (18 in patient rooms and others throughout the ER, diagnostic imaging, and physical therapy

rooms), along with hover mats, hover jacks, a wheelchair mover (for bariatric patients), and sliding mats.

"The program needs your time up front," she said of its implementation. "You can't just buy equipment and expect people to use it."

To make their program successful, Horneck focused on training staff members she calls "super-users," who not only help train others, but help make decisions about purchasing equipment.

"It wasn't just our administration that said, 'You will do this,'" she said. "We wanted staff involved in the choices. It was essential in our culture change."

“We wanted staff involved in the choices. It was essential in our culture change.”

~ Vicki Horneck

Safe lifting



Rick Burrill, a physical therapist in the hospital's clinic, said the lifting equipment is not only saving his back, but can also enhance patient care.

"We have a patient who is over 300 pounds who went through a back surgery," he said. "Without the lifting equipment, we couldn't get them into the pool because there is no way to get them down the pool stairs."

He said that patient is now able to perform exercises in the pool and if the patient falls, the equipment is there as a fail-safe.

"We don't get hurt," said Burrill.



Left: Rick Burrill, a physical therapist, said one of his larger patients, who weighs more than 300 pounds, is able to participate in pool therapy thanks to the overhead lift. Without the lift, staff would not be able to move this patient into the pool.

Above: A trio of Hermiston firefighters lift a patient onto a hospital bed with the help of an inflatable mat.

The culture change is also affecting the hospital's partners, including Hermiston Fire, which has invested in equipment to help paramedics avoid musculoskeletal injuries.

"Many of us have back problems or issues with other joints," said Hermiston firefighter J.W. Roberts. "Firefighters lift people all day long."

Roberts and his fellow paramedics now routinely use a hover mat – an inflatable mat that goes underneath a patient on the ambulance gurney – that allows for a smooth transition to a hospital bed.

Safe lifting



Vicki Horneck shows off one of the hospital's blue mats that are used by hospital and home health staff to help slide or turn patients on beds.



"You could have a 500-pound patient and you can lift them with just a finger using the hover mat," said Mark Johnson, another Hermiston firefighter.

Horneck said the success of the small hospital's safe lifting program is getting out, as she fields inquiries from hospitals in Texas, Florida, and Canada that want to understand how to combat musculoskeletal injuries.

"I tell them you need to develop a plan and share how you want people to use it," she said. "Every employee is trained on how to use the equipment and our super-users are out there reminding people the equipment is there." ■

Firefighters in Hermiston have purchased some of their own lifting equipment to help transition patients from the ambulance to hospital beds without compromising their backs.

Hit, kicked, beaten, and shoved – violence in the Oregon health care industry

By Ellis Brasch

How serious is the problem?

In Oregon, accepted workers' compensation claims in the health care and social assistance sector increased 78 percent between 2007 and 2013. Although many factors could explain that trend, the increase is a cause for concern (accepted claims for all workplace injuries decreased by 25 percent over the same period). In 2014, half of all accepted claims for violence-related injuries in Oregon came solely from health care providers.

More disturbing is the fact that many workplace violence incidents – verbal abuse and physical assaults – go unreported because of a longstanding cultural assumption that violence is part of the job for health care workers. That assumption still exists among many health care providers, and law enforcement officials are sometimes unwilling to intervene in reported violence unless a worker is very seriously injured or killed. Most health care violence incidents are not fatal; however, many are serious enough to require medical attention.

Who is at risk?

Health care workers most at risk for physical assaults in Oregon are nursing aides, orderlies, attendants, registered nurses, counselors, social workers, and health support technicians. These workers filed 64 percent of the 275 accepted claims for assaults in the health care industry in 2014. Nearly all of the assailants were patients or clients, who hit, kicked, beat, or shoved their caregivers.

Inpatient and acute psychiatric services, geriatric long-term care settings, high-volume urban emergency departments, and residential and day social services present the highest violence risks for health care workers.

What do people mean by “workplace violence”?

