

TABLE OF CONTENTS

	Tab
Agenda	ii
Objectives	iii
Follow-up Activities	iv
Action Plan	v
Resource	vi
Introduction	1- 1
Safety	2 - 1
Ergonomics	3 - 1
Safety Management Strategies	4 - 1
OSHA Resources	5 - 1
One Hour Presentation	6 – 1

AGENDA

8:30	Introduction Safety Issues Combative Residents
11:45	LUNCH
12:45	AM Review
12:50	Ergonomics Issues <ul style="list-style-type: none">• OSHA Guidelines• Control Measures (Engineering & Administrative)• Contributing Factors• Assistive Equipment Safety Management Strategies
4:30	DISMISS

Objectives

You will learn:

- Elements of an effective safety and health process in extended care facilities, focusing on management support, employee involvement, communication, and training;
- Strategies and tools for developing your organization's safety and ergonomics management systems and reducing workplace accidents;
- OSHA compliance issues for extended care facilities and resources for ensuring effective implementation;
- Tools and techniques for implementing ergonomic control measures to reduce strain and sprain injuries;
- Resources for on-going assistance and support.

This course is approved by BENHA for 6 hours of credit. Your certificate will contain the approval number.

Safety & Ergonomics for Extended-care Facilities

Suggested follow-up activities

- As a refresher, review the facilities' combative resident policy with staff.
- Review the one hour presentation with safety committee members and then have safety committee present the information at an all staff in-service meeting.
- Perform a safety & ergonomic assessment of your facility.
- Form a staff team representing both labor and management to address safety & ergonomic issues.
- Communicate with staff about safety & ergonomic problems & solutions.
- Train staff on patient handling equipment.
- Implement a simple method for communicating resident needs/requirements to staff (i.e., colored magnets or stickers related to assistance needed by residents).
- Create/update programs on Bloodborne Pathogens, Hazard Communication, Lockout/Tagout, Personal Protective Equipment, Emergency Preparedness, and Combative Residents.
- Reduce the risk factors associated with combative residents.
- Reduce the factors contributing to overexertion.
- Read the guidelines for nursing homes (OSHA 3182) and/or guidelines for preventing workplace violence (OSHA 3148) and implement improvements in your workplace.
- Assess the features of your assistive equipment and, if appropriate, make recommendations to management for improvements.
- Review equipment and procedures in housekeeping, dietary, laundry and storage areas for possible improvements.
- Work with top management to create a plan for improving the safety of your staff.
- Register for an OCOSH class that was referred to during class discussions.
- Contact the local BWC service office and request technical assistance with safety and health, employer services or claims management.

Action Plan

	Task	Other people involved	Target Deadline
<input type="checkbox"/>			

INTERNET WEB SITES
for
OCCUPATIONAL SAFETY & HEALTH INFORMATION
September 2007

The Ohio Bureau of Workers' Compensation provides a variety of safety tools and resources on our web site, www.ohiobwc.com. Click on Safety Services to find out more about what BWC's Division of Safety & Hygiene offers online. Tools and resources include lifting guidelines, recordkeeping spreadsheets, sample OSHA program guides, and training materials. You'll also find a longer version of this list of web sites.

GENERAL

CANADIAN CENTRE FOR OCCUPATIONAL HEALTH & SAFETY (CCOHS)

<http://ccohs.ca>

This Canadian government site has an extensive Internet directory. There is also a unique feature called "OSH Answers" and a guide to safety-related acronyms.

NATIONAL SAFETY COUNCIL (NSC)

<http://www.nsc.org>

Visit this web site for information on safety in the workplace, at home, on the road and in the community.

NYCOSH

<http://www.nycosh.org>

The New York Committee for Occupational Safety & Health offers news releases, links to helpful safety resources, strategies for safer workplaces, information on workplace hazards, workers' compensation and much more.

OCCUPATIONAL HAZARDS

<http://www.occupationalhazards.com>

The online version of the magazine *Occupational Hazards* is filled with today's headlines, articles, white papers, case studies, and product news.

OKLAHOMA STATE UNIVERSITY

<http://www.pp.okstate.edu/ehs>

The Department of Environmental Health & Safety at OSU has an online safety resource library with topics from A-Z. Go to the "Links Library" option.

OREGON HEALTH & SCIENCE UNIVERSITY

<http://www.croetweb.com>

This site consists of information on occupations & industries, chemical hazards, workplace safety issues, ergonomic issues, biological hazards, and includes materials in Spanish.

VERMONT SIRI

<http://hazard.com>

Contains a wide variety of resources: MSDSs, an online library of graphics, articles and PowerPoint presentations, e-mail discussion list archives, and a list of safety & health consultants.

FEDERAL GOVERNMENT**AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**

<http://www.atsdr.cdc.gov/>

Look for information on hazardous substances, emergency response and hazardous waste sites.

BUREAU OF LABOR STATISTICS, SAFETY & HEALTH

<http://www.bls.gov/bls/safety.htm>

Find national statistics on work-related injuries and illnesses and fatalities.

CENTERS FOR DISEASE CONTROL & PREVENTION (CDC)

<http://www.cdc.gov>

A good resource for general public health issues throughout the United States. Health topics from A-Z give an in-depth look at most communicable diseases as well as topics such as safe driving, violence, and air pollution.

ENVIRONMENTAL PROTECTION AGENCY (EPA)

<http://www.epa.gov>

The EPA's web site provides a wealth of information on a wide range of topics. Of particular interest: resources on lead, asbestos, indoor air quality, mold, and school environmental issues.

FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA)

<http://www.fema.gov>

For information on disasters and emergencies nationwide, access this web site. Publications include options for emergency preparedness and prevention, response and recovery, disaster fact sheets, and public awareness information.

MINE SAFETY AND HEALTH ADMINISTRATION

<http://www.msha.gov>

Features information on mine safety and health, including noise, dust, statistics, safety hazard alerts and talks, training, regulations, and rescue.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY & HEALTH (NIOSH)

<http://www.cdc.gov/niosh/homepage.html>

NIOSH's site describes their services and research activities and provides information on many workplace safety and health topics. Most of their publications are available online.

NATIONAL LIBRARY OF MEDICINE (NLM)

<http://www.nlm.nih.gov>

The world's largest medical library: a reliable source for medical, health and chemical hazard information.

OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION (OSHA)

<http://www.osha.gov>

OSHA'S web site includes compliance assistance resources, online publications, statistics, OSHA standards & directives, and a very useful A-Z site index.

OHIO**OHIO DEPT. OF HEALTH**

<http://www.odh.state.oh.us>

Provides a wide variety of public health information, including occupational and environmental health, women's health, and health resources.

OHIO EPA (OEPA)

<http://www.epa.state.oh.us>

Use the "Topic Index" to find Ohio EPA regulations and information on permits, hazardous waste, pollution prevention, wastewater, wetlands, and much more.

STATE LIBRARY OF OHIO/OHIOLINK

<http://slonet.state.oh.us/>

Search the State Library of Ohio's online catalog which includes BWC's Division of Safety & Hygiene library books.

SPECIFIC (BY SUBJECT)**CONSTRUCTION**

<http://www.cdc.gov/elcosh/index.html>

eLCOSH is a comprehensive library of construction safety information presented in both English and Spanish with items searchable by trade, hazard, job site, etc.

DRUG-FREE WORKPLACE

<http://www.dol.gov/workingpartners/welcome.html>

Working Partners for an Alcohol- and Drug-Free Workplace. Provides guidelines on establishing a workplace substance abuse program. Search the Substance Abuse Information Database. From the U.S. Dept. of Labor.

EMERGENCY MANAGEMENT GUIDE FOR BUSINESS & INDUSTRY

<http://www.fema.gov/business/guide/index.shtm>

Presents a step-by-step approach to emergency planning, response, and recovery for companies of all sizes. From the Federal Emergency Management Agency.

ERGONOMICS

<http://www.ergoweb.com>

Ergoweb's site offers ergonomics news, a buyer's guide and case studies, in addition to sources for software and services.

HAZARDOUS MATERIALS AND HAZARDOUS WASTE

<http://tools.niehs.nih.gov/wetp>

The National Clearinghouse for Worker Safety and Health Training is a resource for workers and trainers who are involved in the handling of hazardous waste or in responding to emergency releases of hazardous materials and terrorist actions.

INDOOR AIR QUALITY

<http://sis.nlm.nih.gov/enviro/indoorairpollution.html>

Compiled by the National Library of Medicine, this web page provides information on a variety of indoor air topics as well as glossaries, database searches and web pages in Spanish.

MSDS

<http://www.ilpi.com/msds>

Touted as "Where to find material safety data sheets on the Internet", this site offers links to 100 free sites as well as news, FAQs, and an MSDS glossary.

SAFETY MANUALS & SAMPLE WRITTEN PROGRAMS

OSHA

http://www.osha.gov/dcsp/compliance_assistance/sampleprograms.html

OSHA provides sample written programs for employers to use as guidance when developing their own customized programs tailored to their specific workplaces.

ILLINOIS ONSITE SAFETY & HEALTH CONSULTATION PROGRAM

<http://www2.illinoisbiz.biz/osha/resource.htm>

At this site you will find sample written programs on a variety of topics. Also available are checklists and safety guide books, some in Spanish.

SAFETYNET

<http://medical.smis.doi.gov/prog.htm>

Sponsored by the U.S. Department of the Interior, you will find sample written safety programs to use as templates. Health hazard information and medical reference material is also available.

Ohio Bureau of Workers' Compensation, Div. of Safety & Hygiene Libraries

(800) 644-6292, press options 2 – 2 - 1

(614) 466-7388 (614) 644-9634 (fax)

E-Mail: library@bwc.state.oh.us

www.ohiobwc.com

Resources Available from the Division of Safety & Hygiene (DSH) Libraries

(800) 644-6292 (614) 466-7388

library@bwc.state.oh.us

www.ohiobwc.com

Safety training:

- Safety talks, outlines and scripts - DSH Safety leader's discussion guide, Training Center's One-hour safety presentations, reference books, web resources
- Videos – hundreds of safety and health topics
- Books and articles on training techniques

Machine and equipment safety:

- Safety standards (ANSI, NFPA, CGA)
- Books and articles on power presses, material handling equipment, lockout/tagout, etc.

Sample written programs:

- DSH program profiles and sample written programs
- Reference books
- Internet resources

Illness and injury statistics:

- Statistics from the U.S. Bureau of Labor Statistics
- National Safety Council's *Injury Facts*
- National Institute of Occupational Safety & Health (NIOSH) studies

Hazard communication and chemical safety:

- Chemical safety information
- Material safety data sheets (MSDSs)
- Sample written programs
- Videos
- Internet resources

Safety standards

- American National Standards Institute (ANSI) standards (including standards for construction, machinery and equipment, personal protective equipment)
- National Fire Protection Association (NFPA) fire codes (including the Life Safety Code and the National Electrical Code)
- Compressed Gas Association (CGA) standards

Other topics of interest (books, articles, magazines, videos and standards):

- Confined spaces
- Electrical safety
- Job safety analysis
- New employee orientation
- Powered industrial trucks
- Respiratory protection
- Safety culture
- Scaffolds

Directories and lists of vendors of safety equipment

Occupational Safety & Health Administration (OSHA) regulations

Manual of Uniform Traffic Control Devices (MUTCD)

Recommendations of useful Internet sites

BWC publications

Saving You Time and Research

Requests for copies of OSHA standards, information on starting a safety committee, a video on accident investigation techniques -- these are some of the thousands of inquiries BWC's Division of Safety & Hygiene (DSH) libraries receive each year.

DSH has two libraries to serve you:

- The central library in the William Green Building in downtown Columbus;
- The resource center and video library located at the Ohio Center for Occupational Safety and Health (OCOSH) in Pickerington.

Both libraries are open 8 a.m. to 4:45 p.m., Monday through Friday. Your need for information does not require a visit to the library. You can phone, fax, or e-mail your requests and receive a quick response.

The central library provides free information services on the topics of occupational safety and health, workers' compensation and rehabilitation.

The OCOSH resource center provides similar services for those who visit OCOSH for meetings and training center classes.

The video library offers an extensive collection of videotapes to supplement your organization's safety and health training program. It is a convenient and popular source for Ohio employers to borrow quality occupational safety- and health-related training aids.

Visit our Web site at **www.ohiobwc.com**.

Central Library
30 W. Spring St., Third Floor
Columbus OH 43215-2256
1-800-OHIOBWC
(614) 466-7388
(614) 644-9634 (fax)
library@bwc.state.oh.us

OCOSH Resource Center
13430 Yarmouth Drive
Pickerington OH 43147
1-800-OHIOBWC
Resource center (614) 728-6464
Video library (614) 644-0018

Safety and Ergonomics for Extended Care Facilities



Course Development Team

- Mike Riennerth, Ergonomics Consultant, BWC
- Mike Donohue, Safety Consultant, BWC
- Greg Nartker, Ergonomics Consultant, BWC
- George Kunz, Safety Consultant, BWC
- Rick Hughes, Manager of Occupational Safety & Health, Ohio Masonic Homes
- Mel Tobias, Safety Compliance Manager, Sprenger Retirement Centers
- Marty Grant, Curriculum Designer, BWC

BWC - Safety & Hygiene Services

- Consultative services to assist with safety, ergonomics, and occupational health issues
- Already paid for through WC premiums
- Non-regulatory; no enforcement power
- No reporting to enforcement agencies

Definition

“Extended-care facilities” include:

- Nursing homes
- Mental health facilities
- Full-time care facilities
- Long-term care facilities
- Other?

COURSE OBJECTIVES

- Gain a better appreciation for the benefits of an effective safety & health process
- Learn about tools and resources that can be used to enhance safety management systems
- Review common OSHA compliance requirements for extended care facilities

COURSE OBJECTIVES

- Learn about tools and resources that can be used to assist with OSHA compliance
- Review common ergonomic issues and control measures for extended care facilities
- Discuss management strategies that can assist in the implementation of safety and ergonomics improvements

What are your objectives?

- Introduce yourself
 - Name
 - Occupation
 - Facility
- Mention one of your objectives for attending this course



Key Questions

- Who is responsible for safety at your facility?
- Who is accountable for safety performance at your facility?

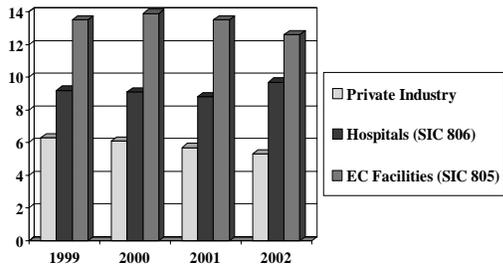
Regulatory Compliance

- Ohio Department of Health (ODH)
 - Resident safety
- Joint Commission for Accreditation of Health Organizations (JCAHO)
 - Resident safety
- Occupational Safety & Health Administration (OSHA)
 - Staff safety

**OSHA 5(a)(1) –
General Duty Clause**

- 1970 OSH Act
- Each employer shall furnish... a workplace free of recognized hazards...

**OSHA Recordable
Injury/Illness Incidence Rates**

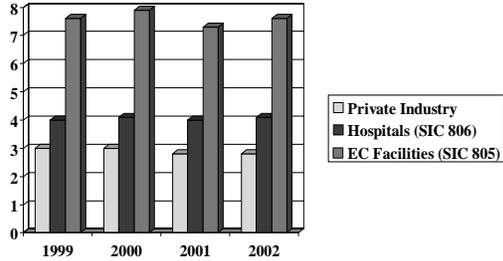


**What is Your Facility's OSHA
Recordable Incidence Rate?**

$$IR = \frac{\# \text{ of OSHA Recordables} \times 200,000}{\# \text{ of exposure hours (hrs. worked)}}$$

The IR represents the number of OSHA recordable injuries/illnesses per 100 full time workers over a given period of time

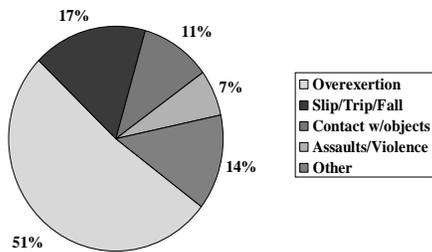
Days Away, Restricted and/or Transferred (DART Rate) (BLS)



Estimate your Experience

Type of injury	Your percentage	Possible Causes
Overexertion		
Slips/Falls		
Contact with		
Struck by		
Caught in/on or between		

Types of Injuries in EC Facilities



Money Matters

What does your facility currently pay?

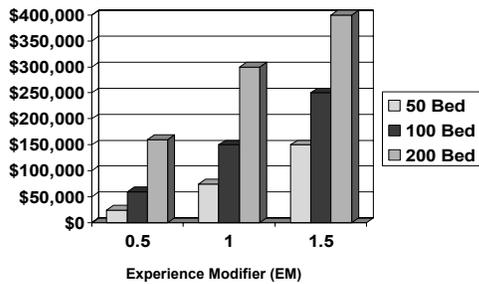
- Workers' compensation coverage
- Healthcare insurance
- Liability insurance
- Property insurance
- Other

What are the Costs of an Ineffective Safety Process?

- The average cost for a medical only injury in Ohio is \$800
- The average cost for a lost-time injury in Ohio is \$44,000 (medical + indemnity + reserves)
- Average workers' comp premiums for a base rated 100-bed facility are about \$160,000/year
- Average workers' comp premiums for a group rated 100-bed facility are about \$80,000/year



Average Annual Workers' Comp Premiums for EC Facilities



Employer Rating Plan History

Payroll period beginning date	Payroll period ending date	Experience rate	Employer rating plan
7/1/2004	12/31/2004	44%	GROUP
7/1/2003	12/31/2003	57%	GROUP
7/1/2002	12/31/2002	82%	EXP
7/1/2001	12/31/2001	110%	EXP
7/1/2000	12/31/2000	127%	EXP
7/1/1999	12/31/1999	143%	EXP
7/1/1998	12/31/1998	172%	EXP
7/1/1997	12/31/1997	220%	EXP

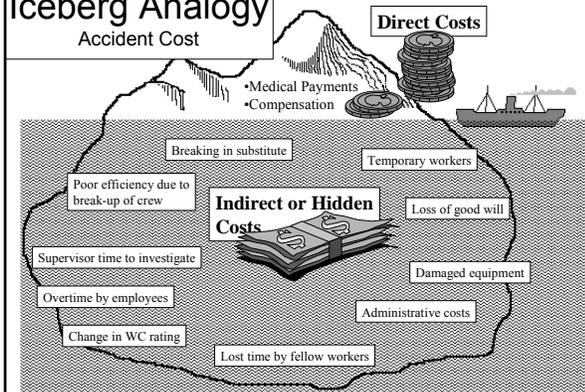
What are Some Other Costs of an Ineffective Safety Process?

- 10 to 20% of people leave the nursing profession due to injury
- Average turnover rate of STNAs in nursing homes is 50-60%
- Average cost to recruit, hire, and train a STNA = \$2,000 - \$ 3,000
- The average cost of OSHA citations for HC facilities is approximately \$10,000 to \$15,000 per inspection



Iceberg Analogy

Accident Cost



What motivates safety activities in your facility?

Safety & Ergonomics Process
The Benefits

- Compliance and hazard prevention
- Reduced injuries and lost time
- Lower worker compensation costs
- Lower absenteeism and turnover
- Better employee relations and morale
- **Better Quality Care!**

Strengths and Weaknesses

- What is one thing that your facility does well to ensure staff safety?
- What is one thing that you feel your facility needs to address to improve staff safety?



Elements of an Effective Safety & Ergonomics Process

- Management Commitment
- Employee Involvement
- Accountability
- Documentation
- Integration
- Communication
- Monitoring/Evaluation
- Flexibility
- Continuous Improvement



**Percentage of Nursing Homes that Filed Claims since 01/01/2004 for
Injury Categories Based on ICD9 Codes**

81.70%	Contusion with intact skin surface
77.45%	Sprains and strains of other and unspecified parts of back
56.37%	Sprains and strains of shoulder and upper arm
55.34%	Open wound of upper limb
50.22%	Sprains and strains of sacroiliac region
45.97%	Sprains and strains of wrist and hand
35.72%	Sprains and strains of knee and leg
31.77%	Sprains and strains of ankle and foot
28.70%	Superficial injury
25.77%	Dorsopathies
23.43%	Rheumatism, excluding the back
20.94%	Burns
20.35%	Other ill-defined sprains and strains
18.01%	Sprains and strains of hip and thigh
16.69%	Injury, other and unspecified
15.37%	Sprains and strains of elbow and forearm
14.93%	Fracture of upper limb
13.62%	Open wound of head, neck, and trunk
12.15%	Fracture of lower limb
11.86%	Disorder of the eye and adnexa
10.69%	Arthropathies and related disorders
9.37%	Dislocation
8.64%	Other an unsecified effects of external causes
7.76%	Intracranial injury, excluding those with skull fracture
7.32%	Symptoms, signs, and ill-defined conditions
7.17%	Foreign body on external eye
6.59%	Toxic effects of substances cheifly nonmedical as to source
6.44%	Open wound of lower limb
6.15%	Other inflammatory conditions of skin and subcutaneous tissue
5.71%	infections of skin and subcutaneous tissue
5.42%	Disorders of the peripheral nervous system
5.27%	Osteopathies, chondropathies, and acquired musuloskelatal deformities
4.39%	Crushing injury
4.10%	Fracture of neck and trunk
3.07%	Hernia of abdominal cavity
2.05%	Mental Disorders
1.46%	Other infectious and parasitic diseases
1.32%	Fracture of skull
1.17%	Diseases of veins and lymphatics, and other diseases of circulatory system
1.02%	Diseases of the ear and mastoid process

1.02% Other diseases of skin and subcutaneous tissue
 0.88% Chronic obstructive pulmonary disease and allied conditions
 0.88% Complications of pregnancy, childbirth, and the puerperium
 0.88% Injury to nerves and spinal cord
 0.88% Pneumoconioses and other lung diseases due to external agents
 0.73% Acute respiratory infections
 0.73% Congenital anomalies
 0.73% Hereditary and degenerative diseases of the central nervous system
 0.44% Complications of surgical and medical care, not elsewhere classified
 0.44% Diseases of oral cavity, salivary glands, and jaws
 0.44% Other bacterial diseases
 0.44% Other diseases of respiratory system
 0.44% Other disorders of the central nervous system
 0.44% Poisoning by drugs, medicinal and biological substances
 0.29% Diseases of arteries, arterioles, and capillaries
 0.29% Diseases of esophagus, stomach, and duodenum
 0.29% Internal injury of thorax, abdomen, and pelvis
 0.29% Intestinal infectious diseases
 0.29% Ischemic heart disease
 0.29% Neoplasm
 0.29% Tuberculosis
 0.29% Uncategorized
 0.15% Diseases of male genital organs
 0.15% Endocrine, Nutritional and metabolic diseases, and immunity disorders
 0.15% Foreign body in mouth, esophagus, and stomach
 0.15% Hypertensive disease
 0.15% Inflammatory disease of female pelvic organs
 0.15% Inflammatory diseases of the central nervous system
 0.15% Injury to blood vessels
 0.15% Mycoses
 0.15% Other diseases due to viruses and Chlamydiae
 0.15% Other diseases of digestive system
 0.15% Other diseases of intestines and peritoneum
 0.15% Other diseases of urinary system
 0.15% Other disorders of female genital tract
 0.15% Pneumonia and influenza

Date: August 29, 2005
To: George Kunz, BWC Safety Consultant
From: John Laughlin, Agency Safety Manager,
The Good Shepherd
622 Center St.
Ashland, Ohio 44805
Subject: Cost reduction for Lutheran Village and Good Shepard

Lutheran Village of Columbus

- Type of facility – Long Term Care and Assisted Living facility. Both are under the same risk number.
- Number of employees – 286
- Number of residents – Long Term Care is 180 beds and the assisted living is 85 beds.
- In order to accurately reflect the progress, all the numbers below are “pre-discount”, since the Bureau has offered 75%, 20% and no discount, etc.

Annual pre-discount premiums:

2001	\$648,416
2002	\$758,964
2003	\$377,246
2004	\$369,272
2005	First half - \$123,172

As you can see, pre-discount savings from 2002 to 2004 is \$389,692 and if the first half of 2005 is any indication, we will reduce even further.

The Good Shepherd in Ashland

- Type of facility – Long Term Care.
- Number of employees – 165
- Number of residents – 130 beds
- In order to accurately reflect the progress, all numbers below are “pre-discount”, since the Bureau has offered 75%, 20% and no discount, etc.

Annual pre-discount premiums;

2001	\$146,904
2002	\$135,585
2003	\$118,838
2004	\$ 89,268
2005	First half - \$39,208

Pre-discount savings from 2001 to 2004 is \$57,636 and 2005 should be slightly better.

Both of our facilities started out with EMs above 200 and are both now below 100 and group rated.

Programs, safety training at both sites

Below are programs, safety training, and other training, etc. related to our safety programs at both sites.

- All accidents are investigated thoroughly on our investigation forms. Recommendations are made when appropriate.
- We use Transitional duty extensively. Both facilities have received Transitional duty grants from BWC.
- Both facilities have completed the 10 step business plan.
- PDP Plus for Lutheran Village.
- Drug Free Workplace.
- Perception surveys were utilized.
- Purchase of hi-lo beds to reduce back strains. (Very successful)
- We are going to implement the use of ceiling lifts and a no lift policy for one wing at The Good Shepherd. We will monitor closely for effectiveness. We may go lift free at both facilities if capital funds are available in the future.
- We are in the 4% discount program through the Safety Council.
- I have used the video library as needed. Good Resource.
- Have utilized Safety and Hygiene many times as consultants and for site visits. I find their input invaluable to our success.
- Have used the Ergonomics Department at both facilities.
- I have used the Fraud Division very successfully on a case I had investigated. I found no merit to the claims made by an employee. They admitted lying and no claim was paid.
- I work closely with our BWC account reps., our MCO and our TPA on claims management. This is a very important part of the process. We are very diligent at minimizing the financial impact of our claims.
- I have used wage continuation successfully, saving around \$70,000 on one claim last year.
- At Lutheran Village of Columbus, we were having injuries related to the food carts. They were too high causing poor visibility in front of them. We had several injuries related to those food carts. The safety recommended we buy new, shorter carts to allow for forward visibility and easier handling. We got the new food carts at around \$59,000. It shows upper management's commitment to safety. These are the things that reduce injuries.
- The safety committee is made up of staff from all departments. Between safety meetings they are assigned to inspect another department using a check sheet for that department. Their findings are brought back to the next meeting.
- We have a monthly safety slogan. If a department Head asks an employee what the slogan is and they can answer it, they get a certificate for \$1.00 to use in the gift shop.
- The Agency is committed to Corporate Compliance, Risk Management, to make our facilities safe for residents, visitors, and staff.

- Our Corporate Facilities Manager is working on a comprehensive preventative Maintenance program which will make the workplace safer.
- The Agency Safety Manager inspects both facilities at least twice a year.
- I have used the training facility in Pickerington as classes come up that I believe will help me do my job better.

New employee orientation

Below is what we go over at new employee orientation and also periodically as required or needed:

- General safety rules.
- Nursing, Dietary, Housekeeping, Laundry, Maintenance specific training as necessary according to those in orientation.
- We have all employees sign and date a form stating that they understand our safety rules and will abide by them or discipline will occur and I will deny their claim. First offense is a final warning and the second offense is discharge.
- Body mechanics and safe, proper lifting techniques.
- We go over filling out the accident forms and make sure they understand that they must be completed ASAP.
- We go over our Drug Free Workplace program in orientation.
- Hand washing procedures.
- Universal precautions.
- Hep. B prevention.
- AIDS prevention.
- Fire alarm procedure.
- Weather policy.
- Resident safety.
- Right to know, 704 labeling system, MSDS reading.

