The Association of Safe Patient Handling Professionals, Inc. (ASPHP) is a member-driven, non-profit organization whose mission is: "To improve the safety of caregivers and their patients by advancing the science and practice of safe patient handling". Led by a Board consisting of leaders in the field of patient care ergonomics (safe patient handling), the ASPHP aspires to build a recognized and credentialed profession through providing education and sharing of current information and best practices.

Association of Safe Patient Handling Professionals, Inc.
Position Statement
Restoring MSD Column to OSHA 300 Log

The Board of the Association of Safe Patient Handling Professionals (ASPHP) supports the restoration of the musculoskeletal disorder (MSD) column on the OSHA 300 log and supports efforts by the Occupational Safety and Health Administration (OSHA) to include this column on future OSHA 300 logs. We are fully in support of the position statement (attached) presented by the American Industrial Hygiene Association (AIHA) and concur with their justifications for restoring the column.

Healthcare, the employment sector we represent and service, is particularly affected by the occurrence of these disorders as the majority of patient handling injuries are musculoskeletal ones. In 2007, Registered Nurses (RNs) were 7th among all occupations for number of reported cases, with 8,580 'days away' work-related musculoskeletal disorders (WMSD) cases. Other healthcare sectors (licensed practical nurses, physical therapists, radiology technicians, etc.) were ranked 2nd, with 24,340 WMSD cases. WMSD typically are the highest cost and one of the highest frequency workers' compensation loss producing sources in healthcare facilities. Additionally, workplace conditions that cause patient handling related WMSD cases often lead to reduced quality of care, including injury to patients. These are also preventable losses.

With no mechanism to officially track such injuries, these injuries are 'lost'. With inclusion of a WMSD column, organizations will have visible data to direct necessary control measures, and OSHA will be provided data to direct resources and attention, if necessary. Effective safe patient handling (SPH) programs with access to such injury data will support institution of ergonomic interventions to reduce risk of injury and organizational losses, and improve the quality of patient care. We strongly support restoration of the MSD column to the OSHA 300 log.

Reference:

BLS, “Lost-Worktime Injuries and Illnesses: Characteristics and Resulting Time Away From Work, 2007.”

Approved:

Board of Directors
Association of Safe Patient Handling Professionals, Inc.
June 10, 2011

American Industrial Hygiene Association

Position Statement

Restoring MSD Column to OSHA 300 Log

The American Industrial Hygiene Association (AIHA) believes there is a need to restore the musculoskeletal disorder (MSD) column on the OSHA 300 log and supports efforts by the Occupational Safety and Health Administration (OSHA) to include this column on future OSHA 300 logs.

Although the OSHA 300 log has not included a column for recording musculoskeletal injuries since 2001, many companies and organizations are tracking MSDs because "what is not measured is not managed". Work-related MSDs result in tremendous cost both financially and in the context of human pain and loss of functionality. Insurance companies routinely classify strains/sprains, over-exertion and cumulative trauma in their Loss Control/Risk Management reports in order to address these costs.

One difficulty in relying totally upon insurance company reports for tracking of these disorders is the lack of consistency of this data. There are differences from state to state in how workers' compensation bureaus define and compensate for MSDs. There are also vast differences in how insurance companies compile, analyze and provide this data to the companies they insure.

Reinstating the MSD column on the OSHA 300 log would make it easier to track this type of injury, especially for companies who have computerized logs (as many do). Inclusion of the MSD column on the OSHA 300 log also relieves companies and organizations from the burden of establishing their own system to track MSDs. Obtaining accurate measurement of real world statistics on matters that impact the health and economics of the country is a proper role of government, specifically OSHA.

The guidance provided by OSHA is sufficient for individuals to discern, in most cases, whether or not to include an individual MSD occurrence on the OSHA 300 log. The OSHA 300 log is designed to identify not only the rate of the illness or injury but also the job or industry section in which it occurs. This information is extremely important, particularly in tight fiscal times, to ensure that shrinking resources are spent in the most cost-effective way. Without this statistic it is much more difficult to correctly target areas where intervention will make the most difference.

Many companies have successfully reduced the incidence of MSDs and the costs associated with them. The science exists to design interventions that will minimize the development of MSDs in the workplace. Some of these designs do cost money, but this cost must always be weighed against the cost of doing nothing. The cost of MSDs must be calculated by including medical, absentee, hiring and training and productivity costs associated with these disorders. This does not include the personal costs to the worker.

Some may argue that MSDs should not be included on the OSHA 300 log because their etiology includes many different factors, some of which are non-occupational. The OSHA 300 log already includes columns for respiratory disease and skin disease. The etiology of both respiratory and skin disorders includes many factors, some of which are non-occupational. In addition, the respiratory and skin disorder categories are very broad and associated with a variety of exposures.

Both respiratory and skin diseases include a multitude of illnesses. For example, respiratory disease may include cancer, chronic obstructive pulmonary disease, and pneumoconiosis, among others, regardless of the cause. Similar arguments apply to skin diseases. The inclusion, therefore, of a MSD column on the OSHA 300 log conforms to the approach exemplified by the current log in dealing with other disorders.

One role that industrial hygienists, ergonomists, and other safety and health professionals play is to help evaluate and control ergonomic risk in the workplace. They help to determine the presence and severity of ergonomic risk, validating (or not) the presence of the causal linkage between workplace factors and worker disorders. When ergonomic risk is identified and quantified it can more readily be controlled. Restoring the MSD column to the OSHA 300 log would provide another mechanism for consistently determining and documenting the presence and severity of ergonomic risk.

References

Hidden Tragedy: Underreporting of Workplace Injuries and Illnesses, A Majority Staff Report by the Committee on Education and Labor, U.S. House of Representatives, June 2008, http://edlabor.house.gov/publications/20080619WorkplaceInjuriesReport.pdf

Ruser, John W., “Examining Evidence on Whether BLS Undercounts Workplace Injuries and Illnesses,” *Monthly Labor Review,* U.S. Department of Labor, BLS, August 2008, http://www.bls.gov/opub/mlr/2008/08/art2full.pdf

Bradstreet, Theodore E. and Steven P. Laundrie, *Characteristics of Workplace Injuries and Illnesses in Maine 2004*, Maine Department of Labor Standards, BLS 733, November 2005,
http://www.maine.gov/labor/labor_stats/publications/charwork/char04.pdf

Approved by AIHA Board of Directors
March 5, 2010