When people talk about workplace violence, they may be referring to a range of hostile acts – from threats and intimidation to homicide. The National Institute for Occupational Safety and Health defines workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.”



Do workplace violence prevention programs work?

An effective violence prevention program is key to undermining the culture of indifference to violence at health care facilities. The best programs take time to build and require commitment from managers and staff but the investment is worth the effort. In the long run, fewer injuries mean lower costs for compensation claims, the reduced risk of lawsuits, and better working conditions for stressed-out staff.

Hit, kicked, beaten, and shoved

What makes a violence prevention program effective?

Earlier this year, federal OSHA updated its 2004 *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, which describes the key elements of a violence prevention program and the most effective ways to reduce the risk of violence in health care settings. The guide notes that effective violence prevention programs have clear goals for preventing violence, they are suitable for the size and work performed at a facility, and they are adaptable to changing situations. The key elements require:

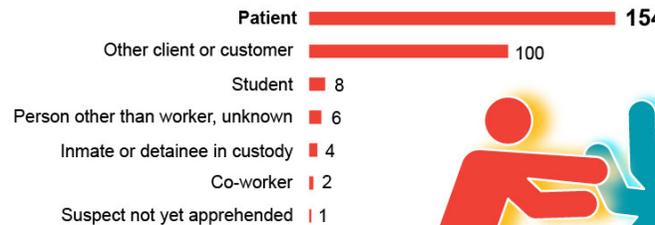
- Management committing to the program
- Employees participating in the program
- Identifying hazards that may lead to violence
- Establishing effective methods for preventing hazards
- Training workers so that they know how to assess potentially violent situations and how to report violent incidents
- Keeping accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories, and employee training
- Regularly evaluating the program to ensure that it stays effective

Do they look familiar? They should. They are similar to the key elements of traditional safety and health programs that safety professionals recommend for all workplaces.

Health care: Workplace violence injuries in Oregon



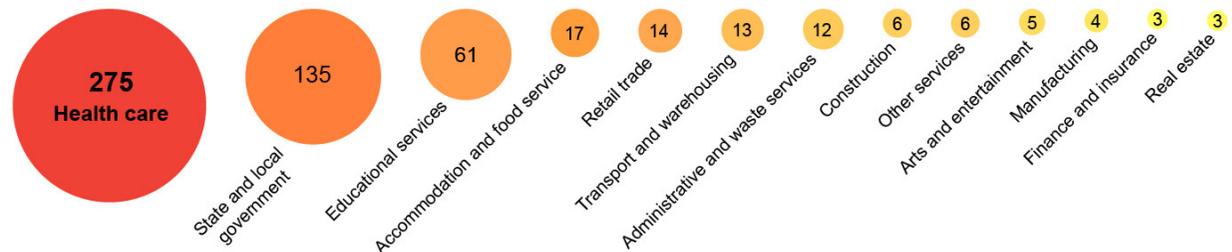
Aggressors



Victims



Where



Data: Accepted disabling workers compensation claims, acceptance year 2014. Source: Central Services Division, Oregon Department of Consumer and Business Services, July 2015.

Are there violence prevention requirements for Oregon health care providers?