**Safety in Extended-Care
Facilities**

- Bloodborne Pathogens
- Hazard Communication
- Lockout/Tagout
- Personal Protective Equipment
- Emergency Preparedness
- Combative Residents

**Bloodborne Pathogens
Program Elements**

- Exposure Control Plan
- Engineering and Work Practice Controls
- Personal Protective Equipment (PPE)
- Vaccination, Testing, and Post-exposure Follow-up Process
- Labeling and Training
- Recordkeeping

**Hazard Communication
Program Elements**

- Written Program
- Chemical Inventory
- Material Safety Data Sheets (MSDS)
- Labeling
- Employee Training

Personal Protective Equipment
Program Elements

- Workplace Hazard Assessment
- Hazard Abatement
 - Use engineering controls whenever feasible
- Product Evaluation/Selection
- Employee Training

Lockout / Tagout
Program Elements

- Document all applicable equipment and energy sources
- Identify authorized and affected employees
- Develop written procedures
- Train employees
- Review and update
- Outside contractors

Emergency Action Plan
Program Elements

- Responsibilities
- Rescue / medical duties
- Employee training
- Escape procedures
- Employee accountability
- Reporting procedures
 - Must be in writing if >10 employees

Violence in the Workplace The Facts

- In the US, workplace violence is the leading cause of on-the-job fatalities for females in all occupations
- The highest number of nonfatal assaults occur in health care and social service sectors
- Nursing aides and orderlies are the victims in more than 50% of all workplace assaults
- Nonfatal assaults are primarily perpetrated by combative patients/residents

Combative Residents = Violence in the Workplace

Combative Residents Program Elements

- Management Commitment
- Supervisor Accountability
- Written Program
- Responsibilities
- Employee Involvement and Training
- Reporting Procedures
- Incident Review
- Control Measures
- Program Review

Combative Residents Risk Factors

- Working alone with residents
- Staff member unfamiliar with residents
- Resident unfamiliar with staff member
- Medication, diet, rest/sleep
- Inadequate communication systems
- Lack of training on how to recognize and manage hostile behavior
- Inadequate or untimely follow-up on incidents

Combative Residents Question

- How does your facility recognize issues related to combative residents?

Combative Residents Question

- What types of control measures does your facility use to reduce the potential for injuries due to combative residents?

**Resources for Managing
Combative Residents**

- OSHA Publication Number 3148
- OCOSH course – GEN316

**Who should be responsible for
maintaining these programs?**

- Bloodborne Pathogens →
- Hazard Communication →
- Lockout/Tagout →
- Personal Protective
Equipment →
- Emergency
Preparedness →
- Combative Residents →

**Safety & Health Programs
Tools and Resources**

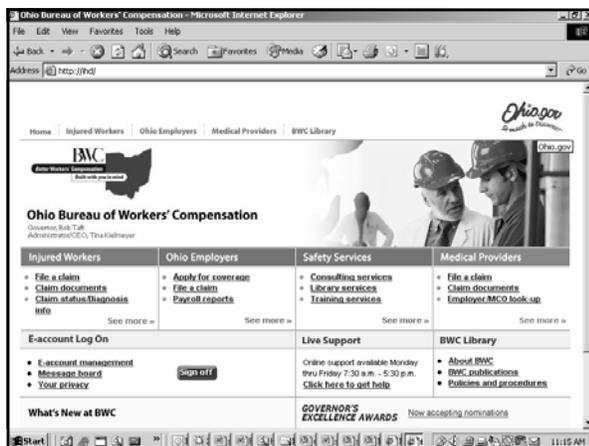
- OCOSH courses
- Sample programs – www.ohiobwc.com
- OSHA E-Tool – www.osha.gov
- Resources Tab

OCOSH courses

<i>Code</i>	<i>Length</i>	<i>Course title</i>
GEN314	1 day	Accident Analysis
IHY220	.5 day	Bloodborne Pathogens
GEN311	1 day	Controlling Costs through Claims Management
GEN310	1 day	Controlling Workers' Compensation Costs
SAF107	3.5 days	Electrical Hazards
SAF108	2 days	Electrical Safety Audits
ERG219	1 day	Ergonomics: Developing an Effective Process
ERG218	3 days	Ergonomics: Applied
GEN101	2 days	Fundamentals of an Effective Safety & Health Program
IHY212	1.5 days	Hazard Communication

OCOSH courses, continued

<i>Code</i>	<i>Length</i>	<i>Course title</i>
SAF124	1 day	Job Safety Analysis
WEB001	Varies	Office Ergonomics online (self-paced at your own computer)
GEN126	1 day	Measuring Safety Performance
GEN320	1 day	OSHA Recordkeeping
SAF120	.5 day	Personal Protective Equipment Selection Criteria
IHY209	2.5 days	Respiratory Protection
RIS100	.5 day	Ten Step Business Plan
GEN316	.5 day	Violence in the Workplace
GEN234	.8 day	Wellness in the Workplace



Ohio Bureau of Workers' Compensation - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Address <http://iwd/>

Home Injured Workers Ohio Employers Medical Providers BWC Library

BWC
Better Workers' Compensation
Balls with you in mind

Ohio Bureau of Workers' Compensation
Governor, Bob Taft
Administrator/CEO, Tina Kiehmeyer

Injured Workers	Ohio Employers	Safety Services	Medical Providers
<ul style="list-style-type: none"> File a claim Claim documents Claim status/Diagnosis info <p>See more »</p>	<ul style="list-style-type: none"> Apply for coverage File a claim Payroll reports <p>See more »</p>	<ul style="list-style-type: none"> Consulting services Library services Training services <p>See more »</p>	<ul style="list-style-type: none"> File a claim Claim documents Employer/MCO look-up <p>See more »</p>
E-account Log On <ul style="list-style-type: none"> E-account management Message board Your privacy <p>Sign off</p>	Live Support Online support available Monday thru Friday 7:30 a.m. - 5:30 p.m. Click here to get help		BWC Library <ul style="list-style-type: none"> About BWC BWC publications Policies and procedures
What's New at BWC		GOVERNOR'S EXCELLENCE AWARDS Now accepting nominations	

Start [Taskbar icons] 11:18 AM

Occupational Safety and Health Administration - OSHA HOME PAGE - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Media Print Copy Paste

Address http://www.osha.gov Go



U.S. Department of Labor

Occupational Safety & Health Administration

www.osha.gov



MyOSHA

GO
Advanced Search
|
A-Z Index

June 9, 2005 Site Index: [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)



OSHA's mission is to assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual improvement in workplace safety and health. [more...](#)

Audiences:

- [En Español](#)
- [Small Business](#)
- [Workers](#)
- [Teen Workers](#)

What's New

My **OSHA**

[Personalize this site to see your favorite topics](#)

In Focus



[OSHA Announces Training Program for Disaster Site Workers](#)

OSHA News

- [OSHA Seeks Comments on Lead in Construction Standard](#)
- [OSHA, Airline Group Renew Alliance](#)
- [ACCSH Public Meeting Scheduled for June 23-24 in Washinaton. D.C.](#)

Find It! in DOL
Department of Labor

Compliance Assistance

- [eTools](#)
- [Grants](#)
- [Hispanic Employer/Worker](#)
- [Posters](#)
- [Recordkeeping](#)
- [Small Business](#)
- [Training](#)

Laws & Regulations

- [Standards](#)
- [Interpretations](#)
- [Federal Registers](#)
- [Directives](#)
- [Dockets & E-Comments](#)

Enforcement

[Federal Agency](#)

Nursing Home eTool - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Media Print Mail

Address <http://www.osha.gov/SLTC/etools/nursinghome/index.html> Go Links >>



U.S. Department of Labor
Occupational Safety & Health Administration

www.osha.gov Search GO [Advanced Search](#) | [A-Z Index](#)



Nursing Home eTool

- ▶ Scope
- ▶ Site Map
- ▶ User Guide
- ▶ References
- ▶ Credits
- ▶ Comments

Occupational Hazards in Long Term Care

Nursing Home eTool

Today nursing homes and personal care facilities employ approximately 1.8 million workers at 21,000 work sites. The nursing home industry injury incident rate is 13.9 injuries and illnesses per 100 full-time workers. This is more than double the incident rate of 6.1 of industry as a whole. This *eTool addresses common hazards and controls found in this industry. (Best Viewed at 800 x 600. See [User Guide](#)).



http://www.osha.gov/SLTC/etools/hospital/engineering/engineering.html Internet

Start [Taskbar icons] 9:17 AM

Ergonomics for Extended Care Facilities

1

What is Ergonomics?

- Designing jobs so people can do them safely and efficiently
- Minimizing potential for overexertion and cumulative trauma (Musculoskeletal Disorders (MSDs))
- Developing a process for making on-going improvements



2

Why is ergonomics important?

- 89% of back injuries in health care facilities are related to patient handling activities
- 10 to 20% of people have to leave nursing due to back pain/injury
- Average turnover rate of STNAs in nursing homes is 50-60%
- Cost to recruit, hire, and train a STNA = \$2,000 - \$ 3,000



3

Composite Results of BWC Safety Grants in EC Facilities

- The BWC Safety Grants program provided 4 to 1 matching of funds for ergonomic improvements (up to \$40,000/policy)
- Approximately 73 EC facilities received safety grants from BWC, amounting to a total of about \$2.5 million
- Most of the grants were for patient lifts, adjustable beds, and assistive devices

4

Composite Results of Safety Grants in EC Facilities (cont'd)

- Thus far, follow-up reports indicate:
 - 38% reduction in the incidence of CTDs (sprains to back, shoulders, wrists, etc.)
 - 41% reduction in lost work days
 - 28% reduction in restricted work days
 - 18% reduction in employee turnover
 - Significant reductions in skin tears, bruises and falls among residents

5

What are the dollar savings of reduced turnover?

- For a facility with 50 STNAs and a 50 % turnover rate
 - 25 aides hired/year x \$3000 avg. hiring cost = \$75,000/year spent recruiting and hiring
- If safety and ergonomics improvements reduce turnover by 15% (conservative estimate)
 - 4 less aides hired/year x \$3000 avg. hiring cost = \$12,000 savings/year in reduced turnover alone

6

What Factors Cause or Contribute to Overexertion?

Contributing Factors

- weight
-
-
-
-
-
-



7

What can be done to Prevent Overexertion?

- Better Equipment
- Better Facilities
- Better Training
- Better Policies
- Better Staffing
- Better Staff Fitness
- Better Safety Management!



8

Equipment Audit

- What equipment do you have?
- How do you currently use it?
- Where is it stored?
- Does the staff know how to use it?

9

OSHA Ergonomics Guidelines for the Nursing Home Industry

- **Section I. Introduction**
 - pp. 5-8 of OSHA 3182
- **Section II. A Process for Protecting Workers**
 - Provide Management Support
 - Involve Employees
 - Identify Problems
 - Implement Solutions
 - Address Reports of Injuries
 - Provide Training
 - Evaluate Ergonomics Efforts

5a1 General Duty Clause

10

OSHA Ergonomics Guidelines for the Nursing Home Industry

- **Section III. Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning**
 - Resident Assessment and Algorithms
 - Suggestions for implementation
 - Types of equipment and considerations
 -

11

Types of Control Measures

- Engineering and Work Practice Controls
- Administrative Controls
- Personal Protective Equipment?



12

Best Practices for Facilities Design and Arrangement

- Automatic doors
- Adequate space for transfers/equipment in bedrooms, bathrooms, and shower rooms
- Minimal need to negotiate ramps/steps
- Low, sloped thresholds
- Non-slip flooring
- Adequate storage space



13

Nursing Department Engineering Controls

- Patient Lifters and Sit-to Stand Lifters
- Drop/Removable Arm Wheelchairs
- Low Profile Wheelchair Scales
- Electric Low-Beds
- Gait Belts with Handles
- Pneumatic Seat Lift
- Transfer Boards/Disks

OSHA Guidelines for Nursing Homes booklet in resource section

14

General Considerations for Assistive Equipment Selection

- Resident safety/comfort
- Capacity/Durability
- Size/Accessibility
- Maneuverability
- Ease/Speed of operation
- Versatility
- Maintainability
- Training required
- Cost
- Compatibility with other equipment



15

Patient Lifting Devices

Important Features and Considerations

- Mechanically powered
- On-board scale
- Minimal chains/sway
- Quick recharging
- Comfortable slings
- Padded corners/edges
- Remote control
- Adequate lift range
- Adequate capacity



16

Sit-to-Stand Devices

Important Features and Considerations

- Mechanically powered
- Remote control
- Accessibility to toilets
- Well-padded shin rest
- Wide, padded strap
- Easily adjustable
- Non-skid foot plate
- Easy lock/unlock casters



17

Bathing Systems

Important Features and Considerations

- Low entry
- Mobile chair/stretcher
- Quick filling
- Accessible with lift
- Constant temp monitor
- Self cleaning/sanitizing
- Height adjustable



18

Resident Beds

Important Features and Considerations

- Electrical operation
- Low to high range
- <20 sec low-high time
- Minimal pinch points
- Safe siderail design
- Remote control
- Locking casters



19

Wheelchairs/Geri-Chairs

Important Features and Considerations

- Drop/removable arms
- (Re)movable footplates
- Multi-purpose design
- Easily operable wheel locks
- Easy fold up design
- Adjustable
- Customizable



20

OSHA Ergonomics Guidelines for the Nursing Home Industry

- **Section IV. Identifying Problems and Implementing Solutions for Activities other than Resident Lifting and Repositioning**

- Refer to pp. 27-30 OSHA Guidelines for Nursing Homes booklet in resource section

21

Dietary Department Engineering Controls

- Anti-slip flooring and mats
- Adequate storage space and shelving
- Gravity flow racks for can foods
- Well-designed serving line
- Dispensers for trays, plates, racks
- Well-designed food service carts
- Well-designed dishwashing line



OSHA Guidelines for Nursing Homes booklet in resource section

22

Housekeeping Department Engineering Controls

- Carts with side garbage removal feature and mop bucket attachment
- Low-profile "slop" sink with hose
- Dock level dumpster/compactor
- Easy dump trash carts
- Soaps and cleaners in small containers
- Light weight aluminum handle mops

OSHA Guidelines for Nursing Homes booklet in resource section

23

Laundry Department Engineering Controls

- Light-weight carts with side access for bag removal
- Laundry chemical dispensing system
- Appropriate-height folding tables
- Anti-fatigue mats
- Linen carts with elevated or spring-loaded bottom



OSHA Guidelines for Nursing Homes booklet in resource section

24

What types of Administrative Controls help to prevent injuries?

-
-
-
-
-
-
-

25

Administrative Controls

- Ordering, Purchasing, and Storage
- Inspection/Maintenance Systems
- Accountability Systems
- Training, Observation, Coaching
- Staffing, Teamwork, Familiarity
- Methods, Policies and Procedures
- Fitness, Wellness Programs
- Work Hours/Work Distribution
- Communication Systems

26

Best Practices for Purchasing and Storage

- Minimize weight and bulk of items handled
- Optimize order quantities/unit loads
- Provide adequate space and access to shelves
- Use gravity flow racks for perishables
- Optimize storage location



27

Best Practices for Facility and Equipment Maintenance

- Efficient work order system and scheduling
- Frequent updates on repair status
- Availability of spare parts and units
- Maintenance of wheels, brakes, cranks, etc.
- Proper floor cleaning products and schedule
- Good drainage & mats



28

Best Practices for Training and In-servicing Staff

- Timeliness of training
- Staff involvement in development/delivery
- Relevance to job/tasks
- Demonstration and return demonstration
- Observation, coaching, positive reinforcement
- Incorporate best practices into policy



29

Best Practices for Staffing and Scheduling

- Evenly distribute the workload and tasks
- Schedule physical tasks to best utilize staff
- Use a buddy system to encourage teamwork
- Establish familiarity with buddy & residents
- Reward attendance and longevity



30

Best Practices for Developing Policies and Procedures

- Get staff involved in development/updates
- Educate on importance
- Clearly communicate expectations/discipline
- Consistently enforce
- Update, Revise, and Reinforce as necessary
- Use positive reinforcement



31

Best Practices for Employee Communication

- Provide frequent updates on safety progress/performance
- Facilitate thorough shift change reports and discussion
- Post safety reminders and committee minutes
- Facilitate inter-departmental communication/cooperation
- Clearly define responsibilities
- Give recognition/rewards for achievement and participation



32

Small Group Problem Solving Topics

- Vertical transfers (e.g. sit to stand)
- Horizontal transfers (e.g. repositioning)
- Ambulating residents
- Showering/Bathing
- Support services (e.g. laundry, dietary)

33

Small Group Problem Solving Assignment

- Summarize the steps to be followed in the problem assessment, and in the solution development & implementation process
- Brainstorm important features for the types of equipment you need to address the problem
- Identify specific administrative controls that you will use to help ensure safety and effective use of equipment
- Explain how you will monitor the effectiveness of the various control measures

34

Implementation Of Ergonomic Improvements

- Develop an implementation team
- Put together an action plan with a timetable
- Develop product evaluation criteria and forms
- Get staff input in evaluation and selection
- Develop and document policies for use
- Document training and competency
- Conduct periodic follow-up assessments

35

Who should be involved in the improvement process?

- ID of needs ⇒
- ID of alternatives ⇒
- Eval of alternatives ⇒
- Selection ⇒
- Purchase ⇒
- Installation ⇒
- Training ⇒
- Evaluation ⇒

36

Tools and Resources for Developing Safety/Ergo Teams

- BWC OCOSH courses
 - GEN 360 - Effective Safety Teams
 - GEN 101 - Fundamentals of an Effective Safety and Health Program
- University outreach programs
- Chambers of Commerce
- Private consulting/training firms

37

OSHA Ergonomics Guidelines for the Nursing Home Industry

- **Section V. Training**
 - Nursing Assistants and Other Workers at Risk of Injury
 - Training for Charge Nurses and Supervisors
 - Training for Designated Program Managers

38

What topics should be addressed in Ergonomics Awareness Training

-
-
-
-
-
-
-



39

Topics for Ergonomics Awareness Training

- Overview of the goals of ergonomics
- Importance of staff input/involvement
- Impact of injuries on staff, residents, and the facility
- Various factors that contribute to injuries
- Examples of recent ergo improvements
- Current concerns/opportunities
- Possible controls and improvements
- Next steps in the improvement process

40

Resources for Ergonomics and Safety Training and Materials

- BWC OCOSH Courses
- Corporate and other Internal Resources
- BWC Library/Video Library
- Ergonomics Training/Consulting Firms
- Product Vendors
- Web Sites

41

OSHA Ergonomics Guidelines for the Nursing Home Industry

- **Section VI. Additional Sources of Information**
- **References**
- **Appendix: A Nursing Home Case Study**
 - Wyandott County Nursing Home

42

Safety and Ergonomics Web Sites for Healthcare Facilities

- www.wa.gov/lni
 - comparison charts for lifts
- www.dir.ca.gov/dosh_publications
 - Back injury prevention guide
- www.osha-slc.gov/SLTC
 - Nursing Home eCAT
- www.silver-cross.com
 - product comparison charts

43

Safety and Ergonomics Web Sites for Healthcare Facilities

- www.patientsafetycenter.com
 - Safe Patient Handling and Movement Resource Guide
- www.healthcare.healthandsafetycentre.org
 - Home Healthcare safety info
- www.saftek.com/safetyplans/nh/
 - Back Injury Prevention Strategies

44

Solution: Sit/Stand Lift



45

Solution: Sit/Stand Lift



46

Solution: Total Lift



47

Solution: Total Lift



48

Model for BWC Safety and Ergonomics Assessment

- Meeting with Administrator/Facility Manager to establish common goals and objectives
- Assessment of Safety Management Systems
- Meetings with Management Team to prioritize and work through safety management improvements
- Questionnaire and Walk-Through with Director of Nursing and/or Safety Team
- Ergonomics/Safety Awareness Training Session to discuss issues and collect employee suggestions
- Meetings to prioritize issues, develop action plans, and assist with implementation process.

49

Safety Management Strategies for Extended Care Facilities

How does your facility manage staff safety and ergonomics?

- Goals and Objectives
- Policies and Procedures
- Orientation and Training
- Safety Committees
- Safety Audits
- Observation and Coaching
- Suggestion Systems
- Accident Analysis



Goals and Objectives

- Facility, department, and individual
- S.M.A.R.T.
- Communicated and monitored by top management
- Celebrations for progress/achievement
- Tied to bonus system

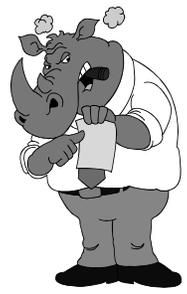


Safety Goals and Objectives
Tools for Development/Enhancement

- Incidence rate calculator
- Safety management assessments
- List of suggested safety responsibilities
- Supervisors safety activity form

Policies and Procedures

- Developed by supervisors and employees
- Clearly documented and communicated
- Reviewed regularly
- Consistently followed and enforced
- Subject to disciplinary process
- Positive

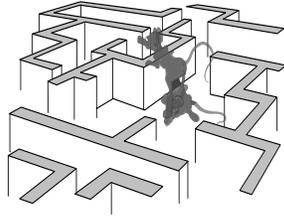


Safety Policies and Procedures
Tools for Development/Enhancement

- Sample Safety and Health Policy Statement
- Sample facility-wide safety rules
- Job Safety Analysis (JSA) forms
- Personal Protective Equipment (PPE) Assessment

Orientation and Training

- Tailored to needs
- Include technical and process issues
- Conducted by the right person(s)
- Verify understanding
- Document
- Provide refresher training/review



Safety Orientation and Training Tools for Development/Enhancement

- Sample safety orientation checklists
- Training development outline
- Training evaluation and follow-up form
- Training documentation form

Safety Committees

- Establish a clear purpose
- Get the right people involved
- Require participation
- Follow a consistent agenda
- Focus on solutions
- Develop action plans
- Communicate



Safety Committees
Tools for Development/Enhancement

- Team formation questions
- Sample committee agenda/minutes
- Committee member position description
- Action plan template
- Committee effectiveness review checklist

Safety Audits

- Conduct regularly, unannounced
- Review conditions and actions
- Abate hazards
- Analyze root causes
- Resolve all issues
- Keep it positive
- Communicate



Safety Audits
Tools for Development/Enhancement

- Sample safety audit forms for various departments/areas in EC facilities
- Sample written plan for a safety audit process
- Suggestions for developing an effective safety audit process
- Safety issues tracking log

Observation/Coaching

- Critique use of equipment and techniques
- Coaching, not policing
- Find out why safe techniques are not being used
- Improve systems to encourage safe behaviors



Observation and Coaching Tools for Development/Enhancement

- Behavior Based Safety program materials
- Sample safety observation forms
- Software for collecting and analyzing data related to observations
- Instructional videos on observation and communication skills for supervisors

Suggestion Systems

- Allow for direct and anonymous suggs
- Review, log, respond, and act promptly
- Solicit after training
- Reward or recognize contributions
- Post progress logs



Safety Suggestion Systems
Tools for Development/Enhancement

- Sample suggestion forms
- Action plan for implementing new equipment
- Logs for summarizing suggestions, follow-up actions, and responsibilities
- Information on reward and recognition systems

Accident Analysis

- Conduct promptly
- Ensure completeness
- Analyze root causes
- Develop systems improvements
- Develop action plans
- Review by safety committee
- Route to senior managers



Accident Analysis and Follow-up
Tools for Development/Enhancement

- Sample accident analysis program
- Sample accident analysis/follow-up forms
- Contributing factors checklists
- Safety committee summary/trend report

Next Step

- Use the safety management request form to indicate which management system you would like to improve and what tools and resources you would like to request.
- Indicate if you would like to have a BWC consultant contact you to provide assistance with tailoring and implementing the safety management tools.

Safety Management Tools

Safety Goals and Objectives Tools	Incidence rate calculator	
	Safety management assessments	
	List of suggested safety responsibilities	
Safety Policies and Procedures Tools	Sample Safety and Health Policy Statement	
	Sample facility-wide safety rules	
	Job Safety Analysis (JSA) forms	
	Personal Protective Equipment (PPE) Assessment	
Safety Orientation and Training Tools	Sample safety orientation checklists	
	Training development outline	
	Training evaluation and follow-up form	
	Training documentation form	
Safety Committee Tools	Team formation questions	
	Sample committee agenda/minutes	
	Committee member position description	
	Action plan template	
Safety Audits Tools	Sample safety audit forms for various departments/areas	
	Sample written plan for a safety audit process	
	Suggestions for developing a safety audit process	
	Safety issues tracking log	
Observation and Coaching Tools	Behavior Based Safety program materials	
	Sample safety observation forms	
	List of videos on observation and communication skills	
Safety Suggestion Systems Tools	Sample suggestion forms	
	Action plan for implementing new equipment	
	Logs for summarizing suggestions and follow-up action	
	Information on reward and recognition systems	
Accident Analysis and Follow-up Tools	Sample accident analysis program	
	Sample accident analysis/follow-up forms	
	Contributing factors checklists	
	Safety committee summary/trend report	

Instructions for Downloading Materials from BWC's Learning Center

1. Go to: www.bwclearningcenter.com
2. Log in using your username and password
 - a. If you have forgotten your username and password call 1-800-OHIOBWC
3. Click the "Team Center" building
4. Click "Team Rooms"
5. Type "safety ergo care" in the keyword field and click search
6. Click the "Safety & Ergonomics for extended Care Facilities" team room which should be the first team room listed
7. Click "Content" listed in the Team Room Tools
8. Click on the document that you wish to download
 - a. Students and instructors are also able to submit resources that might be useful to other team members
9. Log off when finished

Please contact a BWC consultant to request assistance with implementation

Resources

Contents

- Safety & Ergonomic websites
- OSHA 3182 -- *Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders*
- OSHA 3148 -- *Guidelines for Preventing Workplace Violence for Health care & social service workers*

The OSHA booklets contain their original page numbers.

Website Links for HealthCare Ergonomics Resources
August 2004

Topic	Web Link
Patient Handling	
A Back Injury Prevention Guide for Health Care Providers. <i>California/OSHA</i>	http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf
Back in CARE Preventing musculoskeletal injuries in staff in hospitals and residential care facilities. <i>New Zealand/Department of Labour</i>	http://www.osh.dol.govt.nz/order/catalogue/29.shtml -
Ergonomic Healthcare Guidelines <i>University of California at San Diego</i>	http://www-ehs.ucsd.edu/ergo/mcergo/Healthcare_Ergo_Guidelines.pdf
Evidence-Based Patient Handling: Tasks, Equipment and Interventions by Sue Hignett , et al. Taylor and Francis	http://www.amazon.com
Reference Guidelines for Safe Patient Handling <i>Occupational Health & Safety Agency for Healthcare British Columbia</i>	http://www.ohsah.bc.ca/index.php?section_id=309&
Preventing Back Injuries <i>The American Nurses Association</i>	http://ana.org/handlewithcare/
Transfers and Lift for Caregivers <i>Health Care Health and Safety Association of Ontario</i>	http://www.hchsa.on.ca/products/ffacts_e/ap_182.pdf
Ceiling Lift Resources <i>British Columbia Worksafe</i>	http://healthcare.healthandsafetycentre.org/s/ceilingliftresources.asp
Ergo Ideas Bank (search for healthcare) <i>Washington State Department of Labor</i>	http://www.lni.wa.gov/Safety/Topics/Ergonomics/default.asp
Ergonomics Best Practices for Extended-Care Facilities <i>Ohio Bureau of Workers' Compensation</i>	http://www.ohiobwc.com/downloads/brochureware/publications/ExtCareSafeGrant.pdf
Long Term Care: Lifting <i>Joe Jolliff, Retired Nursing Home Administrator</i>	http://home.earthlink.net/~nolifting/
OSHA E-Tools for Nursing Homes and Hospitals <i>US Occupational Safety and Health Agency</i>	http://www.osha.gov/SLTC/etools/nursinghome/index.html
Strategies to Reduce the Risk of Back Pain in Nursing Homes <i>Worksafe Western Australia</i>	http://www.safetyline.wa.gov.au/pagebin/manhhazd0023.htm

Equipment and Facilities Design	
A Guide to Bed Safety <i>Food and Drug Administration</i>	http://www.fda.gov/cdrh/beds/
Assistive Technology Links <i>ABLEDATA</i>	http://www.abledata.com/Site_2/personal_care3.htm#TransferLifts
Designing workplaces for safer handling of patients and residents: Guidelines for the design of health and aged care facilities <i>Worksafe Victoria</i>	http://www.workcover.vic.gov.au/dir090/vwa/publica.nsf/InterPubDocsA/C465B11D72C818334A256BD800224031/\$File/Designing%20Workplaces%20for%20Safer%20Handling%20final.pdf
Lift and Transfer Devices <i>Disability Resource Center</i>	http://www.blvd.com/Lift_and_Transfer_Devices/
Products & Equipment Listing <i>Patient Safety Center of Inquiry, Veterans Health Administration</i>	http://patientsafetycenter.com/TechResGuide/TechResourceGuide.htm
Non-Patient Handling Tasks	
Computer/Office Ergonomics Topics <i>Cornell University</i>	http://ergo.human.cornell.edu/ErgoTips2002/home.html
Evaluating your computer workstation- How to make it work for you <i>Oregon OSHA</i>	http://www.cbs.state.or.us/external/osha/standards/pub.htm
Laboratory Ergonomics <i>National Institute of Environmental Health Sciences</i>	http://www.niehs.nih.gov/odhsb/ergoguid/home.htm
Creating the Ideal Computer Workstation: A Step-by-Step Guide <i>The Department of Defense Ergonomics Working Group</i>	http://chppm-www.apgea.army.mil/ergowg/Workstation_Guide_Web.pdf
Ergonomics in the Laundry <i>LaundryToday</i>	http://laundrytoday.com/archives/vol_8_6/ergonomics_laundry_linen_industry.htm
Women and health at work <i>European Agency for Safety and Health at Work</i>	http://europe.osha.eu.int/good_practice/person/gender/
General Ergonomics – case studies <i>US Navy</i>	http://safetycenter.navy.mil/osh/ergonomics/default.htm
Industry Standards of the Prevention of Work-Related Musculoskeletal Disorders in Sonography <i>Society for Vascular Ultrasound</i>	http://www.svunet.org/advocacy/WRMSD_Report.pdf
Musculoskeletal Health of Cleaners <i>UK, Robens Center of Health Ergnomics</i>	http://www.eihms.surrey.ac.uk/robens/erg/cleaners.htm
UCLA Ergonomics	http://ergonomics.ucla.edu/

Ergonomics Programs - General	
Elements of Ergonomic Programs <i>NIOSH</i>	http://www.cdc.gov/niosh/ephome2.html
Worker Protection: Private Sector Ergonomics Programs Yield Positive Results Report# HEHS-97-163 <i>Government Accounting Office</i>	http://www.gao.gov/reports.htm
A spin-off from the University of Utah in 1995, Ergoweb provides scientifically based, yet application oriented products and services to a wide range of private and public sector clients.	http://www.ergoweb.com
Medical Error and Patient Safety	
Agency for Healthcare Research and Quality	http://www.ahrq.gov/
2004 ISMP Medication Safety Self Assessment for Hospitals <i>Institute for Safe Medication Practices</i>	http://www.ismp.org/survey/hospital/intro.htm
Medical Error in Health Care <i>Cognitive Systems Engineering Lab-Ohio State University-David Woods</i>	http://csel.eng.ohio-state.edu/weblogs/woods/archives/cat_domain_health_care.html
Promoting Safety in Medical Device Use <i>FDA</i>	http://www.fda.gov/cdrh/humanfactors/index.html
Patient Safety <i>Healthcare Accreditation Supersite</i>	http://www.hcpro.com/quality-patient-safety/
<i>Joint Commission of Accreditation of Healthcare Organizations</i>	http://www.jcaho.org/
Keeping Patients Safe: Transforming the Work Environment of Nurses (2004) <i>Board of Health Care Services, Institute of Medicine</i>	http://www.nap.edu/books/0309090679/html/
<i>National Patient Safety Foundation</i>	http://www.npsf.org/
<i>State Patient Safety Organizations</i>	http://www.vipcs.org/resources/stateps.htm

Guidelines for **Nursing** Homes



Ergonomics for the **Prevention** of Musculoskeletal Disorders

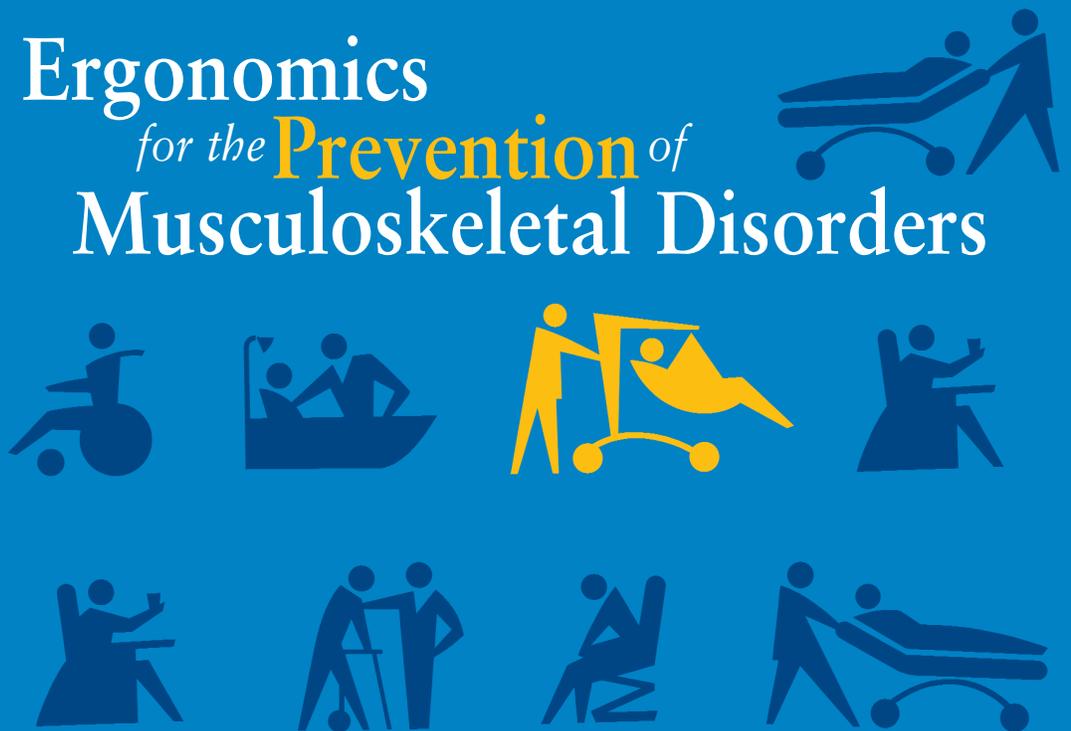


Table of Contents

Executive Summary	2
Section I. Introduction	4
Section II. A Process for Protecting Workers	6
Provide Management Support	6
Involve Employees	6
Identify Problems	6
Implement Solutions	7
Address Reports of Injuries	7
Provide Training	7
Evaluate Ergonomics Efforts	7
Section III. Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning	9
Identifying Problems for Resident Lifting and Repositioning	9
<i>Figure 1.</i> Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair	11
<i>Figure 2.</i> Lateral Transfer to and from: Bed to Stretcher, Trolley	12
<i>Figure 3.</i> Transfer to and from: Chair to Stretcher	13
<i>Figure 4.</i> Reposition in Bed: Side-to-Side, Up in Bed	14
<i>Figure 5.</i> Reposition in Chair: Wheelchair and Dependency Chair	15
<i>Figure 6.</i> Transfer a Patient Up From the Floor	16
Implementing Solutions for Lifting and Repositioning Residents	17
Section IV. Identifying Problems and Implementing Solutions for Activities Other than Resident Lifting and Repositioning	25
Section V. Training	29
Nursing Assistants and Other Workers at Risk of Injury	29
Training for Charge Nurses and Supervisors	29
Training for Designated Program Managers	29
Section VI. Additional Sources of Information	31
References	33
Appendix: A Nursing Home Case Study	34

EXECUTIVE SUMMARY

These guidelines provide recommendations for nursing home employers to help reduce the number and severity of work-related musculoskeletal disorders (MSDs) in their facilities. MSDs include conditions such as low back pain, sciatica, rotator cuff injuries, epicondylitis, and carpal tunnel syndrome. The recommendations in these guidelines are based on a review of existing practices and programs, State OSHA programs, as well as available scientific information, and reflect comments received from representatives of trade and professional associations, labor organizations, the medical community, individual firms, and other interested parties. OSHA thanks the many organizations and individuals involved for their thoughtful comments, suggestions, and assistance.

More remains to be learned about the relationship between workplace activities and the development of MSDs. However, OSHA believes that the experiences of many nursing homes provide a basis for taking action to better protect workers. As the understanding of these injuries develops and information and technology improve, the recommendations made in this document may be modified.

Although these guidelines are designed specifically for nursing homes, OSHA hopes that employers with similar work environments, such as assisted living centers, homes for the disabled, homes for the aged, and hospitals will also find this information useful.

OSHA also recognizes that small employers, in particular, may not have the need for as comprehensive a program as would result from implementation of every action and strategy described in these guidelines. Additionally, OSHA realizes that many small employers may need assistance in implementing an appropriate ergonomics program. That is why we emphasize the availability of the free OSHA consultation service for smaller employers. The consultation service is independent of OSHA's enforcement activity and will be making special efforts to provide help to the nursing home industry.

These guidelines are advisory in nature and informational in content. They are not a new standard or regulation and do not create any new OSHA duties. Under the OSH Act, the extent of an employer's obligation to address ergonomic hazards is governed by the general duty clause. 29 U.S.C. 654(a)(1). An employer's failure to implement the guidelines is not a violation, or evidence of a violation, and may not be used as evidence of a violation, of the general duty clause. Furthermore, the fact that OSHA has developed this document is not evidence and may not be used as evidence of an employer's obligations under the general duty clause; the fact that a measure is recommended in this document but not adopted by an employer is not evidence, and may not be used as evidence, of a violation of the general duty clause. In addition, the recommendations contained herein should be adapted to the needs and resources of each individual place of employment. Thus, implementation of the guidelines may differ from site to site depending on the circumstances at each particular site.

While specific measures may differ from site to site, **OSHA recommends that:**

- **Manual lifting of residents be minimized in all cases and eliminated when feasible.**

- **Employers implement an effective ergonomics process that:**
 - provides management support;
 - involves employees;
 - identifies problems;
 - implements solutions;
 - addresses reports of injuries;
 - provides training; and
 - evaluates ergonomics efforts.

These guidelines elaborate on these recommendations, and include additional information employers can use to identify problems and train employees. Of particular value are examples of solutions employers can use to help reduce MSDs in their workplace. Recommended solutions for resident lifting and repositioning are found in Section III, while recommended solutions for other ergonomic concerns are in Section IV. The appendix includes a case study describing the process one nursing home used to reduce MSDs.

Section I. Introduction

Nursing homes that have implemented injury prevention efforts focusing on resident lifting and repositioning methods have achieved considerable success in reducing work-related injuries and associated workers' compensation costs. Providing a safer and more comfortable work environment has also resulted in additional benefits for some facilities, including reduced staff turnover and associated training and administrative costs, reduced absenteeism, increased productivity, improved employee morale, and increased resident comfort. These guidelines provide recommendations for employers to help them reduce the number and severity of work-related musculoskeletal disorders in their facilities using methods that have been found to be successful in the nursing home environment.

Wyandot County Nursing Home in Upper Sandusky, Ohio, has implemented a policy of performing all assisted resident transfers with mechanical lifts, and has purchased electrically adjustable beds. According to Wyandot no back injuries from resident lifting have occurred in over five years. The nursing home also reported that workers' compensation costs have declined from an average of almost \$140,000 per year to less than \$4,000 per year, reduced absenteeism and overtime have resulted in annual savings of approximately \$55,000, and a reduction in costs associated with staff turnover has saved an additional \$125,000 (1). (see Reference List)

Providing care to nursing home residents is physically demanding work. Nursing home residents often require assistance to walk, bathe, or perform other normal daily activities. In some cases residents are totally dependent upon caregivers for mobility. Manual lifting and other tasks involving the repositioning of residents are associated with an increased risk of pain and injury to caregivers, particularly to the back (2, 3). These tasks can entail high physical demands due to the large amount of weight involved, awkward postures that may result from leaning over a bed or working in a confined area, shifting of weight that may occur if a resident loses balance or strength while moving, and many other factors. The risk factors that workers in nursing homes face include:

- Force – the amount of physical effort required to perform a task (such as heavy lifting) or to maintain control of equipment or tools;
- Repetition – performing the same motion or series of motions continually or frequently; and
- Awkward postures – assuming positions that place stress on the body, such as reaching above shoulder height, kneeling, squatting, leaning over a bed, or twisting the torso while lifting (3).

Excessive exposure to these risk factors can result in a variety of disorders in affected workers (3, 5). These conditions are collectively

After implementing a program designed to eliminate manual lifting of residents, Schoellkopf Health Center in Niagara Falls, New York, reported a downward trend in the number and severity of injuries, with lost workdays dropping from 364 to 52, light duty days dropping from 253 to 25, and workers' compensation losses falling from \$84,533 to \$6,983 annually (4).

referred to as musculoskeletal disorders, or MSDs. MSDs include conditions such as low back pain, sciatica, rotator cuff injuries, epicondylitis, and carpal tunnel syndrome (6). Early indications of MSDs can include persistent pain, restriction of joint movement, or soft tissue swelling (3, 7).

While some MSDs develop gradually over time, others may result from instantaneous events such as a single heavy lift (3). Activities outside of the workplace that involve substantial physical demands may also cause or contribute to MSDs (6). In addition, development of MSDs may be related to genetic causes, gender, age, and other factors (5, 6). Finally, there is evidence that reports of MSDs may be linked to certain psychosocial factors such as job dissatisfaction, monotonous work and limited job control (5, 6). These guidelines address only physical factors in the workplace that are related to the development of MSDs.

At Citizens Memorial Health Care Facility in Bolivar, Missouri, establishment of an ergonomics component in the existing safety and health program was reportedly followed by a reduction in the number of OSHA-recordable lifting-related injuries of at least 45% during each of the next four years, when compared to the level of injuries prior to the ergonomics efforts. The number of lost workdays associated with lifting-related injuries was reported to be at least 55% lower than levels during each of the previous four years. Citizens Memorial reported that these reductions contributed to a direct savings of approximately \$150,000 in workers' compensation costs over a five-year period (8).

Section II. A Process for Protecting Workers

The number and severity of injuries resulting from physical demands in nursing homes—and associated costs—can be substantially reduced (2, 9). Providing an alternative to manual resident lifting is the primary goal of the ergonomics process in the nursing home setting and of these guidelines. **OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible.** OSHA further recommends that employers develop a process for systematically addressing ergonomics issues in their facilities, and incorporate this process into an overall program to recognize and prevent occupational safety and health hazards.

An effective process should be tailored to the characteristics of the particular nursing home but OSHA generally recommends the following steps:

Provide Management Support

Strong support by management creates the best opportunity for success. OSHA recommends that employers develop clear goals, assign responsibilities to designated staff members to achieve those goals, provide necessary resources, and ensure that assigned responsibilities are fulfilled. Providing a safe and healthful workplace requires a sustained effort, allocation of resources and frequent follow-up that can only be achieved through the active support of management.

Involve Employees

Employees are a vital source of information about hazards in their workplace. Their involvement adds problem-solving capabilities and hazard identification assistance, enhances worker motivation and job satisfaction, and leads to greater acceptance when changes are made in the workplace. Employees can:

- submit suggestions or concerns;
- discuss the workplace and work methods;
- participate in the design of work, equipment, procedures, and training;
- evaluate equipment;
- respond to employee surveys;
- participate in task groups with responsibility for ergonomics; and
- participate in developing the nursing home's ergonomics process.

Identify Problems

Nursing homes can more successfully recognize problems by establishing systematic methods for identifying ergonomics concerns in their workplace. Information about where problems or potential problems may occur in nursing homes can be obtained from a variety of sources, including OSHA 300 and 301 injury and illness information, reports of workers' compensation claims, accident and near-miss investigation reports, insurance company reports, employee interviews, employee surveys, and reviews and observations of workplace conditions. Once information is obtained, it can be used to identify and evaluate elements of jobs that are associated with problems. Sections III and

IV contain further information on methods for identifying ergonomics concerns in the nursing home environment.

Implement Solutions

When problems related to ergonomics are identified, suitable options can then be selected and implemented to eliminate hazards. Effective solutions usually involve workplace modifications that eliminate hazards and improve the work environment. These changes usually include the use of equipment, work practices, or both. When choosing methods for lifting and repositioning residents, individual factors should be taken into account. Such factors include the resident's rehabilitation plan, the need to restore the resident's functional abilities, medical contraindications, emergency situations, and resident dignity and rights. Examples of solutions can be found in Sections III and IV.

Address Reports of Injuries

Even in establishments with effective safety and health programs, injuries and illnesses may occur. Work-related MSDs should be managed in the same manner and under the same process as any other occupational injury or illness (10). Like many injuries and illnesses, employers and employees can benefit from early reporting of MSDs. Early diagnosis and intervention, including alternative duty programs, are particularly important in order to limit the severity of injury, improve the effectiveness of treatment, minimize the likelihood of disability or permanent damage, and reduce the amount of associated workers' compensation claims and costs. OSHA's injury and illness recording and reporting regulation (29 CFR 1904) requires employers to keep records of work-related injuries and illnesses. These reports can help the nursing home identify problem areas and evaluate ergonomic efforts. Employees may not be discriminated against for reporting a work-related injury or illness. [29 U.S.C. 660(c)]

Provide Training

Training is necessary to ensure that employees and managers can recognize potential ergonomics issues in the workplace, and understand measures that are available to minimize the risk of injury. Ergonomics training can be integrated into general training on performance requirements and job practices. Effective training covers the problems found in each employee's job. More information on training can be found in Section V.

Evaluate Ergonomics Efforts

Nursing homes should evaluate the effectiveness of their ergonomics efforts and follow-up on unresolved problems. Evaluation helps sustain the effort to reduce injuries and illnesses, track whether or not ergonomic solutions are working, identify new problems, and show areas where further improvement is needed. Evaluation and follow-up are central to continuous improvement and long-term success. Once solutions are introduced, OSHA recommends that employers ensure they are effective. Various indicators (e.g., OSHA 300 and 301 information data and workers' compensation reports) can provide useful empirical data at this stage, as can other techniques such as employee interviews. For example, after introducing a new lift at a nursing home, the employer

should follow-up by talking with employees to ensure that the problem has been adequately addressed. In addition, interviews provide a mechanism for ensuring that the solution is not only in place, but is being used properly. The same methods that are used to identify problems in many cases can also be used for evaluation.

Section III. Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning

Identifying Problems for Resident Lifting and Repositioning

Assessing the potential for work to injure employees in nursing homes is complex because typical nursing home operations involve the repeated lifting and repositioning of the residents. Resident lifting and repositioning tasks can be variable, dynamic, and unpredictable in nature. In addition, factors such as resident dignity, safety, and medical contraindications should be taken into account. As a result, specific techniques are used for assessing resident lifting and repositioning tasks that are not appropriate for assessing the potential for injury associated with other nursing home activities.

An analysis of any resident lifting and repositioning task involves an assessment of the needs and abilities of the resident involved. This assessment allows staff members to account for resident characteristics while determining the safest methods for performing the task, within the context of a care plan that provides for appropriate care and services for the resident. Such assessments typically consider the resident's safety, dignity and other rights, as well as the need to maintain or restore a resident's functional abilities. The resident assessment should include examination of factors such as:

- the level of assistance the resident requires;
- the size and weight of the resident;
- the ability and willingness of the resident to understand and cooperate; and
- any medical conditions that may influence the choice of methods for lifting or repositioning.

These factors are critically important in determining appropriate methods for lifting and repositioning a resident. The size and weight of the resident will, in some situations, determine which equipment is needed and how many caregivers are required to provide assistance. The physical and mental abilities of the resident also play an important role in selecting appropriate solutions. For example, a resident who is able and willing to partially support their own weight may be able to move from his or her bed to a chair using a standing assist device, while a mechanical sling lift may be more appropriate for those residents who are unable to support their own weight. Other factors related to a resident's condition may need to be taken into account as well. For instance, a resident who has recently undergone hip replacement surgery may require specialized equipment for assistance in order to avoid placing stress on the affected area.

A number of protocols have been developed for systematically examining resident needs and abilities and/or for recommending procedures and equipment to be used for performing lifting and repositioning tasks. The following are some examples:

- The *Resident Assessment Instrument* published by the Centers for Medicare and Medicaid Services (CMS) provides a structured, standardized approach for assessing resident capabilities and needs that results in a care plan for each resident. Caregivers can use this information to help them determine the

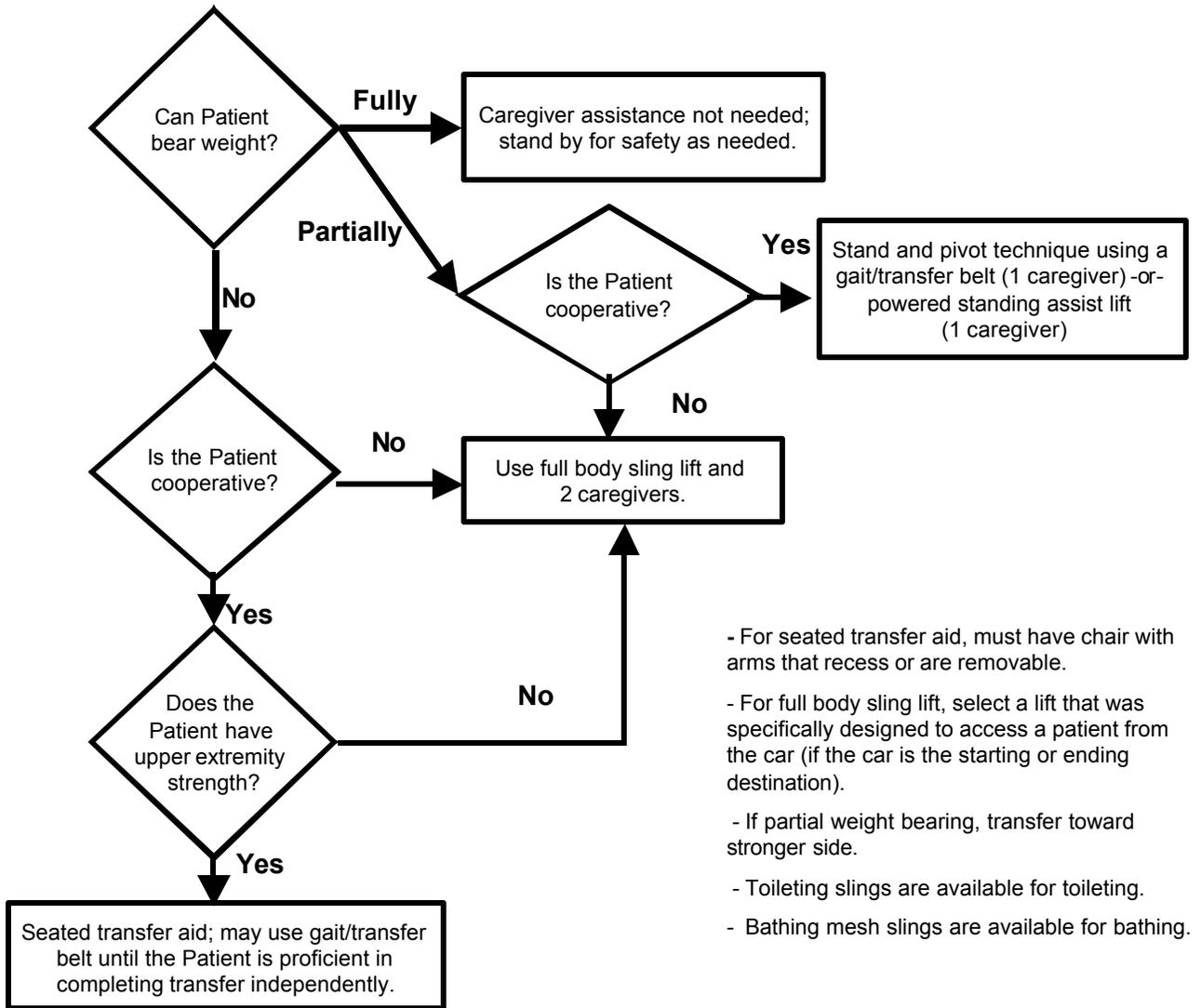
appropriate method for lifting or repositioning residents. Many nursing homes use this system to comply with CMS requirements for nursing homes. Employers can access this information from www.cms.hhs.gov/medicaid/mds20/.

- *Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement* is published by the Patient Safety Center of Inquiry, Veterans Health Administration and the Department of Defense. This document provides flow charts (shown here in Figures 1-6) that address relevant resident assessment factors and recommends solutions for resident lifting and repositioning problems. This material is one example of an assessment tool that has been used successfully. Employers can access this information from www.patientsafetycenter.com. Nursing home operators may find another tool or develop an assessment tool that works better in their facilities.
- Appendix A of the Settlement Agreement between OSHA and Beverly Enterprises entitled *Lift Program Policy and Guide* recommends solutions for resident lifting and repositioning problems, based on the CMS classification system. (A rating of “4” indicates a totally dependent resident. A “3” rating indicates residents that need extensive assistance. A “2/1” rating indicates residents that need only limited assistance/general supervision. Residents rated “0” are independent.) Employers can access this information from www.osha.gov.

The nursing home operator should use an assessment tool which is appropriate for the conditions in an individual nursing home. The special needs of bariatric (excessively heavy) residents may require additional focus. Assistive devices must be capable of handling the heavier weight involved, and modification of work practices may be necessary.

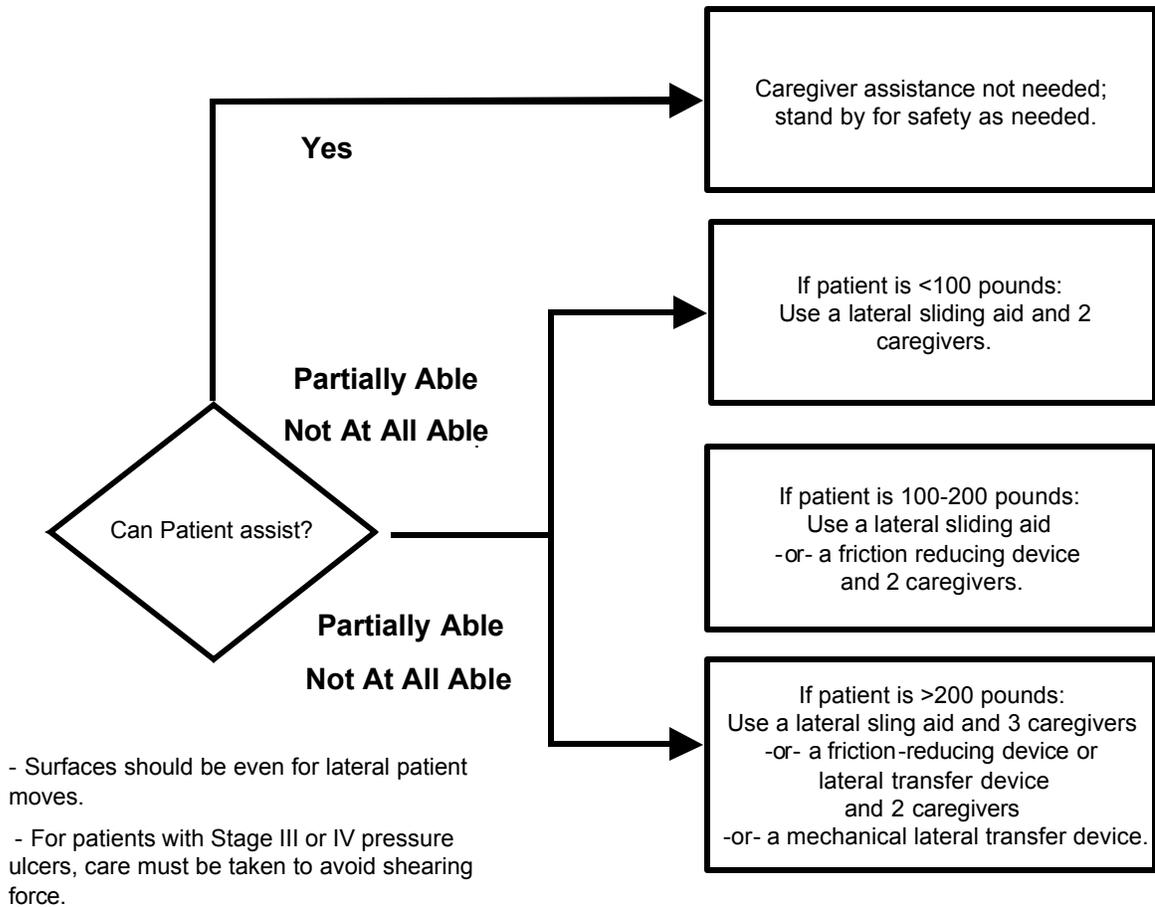
A number of individuals in nursing homes can contribute to resident assessment and the determination of appropriate methods for assisting in transfer or repositioning. Interdisciplinary teams such as staff nurses, certified nursing assistants, nursing supervisors, physical therapists, physicians, and the resident or his/her representative may all be involved. Of critical importance is the involvement of employees directly responsible for resident care and assistance, as the needs and abilities of residents may vary considerably over a short period of time, and the employees responsible for providing assistance are in the best position to be aware of and accommodate such changes.