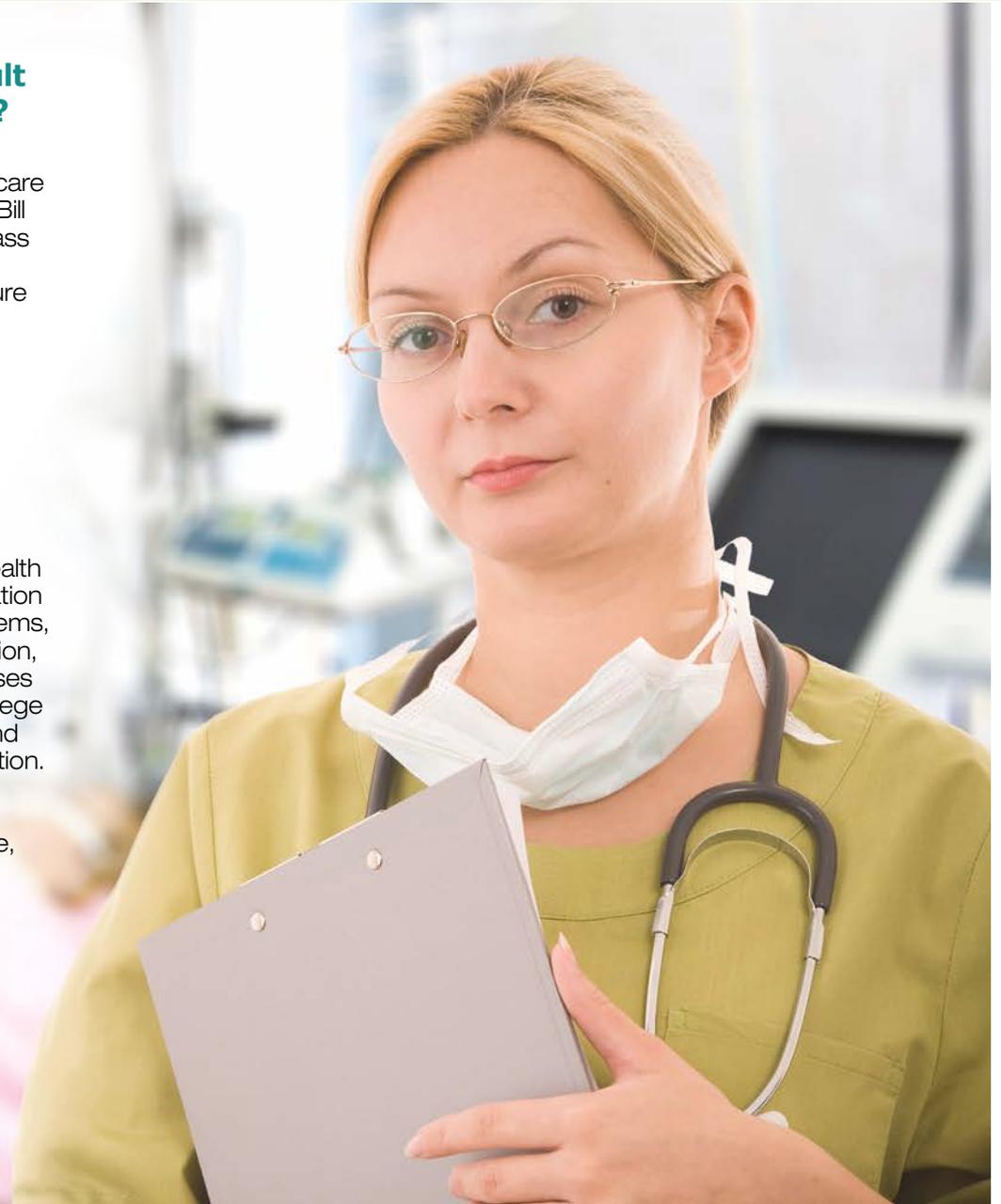
The [Oregon Safe Employment Act \[ORS 654.412 - ORS 654.423\]](#) requires hospitals and *ambulatory surgical centers* to conduct periodic safety assessments to identify violence-related hazards, develop a violence prevention program based on the assessments, and provide regular assault prevention and protection training to employees.

Hospitals and *ambulatory surgical centers* must also keep an ongoing health care assault log of all assaults against their employees. Each record must be maintained for at least five years after the assault was reported. Oregon OSHA has an [online health care assault log](#) that employers can use to record assaults.

Oregon OSHA can cite employers who do not protect their employees from workplace violence under the provisions in the Oregon Safe Employment Act. Inspections may be conducted in response to complaints, from referrals by other agencies, and when there is a violence-related fatality or an overnight hospitalization.

Is it a felony to assault a health care worker?