FIGURE 1. Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair



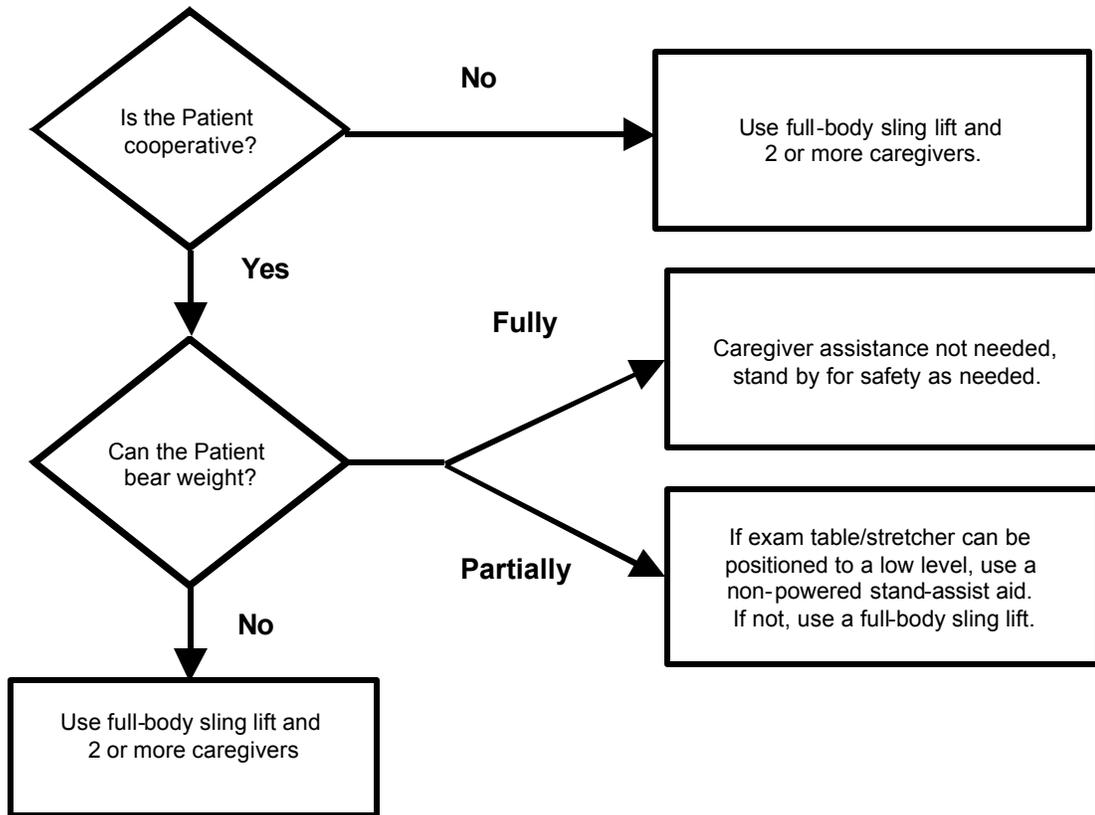
Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 2. Lateral Transfer to and from: Bed to Stretcher, Trolley



Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 3. Transfer to and from: Chair to Stretcher

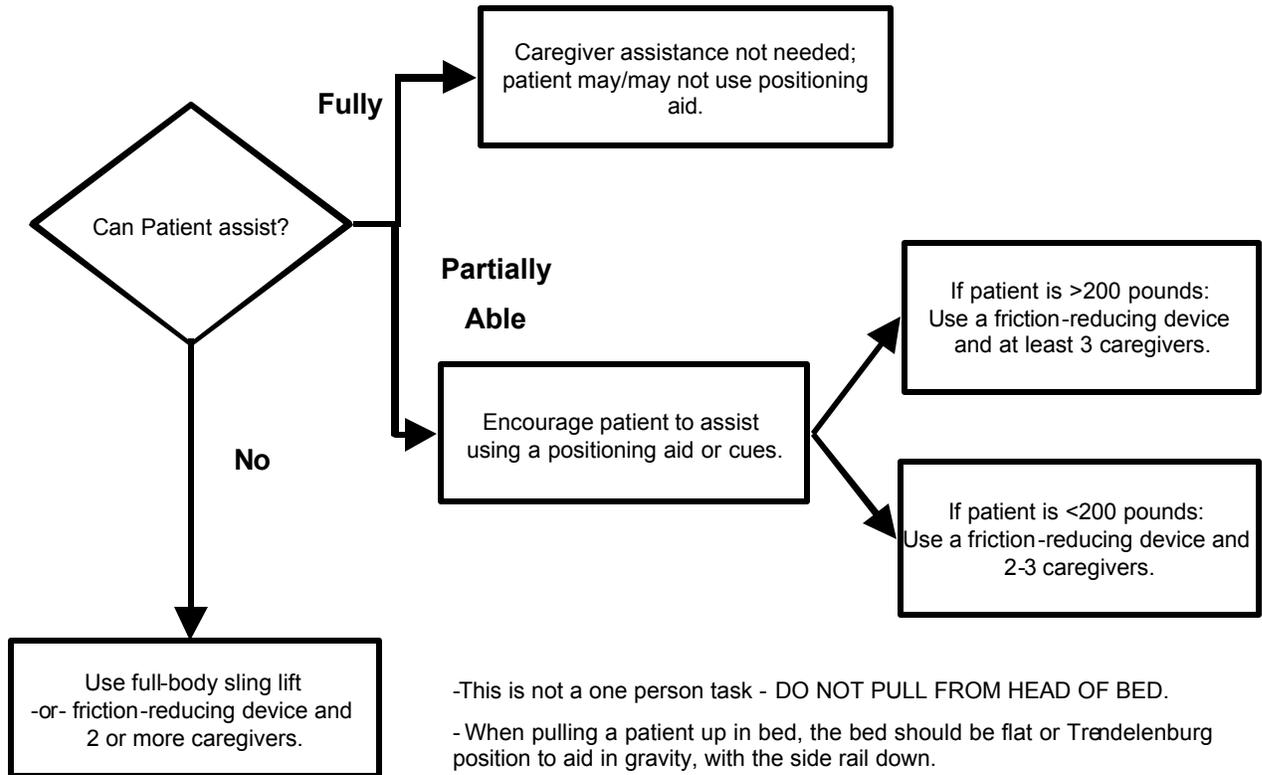


Comments:

- High/low exam tables and stretchers would be ideal.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 4. Reposition in Bed: Side-to-Side, Up in Bed



-This is not a one person task - DO NOT PULL FROM HEAD OF BED.

- When pulling a patient up in bed, the bed should be flat or Trendelenburg position to aid in gravity, with the side rail down.

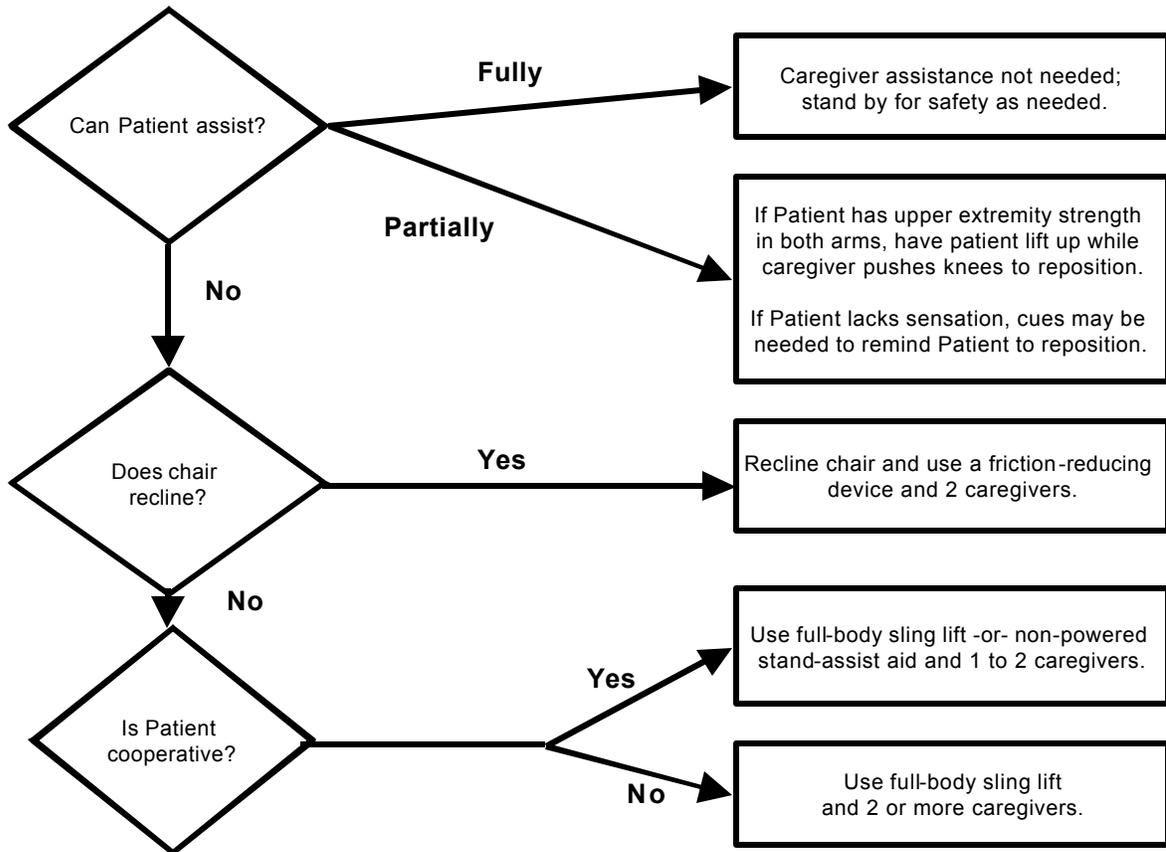
- For patient with Stage III or IV pressure ulcers, care should be taken to avoid shearing force.

- The height of the bed should be appropriate for staff safety (at the elbows).

- If the patient can assist when repositioning "up in bed", ask the patient to flex the knees and push on the count of three.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 5. Reposition in Chair: Wheelchair and Dependency Chair



Comments:

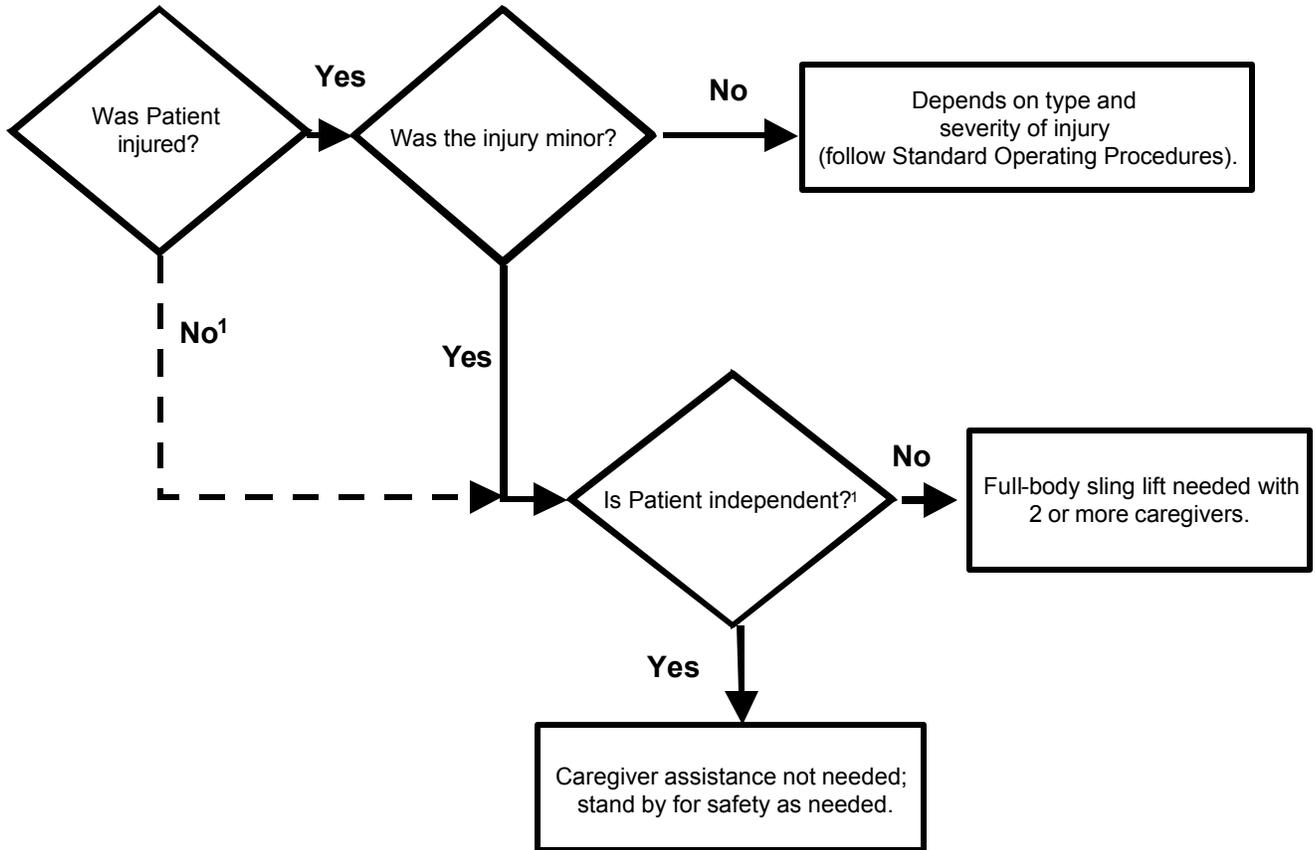
-This is not a one person task: DO NOT PULL FROM BEHIND CHAIR.

- Take full advantage of chair functions, e.g., chair that reclines, or use of arm rest of chair to facilitate repositioning.

- Make sure the chair wheels are locked.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

FIGURE 6. Transfer a Patient Up From The Floor



Comments:

- Use full-body sling that goes all the way down to the floor (most of the newer models are capable of this).
- ¹Modifications made with concurrence of Dr. Audrey Nelson at Veterans Administration Hospital, Tampa, Florida.

Source: The Patient Safety Center of Inquiry (Tampa, FL), Veterans Health Administration & Department of Defense. October 2001.

Implementing Solutions for Resident Lifting and Repositioning

The recommended solutions presented in the following pages are not intended to be an exhaustive list, nor does OSHA expect that all of them will be used in any given facility. The information represents a range of available options that a facility can consider using. Many of the solutions are simple, common sense modifications to equipment or procedures that do not require substantial time or resources to implement. Others may require more significant efforts. The integration of various solutions into the nursing home is a strategic decision that, if carefully planned and executed, will lead to long-term benefits. Administrators should also be cognizant of several factors that might restrict the application of certain measures, such as residents' rehabilitation plans, the need for restoration of functional abilities, other medical contraindications, emergency conditions, and residents' dignity and rights.

The procurement of equipment and the selection of an equipment supplier are important considerations when implementing solutions. Employers should establish close working relationships with equipment suppliers. Such working relationships help with obtaining training for employees, modifying the equipment for special circumstances, and procuring parts and service when needed. Employers will want to pay particular attention to the effectiveness of the equipment, especially the injury and illness experience of other nursing homes that have used the equipment. The following questions are designed to aid in the selection of the equipment and supplier that best meets the needs of an individual nursing home.

- Availability of technical service - Is over-the-phone assistance, as well as onsite assistance, for repairs and service of the lift available?
- Availability of parts - Which parts will be in stock and available in a short time frame and how soon can they be shipped to your location?
- Storage requirements - Is the equipment too big for your facility? Can it be stored in close proximity to the area(s) where it is used?
- If needed, is a charging unit and back up battery included? What is the simplicity of the charging unit and space required for a battery charger if one is needed?
- If the lift has a self-contained charging unit, what is the amount of space necessary for charging and what electrical receptacles are required? What is the minimum charging time of a battery?
- How high is the base of the lift and will it fit under the bed and various other pieces of furniture? How wide is the base of the lift or is it adjustable to a wider and lockable position?
- How many people are required to operate the lift for lifting of a typical 200-pound person?

- Does the lift activation device (pendant) have remote capabilities?
- How many sizes and types of slings are available? What type of sling is available for optimum infection control?
- Is the device versatile? Can it be a sit-to-stand lift, as well as a lift device? Can it be a sit-to-stand lift and an ambulation-assist device?
- What is the speed and noise level of the device? Will the lift go to floor level? How high will it go?

Based on many factors including the characteristics of the resident population and the layout of the facility, employers should determine the number and types of devices needed. Devices should be located so that they are easily accessible to workers. If resident lifting equipment is not accessible when it is needed, it is likely that other aspects of the ergonomics process will be ineffective. If the facility can initially purchase only a portion of the equipment needed, it should be located in the areas where the needs are greatest. Employers should also establish routine maintenance schedules to ensure that the equipment is in good working order.

The following are examples of solutions for resident lifting and repositioning tasks.

Transfer from Sitting to Standing Position

Description: Powered sit-to-stand or standing-assist devices.



When to Use: Transferring residents who are partially dependent, have some weight-bearing capacity, are cooperative, can sit up on the edge of the bed with or without assistance, and are able to bend hips, knees, and ankles. Transfers from bed to chair (wheel chair, Geri or cardiac chair), or chair to bed, or for bathing and toileting. Can be used for repositioning where space or storage is limited.

Points to Remember: Look for a device that has a variety of sling sizes, lift-height range, battery portability, hand-held control, emergency shut-off, and manual override. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow smoother movement for the resident, and less physical exertion by the caregiver.

Resident Lifting

Description: Portable lift device (sling type); can be a universal/hammock sling or a band/leg sling



When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, are very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident fall.

Points to Remember: More than one caregiver may be needed. Look for a device with a variety of slings, lift-height range, battery portability, hand-held control, emergency shut-off, manual override, boom pressure sensitive switch, that can easily move around equipment, and has a support base that goes under beds. Having multiple slings allows one of them to remain in place while resident is in bed or chair for only a short period, reducing the number of times the caregiver lifts and positions resident. Portable compact lifts may be useful where space or storage is limited. Ensure device is rated for the resident weight. Electric/battery powered lifts are preferred to crank or pump type devices to allow a smoother movement for the resident, and less physical exertion by the caregiver. Enhances resident safety and comfort.

Resident Lifting

Description: Ceiling-mounted lift device



When to Use: Lifting residents who are totally dependent, are partial- or non-weight bearing, very heavy, or have other physical limitations. Transfers from bed to chair (wheel chair, Geri or cardiac chair), chair or floor to bed, for bathing and toileting, or after a resident falls. A horizontal frame system or litter attached to the ceiling-mounted device can be used when transferring residents who cannot be transferred safely between 2 horizontal surfaces, such as a bed to a stretcher or gurney while lying on their back, using other devices.

Points to Remember: More than one caregiver may be needed. Some residents can use the device without assistance. May be quicker to use than portable device. Motors can be fixed or portable (lightweight). Device can be operated by hand-held control attached to unit or by infrared remote control. Ensure device is rated for the resident weight. Increases residents' safety and comfort during transfer.

Ambulation

Description: Ambulation assist device

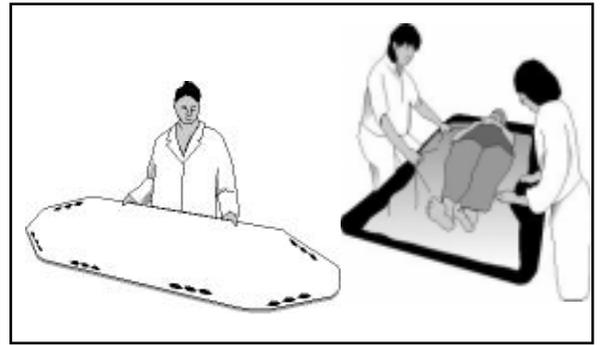


When to Use: For residents who are weight bearing and cooperative and who need extra security and assistance when ambulating.

Points to Remember: Increases resident safety during ambulation and reduces risk of falls. The device supports residents as they walk and push it along during ambulation. Ensure height adjustment is correct for resident before ambulation. Ensure device is in good working order before use and rated for the resident weight to be lifted. Apply brakes before positioning resident in or releasing resident from device.

Lateral Transfer; Repositioning

Description: Devices to reduce friction force when transferring a resident such as a draw sheet or transfer cot with handles to be used in combination slippery sheets, low friction mattress covers, or slide boards; boards or mats with vinyl coverings and rollers; gurneys with transfer devices; and air-assist lateral sliding aid or flexible mattress inflated by portable air supply.



When To Use: Transferring a partial- or non-weight bearing resident between 2 horizontal surfaces such as a bed to a stretcher or gurney while lying on their back or when repositioning resident in bed.

Points to Remember: More than one caregiver is needed to perform this type of transfer or repositioning. Additional assistance may be needed depending upon resident status, e.g., for heavier or non-cooperative residents. Some devices may not be suitable for bariatric residents. When using a draw sheet combination use a good hand-hold by rolling up draw sheets or use other friction-reducing devices with handles such as slippery sheets. Narrower slippery sheets with webbing handles positioned on the long edge of the sheet may be easier to use than wider sheets. When using boards or mats with vinyl coverings and rollers use a gentle push and pull motion to move resident to new surface.

Look for a combination of devices that will increase resident's comfort and minimize risk of skin trauma. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back. Count down and synchronize the transfer motion between caregivers.

Lateral Transfer; Repositioning

Description: Convertible wheelchair, Geri or cardiac chair to bed; beds that convert to chairs.



When to Use: For lateral transfer of residents who are partial- or non-weight bearing. Eliminates the need to perform lift transfer in and out of wheelchairs. Can also be used to assist residents who are partially weight bearing from a sit-to-stand position. Beds that convert to chairs can aid repositioning residents who are totally dependent, non-weight bearing, very heavy, or have other physical limitations.

Points to Remember: More than one caregiver is needed to perform lateral transfer. Additional assistance for lateral transfer may be needed depending on residents status, e.g., for heavier or non-cooperative residents. Additional friction-reducing devices may be required to reposition resident. Heavy duty beds are available for bariatric residents. Device should have easy-to-use controls located within easy reach of the caregiver, sufficient foot clearance, and wide range of adjustment. Motorized height-adjustable devices are preferred to those adjusted by crank mechanism to minimize physical exertion. Always ensure device is in good working order before use. Ensure wheels on equipment are locked. Ensure transfer surfaces are at same level and at a height that allows caregivers to work at waist level to avoid extended reaches and bending of the back.

Repositioning in Chair

Description: Variable position Geri and Cardiac chairs



When to Use: Repositioning partial- or non-weight-bearing residents who are cooperative.

Points to Remember: More than one caregiver is needed and use of a friction-reducing device is needed if resident cannot assist to reposition self in chair. Ensure use of good body mechanics by caregivers. Wheels on chair add versatility. Ensure that chair is easy to adjust, move, and steer. Lock wheels on chair before repositioning. Remove trays, footrests, and seat belts where appropriate. Ensure device is rated for the resident weight.

Lateral Transfer in Sitting Position

Description: Transfer boards – wood or plastic (some with movable seat)

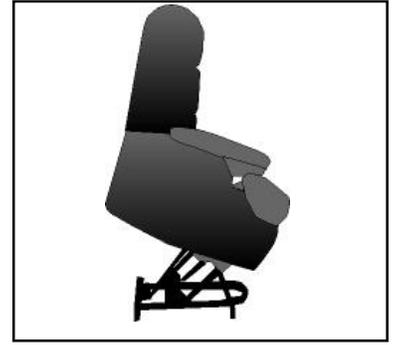


When to Use: Transferring (sliding) residents who have good sitting balance and are cooperative from one level surface to another, e.g., bed to wheelchair, wheelchair to car seat or toilet. Can also be used by residents who require limited assistance but need additional safety and support.

Points to Remember: Movable seats increase resident comfort and reduce incidence of tissue damage during transfer. More than one caregiver is needed to perform lateral transfer. Ensure clothing is present between the resident's skin and the transfer device. The seat may be cushioned with a small towel for comfort. May be uncomfortable for larger residents. Usually used in conjunction with gait belts for safety depending on resident status. Ensure boards have tapered ends, rounded edges, and appropriate weight capacity. Ensure wheels on bed or chair are locked and transfer surfaces are at same level. Remove lower bedrails from bed and remove arms and footrests from chairs as appropriate.

Transfer from Sitting to Standing Position

Description: Lift cushions and lift chairs



When to Use: Transferring residents who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for independent residents who need an extra boost to stand.

Points to Remember: Lift cushions use a lever that activates a spring action to assist residents to rise up. Lift chairs are operated via a hand-held control that tilts forward slowly, raising the resident. Residents need to have physical and cognitive capacity to be able to operate lever or controls. Always ensure device is in good working order before use and is rated for the resident weight to be lifted. Can aid resident independence.

Transfer from Sitting to Standing Position

Description: Stand-assist devices can be fixed to bed or chair or be free-standing



When to Use: Transferring residents who are weight-bearing and cooperative and can pull themselves up from sitting to standing position. Can be used for independent residents who need extra support to stand.

Points to Remember: Check that device is stable before use and is rated for resident weight to be supported. Ensure frame is firmly attached to bed, or if it relies on mattress support that mattress is heavy enough to hold the frame. Can aid resident independence.

Weighing

Description: Scales with ramp to accommodate wheelchairs; portable-powered lift devices with built-in scales; beds with built-in scales.



When to Use: To reduce the need for additional transfer of partial- or non-weight-bearing or totally dependent residents to weighing device.

Points to Remember: Some wheelchair scales can accommodate larger wheelchairs. Built-in bed scales may increase weight of the bed and prevent it from lowering to appropriate work heights.

Transfer from Sitting to Standing Position; Ambulation

Description: Gait belts/transfer belts with handles



When to Use: Transferring residents who are partially dependent, have some weight-bearing capacity, and are cooperative. Transfers such as bed to chair, chair to chair, or chair to car; when repositioning residents in chairs; supporting residents during ambulation; and in some cases when guiding and controlling falls or assisting a resident after a fall.

Points to Remember: More than one caregiver may be needed. Belts with padded handles are easier to grip and increase security and control. Always transfer to resident's strongest side. Use good body mechanics and a rocking and pulling motion rather than lifting when using a belt. Belts may not be suitable for ambulation of heavy residents or residents with recent abdominal or back surgery, abdominal aneurysm, etc. Should not be used for lifting residents. Ensure belt is securely fastened and cannot be easily undone by the resident during transfer. Ensure a layer of clothing is between residents' skin and the belt to avoid abrasion. Keep resident as close as possible to caregiver during transfer. Lower bedrails, remove arms and foot rests from chairs, and other items that may obstruct the transfer.

For use after a fall always assess the resident for injury prior to movement. If resident can regain standing position with minimal assistance, use gait or transfer belts with handles to aid resident. Keep back straight, bend legs, and stay as close to resident as possible. If resident cannot stand with minimal assistance, use a powered portable or ceiling-mounted lift device to move resident.

Repositioning

Description:
Electric powered height adjustable bed

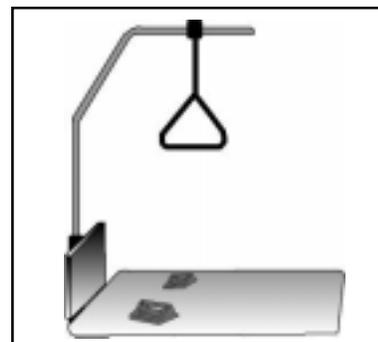


When To Use: For all activities involving resident care, transfer, repositioning in bed, etc., to reduce caregiver bending when interacting with resident.

Points to Remember: Device should have easy-to-use controls located within easy reach of the caregiver to promote use of the electric adjustment, sufficient foot clearance, and wide range of adjustment. Adjustments must be completed in 20 seconds or less to ensure staff use. For residents that may be at risk of falling from bed some beds that lower closer to the floor may be needed. Heavy duty beds are available for bariatric residents. Beds raised and lowered with an electric motor are preferred over crank-adjust beds to allow a smoother movement for the resident and less physical exertion to the caregiver.

Repositioning

Description: Trapeze bar; hand blocks and push up bars attached to the bed frame

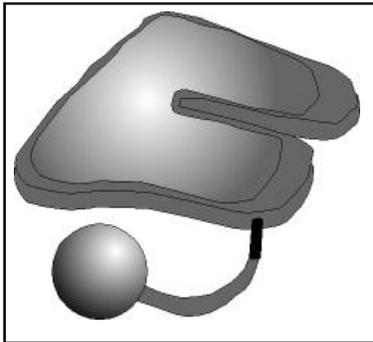


When to Use: Reposition residents that have the ability to assist the caregiver during the activity, i.e., residents with upper body strength and use of extremities, who are cooperative and can follow instructions.

Points to Remember: Residents use trapeze bar by grasping bar suspended from an overhead frame to raise themselves up and reposition themselves in a bed. Heavy duty trapeze frames are available for bariatric residents. If a caregiver is assisting ensure that bed wheels are locked, bedrails are lowered and bed is adjusted to caregiver's waist height. Blocks also enable residents to raise themselves up and reposition themselves in bed. Bars attached to the bed frame serve the same purpose. May not be suitable for heavier residents. Can aid resident independence.

Repositioning

Description: Pelvic lift devices (hip lifters)



When to Use: To assist residents who also are cooperative and can sit up to a position on a special bed pan.

Points to Remember: Convenience of device may reduce need for resident lifting during toileting. Device is positioned under the pelvis. The part of the device located under the pelvis gets inflated so the pelvis is raised and a special bedpan put underneath. The head of the bed is raised slightly during this procedure. Use correct body mechanics, lower bedrails and adjust bed to caregivers waist height to reduce bending.

Bathtub, Shower, and Toileting Activities

Description: Height-adjustable bathtub and easy-entry bathtubs



When to Use: Bathing residents who sit directly in the bathtub, or to assist ambulatory residents climb more easily into a low tub, or easy-access tub. Bathing residents in portable-powered or ceiling-mounted lift device using appropriate bathing sling.

Points to Remember: Reduces awkward postures for caregivers and those who clean the tub after use. The tub can be raised to eliminate bending and reaching for the caregiver. Use correct body mechanics, and adjust the tub to the caregiver's waist height when performing hygiene activities. Increases resident safety and comfort.

Bathtub, Shower, and Toileting Activities

Description: Height-adjustable shower gurney or lift bath cart with water-proof top



When to Use: For bathing non-weight bearing residents who are unable to sit up. Transfer resident to cart with lift or lateral transfer boards or other friction-reducing devices.

Points to Remember: The cart can be raised to eliminate bending and reaching to the caregiver. Foot and head supports are available for resident comfort. May not be suitable for bariatric residents. Look for carts that are power-driven to reduce force required to move and position device.

Bathtub, Shower, and Toileting Activities

Description: Built-in or fixed bath lifts



When to Use: Bathing residents who are partially weight bearing, have good sitting balance, can use upper extremities (have upper body strength), are cooperative, and can follow instructions. Useful in small bathrooms where space is limited.

Points to Remember: Ensure that seat raises so resident's feet clear tub, easily rotates, and lowers resident into water. May not be suitable for heavy residents. Always ensure lifting device is in good working order before use and rated for the resident weight. Choose device with lift mechanism that does not require excessive effort by caregiver when raising and lowering device.

Bathtub, Shower, and Toileting Activities

Description: Shower and toileting chairs

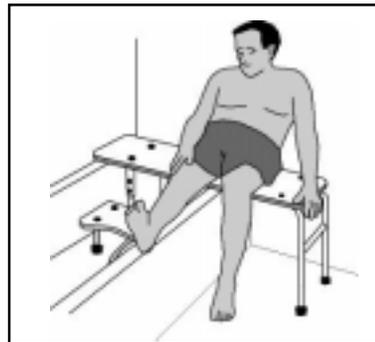


When to Use: Showering and toileting residents who are partially dependent, have some weight bearing capacity, can sit up unaided, and are able to bend hips, knees, and ankles.

Points to Remember: Ensure that wheels move easily and smoothly; chair is high enough to fit over toilet; chair has removable arms, adjustable footrests, safety belts, and is heavy enough to be stable, and that the seat is comfortable, accommodates larger residents, and has a removable commode bucket for toileting. Ensure that brakes lock and hold effectively and that weight capacity is sufficient.

Bathtub, Shower, and Toileting Activities

Description: Bath boards and transfer benches



When to Use: Bathing residents who are partially weight bearing, have good sitting balance, can use upper extremities (have upper body strength), are cooperative, and can follow instructions. Independent residents can also use these devices.

Points to Remember: To reduce friction and possible skin tears, use clothing or material between the resident's skin and the board. Can be used with a gait or transfer belt and/or grab bars to aid transfer. Back support and vinyl padded seats add to bathing comfort. Look for devices that allow for water drainage and have height-adjustable legs. May not be suitable for heavy residents. If wheelchair is used ensure wheels are locked, the transfer surfaces are at the same level, and device is securely in place and rated for weight to be transferred. Remove arms and foot rests from chairs as appropriate and ensure that floor is dry.

Bathtub, Shower, and Toileting Activities

Description: Toilet seat risers



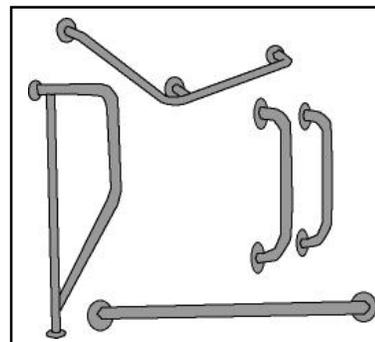
When to Use: For toileting partially weight-bearing residents who can sit up unaided, use upper extremities (have upper body strength), are able to bend hips, knees, and ankles, and are cooperative. Independent residents can also use these devices.

Points to Remember: Risers decrease the distance and amount of effort required to lower and raise residents. Grab bars and height-adjustable legs add safety and versatility to the device. Ensure device is stable and can accommodate resident's weight and size.

Bathtub, Shower, and Toileting Activities

Description Grab bars and stand assists; can be fixed or mobile.

Long-handled or extended shower heads, or brushes can be used for personal hygiene.



When to Use: Bars and assists help when toileting, bathing, and/or showering residents who need extra support and security. Residents must be partially weight bearing, able to use upper extremities (have upper body strength), and be cooperative.

Long-handled devices reduce the amount of bending, reaching, and twisting required by the caregiver when washing feet, legs, and trunk of residents. Independent residents who have difficulty reaching lower extremities can also use these devices.

Points to Remember: Movable grab bars on toilets minimize workplace congestion. Ensure bars are securely fastened to wall before use.

Section IV. Identifying Problems and Implementing Solutions for Activities Other than Resident Lifting and Repositioning

Some reports indicate a significant number of work-related MSDs in nursing homes occur in activities other than resident lifting. (2, 3) Examples of some of the activities that the nursing home operator may want to review are:

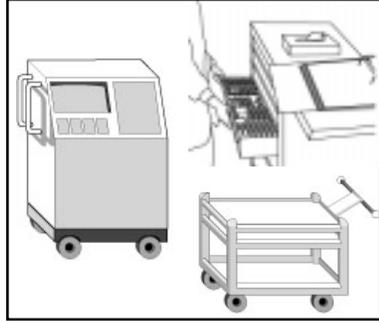
- bending to make a bed or feed a resident;
- lifting food trays above shoulder level or below knee level;
- collecting waste;
- pushing heavy carts;
- bending to remove items from a deep cart;
- lifting and carrying when receiving and stocking supplies;
- bending and manually cranking an adjustable bed; and
- removing laundry from washing machines and dryers.

These tasks may not present problems in all circumstances. Employers should consider the duration, frequency, and magnitude of employee exposure to forceful exertions, repetitive activities and awkward postures when determining if problems exist in these and other areas. In the vast majority of cases, job assessments can be accomplished by observing employees performing the task, by discussing with employees the activities and conditions that they associate with difficulties, and checking injury records. Observation provides general information about the workstation layout, tools, equipment, and general environmental conditions in the workplace. Discussing tasks with employees helps to ensure that a complete picture of the process is obtained. Employees who perform a given task are also often the best sources for identifying the cause of a problem, and developing the most practical and effective solutions. Once information is obtained and problems identified, suitable improvements can be implemented. Finally, there are a number of resources available to help determine if specific activities have the potential for causing injuries. For example, support is available from OSHA's consultation program, insurance companies, and state workers' compensation programs.

The following are examples of possible solutions for activities other than resident lifting and repositioning.

Storage and Transfer of Food, Supplies and Medications

Description:
Use of carts



When to Use: When moving food trays, cleaning supplies, equipment, maintenance tools, and dispensing medications.

Points to Remember: Speeds process for accessing and storing items. Placement of items on the cart should keep the most frequently used and heavy items within easy reach between hip and shoulder height. Carts should have full-bearing wheels of a material designed for the floor surface in your facility. Cart handles that are vertical, with some horizontal adjustability will allow all employees to push at elbow height and shoulder width. Carts should have wheel locks. Handles that can swing out of the way may be useful for saving space or reducing reach. Heavy carts should have brakes. Balance loads and keep loads under cart weight restrictions. Ensure stack height does not block vision. Low profile medication carts with easy-open side drawers are recommended to accommodate hand height of shorter nurses.

Mobile Medical Equipment

Description: Work methods and tools to transport equipment



When to Use: When transporting assistive devices and other equipment

Points to Remember:

Oxygen tanks: Use small cylinders with handles to reduce weight and allow for easier gripping. Secure oxygen tanks to transport device.

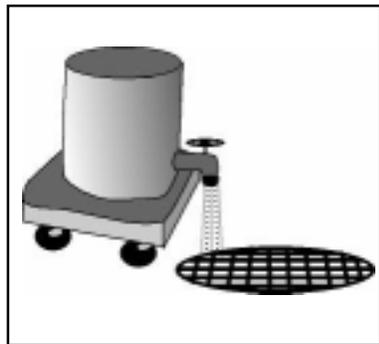
Medication pumps: Use stands on wheels.

Transporting equipment: Push equipment, rather than pull, when possible. Keep arms close to the body and push with whole body and not just arms. Remove unnecessary objects to minimize weight. Avoid obstacles that could cause abrupt stops. Place equipment on a rolling device if possible. Take defective equipment out of service. Perform routine maintenance on all equipment.

Ensure that when moving and transporting residents, additional equipment such as oxygen tanks and IV/medication poles are attached to wheelchairs or gurneys or moved by another caregiver to avoid awkwardly pushing with one hand and holding free-standing equipment with the other hand.

Working with Liquids in Housekeeping

Description: Filling and emptying liquids from containers



When to Use: In housekeeping areas when filling and emptying buckets with floor drain arrangements.

Points To Remember: Reduces risk of spills, slips, speeds process, and reduces waste. The faucet and floor drain is used in housekeeping. Ensure that casters don't get stuck in floor grate. Use hose to fill bucket. Use buckets with casters to move mop bucket around. Ensure casters are maintained and roll easily.

Working with Liquids in Kitchens

Description: Filling and emptying liquids from containers

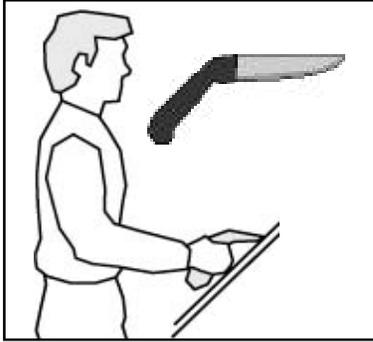


When to Use: In dietary when pouring soups or other liquid foods that are heavy.

Points To Remember: Reduces risk of spills and burns, speeds process, and reduces waste. Use an elevated faucet or hose to fill large pots. Avoid lifting heavy pots filled with liquids. Use ladle to empty liquids, soups, etc. from pots. Small sauce pans can also be used to dip liquids from pots. If the worker stands for more than 2 hours per day, shock-absorbing floors or insoles will minimize back and leg strain. With hot liquids, ensure a splash guard is included.

Hand Tools

Description: Select and use properly designed tools



When to Use: When selecting frequently used tools for the kitchen, housekeeping, laundry and maintenance areas.

Points To Remember: Enhances tool safety, speeds process, and reduces waste. Handles should fit the grip size of the user. Use bent-handled tools to avoid bending wrists. Use appropriate tool weight. Select tools that have minimal vibration or vibration damping devices. Implement a regular maintenance program for tools to keep blades sharp and edges and handles intact. Always wear the appropriate personal protective equipment.

Linen Carts

Description: Spring loaded carts that automatically bring linen within easy reach



When to Use: Moving or storing linen.

Points to Remember: Speeds process for handling linen, and reduces wear on linen due to excessive pulling. Select a spring tension that is appropriate for the weight of the load. Carts should have wheel locks and height-appropriate handles that can swing out of the way. Heavy carts should have brakes.

Handling Bags

Description: Equipment and practices for handling bags

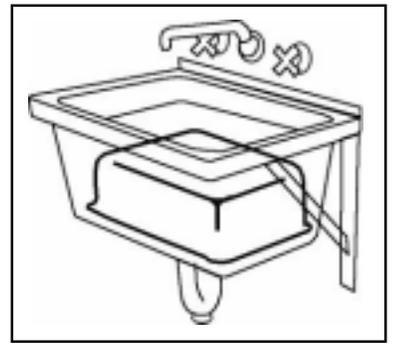


When to Use: When handling laundry, trash and other bags.

Points to Remember: Reduces risk of items being dropped, and speeds process for removing and disposing of items. Receptacles that hold bags of laundry or trash should have side openings that keep the bags within easy reach and allow employees to slide the bag off the cart without lifting. Provide handles to decrease the strain of handling. Chutes and dumpsters should be positioned to minimize lifting. It is best to lower the dumpster or chute rather than lift materials to higher levels. Provide automatic opening or hardware to keep doors open to minimize twisting and awkward handling.

Reaching into Sink

Description: Tools used to modify a deep sink for cleaning small objects



When to Use: Cleaning small objects in a deep sink.

Points to Remember: Place an object such as a plastic basin in the bottom of the sink to raise the work surface. An alternative is to use a smaller porous container to hold small objects for soaking, transfer to an adjacent countertop for aggressive cleaning, and then transfer back to the sink for final rinsing. Store inserts and containers in a convenient location to encourage consistent use. This technique is not suitable in kitchens/food preparation.

Loading or Unloading Laundry

Description: Front-loading washers and dryers



When to Use: When loading or unloading laundry from washers, dryers and other laundry equipment.

Points to Remember: Speeds process for retrieving and placing items, and minimizes wear-and-tear on linen. Washers with tumbling cycles separate clothes, making removal easier. For deep tubs, a rake with long or extendable handle can be used to pull linen closer to the door opening. Raise machines so that opening is between hip and elbow height of employees. If using top loading washers, work practices that reduce risk include handling small loads of laundry, handling only a few items at a time, and bracing your body against the front of the machine when lifting. If items are knotted in the machine, brace with one hand while using the other to gently pull the items free. Ensure that items go into a cart rather than picking up baskets of soiled linen or wet laundry.

Cleaning Rooms (Wet Method)

Description: Work methods and tools to clean resident rooms with water and chemical products



When to Use: When cleaning with water and chemical products; and using spray bottles.

Points to Remember:

Cleaning Implement use: Alternate leading hand; avoid tight static grip and use padded non-slip handles.

Spray bottles: Use trigger handles long enough for the index and middle fingers. Avoid using the ring and little fingers.

For all cleaning: Use chemical cleaners and abrasive sponges to minimize scrubbing force. Use kneepads when kneeling. Avoid bending and twisting. Use extension handles, step stools, or ladders for overhead needs. Use carts to transport supplies or carry only small quantities and weights of supplies. Ventilation of rooms may be necessary when chemicals are used.

Avoid lifting heavy buckets, e.g., lifting a large, full bucket from a sink. Use a hose or similar device to fill buckets with water. Use wheels on buckets that roll easily and have functional brakes. Ensure that casters are maintained. Use rubber-soled shoes in wet areas to prevent slipping.

Cleaning wheelchairs: Cleaning workstation should be at appropriate height.

Cleaning Rooms (Electrical)

Description: Work methods and tools to vacuum and buff floors



When to Use: Vacuuming and buffing floors.

Points to Remember: Both vacuum cleaners and buffers should have lightweight construction, adjustable handles, triggers (buffer) long enough to accommodate at least the index and middle fingers, and easy to reach controls. Technique is important for both devices, including use of appropriate grips, avoiding tight grips and for vacuuming, by alternating grip. The use of telescoping and extension handles, hoses and tools can reduce reaching for low areas, high areas and far away areas. Maintain and service the equipment and change vacuum bags when 1/2 to 3/4 full.

Vacuums and other powered devices are preferred over manual equipment for moderate-to-long duration use. Heavy canisters or other large, heavy equipment should have brakes.

Section V. Training

Training is critical for employers and employees to safely use the solutions identified in these guidelines. Of course, training should be provided in a manner and language that all employees can understand. The following describes areas of training for nursing home employees, their supervisors, and program managers who are responsible for planning and managing the nursing home's ergonomics efforts. OSHA recommends refresher training be provided as needed to reinforce initial training and to address new developments in the workplace.

Nursing Assistants and Other Workers at Risk of Injury

Employees should be trained before they lift or reposition residents, or perform other work that may involve risk of injury. Ergonomics training can be included with other safety and health training, or incorporated into general instructions provided to employees. Training is usually most effective when it includes case studies or demonstrations based on the nursing home's policies, and allows enough time to answer any questions that may arise. Training should ensure that these workers understand:

- policies and procedures that should be followed to avoid injury, including proper work practices and use of equipment;
- how to recognize MSDs and their early indications;
- the advantages of addressing early indications of MSDs before serious injury has developed; and
- the nursing home's procedures for reporting work-related injuries and illnesses as required by OSHA's injury and illness recording and reporting regulation (29 CFR 1904).

Training for Charge Nurses and Supervisors

Charge nurses and supervisors should reinforce the safety program of the facility, oversee reporting guidelines and help assure the implementation of resident and task specific ergonomics recommendations, *e.g.*, using a mechanical lift. Because charge nurses and supervisors are likely to receive reports of injuries, and are usually responsible for implementing the nursing home's work practices, they may need more detailed training than nursing assistants on:

- methods for ensuring use of proper work practices;
- how to respond to injury reports; and
- how to help other workers implement solutions.

Training for Designated Program Managers

Staff members who are responsible for planning and managing ergonomics efforts need training so they can identify ergonomics concerns and select appropriate solutions. These staff members should receive information and training that will allow them to:

- identify potential problems related to physical activities in the workplace through observation, use of checklists, injury data analysis, or other analytical tools;

- address problems by selecting proper equipment and work practices;
- help other workers implement solutions; and
- evaluate the effectiveness of ergonomics efforts.

Section VI. Additional Sources of Information

The following sources may be useful to those seeking further information about ergonomics and the prevention of work-related musculoskeletal disorders in nursing homes.

A Back Injury Prevention Guide for Health Care Providers, Cal/OSHA Consultation Programs, (800) 963-9424, www.dir.ca.gov/dosh/dosh_publications/backinj.pdf

This guide discusses the scope of the back injury problem in health care, how to analyze the workplace, how to identify and implement improvements, and how to evaluate results. It includes checklists that can assist in analyzing the work environment.

Patient Care Ergonomics Resource Guide: Safe Patient Handling and Movement, Patient Safety Center of Inquiry, Veterans Health Administration and Department of Defense, (813) 558-3902, www.patientsafetycenter.com

This document describes a comprehensive program developed to prevent MSDs related to resident lifting and repositioning. It includes assessment criteria and flowcharts for selecting equipment and techniques for safe lifting and repositioning based on resident characteristics.

Resident Assessment Instrument, U.S. Department of Health and Human Services – Centers for Medicare and Medicaid Services (CMS), www.cms.hhs.gov/medicaid/mds20/

This document is used by many nursing homes to evaluate resident needs and capabilities.

Elements of Ergonomics Programs, U.S. Department of Health and Human Services – National Institute for Occupational Safety and Health, (800) 356 4674, www.cdc.gov/niosh/ephome2.html

The basic elements of a workplace program aimed at preventing work-related musculoskeletal disorders are described in this document. It includes a "toolbox," which is a collection of techniques, methods, reference materials, and sources for other information that can help in program development.

In addition, OSHA's Training Institute in Arlington Heights, Illinois, offers courses on various safety and health topics, including ergonomics. Courses are also offered through Training Institute Education Centers located throughout the country. For a schedule of courses, contact the OSHA Training Institute, 2020 South Arlington Heights Road, Arlington Heights, Illinois, 60005, (847) 297-4810, or visit OSHA's training resources webpage at www.osha.gov/fso/ote/training/training_resources.html.

There are many states and territories that operate their own occupational safety and health programs under a plan approved by OSHA (23 cover both private sector, state and local government employees, and three only cover public employees). Information is available on OSHA's Website at www.osha.gov/fso/osp/index.html on how to contact a state plan directly for information about specific state nursing home initiatives and compliance assistance, or state standards that may apply to nursing homes.

A free consultation service is available to provide occupational safety and health assistance to businesses. OSHA Consultation is funded primarily by federal OSHA but delivered by the 50 state governments, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The states offer the expertise of highly qualified occupational safety and health professionals to employers who request help to establish and maintain a safe and healthful workplace. Developed for small and medium-sized employers in hazardous industries or with hazardous operations, the service is provided at no cost to the employer and is confidential. Information on OSHA Consultation can be found at www.osha.gov/html/consultation.html, or by requesting the booklet *Consultation Services for the Employer* (OSHA 3047) from OSHA's Publications Office at (202) 693-1888.

References

- (1) Documents submitted to OSHA by Wyandot County Nursing Home. (Ex. 3-12)
- (2) Garg, A. 1999. Long-Term Effectiveness of “Zero-Lift Program” in Seven Nursing Homes and One Hospital. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institution for Occupational Safety and Health (NIOSH), Cincinnati, OH. August. Contract No. U60/CCU512089-02. (Ex. 3-3)
- (3) Fragala, G., PhD, PE, CSP. 1996. Ergonomics: How to Contain On-the-Job Injuries in Health Care. Joint Commission on Accreditation of Healthcare Organizations.
- (4) Occupational Safety and Health Administration, Region II. Summer, 2002. New York OSHA E-Newsletter, Vol. 1, Issue 2.
- (5) National Institute for Occupational Safety and Health (NIOSH). 1997. Musculoskeletal Disorders and Workplace Factors – A Critical Review of Epidemiologic Evidence for Work-Related Musculoskeletal Disorders of the Neck, Upper Extremity, and Low Back. (Ex. 3-4)
- (6) National Research Council and Institute of Medicine. 2001. Musculoskeletal Disorders and the Workplace – Low Back and Upper Extremities. National Academy of Sciences. Washington, DC: National Academy Press. (Ex. 3-6)
- (7) Taylor and Francis. 1988. Cumulative Trauma Disorders: A Manual for MSDs of the Upper Limb. Putz-Anderson, V., ed.
- (8) Documents submitted to OSHA by Citizens Memorial. (Ex. 3-25)
- (9) U.S. General Accounting Office. 1997. Worker Protection – Private Sector Ergonomics Programs Yield Positive Results. August. GAO/HEHS-97-163. (Ex. 3-92)
- (10) American Health Care Association, American Association of Homes and Services for the Aging, National Center for Assisted Living. 2002. Comments submitted to OSHA. (Ex. 4-15)

Appendix - A Nursing Home Case Study

Introduction

Wyandot County Nursing Home used a process that reflects many of the recommendations in these guidelines to address safety and health concerns and phase-in its current program that entails no manual lifting of residents. First and foremost, Wyandot's administrator provided strong commitment and support in addressing the home's problems. He also involved Wyandot's workers in every phase of the effort. He talked to his employees, learned about stressful parts of their jobs, and then found solutions. He and his employees identified existing and potential sources of injury at the home and worked to implement solutions. He trained employees each time the nursing home introduced new equipment. He continually checked new equipment, and he continues to evaluate the overall effectiveness of his safety and health efforts.

This case study was developed from information provided by Wyandot County Nursing Home. OSHA visited the nursing home to discuss the ergonomics program with the nursing home administrator, observe ergonomics corrective actions, and talk to employees, residents, and family members about their experiences.

Wyandot is located in Upper Sandusky, Ohio. It is a 100-bed, county-run facility that has served Wyandot County in its present building for the past 28 years. It is divided into two sections to serve residents with different levels of need. The A-Wing, with 32 rooms, serves residents who are mostly ambulatory and require only a minimum of help with daily living. In the B- and C-Wings, with 32 double rooms and four private ones, residents receive care that ranges from extensive to total. Wyandot has 90 employees, 45 of whom are nursing assistants. This makes for a nursing staff ratio of 2.4 hours for each resident per day.

Identifying Problems

Before Wyandot implemented its ergonomics program, the home was experiencing problems that were a growing concern to both the county and Wyandot's administrator. According to Wyandot, workers' compensation costs averaged almost \$140,000 from 1995-1997. The turnover rate among nursing assistants averaged over 55 percent during that same time period. This meant that of the 45 nursing assistants working at Wyandot, on average 25 new ones had to be hired each year.

Wyandot's administrator began to look for more effective ways to address injuries among workers and the high turnover rate. A back injury suffered by a worker that cost Wyandot \$240,000 in workers' compensation expenses provided significant motivation to find a strategy that would work. As Wyandot's administrator investigated that injury, he also examined other sources of potential injury within the home. In doing so, he learned that resident transfer and repositioning tasks presented high risks for injuries.

He called on the Ohio Bureau of Workers' Compensation (OBWC), for help because he thought Wyandot was following best practices and people were still being injured. An OBWC ergonomist visited the home and told him that he had unrealistic expectations about his nursing staff's ability to manually lift and reposition residents.

Involving Employees

Wyandot's administrator thought that he could better use his existing staff. After hearing about a "no lift" policy and seeing an impressive demonstration of mechanical lifts at an industry conference, he began to consider setting up a program at Wyandot. He became convinced that such a program would keep employees safer and help slow the turnover rate while ensuring safety and high quality care for residents.

He decided that the best approach was to involve employees at every level in reducing injuries and slowing the turnover rate. More than 30 workers volunteered to examine the tasks of moving and repositioning residents.

Wyandot employees concluded that better body mechanics -- the traditional method of lifting and transferring residents at most nursing homes -- was not the answer. In fact, he and his staff determined that there was no safe way to lift a resident other than with mechanical lifts. To determine what equipment would work best, Wyandot tried out various pieces of equipment, evaluated each lift, and then decided what would be most appropriate for Wyandot's needs.

Implementing Solutions

With recommendations from employees, Wyandot's administrator bought several portable mechanical lifts for the B- and C-wings. These involved portable sit-to-stand lifts, walk/ambulating lifts, and total lifts. Nurses and assistants could move each of these from room to room as they worked with individual residents. However, many of the staff remained unconvinced of the value of using equipment. In fact, initially only the workers who had actually evaluated the lifts were using them.

According to Wyandot's administrator, it was very difficult getting workers to overcome their insistence on doing things the old way. Because many workers said it took too long to use the mechanical lifts, one of the co-charge nurses decided to do a time study. She wanted to test how long it took to lift a resident manually compared to using a mechanical lift. The mechanical lift took about 5 minutes. Meanwhile, to perform the manual lift, a nursing assistant first had to find someone to help. This took 15 minutes. Thus, the time study showed that using the equipment actually saved time.

One worker, who admitted that she did not initially use the sit-to-stand lift because it was a "hassle," reconsidered her opinion after an outbreak of the flu reduced the number of staff members available for assistance. In her words, "I was forced to use the lift. Awesome. It was just great. I was so sorry my fellow employees had to suffer with the flu bug to get me to use this contraption."

Wyandot's administrator also wanted to replace the old hand-crank beds at Wyandot with electric beds. To do this, he also needed to find beds that would be used in the "low-bed" system in place for many residents. There were not many options available, so he took his ideas and engineering background to a bed company and inquired about having beds designed to fit Wyandot's needs. The bed manufacturer

designed the new beds to lift from the floor to a height of about 30 inches in 20 seconds. In addition, these fast beds were designed so that residents would be less likely to slide to the foot of the bed as they were raised to a sitting position. As a result, residents would not need to be repositioned. Also, the beds could be used with a gait-belt for ambulatory residents to assist them from a sitting to a standing position.

About three years after Wyandot began its ergonomics effort, the nursing home received a grant from the OBWC Division of Safety and Hygiene through an ergonomic emphasis program to deal with cumulative trauma disorders. The grant enabled Wyandot's administrator to purchase 58 fast electric beds, a turning point for staff acceptance. When the first ceiling lifts were installed seven months later, employees were ready to use them.

One nursing assistant, who has been with Wyandot for 19 years, explained why she liked the new beds so much. "We can quickly bring the bed up to our work height with a push of a button and we can reposition a resident . . . with ease without stooping or struggling."

The final phase of Wyandot's program began with the introduction of the ceiling lifts. Wyandot's administrator evaluated several ceiling lift systems. Wyandot chose a system with a motorized lift and a ceiling mounted track. Tracks were retrofitted into the rooms at a cost of about \$12,000 for two double rooms and one bathroom. The first double room had a track that extended into the bathroom. However, newer systems used a transfer between the room and bathroom, which simplified the system and reduced costs.

Providing Training

As Wyandot purchased and installed new equipment, workers received training on how to use it, and guidelines for equipment use were put into place. An LPN in-service director did the training. New employees learn how to use the devices and know where to go for further instruction or help. Eventually, most of the nursing assistants adapted to the mechanical lifts and refused to use any other lifting techniques.

Providing Management Support

Wyandot's administrator took a personal interest in ergonomic issues. To address high injury and turnover rates at Wyandot, he remained committed to identifying and solving problems. For example, on one occasion the staff said that the lifts were not easy to roll on the floors in the B- and C-Wings. To solve the problem, he experimented with different wheels that would roll more easily and turn in tight places with less effort. Finally, he worked with a manufacturer to find and buy better casters to suit the home's flooring.