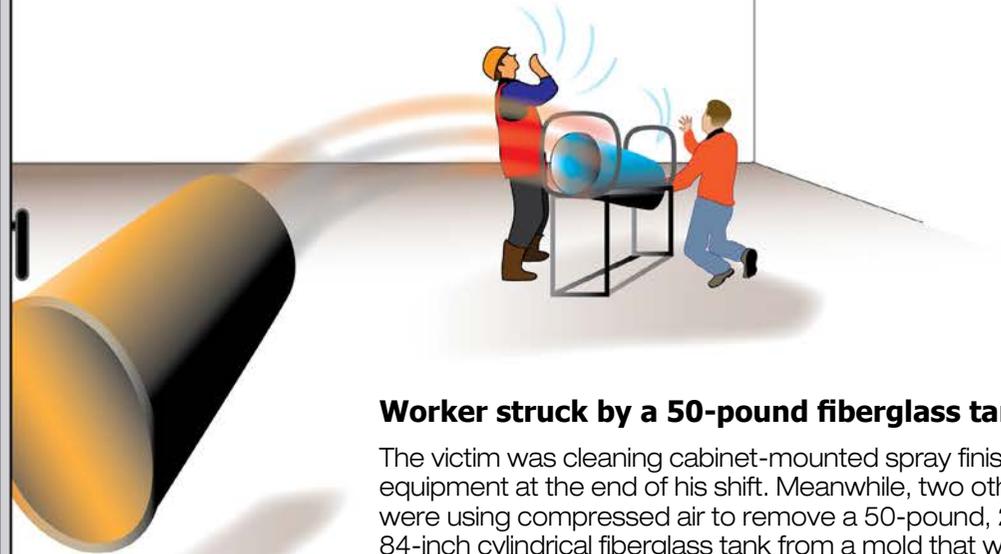
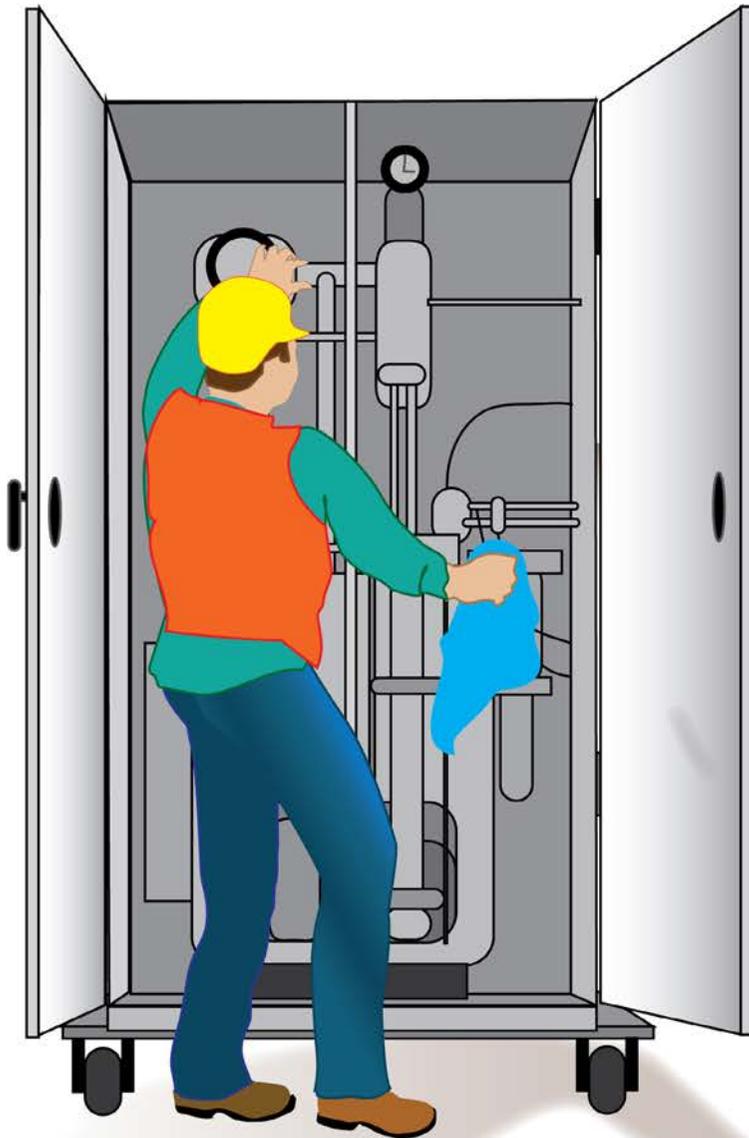
Introduced in January with broad support of the health care community, Oregon Senate Bill 132 would have made it a class C felony to assault a hospital worker. However, the measure was stalled in the Senate Judiciary Committee when the legislature adjourned July 6. Senate Bill 132 was endorsed by a number of health care organizations, including Legacy Health, Oregon Health and Science University, PeaceHealth, Salem Health, St. Charles Health System, the Oregon Association of Hospitals and Health Systems, the Oregon Nurses Association, the Oregon Emergency Nurses Association, the Oregon College of Emergency Physicians, and the Oregon Medical Association. The Service Employees International Union and the American Federation of State, County and Municipal Employees also supported the measure. ■