Evaluating Efforts

To start with, Wyandot's administrator spent \$150,000 to buy equipment. He later set aside another \$130,000 to continue his efforts, for a total of \$280,000. Wyandot has saved \$55,000 annually in payroll costs, according to Wyandot's administrator,

because of reduced overtime and absenteeism. The home estimates savings of more than \$125,000 in turnover costs. Meanwhile, workers' compensation costs also have fallen drastically. For example, Wyandot reports that, after the program was implemented workers' compensation costs declined from an average of \$140,000 per year to began to average less than \$4,000 per year.

From the time workers began to use the sit-to-stand lifts, which were among the first to be introduced at Wyandot, the incidence of back injuries stopped. Once the fast beds were introduced only six new hires were needed in the following year.

Worker satisfaction has increased greatly. One nursing assistant, who has spent most of her career working in nursing homes, confessed to being sore and unhappy at Wyandot before the lifts were introduced. After the innovations at the nursing home, she reported that she is no longer hurting. She concluded that "I think my career is right here in the Wyandot County Nursing Home till my time is due to retire comfortable. And you know if my time comes to be in a nursing home I do hope I get one like ours."

Mechanical lifts have also helped return a sense of dignity to Wyandot's residents. As one nursing assistant put it, through the use of the mechanical lifts, the residents are able to wear normal clothing again, which "improves their self-esteem and keeps them warmer."

The wife of one totally dependent resident who has been at Wyandot for eight years reports that because of her husband's size, he cannot help the nurses and nursing assistants in moving him from place to place. Before the overhead electric lifts and electric beds were installed in his room, it took three and sometimes four nursing assistants to move him from the bed to his cart or to the toilet. He had numerous bruises from falling and dreaded being moved. With the lifts in place, the resident's wife reports that the staff "can easily move him about to his chair and to the toilet. He cannot sit without help but the sling gives him comfortable support and makes it possible to have some dignity."

 **U.S. Department of Labor**
Occupational Safety & Health Administration
www.osha.gov MyOSHA Search GO [Advanced Search](#) | [A-Z Index](#)

[Safety and Health Topics](#) > [Workplace Violence](#) > Health Care and Social Service Workers

Workplace Violence - Health Care and Social Service Workers

[Slide Presentation](#)

Workplace violence has emerged as an important safety and health issue in today's workplace. The Occupational Safety and Health Administration's (OSHA's) response to the problem of workplace violence in certain industries has been the production of OSHA's guidelines and recommendations to those industries for implementing workplace violence prevention programs.

In 1996, OSHA published Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. The guidelines are based on OSHA's voluntary generic Safety and Health Program Management Guidelines.

This presentation will provide an overview of the [Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA 3148](#), 172 KB PDF, 49 pages.



Occupational
Safety and Health
Administration

www.osha.gov

Guidelines for
**Preventing Workplace
Violence for Health Care &
Social Service Workers**

OSHA 3148-01R 2004

This informational booklet provides a general overview of a particular topic related to OSHA standards. It does not alter or determine compliance responsibilities in OSHA standards or the *Occupational Safety and Health Act of 1970*. Because interpretations and enforcement policy may change over time, you should consult current OSHA administrative interpretations and decisions by the Occupational Safety and Health Review Commission and the Courts for additional guidance on OSHA compliance requirements.

This publication is in the public domain and may be reproduced, fully or partially, without permission. Source credit is requested but not required.

This information is available to sensory impaired individuals upon request.
Voice phone: (202) 693-1999; teletypewriter (TTY) number: (877) 889-5627.



Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers



U.S. Department of Labor

Occupational Safety and Health Administration

OSHA 3148-01R
2004

Contents

Notice...3

Acknowledgments...4

Introduction...4

Overview of Guidelines...7

Violence Prevention Programs...8

Management Commitment and Employee Involvement...10

Worksite Analysis...11

Hazard Prevention and Control...14

Safety and Health Training...19

Recordkeeping and Program Evaluation...21

Conclusion...24

References...25

OSHA assistance...25

Safety and Health Program Management Guidelines...25

State Programs...26

Consultation Services...26

Voluntary Protection Programs (VPP)...27

Strategic Partnership Program...27

Alliance Programs...28

OSHA Training and Education...28

Information Available Electronically...29

OSHA Publications...29

Contacting OSHA...30

OSHA Regional Offices...30

Appendices

Appendix A: Workplace Violence Program Checklists...32

Appendix B: Violence Incident Report Forms...40

Appendix C: Suggested Readings...42

Notice

These guidelines are not a new standard or regulation. They are advisory in nature, informational in content and intended to help employers establish effective workplace violence prevention programs adapted to their specific worksites. The guidelines do not address issues related to patient care. They are performance-oriented, and how employers implement them will vary based on the site's hazard analysis.

Violence inflicted on employees may come from many sources—external parties such as robbers or muggers and internal parties such as coworkers and patients. These guidelines address only the violence inflicted by patients or clients against staff. However, OSHA suggests that workplace violence policies indicate a zero-tolerance for all forms of violence from all sources.

The *Occupational Safety and Health Act of 1970 (OSH Act)*¹ mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. OSHA will rely on Section 5(a)(1) of the *OSH Act*, the “General Duty Clause,”² for enforcement authority. Failure to implement these guidelines is not in itself a violation of the General Duty Clause. However, employers can be cited for violating the General Duty Clause if there is a recognized hazard of workplace violence in their establishments and they do nothing to prevent or abate it.

When Congress passed the *OSH Act*, it recognized that workers' compensation systems provided state-specific remedies for job-related injuries and illnesses. Determining what constitutes a compensable claim and the rate of compensation were left to the states, their legislatures and their courts. Congress acknowledged this point in Section 4(b)(4) of the *OSH Act*, when it stated categorically: “Nothing in this chapter shall be construed to supersede or in any manner affect any workmen's compensation law. . .”³ Therefore,

¹ Public Law 91-596, December 29, 1970; and as amended by P.L. 101-552, Section 3101, November 5, 1990.

² “Each employer 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.”

³ 29 U.S.C. 653(b)(4).

these non-mandatory guidelines should not be viewed as enlarging or diminishing the scope of work-related injuries. The guidelines are intended for use in any state and without regard to whether any injuries or fatalities are later determined to be compensable.

Acknowledgments

Many people have contributed to these guidelines. They include health care, social service and employee assistance experts; researchers; educators; unions and other stakeholders; OSHA professionals; and the National Institute for Occupational Safety and Health (NIOSH).

Also, several states have developed relevant standards or recommendations, such as California OSHA's *CAL/OSHA Guidelines for Workplace Security and Guidelines for Security and Safety of Health Care and Community Service Workers*; New Jersey Public Employees Occupational Safety and Health's *Guidelines on Measures and Safeguards in Dealing with Violent or Aggressive Behavior in Public Sector Health Care Facilities*; and the State of Washington Department of Labor and Industries' *Violence in Washington Workplaces and Study of Assaults on Staff in Washington State Psychiatric Hospitals*. Other organizations with relevant recommendations include the Joint Commission on Accreditation of Health Care Organizations' *Comprehensive Accreditation Manuals for Hospitals*, the Metropolitan Chicago Healthcare Council's *Guidelines for Dealing with Violence in Health Care*, and the American Nurses Association's *Promoting Safe Work Environments for Nurses*. These and other agencies have information available to assist employers.

Introduction

Workplace violence affects health care and social service workers.

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."⁴ This includes terrorism as illustrated by the

⁴CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002.

terrorist acts of September 11, 2001 that resulted in the deaths of 2,886 workers in New York, Virginia and Pennsylvania. Although these guidelines do not address terrorism specifically, this type of violence remains a threat to U.S. workplaces.

For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard within these industries. OSHA's violence prevention guidelines provide the agency's recommendations for reducing workplace violence, developed following a careful review of workplace violence studies, public and private violence prevention programs and input from stakeholders. OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees can be reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

Extent of the problem

The Bureau of Labor Statistics (BLS) reports that there were 69 homicides in the health services from 1996 to 2000. Although workplace homicides may attract more attention, the vast majority of workplace violence consists of non-fatal assaults. BLS data shows that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury.

Injury rates also reveal that health care and social service workers are at high risk of violent assault at work. BLS rates measure the number of events per 10,000 full-time workers—in this case, assaults resulting in injury. In 2000, health service workers overall had an incidence rate of 9.3 for injuries resulting from assaults and violent acts. The rate for social service workers was 15, and for nursing and personal care facility workers, 25. This compares to an overall private sector injury rate of 2.

The Department of Justice's (DOJ) National Crime Victimization Survey for 1993 to 1999 lists average annual rates of non-fatal violent crime by occupation. The average annual rate for non-fatal

violent crime for all occupations is 12.6 per 1,000 workers. The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69. (Note: These data do not compare directly to the BLS figures because DOJ presents violent incidents per 1,000 workers and BLS displays injuries involving days away from work per 10,000 workers. Both sources, however, reveal the same high risk for health care and social service workers.)

As significant as these numbers are, the actual number of incidents is probably much higher. Incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

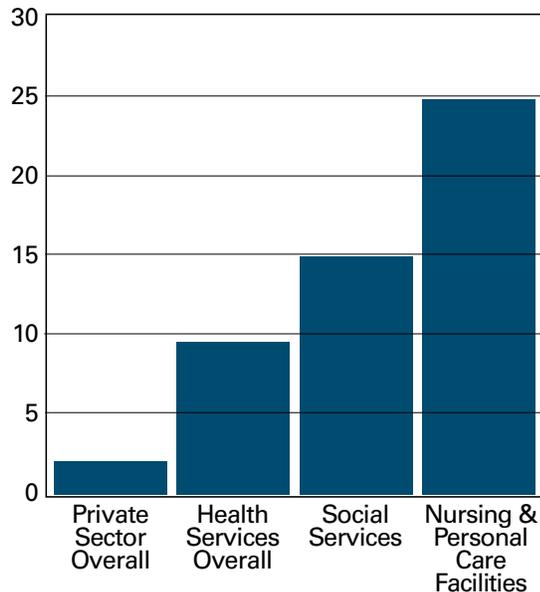
The risk factors

Health care and social service workers face an increased risk of work-related assaults stemming from several factors. These include:

- The prevalence of handguns and other weapons among patients, their families or friends;
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals;
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these

Incidence rates for nonfatal assaults and violent acts by industry, 2000

Incidence rate per 10,000 full-time workers



Source: U.S. Department of Labor, Bureau of Labor Statistics. (2001). *Survey of Occupational Injuries and Illnesses, 2000*.

-
- patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others);
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets;
 - Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly;
 - The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members;
 - Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients;
 - Isolated work with clients during examinations or treatment;
 - Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings);
 - Lack of staff training in recognizing and managing escalating hostile and assaultive behavior; and
 - Poorly lit parking areas.

Overview of Guidelines

In January 1989, OSHA published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include workplace violence prevention programs.⁵ OSHA's violence prevention guidelines build on these generic guidelines by identifying common risk factors and describing some feasible solutions. Although not exhaustive, the workplace violence guidelines include policy recommendations and practical corrective methods to help prevent and mitigate the effects of workplace violence.

⁵OSHA's Safety and Health Program Management Guidelines (54 *Federal Register* (16):3904–3916, January 26, 1989).

The goal is to eliminate or reduce worker exposure to conditions that lead to death or injury from violence by implementing effective security devices and administrative work practices, among other control measures.

The guidelines cover a broad spectrum of workers who provide health care and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community-care facilities and long-term care facilities. They include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home health care workers, social workers, welfare workers and emergency medical care personnel. The guidelines may also be useful in reducing risks for ancillary personnel such as maintenance, dietary, clerical and security staff in the health care and social service industries.

Violence Prevention Programs

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program does not need to be written or heavily documented to be satisfactory.

What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment. Employers should communicate information about the prevention program and startup date to all employees.

At a minimum, workplace violence prevention programs should:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensure that managers, supervisors, coworkers, clients, patients and visitors know about this policy.

-
- Ensure that no employee who reports or experiences workplace violence faces reprisals.⁶
 - Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.
 - Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
 - Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
 - Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
 - Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery.

Elements of an effective violence prevention program

The five main components of any effective safety and health program also apply to the prevention of workplace violence:

- Management commitment and employee involvement;
- Worksite analysis;
- Hazard prevention and control;
- Safety and health training; and
- Recordkeeping and program evaluation.

⁶Section 11 (c)(1) of the OSH Act applies to protected activity involving the hazard of workplace violence as it does for other health and safety matters:

“No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act.”

Management Commitment and Employee Involvement

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and frontline employees must work together, perhaps through a team or committee approach. If employers opt for this strategy, they must be careful to comply with the applicable provisions of the *National Labor Relations Act*.⁷

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence. This commitment should include:

- Demonstrating organizational concern for employee emotional and physical safety and health;
- Exhibiting equal commitment to the safety and health of workers and patients/clients;
- Assigning responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors and employees understand their obligations;
- Allocating appropriate authority and resources to all responsible parties;
- Maintaining a system of accountability for involved managers, supervisors and employees;
- Establishing a comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents; and
- Supporting and implementing appropriate recommendations from safety and health committees.

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement and evaluate the program.

⁷29 U.S.C. 158(a)(2).

Employee involvement should include:

- Understanding and complying with the workplace violence prevention program and other safety and security measures;
- Participating in employee complaint or suggestion procedures covering safety and security concerns;
- Reporting violent incidents promptly and accurately;
- Participating in safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections and respond with recommendations for corrective strategies; and
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior or criminal intent and discusses appropriate responses.

Worksite Analysis

Value of a worksite analysis

A worksite analysis involves a step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific areas where hazards may develop. A threat assessment team, patient assault team, similar task force or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. This group may also be responsible for implementing the workplace violence prevention program. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal and human resources staff.

The team or coordinator can review injury and illness records and workers' compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes or employee training. As the team or coordinator identifies appropriate controls, they should be instituted.

Focus of a worksite analysis

The recommended program for worksite analysis includes, but is not limited to:

- Analyzing and tracking records;
- Screening surveys; and
- Analyzing workplace security.

Records analysis and tracking

This activity should include reviewing medical, safety, workers' compensation and insurance records—including the OSHA Log of Work-Related Injury and Illness (OSHA Form 300), if the employer is required to maintain one—to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular:

- Departments;
- Units;
- Job titles;
- Unit activities;
- Workstations; and
- Time of day.

Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement. Monitor trends and analyze incidents. Contacting similar local businesses, trade associations and community and civic groups is one way to learn about their experiences with workplace violence and to help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

Value of screening surveys

One important screening tool is an employee questionnaire or survey to get employees' ideas on the potential for violent incidents and to identify or confirm the need for improved security measures. Detailed baseline screening surveys can help pinpoint tasks that put

employees at risk. Periodic surveys—conducted at least annually or whenever operations change or incidents of workplace violence occur—help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures or controls. Also, the surveys help assess the effects of changes in the work processes. The periodic review process should also include feedback and follow-up.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists and insurance safety auditors, may offer advice to strengthen programs. These experts can also provide fresh perspectives to improve a violence prevention program.

Conducting a workplace security analysis

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations and situations that could lead to violence.

To find areas requiring further evaluation, the team or coordinator should:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.
- Note high-risk factors such as types of clients or patients (for example, those with psychiatric conditions or who are disoriented by drugs, alcohol or stress); physical risk factors related to building layout or design; isolated locations and job activities; lighting problems; lack of phones and other communication devices; areas of easy, unsecured access; and areas with previous security problems.
- Evaluate the effectiveness of existing security measures, including engineering controls. Determine if risk factors have been reduced or eliminated and take appropriate action.

Hazard Prevention and Control

After hazards are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

Engineering controls and workplace adaptations to minimize risk

Engineering controls remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those described in the following paragraphs. The selection of any measure, of course, should be based on the hazards identified in the workplace security analysis of each facility.

Among other options, employers may choose to:

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones and private channel radios where risk is apparent or may be anticipated. Arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors—installed or hand-held, where appropriate—to detect guns, knives or other weapons, according to the recommendations of security consultants.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations and install deep service counters or bullet-resistant, shatter-proof glass in reception, triage and admitting areas or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings with-

out grids for patients who “act out” and establish separate rooms for criminal patients.

- Provide comfortable client or patient waiting rooms designed to minimize stress.
- Ensure that counseling or patient care rooms have two exits.
- Lock doors to staff counseling rooms and treatment rooms to limit access.
- Arrange furniture to prevent entrapment of staff.
- Use minimal furniture in interview rooms or crisis treatment areas and ensure that it is lightweight, without sharp corners or edges and affixed to the floor, if possible. Limit the number of pictures, vases, ashtrays or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient/client and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting, both indoors and outdoors.
- Replace burned-out lights and broken windows and locks.
- Keep automobiles well maintained if they are used in the field.
- Lock automobiles at all times.

Administrative and work practice controls to minimize risk

Administrative and work practice controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. Some options for employers are to:

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Give police physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep log books and reports of such incidents to help determine any necessary actions to prevent recurrences.

-
- Advise employees of company procedures for requesting police assistance or filing charges when assaulted and help them do so, if necessary.
 - Provide management support during emergencies. Respond promptly to all complaints.
 - Set up a trained response team to respond to emergencies.
 - Use properly trained security officers to deal with aggressive behavior. Follow written security procedures.
 - Ensure that adequate and properly trained staff are available to restrain patients or clients, if necessary.
 - Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
 - Ensure that adequate and qualified staff are available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
 - Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
 - Establish a list of “restricted visitors” for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses’ stations and visitor sign-in areas.
 - Review and revise visitor check systems, when necessary. Limit information given to outsiders about hospitalized victims of violence.
 - Supervise the movement of psychiatric clients and patients throughout the facility.
 - Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
 - Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Do not allow employees to enter seclusion rooms alone.
 - Establish policies and procedures for secured areas and emergency evacuations.

-
- Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.
 - Establish a system—such as chart tags, log books or verbal census reports—to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed.
 - Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions).
 - Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.
 - Prepare contingency plans to treat clients who are “acting out” or making verbal or physical attacks or threats. Consider using certified employee assistance professionals or in-house social service or occupational health service staff to help diffuse patient or client anger.
 - Transfer assaultive clients to acute care units, criminal units or other more restrictive settings.
 - Ensure that nurses and physicians are not alone when performing intimate physical examinations of patients.
 - Discourage employees from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. Urge community workers to carry only required identification and money.
 - Survey the facility periodically to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.
 - Provide staff with identification badges, preferably without last names, to readily verify employment.
 - Discourage employees from carrying keys, pens or other items that could be used as weapons.
 - Provide staff members with security escorts to parking areas in evening or late hours. Ensure that parking areas are highly visible, well lit and safely accessible to the building.
 - Use the “buddy system,” especially when personal safety may be threatened. Encourage home health care providers, social service workers and others to avoid threatening situations.

-
- Advise staff to exercise extra care in elevators, stairwells and unfamiliar residences; leave the premises immediately if there is a hazardous situation; or request police escort if needed.
 - Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits and the refusal to provide services in a clearly hazardous situation.
 - Establish a daily work plan for field staff to keep a designated contact person informed about their whereabouts throughout the workday. Have the contact person follow up if an employee does not report in as expected.

Employer responses to incidents of violence

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for employees who are victimized personally or may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of its severity. Provide the injured transportation to medical care if it is not available onsite.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These may include:

- Short- and long-term psychological trauma;
- Fear of returning to work;
- Changes in relationships with coworkers and family;
- Feelings of incompetence, guilt, powerlessness; and
- Fear of criticism by supervisors or managers.

Consequently, a strong follow-up program for these employees will not only help them to deal with these problems but also help prepare them to confront or prevent future incidents of violence.

Several types of assistance can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical-incident stress debriefing or employee assistance programs may be provided to assist victims. Certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists

or social workers may provide this counseling or the employer may refer staff victims to an outside specialist. In addition, the employer may establish an employee counseling service, peer counseling or support groups.

Counselors should be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, this type of counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Safety and Health Training

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their coworkers through established policies and procedures.

Training for all employees

Every employee should understand the concept of “universal precautions for violence” — that is, that violence should be expected but can be avoided or mitigated through preparation. Frequent training also can reduce the likelihood of being assaulted.

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It also includes instructions to limit physical interventions in workplace altercations whenever possible, unless enough staff or emergency response teams and security personnel are available. In addition, all employees should be trained to behave compassionately toward coworkers when an incident occurs.

The training program should involve all employees, including supervisors and managers.

New and reassigned employees should receive an initial orientation before being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level

appropriate for the staff. Effective training programs should involve role playing, simulations and drills.

Topics may include management of assaultive behavior, professional assault-response training, police assault-avoidance programs or personal safety training such as how to prevent and avoid assaults. A combination of training programs may be used, depending on the severity of the risk.

Employees should receive required training annually. In large institutions, refresher programs may be needed more frequently, perhaps monthly or quarterly, to effectively reach and inform all employees.

What training should cover

The training should cover topics such as:

- The workplace violence prevention policy;
- Risk factors that cause or contribute to assaults;
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- Ways to prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications as chemical restraints;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- Progressive behavior control methods and safe methods to apply restraints;
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Ways to protect oneself and coworkers, including use of the “buddy system;”
- Policies and procedures for reporting and recordkeeping;
- Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences; and

- Policies and procedures for obtaining medical care, counseling, workers' compensation or legal assistance after a violent episode or injury.

Training for supervisors and managers

Supervisors and managers need to learn to recognize high-risk situations, so they can ensure that employees are not placed in assignments that compromise their safety. They also need training to ensure that they encourage employees to report incidents.

Supervisors and managers should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program and staffing policy and procedures to reduce or eliminate the hazards.

Training for security personnel

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing and observing and reviewing reports of behavior of individuals in threatening situations.

Recordkeeping and Program Evaluation

How employers can determine program effectiveness

Recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made.

Records employers should keep

Recordkeeping is essential to the program's success. Good records help employers determine the severity of the problem,

evaluate methods of hazard control and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who “pool” data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories and training can help identify problems and solutions for an effective program.

Important Records:

- OSHA Log of Work-Related Injury and Illness (OSHA Form 300). Employers who are required to keep this log must record any new work-related injury that results in death, days away from work, days of restriction or job transfer, medical treatment beyond first aid, loss of consciousness or a significant injury diagnosed by a licensed health care professional. Injuries caused by assaults must be entered on the log if they meet the recording criteria. All employers must report, within 24 hours, a fatality or an incident that results in the hospitalization of three or more employees.⁸
- Medical reports of work injury and supervisors’ reports for each recorded assault. These records should describe the type of assault, such as an unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost work time that resulted and the nature of injuries sustained. These medical records are confidential documents and should be kept in a locked location under the direct responsibility of a health care professional.
- Records of incidents of abuse, verbal attacks or aggressive behavior that may be threatening, such as pushing or shouting and acts of aggression toward other clients. This may be kept as part of an assaultive incident report. Ensure that the affected department evaluates these records routinely. (See sample violence incident forms in Appendix B.)
- Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient’s chart. All staff who care for a potentially aggressive, abusive or violent client

⁸29 CFR Part 1904, revised 2001.

should be aware of the person's background and history. Log the admission of violent patients to help determine potential risks.

- Documentation of minutes of safety meetings, records of hazard analyses and corrective actions recommended and taken.
- Records of all training programs, attendees and qualifications of trainers.

Elements of a program evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate its success. Responsible parties (including managers, supervisors and employees) should reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.

Management should share workplace violence prevention evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives or other employee groups.

All reports should protect employee confidentiality either by presenting only aggregate data or by removing personal identifiers if individual data are used.

Processes involved in an evaluation include:

- Establishing a uniform violence reporting system and regular review of reports;
- Reviewing reports and minutes from staff meetings on safety and security issues;
- Analyzing trends and rates in illnesses, injuries or fatalities caused by violence relative to initial or "baseline" rates;
- Measuring improvement based on lowering the frequency and severity of workplace violence;
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work;
- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness;

-
- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as they develop;
 - Surveying employees periodically to learn if they experience hostile situations concerning the medical treatment they provide;
 - Complying with OSHA and State requirements for recording and reporting deaths, injuries and illnesses; and
 - Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.

Sources of assistance for employers

Employers who would like help in implementing an appropriate workplace violence prevention program can turn to the OSHA Consultation Service provided in their State. To contact this service, see OSHA's website at www.osha.gov or call (800) 321-OSHA.

OSHA's efforts to help employers combat workplace violence are complemented by those of NIOSH, public safety officials, trade associations, unions, insurers and human resource and employee assistance professionals, as well as other interested groups. Employers and employees may contact these groups for additional advice and information. NIOSH can be reached toll-free at (800) 35-NIOSH.

Conclusion

OSHA recognizes the importance of effective safety and health program management in providing safe and healthful workplaces. Effective safety and health programs improve both morale and productivity and reduce workers' compensation costs.

OSHA's violence prevention guidelines are an essential component of workplace safety and health programs. OSHA believes the performance-oriented approach of these guidelines provides employers with flexibility in their efforts to maintain safe and healthful working conditions.

References

California State Department of Industrial Relations, Cal/OSHA. (1998). *Guidelines for Security and Safety of Health Care and Community Service Workers*.
www.dir.ca.gov/dosh/dosh%5Fpublications/hcworker.html

Centers for Disease Control and Prevention, National Institute for Occupational Health. (2002). *Occupational Hazards in Hospitals*. DHHS (NIOSH) Pub. No. 2002-101.
www.cdc.gov/niosh/2002-101.html

U.S. Department of Justice, Bureau of Justice Statistics. (2001). *National Crime Victimization Survey. Violence in the Workplace, 1993–99*. www.ojp.gov/bjs/pub/pdf/vw99.pdf

U.S. Department of Labor, Bureau of Labor Statistics. (2002). *Census of Fatal Occupational Injuries, 2001*.
www.bls.gov/iif/oshwc/foi/cfnr0008.pdf

U.S. Department of Labor, Bureau of Labor Statistics. (2001). *Survey of Occupational Injuries and Illnesses, 2000*.
www.bls.gov/iif/oshwc/osh/os/osnr0013.pdf

Washington, Department of Labor and Industries. *Workplace Violence: Awareness and Prevention for Employers and Employees, 2000*. www.lni.wa.gov/ipub/417-140-000.htm

OSHA assistance

OSHA can provide extensive help through a variety of programs, including technical assistance about effective safety and health programs, state plans, workplace consultations, voluntary protection programs, strategic partnerships, training and education and more. An overall commitment to workplace safety and health can add value to your business, to your workplace and to your life.

Safety and Health Program Management Guidelines

Effective management of worker safety and health protection is a decisive factor in reducing the extent and severity of work-related injuries and illnesses and their related costs. In fact, an effective safety and health program forms the basis of good worker protection and can save time and money (about \$4 for every dollar

spent) and increase productivity and reduce worker injuries, illnesses and related workers' compensation costs.

To assist employers and employees in developing effective safety and health programs, OSHA published recommended *Safety and Health Program Management Guidelines* (54 *Federal Register* (16): 3904-3916, January 26, 1989). These voluntary guidelines apply to all places of employment covered by OSHA.

The guidelines identify four general elements critical to the development of a successful safety and health management program:

- Management leadership and employee involvement.
- Work analysis.
- Hazard prevention and control.
- Safety and health training.

The guidelines recommend specific actions, under each of these general elements, to achieve an effective safety and health program. The *Federal Register* notice is available online at www.osha.gov.

State Programs

The Occupational Safety and Health Act of 1970 (OSH Act) encourages states to develop and operate their own job safety and health plans. OSHA approves and monitors these plans. There are currently 26 state plans: 23 cover both private and public (state and local government) employment; 3 states, Connecticut, New Jersey and New York, cover the public sector only. States and territories with their own OSHA-approved occupational safety and health plans must adopt standards identical to, or at least as effective as, the federal standards.

Consultation Services

Consultation assistance is available on request to employers who want help in establishing and maintaining a safe and healthful workplace. Largely funded by OSHA, the service is provided at no cost to the employer. Primarily developed for smaller employers with more hazardous operations, the consultation service is delivered by state governments employing professional safety and health consultants. Comprehensive assistance includes an appraisal of all-mechanical systems, work practices and occupational safety

and health hazards of the workplace and all aspects of the employer's present job safety and health program. In addition, the service offers assistance to employers in developing and implementing an effective safety and health program. No penalties are proposed or citations issued for hazards identified by the consultant. OSHA provides consultation assistance to the employer with the assurance that his or her name and firm and any information about the workplace will not be routinely reported to OSHA enforcement staff.

Under the consultation program, certain exemplary employers may request participation in OSHA's Safety and Health Achievement Recognition Program (SHARP). Eligibility for participation in SHARP includes receiving a comprehensive consultation visit, demonstrating exemplary achievements in workplace safety and health by abating all identified hazards and developing an excellent safety and health program.