Incident | Struck by

Business | Fiberglass and composite products manufacturer

Employee | Production worker



Worker struck by a 50-pound fiberglass tank

The victim was cleaning cabinet-mounted spray finishing equipment at the end of his shift. Meanwhile, two other workers were using compressed air to remove a 50-pound, 24-inch by 84-inch cylindrical fiberglass tank from a mold that was inside the tank. They had inserted a compressed air nozzle into a tube that was attached to the mold and were pressurizing the space between the tank and the mold so the tank would be easier to remove.

But the job was difficult and, after two attempts, the tank still stuck to the mold. On the third attempt, however, the tank suddenly rocketed away from the mold, flew 16 to 30 feet in the air, and struck an open door on the equipment that the victim was cleaning. The impact smashed the door into the worker.

His co-workers called 911 and he was taken to a hospital in Portland where he remained overnight with a fractured ankle and a lacerated leg.

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SAFETY NOTES

Findings

- The mold was designed for a 24-inch by 60-inch tank, not a 24-inch by 84-inch tank. To create a 24-inch by 84-inch tank, workers applied fiberglass around the 24-inch by 60-inch mold. Then, after the fiberglass cured, they slid the mold forward 24 inches and added a top section to the tank. However, that created six cubic feet of empty space between the end of the tank and the end of the mold. The empty space would create a potent source of potential energy for compressed air.
- The workers had no idea how much compressed air to use to safely remove the tank from the mold. The tube they used to pressurize the space between the mold and the tank was not securely attached. There was no way to safely relieve pressure between the tank and the mold, and there was no way to determine the pressure level.
- There was no consistency in the way workers were trained to prepare the mold, use compressed air, and position the mold. Also, there was no standard for “waxing” the molds – a term for adding a layer of mold-release wax on the outside surface of the mold. Some workers waxed molds after they had created four or five tanks, other waxed molds after every tank.
- Management knew when the accident happened and was aware of Oregon OSHA’s reporting requirement, but did not report it within 24 hours.



Applicable standards

- 437-001-0760(1)(b)(C):** The employer did not take all reasonable means to ensure that employees safely accomplished their work when they were exposed to a hazard.
- 437-002-0210(2)(c):** All compressed air or gas piping systems that used plastic pipe were not designed by a competent person to specifications for a specific application.
- 437-001-0760(1)(a):** The employer did not ensure that workers were properly instructed and supervised in the safe operation of machinery, tools, equipment, processes, or practices.
- 437-001-0700(21)(c):** The employer did not report an overnight hospitalization to the nearest Oregon OSHA field office within 24 hours after occurrence or employer knowledge of the accident.



Left: A 24-inch by 60-inch tank on a 24-inch by 60-inch mold; there were no 24-inch by 84-inch tanks on site at time of inspection.

Center: The tube and nozzle used to pump compressed air between the mold and the tank.

Right: The spray finishing cabinet that the victim was cleaning. Note the missing cabinet door and the damaged hinges.