Employers accepted into SHARP may receive an exemption from programmed inspections (not complaint or accident investigation inspections) for a period of one year. For more information concerning consultation assistance, see the OSHA website at www.osha.gov.

Voluntary Protection Programs (VPP)

Voluntary Protection Programs and onsite consultation services, when coupled with an effective enforcement program, expand worker protection to help meet the goals of the *OSH Act*. The three levels of VPP are Star, Merit, and Demonstration designed to recognize outstanding achievements by companies that have successfully incorporated comprehensive safety and health programs into their total management system. The VPPs motivate others to achieve excellent safety and health results in the same outstanding way as they establish a cooperative relationship between employers, employees and OSHA.

For additional information on VPP and how to apply, contact the OSHA regional offices listed at the end of this publication.

Strategic Partnership Program

OSHA's Strategic Partnership Program, the newest member of OSHA's cooperative programs, helps encourage, assist and recognize the efforts of partners to eliminate serious workplace

hazards and achieve a high level of worker safety and health. Whereas OSHA's Consultation Program and VPP entail one-on-one relationships between OSHA and individual worksites, most strategic partnerships seek to have a broader impact by building cooperative relationships with groups of employers and employees. These partnerships are voluntary, cooperative relationships between OSHA, employers, employee representatives and others (e.g., trade unions, trade and professional associations, universities and other government agencies).

For more information on this and other cooperative programs, contact your nearest OSHA office, or visit OSHA's website at www.osha.gov.

Alliance Programs

The Alliances Program enables organizations committed to workplace safety and health to collaborate with OSHA to prevent injuries and illnesses in the workplace. OSHA and the Alliance participants work together to reach out to, educate and lead the nation's employers and their employees in improving and advancing workplace safety and health.

Alliances are open to all groups, including trade or professional organizations, businesses, labor organizations, educational institutions and government agencies. In some cases, organizations may be building on existing relationships with OSHA that were developed through other cooperative programs.

There are few formal program requirements for Alliances and the agreements do not include an enforcement component. However, OSHA and the participating organizations must define, implement and meet a set of short- and long-term goals that fall into three categories: training and education; outreach and communication; and promoting the national dialogue on workplace safety and health.

OSHA Training and Education

OSHA area offices offer a variety of information services, such as compliance assistance, technical advice, publications, audiovisual aids and speakers for special engagements. OSHA's Training Institute in Arlington Heights, Ill., provides basic and advanced courses in safety and health for federal and state compliance officers, state consultants, federal agency personnel, and private

sector employers, employees and their representatives.

The OSHA Training Institute also has established OSHA Training Institute Education Centers to address the increased demand for its courses from the private sector and from other federal agencies. These centers are nonprofit colleges, universities and other organizations that have been selected after a competition for participation in the program.

OSHA also provides funds to nonprofit organizations, through grants, to conduct workplace training and education in subjects where OSHA believes there is a lack of workplace training. Grants are awarded annually. Grant recipients are expected to contribute 20 percent of the total grant cost.

For more information on grants, training and education, contact the OSHA Training Institute, Office of Training and Education, 2020 South Arlington Heights Road, Arlington Heights, IL 60005, (847) 297-4810 or see "Outreach" on OSHA's website at www.osha.gov. For further information on any OSHA program, contact your nearest OSHA area or regional office listed at the end of this publication.

Information Available Electronically

OSHA has a variety of materials and tools available on its website at www.osha.gov. These include *e-Tools* such as *Expert Advisors*, *Electronic Compliance Assistance Tools (e-cats)*, *Technical Links*; regulations, directives and publications; videos and other information for employers and employees. OSHA's software programs and compliance assistance tools walk you through challenging safety and health issues and common problems to find the best solutions for your workplace.

OSHA's CD-ROM includes standards, interpretations, directives and more, and can be purchased on CD-ROM from the U.S. Government Printing Office. To order, write to the Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954 or phone (202) 512-1800, or order online at <http://bookstore.gpo.gov>.

OSHA Publications

OSHA has an extensive publications program. For a listing of free or sales items, visit OSHA's website at www.osha.gov or contact the OSHA Publications Office, U.S. Department of Labor, 200 Constitution Avenue, NW, N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA or contact your nearest OSHA regional or area office listed at the end of this publication. The teletypewriter (TTY) number is (877) 889-5627.

You can also file a complaint online and obtain more information on OSHA federal and state programs by visiting OSHA's website at www.osha.gov.

OSHA Regional Offices

Region I

(CT,* ME, MA, NH, RI, VT*)
JFK Federal Building, Room E340
Boston, MA 02203
(617) 565-9860

Region II

(NJ,* NY,* PR,* VI*)
201 Varick Street, Room 670
New York, NY 10014
(212) 337-2378

Region III

(DE, DC, MD,* PA,* VA,* WV)
The Curtis Center
170 S. Independence Mall West
Suite 740 West
Philadelphia, PA 19106-3309
(215) 861-4900

Region IV

(AL, FL, GA, KY,* MS, NC,* SC,* TN*)
61 Forsyth Street, SW
Atlanta, GA 30303
(404) 562-2300

Region V

(IL, IN,* MI,* MN,* OH, WI)
230 South Dearborn Street, Room 3244
Chicago, IL 60604
(312) 353-2220

Region VI

(AR, LA, NM,* OK, TX)
525 Griffin Street, Room 602
Dallas, TX 75202
(214) 767-4731 or 4736 x224

Region VII

(IA,* KS, MO, NE)
City Center Square
1100 Main Street, Suite 800
Kansas City, MO 64105
(816) 426-5861

Region VIII

(CO, MT, ND, SD, UT,* WY*)
1999 Broadway, Suite 1690
PO Box 46550
Denver, CO 80201-6550
(303) 844-1600

Region IX

(American Samoa, AZ,* CA,* HI, NV,* Northern Mariana Islands)
71 Stevenson Street, Room 420
San Francisco, CA 94105
(415) 975-4310

Region X

(AK,* ID, OR,* WA*)
1111 Third Avenue, Suite 715
Seattle, WA 98101-3212
(206) 553-5930

*These states and territories operate their own OSHA-approved job safety and health programs (Connecticut, New Jersey and New York plans cover public employees only). States with approved programs must have a standard that is identical to, or at least as effective as, the federal standard.

Note: To get contact information for OSHA Area Offices, OSHA-approved State Plans and OSHA Consultation Projects, please visit us online at www.osha.gov or call us at 1-800-321-OSHA.

Appendix A: Workplace Violence Program Checklists

Reprinted with permission of the American Nurses Association, Promoting Safe Work Environments for Nurses, 2002.

Checklist 1:

Organizational Assessment Questions Regarding Management Commitment and Employee Involvement

- Is there demonstrated organizational concern for employee emotional and physical safety and health as well as that of the patients?
- Is there a written workplace violence prevention program in your facility?
- Did front-line workers as well as management participate in developing the plan?
- Is there someone clearly responsible for the violence prevention program to ensure that all managers, supervisors, and employees understand their obligations?
- Do those responsible have sufficient authority and resources to take all action necessary to ensure worker safety?
- Does the violence prevention program address the kinds of violent incidents that are occurring in your facility?
- Does the program provide for post-assault medical treatment and psychological counseling for health-care workers who experience or witness assaults or violence incidents?
- Is there a system to notify employees promptly about specific workplace security hazards or threats that are made? Are employees aware of this system?
- Is there a system for employees to inform management about workplace security hazards or threats without fear of reprisal? Are employees aware of this system?
- Is there a system for employees to promptly report violent incidents, “near misses,” threats, and verbal assaults without fear of reprisal?
- Is there tracking, trending, and regular reporting on violent incidents through the safety committee?

-
- Are front-line workers included as regular members and participants in the safety committee as well as violence tracking activities?
 - Does the tracking and reporting capture all types of violence—fatalities, physical assaults, harassment, aggressive behavior, threats, verbal abuse, and sexual assaults?
 - Does the tracking and reporting system use the latest categories of violence so data can be compared?
 - Have the high-risk locations or jobs with the greatest risk of violence as well as the processes and procedures that put employees at risk been identified?
 - Is there a root-cause analysis of the risk factors associated with individual violent incidents so that current response systems can be addressed and hazards can be eliminated and corrected?
 - Are employees consulted about what corrective actions need to be taken for single incidents or surveyed about violence concerns in general?
 - Is there follow-up of employees involved in or witnessing violent incidents to assure that appropriate medical treatment and counseling have been provided?
 - Has a process for reporting violent incidents within the facility to the police or requesting police assistance been established?

Identifying Risks for Violence by Unit/Work Area

Perform a step-by-step review of each work area to identify specific places and times that violent incidents are occurring and the risk factors that are present. To ensure multiple perspectives, it is best for a team to perform this worksite analysis. Key members of the analysis team should be front-line health care workers, including nurses from each specialty unit, as well as the facility's safety and security professionals.

Find Out What's Happening on Paper

The first step in this worksite analysis is to obtain and review data that tells the “who, what, when, where and why” about violent incidents. These sources include:

- Incident report forms
- Workers' compensation reports of injury

-
- OSHA 300 injury and illness logs
 - Security logs
 - Reports to police
 - Safety committee reports
 - Hazard inspection reports
 - Staff termination records
 - Union complaints

Using this information, attempt to answer the questions in Checklist 2.

Checklist 2:

Analyze Workplace Violence Records

- How many incidents occurred in the last 2 years?
- What kinds of incidents occurred most often (assault, threats, robbery, vandalism, etc.)?
- Where did incidents most often occur?
- When did incidents most often occur (day of week, shift, time, etc.)?
- What job task was usually being performed when an incident occurred?
- Which workers were victimized most often (gender, age, job classification, etc.)?
- What type of weapon was used most often?
- Are there any similarities among the assailants?
- What other incidents, if any, are you aware of that are not included in the records?
- Of those incidents you reviewed, which one or two were most serious?

Use the data collected to stimulate the following discussions:

- Are there any important patterns or trends among the incidents?
- What do you believe were the main factors contributing to violence in your workplace?

-
- What additional corrective measures would you recommend to reduce or eliminate the problems you identified?

Conduct a Walkthrough

It is important to keep in mind that injuries from violence are often not reported. One of the best ways to observe what is really going on is to conduct a workplace walkthrough.

A walkthrough, which is really a workplace inspection, is the first step in identifying violence risk factors and serves several important functions. While on a walkthrough, hazards can be recognized and often corrected before anyone's health and safety is affected.

While inspecting for workplace violence risk factors, review the physical facility and note the presence or absence of security measures. Local police may also be able to conduct a security audit or provide information about experience with crime in the area.

Ask the Workers

A simple survey can provide valuable information often not found in department walkthroughs and injury logs. Some staff may not report violent acts or threatening situations formally but will share the experiences and suggestions anonymously. This can provide information about previously unnoticed deficiencies or failures in work practices or administrative controls. It also can help increase employee awareness about dangerous conditions and encourage them to become involved in prevention activities.

Types of questions that employees should be asked include:

- What do they see as risk factors for violence?
 - The most important risk factors in their work areas
 - Aspects of the physical environment that contribute to violence
 - Dangerous situations or "near misses" experienced
 - Assault experiences—past year, entire time at facility
 - Staffing adequacy
- How are current control measures working?
 - Hospital practices for handling conflict among staff and patients
 - Effectiveness of response to violent incidents

-
- How safe they feel in the current environment
 - What ideas do employees have to protect workers?
 - Highest priorities in violence prevention
 - Ideas for improvements and prevention measures
 - How satisfied are they in their jobs?
 - With managers/fellow workers
 - Adequacy of rewards and praise
 - Impact on health

Checklist 3:

Identifying Environmental Risk Factors for Violence

Use the following checklist to assist in your workplace walkthrough.

General questions about approach:

- Are safety and security issues specifically considered in the early stages of facility design, construction, and renovation?
- Does the current violence prevention program provide a way to select and implement controls based on the specific risks identified in the workplace security analysis? How does this process occur?

Specific questions about the environment:

- Do crime patterns in the neighborhood influence safety in the facility?
- Do workers feel safe walking to and from the workplace?
- Are entrances visible to security personnel and are they well lit and free of hiding places?
- Is there adequate security in parking or public transit waiting areas?
- Is public access to the building controlled, and is this system effective?
- Can exit doors be opened only from the inside to prevent unauthorized entry?

-
- Is there an internal phone system to activate emergency assistance?
 - Have alarm systems or panic buttons been installed in high-risk areas?
 - Given the history of violence at the facility, is a metal detector appropriate in some entry areas? Closed-circuit TV in high-risk areas?
 - Is there good lighting?
 - Are fire exits and escape routes clearly marked?
 - Are reception and work areas designed to prevent unauthorized entry? Do they provide staff good visibility of patients and visitors? If not, are there other provisions such as security cameras or mirrors?
 - Are patient or client areas designed to minimize stress, including minimizing noise?
 - Are drugs, equipment, and supplies adequately secured?
 - Is there a secure place for employees to store their belongings?
 - Are “safe rooms” available for staff use during emergencies?
 - Are door locks in patient rooms appropriate? Can they be opened during an emergency?
 - Do counseling or patient care rooms have two exits, and is furniture arranged to prevent employees from becoming trapped?
 - Are lockable and secure bathrooms that are separate from patient-client and visitor facilities available for staff members?

Checklist 4:

Assessing the Influence of Day-to-Day Work Practices on Occurrences of Violence

- Are identification tags required for both employees and visitors to the building?
- Is there a way to identify patients with a history of violence? Are contingency plans put in place for these patients—such as restricting visitors and supervising their movement through the facility?
- Are emergency phone numbers and procedures posted or readily available?

-
- Are there trained security personnel accessible to workers in a timely manner?
 - Are waiting times for patients kept as short as possible to avoid frustration?
 - Is there adequate and qualified staffing at all times, particularly during patient transfers, emergency responses, mealtimes, and at night?
 - Are employees prohibited from entering seclusion rooms alone or working alone in emergency areas of walk-in clinics, particularly at night or when assistance is unavailable?
 - Are broken windows, doors, locks, and lights replaced promptly?
 - Are security alarms and devices tested regularly?

Checklist 5:

Post-Incident Response

- Is comprehensive treatment provided to victimized employees as well as those who may be traumatized by witnessing a workplace violence incident? Required services may include trauma-crisis counseling, critical incident stress debriefing, psychological counseling services, peer counseling, and support groups.

Checklist 6:

Assessing Employee and Supervisor Training

- Does the violence prevention program require training for all employees and supervisors when they are hired and when job responsibilities change?
- Do agency workers or contract physicians and house staff receive the same training that permanent staff receive?
- Are workers trained in how to handle difficult clients or patients?
- Does the security staff receive specialized training for the health-care environment?
- Is the training tailored to specific units, patient populations, and job tasks, including any tasks done in the field?
- Do employees learn progressive behavior control methods and safe methods to apply restraints?

-
- Do workers believe that the training is effective in handling escalating violence or violent incidents?
 - Are drills conducted to test the response of health-care facility personnel?
 - Are workers trained in how to report violent incidents, threats, or abuse and obtain medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury?
 - Are employees and supervisors trained to behave compassionately toward coworkers when an incident occurs?
 - Does the training include instruction about the location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures?

Checklist 7:

Recordkeeping and Evaluation

Does the violence prevention program provide for:

- Up-to-date recording in the OSHA Log of Work-Related Injury and Illness (OSHA 300)?
- Records of all incidents involving assault, harassment, aggressive behavior, abuse, and verbal attack with attention to maintaining appropriate confidentiality of the records?
- Training records?
- Workplace walkthrough and security inspection records?
- Keeping records of control measures instituted in response to inspections, complaints, or violent incidents?
- A system for regular evaluation of engineering, administrative, and work practice controls to see if they are working well?
- A system for regular review of individual reports and trending and analysis of all incidents?
- Employee surveys regarding the effectiveness of control measures instituted?
- Discussions with employees who are involved in hostile situations to ask about the quality of post-incident treatment they received?
- A provision for an outside audit or consultation of the violence programs for recommendations on improving safety?

Appendix B

Violence Incident Report Forms

Sample 1

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence. (Sample/Draft—Adapt to your own location and business circumstances.)

Confidential Incident Report

To: _____ Date of Incident: _____

Location of Incident (Map/sketch on reverse side or attached): _____

From: _____ Phone: _____ Time of Incident: _____

Nature of the Incident ("X" all applicable boxes):

Assaults or Violent Acts: _____ Type "1" _____ Type "2" _____ Type "3" _____ Other

Preventative or Warning Report

Bomb or Terrorist Type Threat Yes No

Transportation Accident Contacts with Objects or Equipment

Falls Exposures Fires or Explosions Other

Legal Counsel Advised of Incident? Yes No EAP Advised? Yes No

Warning or Preventative Measures? Yes No

Number of Persons Affected: _____

(For each person, complete a report; however, to the extent facts are duplicative, any person's report may incorporate another person's report.)

Name of Affected Person(s): _____ Service Date: _____

Position: _____ Member of Labor Organization? Yes No

Supervisor: _____ Has Supervisor Been Notified? Yes No

Family: _____ Has Been Notified by: _____? Yes No

Lost Work Time? Yes No Anticipated Return to Work: _____

Third parties or non-employee involvement (include contractor and lease employees, visitors, vendors, customers)? Yes No

Nature of the Incident

Briefly describe: (1) event(s); (2) witnesses with addresses and status included; (3) location details; (4) equipment/weapon details; (5) weather; (6) other records of the incident (e.g., police report, recordings, videos); (7) the ability to observe and reliability of witnesses; (8) were the parties possibly impaired because of illness, injury, drugs or alcohol? (were tests taken to verify same?); (9) parties notified internally (employee relations, medical, legal, operations, etc.) and externally (police, fire, ambulance, EAP, family, etc.).

Previous or Related Incidents of This Type? Yes No

Or by This Person? Yes No Preventative Steps? Yes No

OSHA Log or Other OSHA Action Required? Yes No

Incident Response Team: _____

Team Leader: _____

Signature

Date

Source: Reprinted with permission of Karen Smith Keinbaum, Esq., Counsel to the Law Firm of Abbott, Nicholson, Quilter, Esshaki & Youngblood, P. C., Detroit, MI.

Sample 2

The following items serve merely as an example of what might be used or modified by employers in these industries to help prevent workplace violence.

A reportable violent incident should be defined as any threatening remark or overt act of physical violence against a person(s) or property whether reported or observed.

1. **Date:** _____ Day of Week: _____ Time: _____ Assailant: Female Male

2. **Specific Location:** _____

3. **Violence Directed Toward:** Patient Staff Visitor Other

Assailant: Patient Staff Visitor Other

Assailant's Name: _____

Assailant: Unarmed Armed (weapon)

4. Predisposing Factors:

Intoxication Dissatisfied with Care/Waiting Time

Grief Reaction Prior History of Violence

Gang Related Other (Describe) _____

5. **Description of Incident:** Physical Abuse Verbal Abuse Other

6. **Injuries:** Yes No

7. **Extent of Injuries:** _____

8. **Detailed Description of the Incident:** _____

9. Did Any Person Leave the Area because of Incident?

Yes No Unable to Determine

10. Present at Time of Incident:

Police Name of Department: _____

Hospital Security Officer

11. Needed to Call:

Police Name of Department: _____

Hospital Security

12. Termination of Incident:

Incident Diffused Yes No Police Notified Yes No

Assailant Arrested Yes No

13. Disposition of Assailant:

Stayed on Premises Escorted off Premises Left on Own Other

14. **Restraints Used:** Yes No Type: _____

15. **Report Completed By:** _____ Title: _____

Witnesses: _____

Supervisor Notified: _____ Time: _____

Please put additional comments, according to numbered section, on reverse side of form.

Source: Reprinted with permission of the Metropolitan Chicago Healthcare Council, *Guidelines for Dealing with Violence in Health Care*, Chicago, IL, 1995.

Appendix C

Suggested Readings

Alspach, G. (1993). "Nurses as Victims of Violence." *Critical Care Nurse* 13(5):13–17.

Biles, P.D. (1997). "OSHA's Guidelines for Protecting Health Care Workers from Workplace Violence." *Joint Commission on Accreditation of Healthcare Organizations: Environment of Care/PTSM Series* 3:29–35.

Cal/OSHA. (1998). "Guidelines for Security and Safety of Health Care and Community Service Workers."
www.dir.ca.gov/dosh/dosh%5Fpublications/hcworker.html

Carroll, V. and Morin, K.H. (1998). "Workplace Violence Affects One-Third of Nurses." nursingworld.org/tan/98sepoct/violence.htm

Centers for Disease Control and Prevention, National Institute for Occupational Health. (2002). "Occupational Hazards in Hospitals." DHHS (NIOSH) Pub. No. 2002–101. www.cdc.gov/niosh/2002-101.html

Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. (1996). "Violence in the Workplace: Risk Factors and Preventive Strategies." *Current Intelligence Bulletin* 57, DHHS (NIOSH) Pub. No. 96-100.
www.cdc.gov/niosh/violcont.html

Colling, R.L. (1997). "Controlling Workplace Violence: A Security Management Plan Approach." *Joint Commission on Accreditation of Healthcare Organizations: Environment of Care/PTSM Series* 3:37–47.

Colorado Nurses Association, Task Force on Workplace Violence. (1998). "Survey on Workplace Violence of Nurses in Seven State Nurses Associations." Available from Colorado Nurses Association, Denver, CO. www.nurses-co.org

Davis, S. (1991). "Violence in Psychiatric Inpatients: A Review." *Hospital and Community Psychiatry* 42:585–590.

DiBenedetto, D.V. (1992). "Occupational Hazards of the Healthcare Industry: Protecting Healthcare Workers." *AAOHN Journal* 43(3):131–137.

Dillon, S. (1992). "Social Workers: Targets in a Violent Society." *New York Times*: A1; A18, November 1, 1992.

-
- Distasio, C.A. (2002) "Protecting Yourself From Violence in the Workplace." *Nursing* 2002 32(6):58–63. www.nursingcenter.com/library/JournalArticle.asp?Article_ID=273445
- Elliott, P.P. (1997). "Violence in Health Care: What Nurse Managers Need to Know." *Nursing Management* 28 (12):38–41.
- Fazzone, P.A.; Barloon, L.F.; McConnell, S.J.; and Chitty, J.A. (2000). "Personal Safety, Violence and Home Health." *Public Health Nursing* 17(1):43–52.
- Flannery, R.B., Jr. (1995). "Violence in the Workplace." New York: Crossroad Press.
- Flannery, R.B., Jr.; Hanson, M.A.; and Penk, W.E. (1994). "Risk Factors for Psychiatric Inpatient Assaults on Staff." *Journal of Mental Health Administration* 21:24–31.
- Gates, D.M.; Fitzwater, E.; and Meyer, U. (1999). "Violence Against Caregivers in Nursing Homes." *Journal of Gerontological Nursing* 25(4):12–22.
- Gilmore–Hall, A. (2001). "Violence in the Workplace: Are You Prepared?" *American Journal of Nursing* 101(7):55–56.
- Hansen, B. (1996). "Workplace Violence in the Hospital Psychiatric Setting." *AAOHN Journal* 44(12):575–580.
- Hunter, E. (1997). "Violence Prevention in the Home Health Setting." *Home Healthcare Nurse* 15(6):403–409.
- Joint Commission on Accreditation of Healthcare Organizations. (2002). "Comprehensive Accreditation Manual for Hospitals." Oakbrook, IL: JCAHO.
- Kinkle, S.L. (1993). "Violence in the Emergency Department: How to Stop it Before it Starts." *American Journal of Nursing* 93(7):22–24.
- Morgan, L. (1999). "In Harm's Way: Health Care Professionals Face Increasing Abuse in the Workplace." *Nurseweek*, August 2, 1999. www.nurseweek.com/features/99-8/violence.html
- Morrison, E., and Herzog, E. (1992). "What Therapeutic and Protective Measures, As Well As Legal Actions, Can Staff Take When They Are Attacked by Patients?" *Journal of Psychosocial Nursing* 30(7):41–44.
- Morrison, E.F. (1993). "Toward a Better Understanding of Violence in Psychiatric Settings: Debunking the Myths." *Archives of Psychiatric Nursing* (7)6:328–335.
- Nadwairski, J.A. (1992). "Inner-City Safety for Home Care Providers." *Journal of Nursing Administration* 22(9):42–47.

-
- National Security Institute. (1995). "Guidelines for Workplace Violence Prevention Programs for Health Care Workers in Institutional and Community Settings." nsi.org/library/work/violenc1.html
- Ore, T. (2002). "Occupational Assault among Community Care Workers." *Journal of Healthcare Management* 18(1):72–89.
- Rippon, T.J. (2000). "Aggression and Violence in Health Care Professions." *Journal of Advanced Nursing* 31(2):452–460.
- Rusting Publications. (2001). "What Hospital Security Should be Doing Now to Better Prepare for Future Terrorist Activity." *Hospital Security and Safety Management* 22(6):5–10.
- Schulte, J.M., et al. (1998). "Violence and Threats of Violence Experienced by Public Health Workers." *Journal of the American Medical Association* 280(5):439–442.
- Simonowitz, J.A. (1995). "Violence in Health Care: A Strategic Approach." *Nurse Practitioner Forum* 6(2):120–129.
- Simonowitz, J.A.; Rigdon, J.E.; and Mannings, J. (1997). "Workplace Violence: Prevention Efforts by the Occupational Health Nurse." *AAOHN Journal* 45(6):305–316.
- Smith-Pittman, M.H. and McKay, Y.D. (1999). "Workplace Violence in Health Care Environments." *Nursing Forum* 34(3):5–13. www.cinahl.com/cgi-bin/jrlgetarticle?nfor3403
- Snyder, W., III. (1994). "Hospital Downsizing and Increased Frequency of Assaults on Staff." *Hospital and Community Psychiatry* 45:378–379.
- Sygnatur, E.F. and Toscano, G.A. (2000). "Work-Related Homicides: The Facts." *Compensation and Working Conditions* 5(1). www.bls.gov/opub/cwc/2000/spring/art1full.pdf
- University of Iowa, Injury Prevention Research Center. (2001). "Workplace Violence: A Report to the Nation." www.public-health.uiowa.edu/IPRC/NATION.PDF
- Worthington, K. and Franklin, P. (2001). "Workplace Violence: What to Do if You're Assaulted." *American Journal of Nursing* 101(4):73.
- Worthington, K. (2000). "Violence in the Health Care Workplace." *American Journal of Nursing* 100(11):69–70.
- Yassi, A., et al. (1998). "Causes of Staff Abuse in Health Care Facilities: Implications for Prevention." *AAOHN Journal* 46(10):484–491.



**Occupational Safety
and Health Administration**

U.S. Department of Labor

www.osha.gov

One Hour Safety Presentation

The main goal of the Division of Safety & Hygiene is the reduction of accidents and illnesses in the workplace. Toward this goal, the One Hour Safety presentation is designed to support the delivery of a presentation to co-workers in your workplace to help them understand and promote safer and healthier work environments. It is recommended that you take the DSH Training Center course as a background for using One Hour Safety Presentation to train others at your workplace. Call 1-800-OHIOBWC, option 2, 2, 2 for class dates and locations.

The One Hour Safety Presentation contains:

- Transparency Masters from which films can be made to use on an overhead projector,
- Instructor Notes which gives the instructor suggestions and script notations to use during the presentation, and
- Student Handouts which can be copied for those attending the presentation.

Materials are included for a one-hour presentation on each of these topics:

- ✓ Accident Analysis
- ✓ Bloodborne Pathogens
- ✓ Effective Safety Teams
- ✓ Enhancing Safety through a Drug-Free Workplace
- ✓ Ergonomics Basic Principles
- ✓ Ergonomics Developing an Effective Process
- ✓ Hazard Communication
- ✓ Lockout/Tagout and Safety-related Work Practices
- ✓ Machine Guarding Basics
- ✓ Measuring Safety Performance
- ✓ Powered Industrial Trucks Training Program
- ✓ Respiratory Protection
- ✓ Violence in the Workplace

Applications used:

- 1) Text documents (ending in .txt) can be opened with any word processing program.
- 2) Microsoft PowerPoint slides (ending in .ppt) can be opened with the Microsoft PowerPoint program. If you do not have PowerPoint and you do have Windows 95, 98, 2000 or Windows NT operating system, you can view the PowerPoint slides by downloading a free PowerPoint Viewer from the following website:
<http://office.microsoft.com/downloads/default.aspx?Product=PowerPoint&Version=95|97|98|2000|2002&Type=Converter|Viewer>
- 3) Adobe Reader document (ending in .pdf) contains the One Hour Safety Presentation in read-only format. It can be opened when you download Adobe Reader, which is available free of charge at the following website:
<http://www.adobe.com/products/acrobat/readstep2.html>

If you have comments or questions about these materials for One Hour Safety Presentation, please e-mail us: OCOSHTrng@bwc.state.oh.us

Transparency Masters

Safety and Ergonomics **for** *Extended Care Facilities*

BWC

Better Workers' Compensation

Built with you in mind.