Portland-area OSHA office moves to Tigard location

The Oregon OSHA Portland area office has relocated to a new location in Tigard:

Durham Plaza

16760 SW Upper Boones Ferry Road, Suite 200

Tigard, Oregon 97224

Workplace safety and health materials, such as guides and posters, will still be available to employers at the new location or they can visit www.osha.org to get materials online.

Oregon OSHA convenes stakeholder group to review fall protection standard

Following a determination by federal OSHA that Oregon OSHA's fall protection standard and use of slide guards is not "at least as effective as the federal standard," Oregon OSHA will be working with a stakeholder group to address pending policy changes. The first in a series of meetings is planned for 11 a.m. Tuesday, Aug. 4, at the Associated General Contractors boardroom in Wilsonville. The discussion will cover the implementation, challenges, and fiscal impact of a revised fall protection standard.

Federal OSHA identified several state plans, including Oregon, as having a fall protection rule that did not meet its requirement. Currently, Oregon OSHA's fall protection rule in the construction standard has a trigger height at 10 feet, while the federal standard is at six feet. Additionally, Oregon has a

unique provision that recognizes slide guards as a fall protection system.

Many commercial construction employers have already implemented a six-foot trigger height for fall protection and do not use slide guards as a fall protection system. However, residential construction employers may see more of a significant impact.

For more information on attending stakeholder meetings on the topic, please contact Oregon OSHA's Jeff Wilson at jeffrey.r.wilson@oregon.gov or 503-947-7421 or Tom Bozicevic at tom.bozicevic@oregon.gov or 503-947-7431.



Workplace safety training grants available

Oregon OSHA is accepting applications for the development of innovative workplace safety and health training programs. Unique projects such as mobile apps, videos, or online educational games to engage workers are encouraged.

The training grants will focus on programs that target a high-hazard Oregon industry (construction, agriculture, young workers, etc.) or a specific work process to reduce or eliminate hazards. Any labor consortium, employer consortium, association, educational institution affiliated with a labor group, or other nonprofit organization may apply. Applicants may apply for up to \$40,000 per grant project without a requirement for any matching dollars or in-kind contributions. Grant applications are due **Oct. 9, 2015**.

Some examples of past grant projects include:

- A bilingual training program for hazard identification
- A video on Christmas tree harvest safety
- An online training program to help workers comply with electrical standards
- An educational program for prevention of ergonomic-related injuries for nurses

The Oregon State Legislature established the grant program in 1990. Employers cannot use the program to fund training projects for their employees.

Materials produced by grant recipients become the property of Oregon OSHA. They are housed in the Oregon OSHA Resource Center and are available to the public for checkout from the library. Some programs are also available online.

Grant application information is available at <http://www.orosha.org/grant-programs.html>. Contact Teri Watson at 503-947-7406 or teri.a.watson@oregon.gov for more information.



Southern Oregon company joins SHARP

Oregon OSHA welcomes Roseburg's Forest Products Dillard Lumber plant to the Safety and Health Achievement Recognition Program (SHARP). SHARP provides Oregon employers with coaching and direction to learn to more effectively manage workplace safety and health and,

in turn, be recognized for their achievement. The company held an award ceremony at its plant in July.

To learn more about how to get involved with SHARP, go to <http://www.orosha.org/subjects/sharp.html>.

Left to right: Safety supervisor Ron Richardson, safety committee chairman Ben Austin, and plant manager Jeff Thompson.

Public hearings scheduled for changes to electric power generation transmission and distribution standard for general industry and construction



Oregon OSHA is seeking public comment on a new proposal to replace the federal general industry and construction rules on electric power generation transmission and distribution with Oregon-initiated rules that cover both industries.

After receiving many written comments and testimony at three public hearings in November and

December 2014, Oregon OSHA did not adopt the previous rule as proposed. Instead, opting to take an alternate approach by merging the Electric Power Generation, Transmission, and Distribution standards in Subdivisions 2/R and 3/V into a new Division 2/RR.

Public hearings on the combined rule change are scheduled for:

Thursday, Aug. 27, 10 a.m.

Durham Plaza
16760 SW Upper Boones Ferry Road, Suite 200
Tigard

Thursday, Sept. 3, 2015, 10 a.m.

City of Medford
Lausmann Annex
200 S Ivy
Medford

Tuesday, Sept. 8, 1:30 p.m.

Oregon OSHA
Red Oaks Square
1230 NE Third St., Suite A-115
Bend

To review the rule changes, go to www.orosha.org/pdf/notices/proposed2015/ltrn-div-2-3-elec-pwr-gen-div-2RR.pdf.

GOING THE DISTANCE



Company: HumanFit, LLC

Ergonomist/Human Factors Consultant:

Lynda Enos, RN, MS, COHN-S, CPE

Common Hazards: Musculoskeletal injuries (sprains, strains) primarily from manual patient lifting and moving and slips, trips, and falls; workplace violence (including violence from patients, visitors, and co-workers); bloodborne pathogens; exposure to infectious diseases and chemical hazards; and psychosocial hazards (shift work, long hours, and overtime).

What is your background and how did it bring you into the work you do today?

I started my career as a registered nurse and then a nurse midwife in the United Kingdom. After immigrating to the U.S. with my husband in the 1980s, I worked as an occupational health nurse at an aerospace manufacturing company in Texas. It was in that work environment that I became interested in prevention of worker injuries and, specifically, how to design work processes and products to reduce acute and cumulative work-related musculoskeletal disorders.

GOING THE DISTANCE



I completed my undergraduate degree in nursing and certified as an occupational health nurse, but decided that completing a graduate degree in ergonomics and certifying as a professional ergonomist would give me the additional knowledge I needed.

During the past 23 years, I have provided comprehensive ergonomics consulting services to more than 250 companies, including health care, manufacturing, semiconductor, wood products, and service sector facilities nationwide.

In 2001, while working with Auburn Engineers, I was asked to research and co-author the federal OSHA “Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders.” As I worked on this project, I realized that ergonomics and prevention of worker injuries, specifically musculoskeletal disorders in health care, was not being addressed as well as it was in manufacturing and other industries at that time.

As a nurse who had suffered a serious back injury from manually lifting and moving patients early in my career, I returned to work in the health care environment with

the goal of designing work systems to prevent similar injuries occurring to nurses and other health care workers.

The past 14 years, I have worked with many health care organizations, including acting as a consultant and ergonomist for Oregon Nurses Association. I had the unique opportunity to provide safe patient handling, ergonomics, and safety consulting services to 25 hospitals in Oregon for up to five years per facility.

Currently, I am working with several health care facilities in the Northwest, including Oregon Health and Science University (OHSU), where I am assisting to implement a housewide comprehensive safe patient handling (SPH) program.

I have been actively involved as a volunteer in several professional organizations, including the American Nurses Association (ANA) as a contributor for the ANA Safe Patient Handling and Mobility Standards that were released in June 2013 and as co-chair of the Oregon Coalition for Health Care Ergonomics (OCHE) since 2003. In 2014, I had the honor of receiving the Ergonomics Professional of the Year Award from the Puget Sound Human Factors and Ergonomics society.

Enos, demonstrates lifting equipment. She suffered a serious back injury from lifting a patient when she was a young nurse.

GOING THE DISTANCE

What do you see as some of the challenges in health care given that there is no OSHA standard for ergonomics?

Successful ergonomics and safe patient handling programs are multifaceted; thus, health care organizations have to be committed to providing ongoing financial and personnel resources for the purchase of patient lift equipment and education of staff. I believe ongoing support has to be provided that facilitates the necessary change in culture or behavior from a manual handling to safe patient handling work environment.



Above: Enos demonstrates how to lift a patient off the floor with an air assist device.

Right: Enos works with OHSU on the hospital's safe patient handling program. Nursing assistant Annie Mae Jensen is lifted in the sling with critical care nurse Matt Huff observing.