Course Objectives

- Responsibility for safety
- Why are Safety and Ergonomics programs necessary and important
- What makes an effective process
- Identifying areas for improvement
- Implementing improvement ideas using the process

Safety for Extended Care Facilities

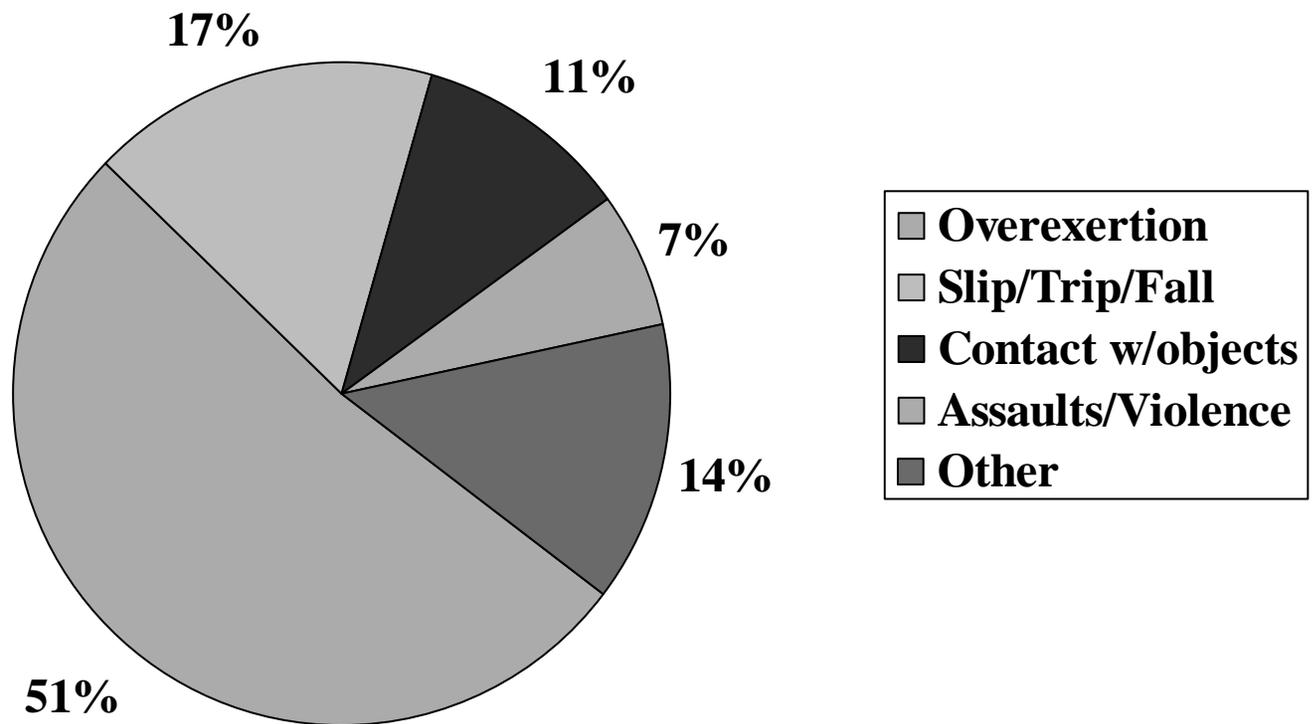


Key Questions

- Who is responsible for safety?
 -
 -
- Who is accountable for safety performance?
 -
 -



Types of Injuries in Extended Care Facilities



Typical Safety Programs from a compliance perspective (i.e. OSHA)

- Bloodborne Pathogens
- Hazard Communication
- Lockout/Tagout
- Personal Protective Equipment
- Emergency Preparedness
- Workplace Violence

Non-Typical Safety Program

Combative Residents

- Growing attention is being focused towards issues surrounding the potential for injuries when dealing with a combative resident
- What was once considered to be “Part of the Job” is now being looked at from an injury management perspective to help decrease injuries and save Workers’ Compensation costs

Who regulates combative residents issues and why?

- 1970 OSH Act - “Each employer shall furnish... a workplace free of recognized hazards...”
- In the US, workplace violence is the leading cause of on-the-job fatalities for females in all occupations
- The highest number of nonfatal assaults occur in health care and social service sectors
- Nursing aides and orderlies are the victims in more than 50% of all workplace assaults
- Nonfatal assaults are primarily perpetrated by combative patients/residents

Combative Residents

=

*Violence in the
Workplace*

Combative Residents Risk Factors

- Working alone with residents
- Staff member unfamiliar with residents
- Resident unfamiliar with staff member
- Medication, diet, rest/sleep cycles
- Inadequate communication systems
- Lack of training on how to recognize and manage hostile behavior
- Inadequate or untimely follow-up on incidents

Combative Residents

What are the issues/challenges at your facility?

Example – Are combative residents identified? If they are, is the information easily available to all staff regarding the nature of the resident and the type of behaviors they exhibit?

Other Challenges

-
-
-
-
-



Combative Residents Question

- What control measures does your facility use to reduce the potential for injuries due to combative residents?

—

—

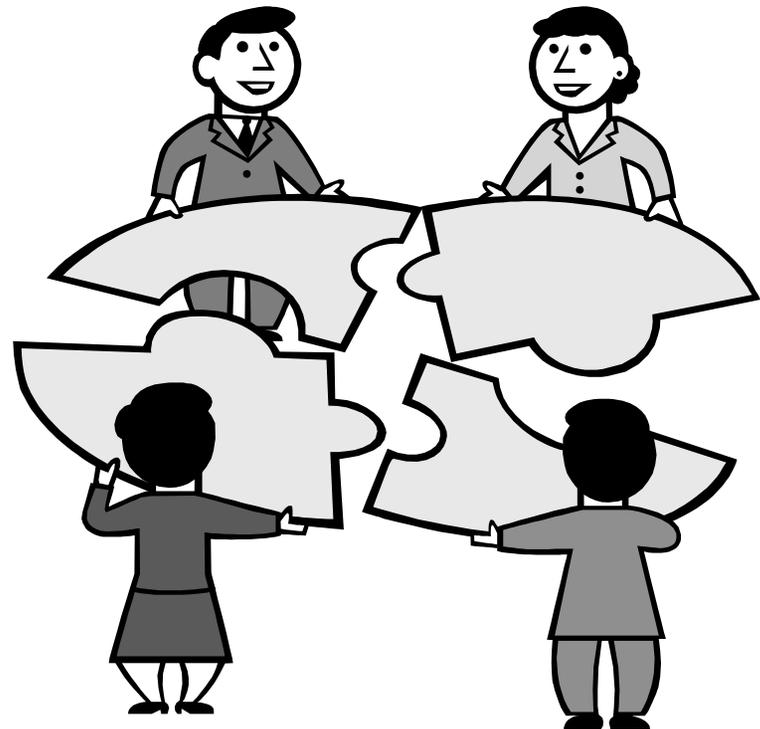
—

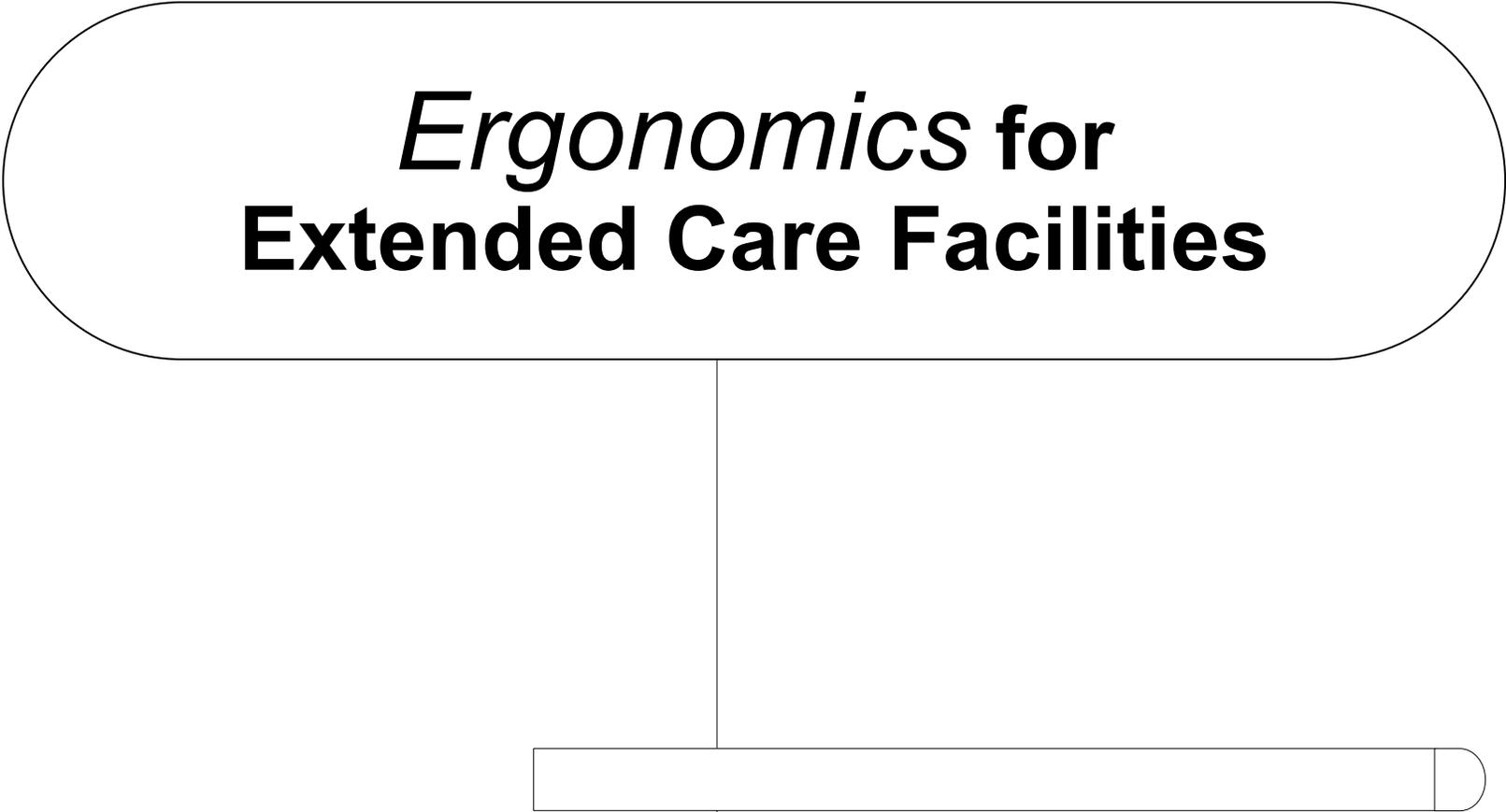
—

—

Elements of an Effective Safety & Ergonomics Process

- ❑ Management Commitment
- ❑ Employee Involvement
- ❑ Accountability
- ❑ Documentation
- ❑ Integration
- ❑ Communication
- ❑ Monitoring/Evaluation
- ❑ Flexibility
- ❑ Continuous Improvement





Ergonomics for
Extended Care Facilities

What is Ergonomics?

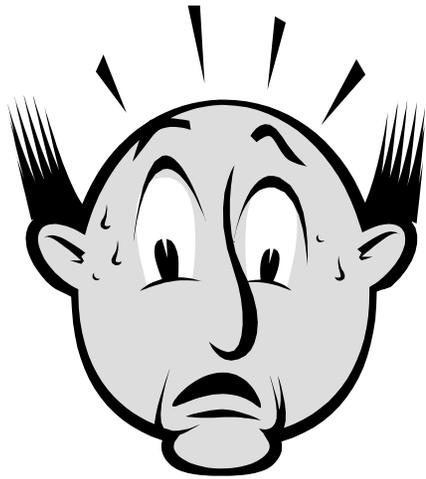
Definition = “The Science of Work”

Goal - Designing a work environment within a worker's capabilities so a job can be done safely and efficiently

Result - Minimizing potential for overexertion and cumulative trauma disorders (CTDs)

*** These conditions are sometimes referred to as Musculoskeletal Disorders (MSDs)

Why is ergonomics important?



- 89% of back injuries in health care facilities are related to patient handling activities
- 10 to 20% of people have to leave nursing due to back pain/injury
- Average turnover rate of STNAs in nursing homes is over 50% annually
- Average cost to recruit, hire, and train an STNA = \$2,000 - \$ 3,000

What factors cause, or contribute to overexertion?

Some Contributing Factors

- Weight to be moved
- Frequency of exertion
- Duration of exertion
- Posture during exertion
- Temperature
- Poor tool design
- Stability of the load
- Type of grip with the load
- Start and ending level of load
- Etc.



“Overexertion” doesn’t just mean being tired or worn out.

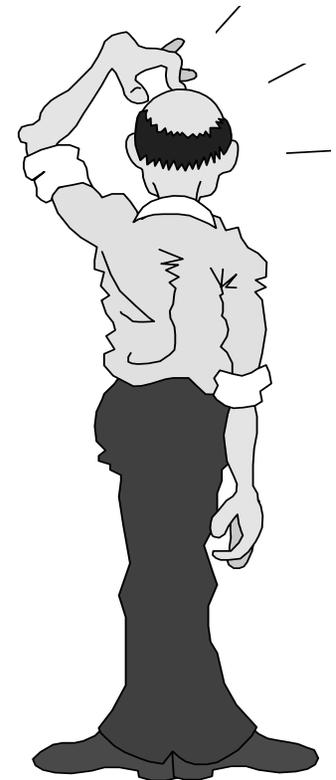
Simply stated - “Overexertion is the body is trying to do more physical work than it’s capacity.”

This can result in an overexertion injury.

What can be done to prevent overexertion?

Control Measures

- Engineering and Work Practice Controls
 - Equipment (i.e. mechanical assistance device)
 - Physical Plant/Facilities
- Administrative Controls
 - Proper Training
 - Comprehensive Policies
 - Adequate and Appropriate Staffing
- Personal Controls
 - Personal Fitness/Health
 - Personal Safety
 - Employee Involvement in Ergo Process



Areas to consider for Safety, Hygiene, or Ergonomic review/intervention

- Facilities Design and Physical Layout
- Purchasing and Storage Area
- Maintenance Department
- Dietary Department
- Housekeeping Department
- Laundry Department
- Nursing Department
 - Patient Handling Equipment
 - Sit-to-Stand Devices
 - Bathing Systems
 - Resident Beds
 - Wheelchairs/Geri-Chairs
 - Lift Transfer Devices
 - Slide Transfer Devices
 - Ambulation Devices



Implementation of Ergonomic Improvements

- Identify an opportunity for improvement
- Develop an implementation team (involve front line staff)
- Put together an action plan with a timetable
- Develop product/process evaluation criteria and forms
- If needed, get staff input in evaluation and selection of equipment
- Develop and document policies for use
- Document training and competency
- Conduct periodic follow-up assessments and make changes as needed

Questions????????????



Instructor Notes

Safety and Ergonomics for *Extended Care Facilities*



Welcome comments - housekeeping details for the class. Sign in, breaks, emergency. We have an opportunity to focus on risk identification, evaluation and control of hazards associated with work in the extended care industry.

Course Objectives

- Responsibility for safety
- Why are Safety and Ergonomics programs necessary and important
- What makes an effective process
- Identifying areas for improvement
- Implementing improvement ideas using the process

Safety for Extended Care Facilities



Welcome comments - housekeeping details for the class. Sign in, breaks, emergency. We have an opportunity to focus on risk identification, evaluation and control of hazards associated with work in the extended care industry.

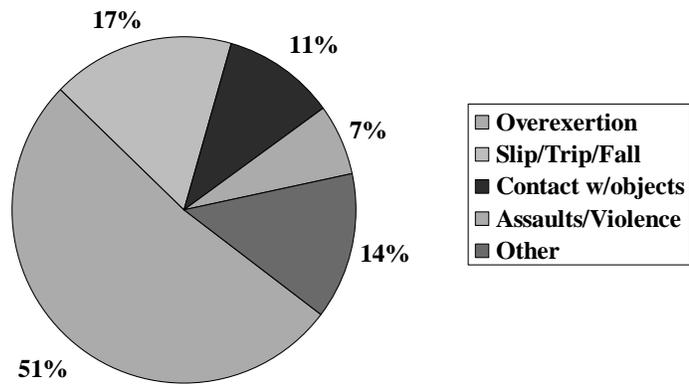
Key Questions

- Who is responsible for safety?
 -
 -
- Who is accountable for safety performance?
 -
 -



Everybody is responsible is a logical answer. But MANAGEMENT is responsible is the correct (legal) answer. Mgt is paying for training, premiums, fines, ,etc. If Mgt is responsible where should accountability start – at the top – not the bottom. Yet many safety approaches favor holding only rank and file responsible.

Types of Injuries in Extended Care Facilities



Define overexertion – muscle strains/sprains due to forceful exertion

Typical Safety Programs from a compliance perspective (i.e. OSHA)

- Bloodborne Pathogens
- Hazard Communication
- Lockout/Tagout
- Personal Protective Equipment
- Emergency Preparedness
- Workplace Violence

Refer to our 10 step program in the premium reduction program / drug free program.

Non-Typical Safety Program

Combative Residents

- Growing attention is being focused towards issues surrounding the potential for injuries when dealing with a combative resident
- What was once considered to be “Part of the Job” is now being looked at from an injury management perspective to help decrease injuries and save Workers’ Compensation costs

Refer to our 10 step program in the premium reduction program / drug free program.

Who regulates combative residents issues and why?

- 1970 OSH Act - “Each employer shall furnish... a workplace free of recognized hazards...”
- In the US, workplace violence is the leading cause of on-the-job fatalities for females in all occupations
- The highest number of nonfatal assaults occur in health care and social service sectors
- Nursing aides and orderlies are the victims in more than 50% of all workplace assaults
- Nonfatal assaults are primarily perpetrated by combative patients/residents

Combative Residents
=
*Violence in the
Workplace*

Combative Residents Risk Factors

- Working alone with residents
- Staff member unfamiliar with residents
- Resident unfamiliar with staff member
- Medication, diet, rest/sleep cycles
- Inadequate communication systems
- Lack of training on how to recognize and manage hostile behavior
- Inadequate or untimely follow-up on incidents

How do you deal with combative residents?

Combative Residents

What are the issues/challenges at your facility?

Example – Are combative residents identified? If they are, is the information easily available to all staff regarding the nature of the resident and the type of behaviors they exhibit?



Other Challenges

-
-
-
-
-

Combative Residents Question

- What control measures does your facility use to reduce the potential for injuries due to combative residents?

-
-
-
-
-

There is no single correct method

Ways to communicate potential for combative behavior?

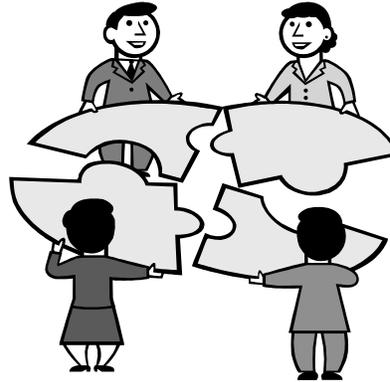
- colored magnets or stickers on door frames

Ways to prevent combative behavior?

- socks on hands
- staff training

Elements of an Effective Safety & Ergonomics Process

- ❑ Management Commitment
- ❑ Employee Involvement
- ❑ Accountability
- ❑ Documentation
- ❑ Integration
- ❑ Communication
- ❑ Monitoring/Evaluation
- ❑ Flexibility
- ❑ Continuous Improvement



Refer to our 10 step program in the premium reduction program / drug free program.



To start the afternoon, let's review the objectives that you identified at the beginning of today's class....

What have we covered?

What still needs to be covered?

Did your objectives change?

What is Ergonomics?

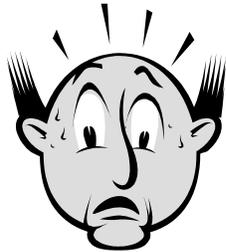
Definition = “The Science of Work”

Goal - Designing a work environment within a worker's capabilities so a job can be done safely and efficiently

Result - Minimizing potential for overexertion and cumulative trauma disorders (CTDs)

*** These conditions are sometimes referred to as Musculoskeletal Disorders (MSDs)

Why is ergonomics important?



- 89% of back injuries in health care facilities are related to patient handling activities
- 10 to 20% of people have to leave nursing due to back pain/injury
- Average turnover rate of STNAs in nursing homes is over 50% annually
- Average cost to recruit, hire, and train an STNA = \$2,000 - \$ 3,000

In 1987, a NIOSH study found that 89% of back injury reports filed by hospital nursing personnel were related to patient handling.

In 1990, a NIOSH study to determine the occupational groups with the highest incidence of compensable back injuries found that NAs, LPNs, and RNs were all in the top 20 groups.

1994 BLS Data indicate that nursing home workers face third highest rate of occupational injuries and illnesses among all U.S. industries with 100,000 or more nonfatal injury or illness cases (221,000 industry inj. / illness cases in 1994 -- behind only meat products processing and motor vehicle / equipment manufacturing.) More than half of nursing home injuries were related to handling patients, and 42% are back injuries.

In 1995, the average direct cost for each lost-time back injury claim in the State of Ohio was approximately \$25,000, with some claims costing in excess of \$100,000 in medical costs and compensation alone.

What factors cause, or contribute to overexertion?

Some Contributing Factors

- Weight to be moved
- Frequency of exertion
- Duration of exertion
- Posture during exertion
- Temperature
- Poor tool design
- Stability of the load
- Type of grip with the load
- Start and ending level of load
- Etc.



“Overexertion” doesn’t just mean being tired or worn out.
Simply stated - “Overexertion is the body is trying to do more physical work than it’s capacity.”
This can result in an overexertion injury.

In addition to the obvious answer – weight – what other factors increase potential for overexertion (e.g. back and shoulder strains)?

It sometimes helps to break down the risk factors into four groups:

Task related

Management related

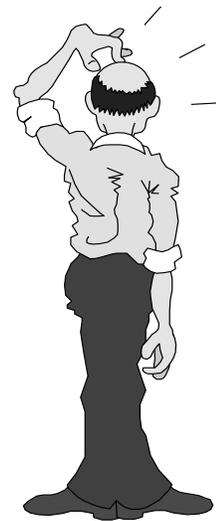
Resident related

Staff related

What can be done to prevent overexertion?

Control Measures

- Engineering and Work Practice Controls
 - Equipment (i.e. mechanical assistance device)
 - Physical Plant/Facilities
- Administrative Controls
 - Proper Training
 - Comprehensive Policies
 - Adequate and Appropriate Staffing
- Personal Controls
 - Personal Fitness/Health
 - Personal Safety
 - Employee Involvement in Ergo Process



No single approach will be effective for reducing injuries

What do we mean by better safety management?

Management = Planning, organizing, coordinating, and monitoring activities to achieve goals – with the goal being SAFETY.

Whose safety? Staff Safety, which in turn will increase resident safety

Areas to consider for Safety, Hygiene, or Ergonomic review/intervention

- Facilities Design and Physical Layout
- Purchasing and Storage Area
- Maintenance Department
- Dietary Department
- Housekeeping Department
- Laundry Department
- Nursing Department
 - Patient Handling Equipment
 - Sit-to-Stand Devices
 - Bathing Systems
 - Resident Beds
 - Wheelchairs/Geri-Chairs
 - Lift Transfer Devices
 - Slide Transfer Devices
 - Ambulation Devices



Implementation of Ergonomic Improvements

- Identify an opportunity for improvement
- Develop an implementation team (involve front line staff)
- Put together an action plan with a timetable
- Develop product/process evaluation criteria and forms
- If needed, get staff input in evaluation and selection of equipment
- Develop and document policies for use
- Document training and competency
- Conduct periodic follow-up assessments and make changes as needed

Questions??????????????



Student Handouts

Safety and Ergonomics for Extended Care Facilities



Course Objectives

- Responsibility for safety
- Why are Safety and Ergonomics programs necessary and important
- What makes an effective process
- Identifying areas for improvement
- Implementing improvement ideas using the process

Safety for Extended Care Facilities

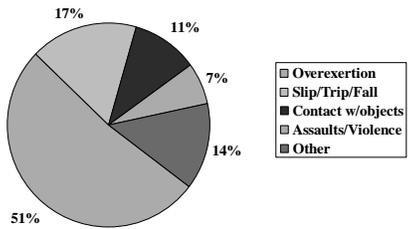


Key Questions

- Who is responsible for safety?
 -
 -
- Who is accountable for safety performance?
 -
 -



Types of Injuries in Extended Care Facilities



Typical Safety Programs from a compliance perspective (i.e. OSHA)

- Bloodborne Pathogens
- Hazard Communication
- Lockout/Tagout
- Personal Protective Equipment
- Emergency Preparedness
- Workplace Violence

Non-Typical Safety Program

Combative Residents

- Growing attention is being focused towards issues surrounding the potential for injuries when dealing with a combative resident
- What was once considered to be “Part of the Job” is now being looked at from an injury management perspective to help decrease injuries and save Workers’ Compensation costs

Who regulates combative residents issues and why?

- 1970 OSH Act - “Each employer shall furnish... a workplace free of recognized hazards...”
- In the US, workplace violence is the leading cause of on-the-job fatalities for females in all occupations
- The highest number of nonfatal assaults occur in health care and social service sectors
- Nursing aides and orderlies are the victims in more than 50% of all workplace assaults
- Nonfatal assaults are primarily perpetrated by combative patients/residents

Combative Residents
=
Violence in the Workplace

Combative Residents Risk Factors

- Working alone with residents
- Staff member unfamiliar with residents
- Resident unfamiliar with staff member
- Medication, diet, rest/sleep cycles
- Inadequate communication systems
- Lack of training on how to recognize and manage hostile behavior
- Inadequate or untimely follow-up on incidents

Combative Residents What are the issues/challenges at your facility?

Example – Are combative residents identified? If they are, is the information easily available to all staff regarding the nature of the resident and the type of behaviors they exhibit?



Other Challenges

-
-
-
-

Combative Residents Question

- What control measures does your facility use to reduce the potential for injuries due to combative residents?

-
-
-
-

Elements of an Effective Safety & Ergonomics Process

- Management Commitment
- Employee Involvement
- Accountability
- Documentation
- Integration
- Communication
- Monitoring/Evaluation
- Flexibility
- Continuous Improvement



Ergonomics for Extended Care Facilities



What is Ergonomics?

Definition = "The Science of Work"

Goal - Designing a work environment within a worker's capabilities so a job can be done safely and efficiently

Result - Minimizing potential for overexertion and cumulative trauma disorders (CTDs)

*** These conditions are sometimes referred to as Musculoskeletal Disorders (MSDs)

Why is ergonomics important?



- 89% of back injuries in health care facilities are related to patient handling activities
- 10 to 20% of people have to leave nursing due to back pain/injury
- Average turnover rate of STNAs in nursing homes is over 50% annually
- Average cost to recruit, hire, and train an STNA = \$2,000 - \$ 3,000

What factors cause, or contribute to overexertion?

Some Contributing Factors

- Weight to be moved
- Frequency of exertion
- Duration of exertion
- Posture during exertion
- Temperature
- Poor tool design
- Stability of the load
- Type of grip with the load
- Start and ending level of load
- Etc.



“Overexertion” doesn’t just mean being tired or worn out.

Simply stated - “Overexertion is the body is trying to do more physical work than it’s capacity.”

This can result in an overexertion injury.

What can be done to prevent overexertion?

Control Measures

- Engineering and Work Practice Controls
 - Equipment (i.e. mechanical assistance device)
 - Physical Plant/Facilities
- Administrative Controls
 - Proper Training
 - Comprehensive Policies
 - Adequate and Appropriate Staffing
- Personal Controls
 - Personal Fitness/Health
 - Personal Safety
 - Employee Involvement in Ergo Process



Areas to consider for Safety, Hygiene, or Ergonomic review/intervention

- Facilities Design and Physical Layout
- Purchasing and Storage Area
- Maintenance Department
- Dietary Department
- Housekeeping Department
- Laundry Department
- Nursing Department
 - Patient Handling Equipment
 - Sit-to-Stand Devices
 - Bathing Systems
 - Resident Beds
 - Wheelchairs/Geri-Chairs
 - Lift Transfer Devices
 - Slide Transfer Devices
 - Ambulation Devices



Implementation of Ergonomic Improvements

- Identify an opportunity for improvement
- Develop an implementation team (involve front line staff)
- Put together an action plan with a timetable
- Develop product/process evaluation criteria and forms
- If needed, get staff input in evaluation and selection of equipment
- Develop and document policies for use
- Document training and competency
- Conduct periodic follow-up assessments and make changes as needed

Questions????????????????