Without ergonomics regulation to help direct and prioritize implementation of worker safety initiatives, programs such as safe patient handling have to demonstrate a direct contribution to the achievement of the health care organizations' business objectives, mission, and patient and staff satisfaction, if they are to compete for budget and staffing resources.

Hospital and health care settings have a variety of overlapping government regulations. How do you keep an employer focused on worker safety?

Repeatedly demonstrating to employers that prevention of worker injuries benefits their organizations' business goals and mission is critical, so that worker safety programs are consistently treated as a priority, as much as patient safety initiatives.

The education of health care executives and senior management about the true cost of worker injuries such as workers' compensation, staff replacement costs, and negative impact on patient care and safety, is essential.



Executive rounding and manager and staff "huddles" are increasingly being used as a tool to improve patient safety efforts in health care organizations. Incorporating discussion about worker safety issues, such as patient lifting and mobility, into these activities can help to engage employers and workers in safety efforts and enhance a culture of safety.

Similarly, incorporating key questions related to worker safety as part of "Environment of Care" rounds, which are conducted as part of a health care organization's accreditation requirement, can help an organization focus on a proactive approach to patient and worker safety. It is estimated that at least 50 percent of worker-related injuries and incidents go unreported in health care.

GOING THE DISTANCE



Huff removes the lifting sling from Jensen.

“ When a nurse, aide, or tech says to me that they don't feel as tired at the end of their shift because they used the lift equipment to move patients, I know that their risk of disabling injury and likelihood of making a mistake during patient care due to fatigue is reduced.” ~ Lynda Enos

How do you stay motivated to continue this type of work?

There are many things that keep me motivated, including the positive feedback I receive or hear from health care workers related to the impact of safe patient handling and ergonomics programs. When a nurse, aide, or tech says to me that they don't feel as tired at the end of their shift because they used the lift equipment to move patients, I know that their risk of disabling injury and likelihood of making a mistake during patient care due to fatigue is reduced.

I am also encouraged by the recent focus by regulatory bodies (Centers for Medicare and Medicaid Services and the Joint Commission) to explore and communicate the relationship and importance of health care worker safety to the delivery of safe patient care.

In addition, increasing media attention has helped communicate the seriousness of injuries related to manual patient handling and movement to a broader audience. This has influenced federal OSHA to increase its enforcement efforts of worker safety programs in hospitals, with a focus on safe patient handling efforts.

Therefore, educating health care workers about the importance of early reporting of occupational injuries and how to bring safety concerns to their supervisor and the organization's safety and health committee is critical. This allows employers to be more accurately informed about the scope of safety issues at their facility.

GOING THE DISTANCE

What advice do you have for others in health care hoping to make a difference?

Don't reinvent the wheel. Safety and health challenges are similar across health care environments and there are many resources and tools already developed that can be freely shared such as those on the Oregon Coalition for Health Care Ergonomics website.

I encourage people to network and share information with other like-minded professionals. Organizations, such as the American Society for Safety Professionals (ASSE), have an active and dynamic Healthcare Practice Specialty group, as do the Northwest chapter of the Association of Occupational Professional in Health Care (AOHP). Contact me directly if you are interested in joining the OCHE network in Oregon.

Know your numbers. Make sure that administrators, managers, and staff understand the full cost of worker injuries (beyond workers' compensation costs) and all the evidence-based benefits of safe patient handling, ergonomics, and other safety programs.

Be persistent and patient in your efforts. Developing a true culture of safety in health care that integrates worker and patient safety with equal importance and changing everyday work practices takes a team effort and time. ■





Central Oregon Occupational Safety & Health Conference

September 29 & 30, 2015 • Bend
Riverhouse Convention Center

The event features topics for general industry and emergency services, brewery, and recreation safety.

Register online! www.regonline.com/central_oregon15



Southern Oregon Occupational Safety & Health Conference

October 13-15, 2015 • Ashland
Ashland Hills Hotel & Suites

Join us for training designed for all industries!

Learn more at www.orosha.org/conferences or www.asse-southernoregon.org